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ARTICLES

FACE TO FACE: A CALL FOR RADICAL RESPONSIBILITY IN PLACE OF COMPASSION

LOIS SHEPHERD[†]

*"We all are responsible for everything and everyone in the face of
everybody, and I more than the others."*¹

INTRODUCTION

The problem with compassion is not that it is too emotional or irrational, not that it is unprincipled or counter to the rule of law, not that it is too intrusive or interfering. Although these have been the traditional arguments against any significant role for compassion in law and social policy, they have been soundly countered by recent scholars and jurists. Compassionate responses, we have learned, can be rational, principled, and respectful of autonomy. When we feel compassion it is for good reasons; our emotional response to someone else's suffering can prompt us to sort through those reasons, to discover the conditions that cause that suffering, and to improve our judgment.

This is good, but compassion is not enough. It allows us to peek outside the window of our enclosed tower, to imagine what might be experienced by those below, and to do nothing.

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¹ This sentence from Dostoyevsky is a favorite of Emmanuel Levinas, who was heavily influenced by Dostoyevsky's works. See ADRIAAN PEPPERZAK, *TO THE OTHER: AN INTRODUCTION TO THE PHILOSOPHY OF EMMANUEL LEVINAS* 171 (1993). In the 1976 Norton Critical Edition of *The Brothers Karamazov*, this sentiment is not expressed exactly as quoted but is found generally in *Notes of the Life in God of the Elder Zosima*. See FYODOR DOSTOEVSKY, *THE BROTHERS KARAMAZOV* 268, 299 (Ralph E. Matlaw ed., Constance Garnett translation revised by Ralph E. Matlaw 1976); see also EMMANUEL LEVINAS, *ETHICS AND INFINITY* 98 & 101 (Richard A. Cohen trans., 1985) (conversations with Philippe Nemo in which Emmanuel Levinas quotes Dostoyevsky for this point, in two different versions).

Consider Joshua DeShaney.² State workers had reliable reports that the four-year-old boy was subject to repeated physical abuse by his father, but they did nothing to protect him. Joshua eventually suffered so great a beating that he fell into a coma; when he emerged from the coma, he was permanently and profoundly retarded.³ When the Supreme Court heard his claim that the state protective agency should have acted to protect him, it expressed compassion. "The facts of this case are undeniably tragic,"⁴ we are told. "Judges and lawyers, like other humans, are moved by natural sympathy in a case like this"⁵

But the Court refused to consider whether and how the Wisconsin state agency should have acted under the circumstances given what it knew, whether it exercised poor judgment, or whether it exhibited indifference to the welfare of the child.⁶ Such an inquiry was deemed unnecessary because, although the justices may have felt compassion, they would not "yield[] to that impulse"⁷ in any way that imposed any obligation on any state governmental agency or employee to actually help the child. Chief Justice Rehnquist cautioned us "to remember

² DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189 (1989).

³ *Id.* at 191-93.

⁴ *Id.* at 191.

⁵ *Id.* at 202-03.

⁶ *Id.* at 201-02.

⁷ *Id.* at 202-03. Jurists are often so admonished not to let their judgments be clouded by compassion. For example, in defending its ban against physician-assisted suicide in the Supreme Court case of *Washington v. Glucksberg*, 521 U.S. 702 (1997), the State of Washington urged the Court not to be swayed by its compassion for the patient-plaintiffs. Brief for the Petitioners at 16, *Glucksberg* (No. 96-110). While it acknowledged that the plaintiffs' stories were compelling ("These accounts cannot be read without evoking at least two strong emotional reactions—sympathy for those afflicted, and apprehensiveness that some day a similar fate may befall the reader or a loved one." *Id.*), the state insisted that the Court's jurisprudence "has not been and should not be determined on the basis of anecdotes, no matter what points they make or how compellingly they make them" and that the Court should focus "in a principled manner" on the needs of the society as a whole, building upon its prior jurisprudence. *Id.* at 18; *see also* Compassion in Dying v. Washington, 49 F.3d 586, 588, 590, 594 (9th Cir. 1995) ("Compassion is a proper, desirable, even necessary component of judicial character; but compassion is not the most important, certainly not the sole law of human existence. Unrestrained by other virtues, . . . it leads to catastrophe. Justice, prudence, and fortitude are necessary too. Compassion cannot be the compass of a federal judge. That compass is the Constitution of the United States."), *rev'd en banc* 79 F.3d 790 (1996), *rev'd sub nom.* Washington v. Glucksberg, 521 U.S. 702 (1997) (denying existence of constitutional right to physician-assisted suicide for terminally ill).

once again that the harm was inflicted not by the State of Wisconsin, but by Joshua's father."⁸ The Constitution does not give people rights to receive anything from the state but only gives them rights to avoid state interference in their lives.⁹ No matter that what the child needed was state interference or intrusion into his life, not freedom from such interference. He was not entitled to help, and there was really little need to discuss it further.¹⁰ In a culture and jurisprudence that celebrates the people's right to hands off government, hands off includes a helping hand.

Compassion, as commonly thought of, motivates or prompts but does not actually require action. Moreover, it often allows us to stay within our own walls and simply peer out, making it presumptuous and self-referential. For these and other reasons, drawing on the radical ethical writings of the late twentieth-century philosopher Emmanuel Levinas,¹¹ I propose in this

⁸ *DeShaney*, 489 U.S. at 203.

⁹ The majority opinion of Chief Justice Rehnquist reads:

The [Due Process] Clause is phrased as a limitation on the State's power to act, not as a guarantee of certain minimal levels of safety and security. It forbids the State itself to deprive individuals of life, liberty, or property without 'due process of law,' but its language cannot fairly be extended to impose an affirmative obligation on the State to ensure that those interests do not come to harm through other means.

Id. at 195.

¹⁰ As Justice Brennan's dissent points out:

Presumably, then, [under the majority's analysis] if respondents decided not to help Joshua because his name began with a 'J,' or because he was born in the spring, or because they did not care enough about him even to formulate an intent to discriminate against him based on an arbitrary reason, respondents would not be liable to the DeShaneys because they were not the ones who dealt the blows that destroyed Joshua's life.

Id. at 210 (Brennan, J., dissenting, joined by Marshall, & Blackmun, JJ.) Justice Brennan's primary disagreement with the majority was that it characterized the issue as one simply of whether a person has a right to basic governmental services rather than recognizing that in this case the state may have undertaken a vital duty to provide protection and then ignored it. *See id.* at 203–05, 212 (Brennan, J., dissenting).

¹¹ Levinas scholar Adriaan Peperzak explains that "[s]ince 1961 the work of Emmanuel Levinas has slowly acquired a pivotal position in the world of philosophy." PEPERZAK, *supra* note 1, at ix. Others have called him "one of the most profound, exacting, and original philosophers of twentieth-century Europe" and "[o]ne of the most significant ethical thinkers of the twentieth century." A.T. Nuyen, *Levinas and the Ethics of Pity*, 40 INT'L PHIL. Q. 411 (2000) (citing SEÁN HAND, *THE LÉVINAS READER V* (1989); *THE CONTINENTAL PHILOSOPHY READER 122* (Richard Kearney & Mara Rainwater eds., 1996)). Emmanuel Levinas was born to Jewish parents in 1906 in Lithuania, where he was steeped in Jewish orthodoxy but also

Article to interrupt any complacent acceptance of the idea that compassion, as we commonly understand and apply it, is an adequate ethical response to someone who is suffering.

I take as a given that there is a place for caring, humane, sympathetic, and empathetic responses towards people whose lives are implicated in the decisions of our courts, our laws, and our actions. Indeed, as scholars Robin West,¹² Martha Nussbaum,¹³ and Lynne Henderson¹⁴ have written, and Justice

early confronted with Russian Christianity and the work of Russian authors. He emigrated to France in 1923 and became a French citizen in 1930. Levinas was captured during the Nazi occupation of France and sent to a prisoners' camp where he was required to do forced labor. His parents and brothers were murdered by Nazi collaborators in Eastern Europe. PEPERZAK, *supra* note 1, at 2–4. This experience and the times in which he lived may provide some understanding of his concerns about totalitarianism. See *infra* notes 110–120 and accompanying text. The corpus of his work is split between theological and philosophical writings. He was an early student of the German philosopher Heidegger but ultimately became one of his greatest critics. See PEPERZAK, *supra* note 1, at 3–4. While his earliest philosophical writings critique Heidegger's approach, Levinas soon began developing his own account of metaphysical ethics, as embodied in his two most influential works, *Totality and Infinity* and *Otherwise than Being*. See *id.* at 5–7.

¹² In her book *Caring for Justice*, West argues for a vision of justice that includes an essential component of care. Justice without care, she writes, is not only not caring, it is not justice. ROBIN WEST, *CARING FOR JUSTICE* 24 (1997). If, West writes, “the act of caring for others to whom we are connected in some way is central to our moral lives, then our capacity for care should be at the center of our understanding of our public and legal, as well as private and personal, virtues, and specifically . . . should be central to the meaning of legal justice.” *Id.* at 9. Thus, justice cannot be done without attention to and concern for the needs of the people whose rights and responsibilities are being adjudicated.

¹³ Martha Nussbaum tells us that “compassion, in the philosophical tradition, is a central bridge between the individual and the community.” Martha C. Nussbaum, *Compassion: The Basic Social Emotion*, 13 *SOC. PHIL. & POL'Y.* 27, 28 (1996) [hereinafter *Compassion*] and that as such, we should “understand better how to produce it and how to remove obstacles to it.” *Id.* She advocates a civic, public education in compassion, largely through the study of the humanities and the arts, as a way to train individuals to imagine the pain and experiences of others and to “cross boundaries of class, nationality, race, and gender.” *Id.* at 50–51. According to Nussbaum, we should seek political leaders who display compassion, who are capable of imagining the pain of others. See *id.* at 51. On a broader scope, we should judge economic conditions not by GNP per capita, but by quality-of-life measurements, and we should structure our public institutions in ways informed by compassion, creating “institutions that place people in similar circumstances, weakening or removing hierarchies of wealth, gender, and class.” See *id.* at 52–53, 57. See generally MARTHA NUSSBAUM, *POETIC JUSTICE* (1995).

¹⁴ Lynne N. Henderson, *Legality and Empathy*, 85 *MICH. L. REV.* 1574, 1576 (1987) (rejecting the assumption that legality and empathy “are mutually exclusive concepts”); see also SUSAN M. BEHUNIAK, *A CARING JURISPRUDENCE* 122–28 (1999) (arguing that to integrate caring and justice in the decision-making of the Supreme Court requires the Court to listen to the knowledge of those affected by the decisions

Blackmun has urged his fellow justices to recognize,¹⁵ I agree that caring responses should play a greater role in our law and policy decisions, and we should better recognize and legitimize its current role. The impulse is correct; cold interpretations of the law are not just.¹⁶ I am concerned, however, about what such caring responses should comprise. Compassion is problematic in a number of ways and requires careful unpacking. We generally think of compassion as an emotional response to another's suffering that we come to by way of imagining ourselves to be in that person's shoes. Compassion respects the equality of all people, as opposed to pity, which is thought to

and to appreciate the nature of injuries that litigants claim, rather than simply the legitimacy of their rights); Judith S. Kaye, *The Human Dimension in Appellate Judging: A Brief Reflection on a Timeless Concern*, 73 CORNELL L. REV. 1004 (1988); Laurence H. Tribe, *Remarks: Revisiting the Rule of Law*, 64 N.Y.U. L. REV. 726, 729-30 (1989) (criticizing the Supreme Court's decision in *DeShaney* and stating, "There need be no ultimate conflict between the Rule of Law and the Rule of Love . . . [T]o say that our idea of 'law' is to be constructed with straightedge and compass, without sympathy and compassion, is *dead wrong*").

¹⁵ Justice Blackmun, in dissent in *DeShaney*, criticizes what he sees as the majority's incapacity to incorporate its compassion into a broader reading of the precedent cases: "Faced with the choice [between a broad or narrow reading of the precedents], I would adopt a 'sympathetic' reading, one which comports with dictates of fundamental justice and recognizes that compassion need not be exiled from the province of judging." 489 U.S. at 213 (Blackmun, J., dissenting). For a discussion about the proper role of compassion in the *DeShaney* controversy as represented by Blackmun's dissent, see Benjamin Zipursky, Note, *DeShaney and the Jurisprudence of Compassion*, 65 N.Y.U. L. REV. 1101 (1990). Justice Blackmun urged his fellow justices toward compassion and sympathy in other contexts as well. The author of the original abortion decision in *Roe v. Wade*, and one of the staunchest supporters of the abortion right, Justice Blackmun repeatedly described the harms of unwanted motherhood in his opinions. See *Planned Parenthood v. Casey*, 505 U.S. 833, 928 (1992) (Blackmun, J., concurring in part and dissenting in part) ("By restricting the right to terminate pregnancies, the State conscripts women's bodies into its service, forcing women to continue their pregnancies, suffer the pains of childbirth, and in most instances, provide years of maternal care."); *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 558 (1989) (Blackmun, J., dissenting) ("Of the aspirations and settled understandings of American women, of the inevitable and brutal consequences of what it is doing, the tough-approach plurality utters not a word. This silence is callous."); *Roe v. Wade*, 410 U.S. 113, 153 (1973) ("The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent."). See generally Stephen Breyer, *In Memoriam: Justice Harry A. Blackmun: Principle and Compassion*, 99 COLUM. L. REV. 1393, 1396 (1999) (writing that Blackmun's vision as a justice grew out of compassion).

¹⁶ See generally *DeShaney*, 489 U.S. at 212 (Blackmun, J., dissenting) (arguing that the Court's failure to be moved by compassion prevents it from understanding either the facts or legal norms of the case); WEST, *supra* note 12.

invoke claims of superiority. Compassion motivates us to want to help the object of our compassion. Again, this all sounds good. Understanding or attempting to understand the concrete experiences of particular individuals, by imagining oneself to be in their situation, can improve the accuracy of evaluative judgments needed to sort out the equities involved in a particular situation.¹⁷

At the same time, I have long been concerned about the idea that we can imagine what someone else suffers. Many troubling actions have been taken in the name or under the guise of compassion for others. Some of these past actions seem quite obvious now as not having been based truly on fellow feeling and have received universal condemnation—the extermination of children with mental disabilities by doctors in Nazi Germany is one such example.¹⁸ Some currently accepted practices bear the marks of similar, compassionate rhetoric and some of the same ethically troubling consequences. I am thinking here of prenatal genetic screening practices that aim to reduce the incidence of mental retardation, for example, by avoiding the births of certain children, or the effect that compassion may have on the elderly or people with disabilities, when offered by healthy middle-aged people who may cringe with horror at imagining themselves elderly, infirm, incontinent, or dependent on others. To the extent some of the current right-to-die advocacy depends upon expressions of compassion rather than simply respect for autonomy, it carries troubling elements of presumptiveness and projection.

¹⁷ See generally *Compassion*, *supra* note 13.

¹⁸ See Robert N. Proctor, *Nazi Doctors, Racial Medicine, and Human Experimentation*, in *THE NAZI DOCTORS AND THE NUREMBERG CODE* 23–25 (George J. Annas & Michael A. Grodin eds., 1992) (explaining the popularity within and outside the medical community for euthanizing those with mental disabilities or other qualities that made their “lives not worth living,” including children). Proctor writes, “Parents were made to feel shame and embarrassment at having to raise an abnormal or malformed child. Hospital archives are full of letters from parents requesting their children be granted euthanasia.” *Id.* at 25; see also Paul A. Lombardo, *Taking Eugenics Seriously: Three Generations of ??? are Enough?*, 30 *FLA. ST. U. L. REV.* 191 (2003) (drawing parallels between the motives and methods of past eugenic practices and the current pursuit of genetic advances); Paul K. Longmore, *Elizabeth Bouvia, Assisted Suicide and Social Prejudice*, 3 *ISSUES L. & MED.* 141, 147 (1987) (stating that many of the Nazi doctors “were well-intentioned, even compassionate men, who were convinced that both society and people with disabilities themselves would be better off if they were relieved of their burdensome lives”).

I have also been concerned about the seemingly noncommittal aspect of compassion, both the voluntary nature of the feeling—decision makers can't be required to feel compassion—and the voluntary nature of taking action. Forgetting for the moment about policymakers or judges, my grappling with this aspect of compassion has also had a personal component. Like many people, I suspect there have been many times when I have felt compassion but have quickly turned my attention away, and done nothing. It felt wrong and it still does.

Emmanuel Levinas did think something was wrong. His work centered on the responsibility that one human being has for another, and in my view, the ethical response he identifies requires much more than compassion. Some authors have suggested that Levinas's writings might be aligned with the approach of an "ethic of care"¹⁹ or with a greater role for

¹⁹ By "ethic of care," I refer to the work of relational feminists originating in Carol Gilligan's empirical work about the differences in moral reasoning between girls and boys, women and men. See generally CAROL GILLIGAN, *IN A DIFFERENT VOICE* (1982). Generally, the ethic of care is understood to claim that "the act of caring for others to whom we are connected in some way is central to our moral lives," and should inform our moral reasoning. WEST, *supra* note 12, at 9. With respect to the similarities between Levinas' work and the ethic of care, see, e.g., Myra Bookman & Mitchell Aboulafia, *Ethics of Care Revisited: Gilligan and Levinas*, 44 PHIL. TODAY 169, 171 (2000), which argues that while Levinas writes in a phenomenological and philosophical tradition and Gilligan in the social sciences tradition, both reject autonomy as the beginning point for understanding ethics. "Both, for example, isolate the problem of egoism, whereby reducing the other to the same results in a moral ideal of 'symmetry' and 'reciprocity.'" *Id.* Bookman and Aboulafia point out important similarities between the work of Levinas and Gilligan, but as often conceived, the ethic of care refers to the requirement of care toward intimates (families and friends) and the "proximate stranger" and does not describe the obligations owed to those outside that "scope of . . . care." See Hilde L. Nelson, *Against Caring*, 3 J. CLINICAL ETHICS 8, 8, 11 (1992) (arguing that because the ethics of care is limited in this way, it cannot provide answers to questions of social justice). *But see* Nel Noddings, *In Defense of Caring*, 3 J. CLINICAL ETHICS 15, 17 (1992) (agreeing that much work is to be done, but that an ethics of caring can address social problems).

Parenthetically, both Nelson and Noddings discuss a hypothetical in which a nurse is dismayed that she has been placed in a position of providing amniocentesis counseling services to a couple who plan to abort if they discover that the woman is pregnant with a girl rather than a boy. While the focus of Nelson and Noddings' disagreement is on how the ethic of care might apply in this nursing situation in a way that values the nurse's abhorrence of such devaluation of females, neither challenges in any way one of the assumptions within the hypothetical itself: that amniocentesis to avoid Down syndrome is perfectly acceptable. That assumption, I submit, is troubling under the orientation that Levinas' work provides. See *infra* text accompanying notes 67–69, 98–108 for a discussion of such prenatal testing and selection practices.

compassion in issues of public policy or adjudication.²⁰ Although I believe that is true as a general matter, I think it is much more useful and interesting to consider the ways the radical philosophy of Levinas challenges rather than supports our current ideas of what an ethical response based on care would require. Compassion is not enough; compassion also sometimes misses the mark.

At heart, Levinas's ethics laud hospitality or welcome of the other person, of each other person, which is a dimension not incompatible with compassion but not in required tandem of it either.²¹ In addition, while compassion permits its object to remain, in some ways, just that, an object—something that is understood by the observer through self knowledge—an ethical response prompted by Levinas's writings would require recognition and appreciation of the unique "otherness" or "alterity" of the other person.²² Furthermore, the observer would not be permitted, as compassion allows, to superimpose her own view of the world and what it is and means to suffer on the one who is suffering but would instead be changed—ruptured—by the encounter with the other person, to be in relation with him in a way that she is no longer merely an observer.²³ Levinas's ethics call for responsibility as well, responsibility to the other person for her suffering and needs, and in this way is radically different from compassion, which may motivate good and caring deeds, but not obligate oneself to them. Compassion is an ethical response premised on equality, yet the obligation Levinas describes is one of unequal personal responsibility, as Levinas's favored quote from Dostoyevsky, quoted earlier, makes clear.

In Part I of this Article, I set out the current understanding of compassion as an ethical response to another person who suffers. I will discuss the shortcomings that flow from compassion's emphasis on imaginative dwelling of the other person's condition, on its assumed basis in equality, and on its lack of any corresponding duties. In Part II, I suggest an alternative to compassion in the form of an ethics of radical responsibility, drawing on Levinas's work on welcome, alterity,

²⁰ See, e.g., Nuyen, *supra* note 11, at 416–17 (stating that the motivation to follow Levinas' ethics can be found in the feeling of pity).

²¹ See *infra* text accompanying notes 94–116.

²² See *infra* text accompanying notes 110–26.

²³ See *infra* text accompanying notes 127–34.

rupture, and responsibility. Finally, in Part III, I contrast the approaches of two legal cases in which patients received approval for the withdrawal of life-sustaining treatment. Despite the similarity of results, the opinions in those cases differ widely in their orientation toward the patient: one revealing the inadequacies of an approach based on what might be understood as compassion; the other adopting an approach more consonant with an ethics of radical responsibility.

I. COMPASSION

*"It's considered an absolute necessity these days for writers to have compassion. Compassion is a word that sounds good in anybody's mouth and which no book jacket can do without. It is a quality which no one can put his finger on in any exact critical sense, so it is always safe for anybody to use."*²⁴

A. What is Compassion?

Compassion literally means, "to suffer together with."²⁵ Its use suggests that the object of compassion is suffering and not merely some inconvenience but a deeper injury, whether it is physical or mental pain, deprivation, or loss. According to Lawrence Blum, "The negative condition must be relatively central to a person's life and well-being, describable as pain, misery, hardship, suffering, affliction, and the like."²⁶ The suffering must be "serious rather than trivial"²⁷ according to Martha Nussbaum, to have some size, as Aristotle explained.²⁸ Because the size or depth of the suffering is evaluated from the perspective of the observer or the one who feels compassion, it requires judgment.²⁹ Compassion is not emotion without reason.³⁰ We are not likely to feel compassion for the person who

²⁴ FLANNERY O'CONNOR, *COLLECTED WORKS* 817 (1998).

²⁵ OXFORD ENGLISH DICTIONARY 597 (2d ed. 1989). For a discussion of this definition, its obsolescence but then recent revival by compassionate conservatism, see Kathleen Woodward, *Calculating Compassion*, 77 *IND. L.J.* 223, 231–32, 242–43 (2002).

²⁶ Lawrence Blum, *Compassion*, in *THE VIRTUES: CONTEMPORARY ESSAYS ON MORAL CHARACTER* 230 (Robert B. Kruschwitz & Robert C. Roberts eds., 1987).

²⁷ *Compassion*, *supra* note 13, at 31.

²⁸ *Id.* (referring to ARISTOTLE'S RHETORIC, 1386a6–7).

²⁹ *Id.* at 31–33.

³⁰ *Id.* at 28. That compassion has both an affective and cognitive component has been recognized by a number of scholars. See, e.g., Henderson, *supra* note 14, at 1575–76. The compatibility or "interpenetration" of emotion and reason is readily

has experienced some trivial loss, such as of a paper clip, or even a serious loss if it is easily replaceable, even if that person believes he suffers deeply. At the same time, we may feel compassion for someone who has been deprived of an element of human flourishing, such as education, even if he is unaware of it.³¹ This judgment, the judgment of the observer as to the existence and degree of suffering of the other person, is accomplished through imagining the experiences of the other person—how would I feel, the observer asks, if that happened to me?³²

Tying these elements of emotion and judgment together, Blum defines compassion in the following manner: “[N]ot a simple feeling-state but a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, an active regard for his good, a view of him as a fellow human being, and emotional responses of a certain degree of intensity.”³³

Imaginative dwelling on the condition suffered by the other person is a central component of compassion. We put ourselves in the shoes of the person who is suffering and imagine what it would be like to experience the same condition. This requires an appreciation of the ways in which people are alike, the ways in which they have an equal capacity to suffer and feel pain. “[T]he other person’s suffering (though not necessarily their particular afflicting condition) is seen as the kind of thing that could happen to anyone, including oneself insofar as one is a human being.”³⁴ Compassion may also involve an element of fear, as the observer not only imagines what it may be like to be in the

taken as a given by a significant body of recent scholarship, enabling the authors to address interesting questions about the role of emotions in law other than the longstanding question of the dichotomy between reason and the passions. See Kathryn Abrams, *The Progress of Passion*, 100 MICH. L. REV. 1602, 1602 (2002) (reviewing THE PASSIONS OF LAW (Susan A. Bandes ed., 1999)).

³¹ *Compassion*, *supra* note 13, at 31–32.

³² Blum, *supra* note 26, at 230–31.

³³ *Id.* at 231. Nussbaum tells us that compassion (though in this context, she uses the term “pity” because she draws on Aristotle’s work on pity) requires three beliefs: “(1) the belief that the suffering is serious rather than trivial; (2) the belief that the suffering was not caused primarily by the person’s own culpable actions; and (3) the belief that the pitier’s own possibilities are similar to those of the sufferer.” *Compassion*, *supra* note 13, at 31.

³⁴ Blum, *supra* note 26, at 232.

position of the person suffering but fears that she too may some day suffer in the same manner.³⁵

Appreciating the fact that a compassionate response follows a recognition of the shared capacity to suffer and feel pain, animal rights activists have long sought to elicit a compassionate response from humans for animals by emphasizing that animals feel pain just like people do. Peter Singer, for example, in his well-known book *Animal Liberation* shows photographs of animals who grimace and writhe with human-like expression when subjected to a stimulus that would be painful to humans.³⁶ Along the same idea, someone who seeks to encourage others to join in the poor treatment of a targeted individual or group will do the opposite, portraying that individual or group as very different from an accepted norm, often as other or less than human. Much has been written about this phenomenon, for example, in the history of the treatment of Jews by the Nazis and the treatment of American blacks by Southern white racists.³⁷

Some believe that the compassionate person suffers equally with the object of compassion, as the word "compassion" literally suggests. For example, Hannah Arendt writes that if you truly feel compassion, you are in the shoes of another; you are equally pained.³⁸ For most people, however, the imagined suffering of another onto oneself does not mean that the compassionate person truly suffers equally with the object of compassion. We may transitorily or vicariously suffer like the other, but it is not the actual suffering experienced by the person who is the object of compassion.³⁹

Because compassion embodies notions of shared human suffering, it is generally viewed as a moral response superior to pity:

³⁵ *Compassion*, *supra* note 13, at 36.

³⁶ PETER SINGER, *ANIMAL LIBERATION* 8 (2d ed. 1990) ("If a being suffers there can be no moral justification for refusing to take that suffering into consideration. No matter what the nature of the being, the principle of equality requires that its suffering be counted equally with the like suffering . . . of any other being.").

³⁷ See, e.g., JESSIE DANIELS, *WHITE LIES* (1997).

³⁸ ELIZABETH V. SPELMAN, *FRUITS OF SORROW: FRAMING OUR ATTENTION TO SUFFERING* 62–68 (1997).

³⁹ See Blum, *supra* note 26, at 231 (insisting on importance of maintaining distinction between subject and object of compassion); *Compassion*, *supra* note 13, at 35 ("If one really had the experience of feeling pain in one's own body, then one would precisely have failed to comprehend the pain of another *as other*.").

This way of viewing the other person contrasts with the attitude characteristic of pity, in which one holds oneself apart from the afflicted person and from their suffering thinking of it as something that defines that person as fundamentally different from oneself. In this way the other person's condition is taken as given whereas in compassion the person's affliction is seen as deviating from the general conditions of human flourishing. That is why pity (unlike compassion) involves a kind of condescension, and why compassion is morally superior to pity.⁴⁰

Pity, then, is a response inferior to compassion because it may allow the subject to view the object of pity with condescension. Rather than acknowledging the shared humanity of the subject and the object, pity appears to allow the subject to feel superior to the object. The condition of the sufferer is the focus of the compassionate person's concern;⁴¹ by focusing on the condition as unfortunate, rather than the person as unfortunate, compassion remains true to the equal valuation of all persons. Lawrence Blum writes:

Because compassion involves a sense of shared humanity, it promotes the *experience* of equality, even when accompanied by an acknowledgment of actual social inequality. Compassion forbids regarding social inequality as establishing human inequality. This is part of the moral force of compassion: by transcending the recognition of social inequality, it promotes the sensed experience of equality in common humanity.⁴²

Thus, whereas pity permits distance from and condescension toward the person who is the object of pity, compassion is thought to bring the subject and object of compassion together in their shared human vulnerability.

To sum up, compassion appears to be understood generally as a complex emotional response regarding the suffering of another person, a response that has the following characteristics: It generally involves imaginative dwelling on the other person's suffering—wondering what it would be like to be in that condition—it avoids an assumption of superiority by appreciating the shared humanity of all persons by the subject recognizing that the condition experienced by the sufferer could

⁴⁰ Blum, *supra* note 26, at 232–33.

⁴¹ *Id.*

⁴² *Id.* at 233.

also be experienced by the subject—"this could happen to me"—or those she loves, and there is, in Blum's words, "an active regard for [the sufferer's] good,"⁴³ or, in other words, the observer's experience of compassion serves to prompt a desire to help.

B. Problems with Compassion

Yet compassion can just as easily lead to injustice, misery, and disregard at the hands of the timid, the selfish, and even the well-meaning. In this section, I discuss the three major weaknesses of compassion: the element of imaginative dwelling, the assumption of equality between observer and sufferer, and the lack of any requirement of actual responsibility. During this critique, I draw indirectly from the work of Emmanuel Levinas. In the next part of this Article, I will more explicitly refer to Levinas's work for the ways in which it might be used to construct an alternative model of a caring response to the situation of another person that does not disappoint our expectations about the kind of care and respect due the person who suffers.

1. Imaginative Dwelling

Compassion, "suffering with," suggests that when we are with people for whom we feel compassion we in a sense suffer as they suffer, we suffer along with them. How do we suffer as they suffer, when we are not feeling the actual pain or grief or deprivation? The common answer to this is that we can imagine ourselves in that situation. Thus, we may not feel compassion for a bug that is squashed because we do not believe bugs have a nervous system as advanced as ours that can feel pain as we feel pain. On the other hand, we know that another person, unless he is paralyzed or sedated or in some other unusual condition, will feel physical pain in certain instances because we also know we would feel pain in that instance. Likewise with respect to mental suffering, we know that a person would feel grief over the loss of a loved one because we would feel such grief if we lost a loved one. Our shared humanity allows us to feel the suffering of others—to have compassion.

⁴³ Blum, *supra* note 26, at 231.

a. *Compassion Risks Presumptuousness*

A significant objection to this imaginative dwelling is often expressed in your run-of-the-mill made-for-television movie, where the caring person sympathetically says, "I know how you feel," and the person who is suffering protests angrily, tearfully, and usually with justification, "No, you don't; how could you?" We are either terribly naïve or, worse, unthinkingly presumptuous, if we think that we know how the other person feels or that we even transitorily or vicariously experience or share in the suffering of the other person. Too often, what seems like sharing is actually presuming, presuming that we can know what another experiences when we are not that person and when we may never have experienced anything similar.

On a recent trip to South Africa, I visited with an elderly woman living in Soweto. Her 100 square foot home, crowded in with many others just like it, was made of salvaged materials of corrugated metal with a dirt floor, no running water, no toilet, little light, and many flies. She shared it with two children. She tried to make a little money through sewing. In recent times, she had almost daily heard gun shots on the nearby road. I realized, as I listened to her tell about her life now and under apartheid, that as a middle-aged, middle-class, educated, professional American white woman, I had no idea what it would be like to be in her situation. I could listen and attempt to understand, but I could not really understand. I could not know and feel her experience. We were in no way sharing this experience; it was her experience. I gave her some money. That didn't feel very good either. If there were any true generosity involved, it was on her part and not mine, in opening her home to me.

The appreciation that imagination fails does not mean that we should never attempt to understand by imagining. Imagining may help us get closer to understanding, and understanding guides us toward right actions. Martha Nussbaum has urged policymakers and judges and other people who can determine or influence the kind of lives others will live to read literature because in reading good literature an individual loses himself in the experience of the characters, if only momentarily.⁴⁴ In reading novels, according to Nussbaum,

⁴⁴ See generally NUSSBAUM, *supra* note 13.

the reader “imagine[s] what it is like to live the life of another person who might, given changes in circumstance, be oneself or one of one’s loved ones.”⁴⁵ That improved understanding informs our judgment.⁴⁶

I do not want to discount the value of broadening our understanding and empathetic abilities through reading. Getting closer to understanding and appreciating the experiences of another through reading and learning about their stories is to be encouraged. Nussbaum has made a powerful case that it may help us to fulfill our responsibilities toward others. Yet, clearly, we wouldn’t think it appropriate to say to the woman in Soweto, “I know how you feel because I read about something similar in a book.” Compassion through imaginative dwelling seems uncomfortably close to that sentiment and is a response we must guard against.

Moreover, while literature or art may cause us to feel despair or suffering in a way that deepens our knowledge of despair or suffering, we must acknowledge that it does so in a way that carries little or no risk, and the transitory nature of those feelings of sorrow or grief or suffering when reading a sad story or watching a sad movie too closely mirrors the transitory nature of our feelings of compassion when we encounter someone who is suffering.⁴⁷

⁴⁵ *Id.* at 5. Nussbaum writes: “Literature focuses on the possible, inviting its readers to wonder about themselves.” *Id.*

[G]ood literature is disturbing in a way that history and social science writing frequently are not. Because it summons powerful emotions, it disconcerts and puzzles. It inspires distrust of conventional pieties and exacts a frequently painful confrontation with one’s own thoughts and intentions. One may be told many things about people in one’s own society and yet keep that knowledge at a distance. Literary works that promote identification and emotional reaction cut through those self-protective stratagems, requiring us to see and to respond to many things that may be difficult to confront—and they make this process palatable by giving us pleasure in the very act of confrontation.

Id. at 5–6.

⁴⁶ *Id.* at 12. Nussbaum makes two important claims for the reader’s experience: “first, that it provides insights that should play a role (though not as uncriticized foundations) in the construction of an adequate moral and political theory; second, that it develops moral capacities without which citizens will not succeed in making reality out of the normative conclusions of any moral or political theory, however excellent.” *Id.*

⁴⁷ See Lauren G. Berlant, *Poor Eliza*, 70 AM. LITERATURE 635, 641 (1998) (expressing concern that scenes of suffering in sentimental narratives do not call us to action but instead return us to a private world of passivity).

In addition, there may be problems both with authenticity—the author or artist may be portraying a situation or condition that she does not have adequate knowledge of—and with universality—while the character in the book, film, or picture may be experiencing a situation or condition as suffering, that may not be a common experience, and in any event, cannot be considered a universal experience. In a 1987 article, Paul Longmore pointed out the inaccuracies and biases that characterized current films and plays that dramatized issues of assisted suicide.⁴⁸ According to Longmore, in the play and movie “Whose Life Is It Anyway?” a man paralyzed by a spinal cord injury inaccurately believes he is completely incapacitated sexually; his physicians do not correct this misimpression either for the character or the audience.⁴⁹ The man is shown in a wheelchair pushed by another person, rather than in a motorized wheelchair that would allow him more independence.⁵⁰ “This cavalier disregard of the facts of disability, so characteristic of the advocates of assisted suicide, helps the storyteller persuade the audience that severely physically disabled people are helpless and hopeless.”⁵¹ The main character calls himself a “vegetable” and “not a man” and, like the severely disabled characters in other dramatizations, pleads for assisted suicide.⁵² As Longmore explains, in stories such as this:

[D]isability means loss of self-control and self-determination, loss of one's humanity, and separation from the human community—in other words, social death. This is the inevitable consequence of a major physical disability. It does not result from discrimination or inaccessibility. . . . Stacking the deck,

⁴⁸ See Longmore, *supra* note 18, at 150–52. See generally Adam A. Milani, *Better Off Dead than Disabled?: Should Courts Recognize a “Wrongful Living” Cause of Action When Doctors Fail to Honor Patients’ Advance Directives?*, 54 WASH. & LEE L. REV. 149 (1997) (discussing such popular depictions of disability as evidence of societal prejudice that must be considered when evaluating the wisdom of recognizing a tort of wrongful living).

⁴⁹ Longmore, *supra* note 18, at 151. Another example Longmore gives is of a postpolio quadriplegic man in the stage drama “Nevis Mountain Dew” who complains about his lost sensory feeling, bladder control, and sexual function, none of which result from polio. *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

these dramas manipulate viewers to accept death as the only reasonable and merciful solution.⁵³

Thus, one of the things we must guard against in our feelings of compassion and the actions we take on the basis of them is that we may inaccurately judge the degree and nature of the suffering of another person. We know, for example, that able-bodied people consistently overestimate the degree of suffering of persons with disabilities.⁵⁴ The inability to truly understand the suffering of other people means that this route to ethical action—compassion through imaginative dwelling—is not sufficient. Our ethical responsibility towards other people must stem from and its contours be shaped by something other than, or additional to, a response to their condition as we imagine it to be experienced.

b. Compassion Risks Appropriating the Suffering of Another

Imaginative dwelling also demands that when we do try to imagine the suffering of the other person, we imagine the events

⁵³ *Id.* at 151–52.

⁵⁴ National Council on Disability, *Assisted Suicide: A Disability Perspective*, 14 ISSUES L. & MED. 273 (1998) (position paper drafted for the National Council on Disability by Robert L. Burgdorf, Jr.). This paper, in challenging various misconceptions about the negative aspects of disability, notes that Americans with disabilities are just as likely to be married as those without disabilities although the expectation is often otherwise. *Id.* at 286. Likewise, people with disabilities do not consider their disability to have much impact on their ability to have children or their interest in doing so. *Id.*; see also Marsha Saxton, *Prenatal Screening and Discriminatory Attitudes About Disability*, 13 WOMEN & HEALTH 217, 222 (1987). Saxton, a person with spina bifida and a former director of a center for persons with disabilities, notes that:

[J]ust as the larger population, some of these individuals experience considerable difficulty in their lives while others do fine, have jobs, and enjoy a full and satisfying life with friends and family. . . . As a group, people with disabilities do not 'suffer' any more than any other group or category of humans. Our limitations may be more outwardly visible, our need for help more apparent, but like anybody else, the 'suffering' we may experience is primarily a result of not enough human caring, acceptance, and respect.

Id. at 221–22; see also HARLAN L. LANE, *THE MASK OF BENEVOLENCE: DISABLING THE DEAF COMMUNITY* (1992). Lane writes:

What is unforgivable [to hearing people] is that members of the deaf community insist they are fine—for example, two-thirds of deaf adults interviewed in a 1988 survey thought their social life was better than hearing people's—when in fact we can give them a thousand reasons why they can't be.

Id. at 9.

or condition from which another suffers as happening to ourselves. The focus leaves the other person and comes to the self, or at least the focus is split between the other person and the self. In a sense, we appropriate the other person's suffering. Filtering the other's experience through our own selves (which could include not only our selves as we are aware of them but also the regions of our selves—fears, regrets, embarrassments, losses—of which we are unaware) not only risks producing an inaccurate calculation of the other person's suffering but also creates a power over that person, a power of assumed knowledge.⁵⁵

For example, under this understanding of compassion, a person contemplating whether to assist in hastening the death of another may ask himself, "Would I want to live that way?" Of course, that is not the true question. The quality of the compassionate person's life is not in question, and his continued existence is not at risk. At the very least we must acknowledge that that is not the question that should be asked when the person seeking a hastened death is competent. Furthermore, it also seems to be an inappropriate question when the person for whom a hastened death is being considered is incompetent. In that situation, the viewpoint of the competent person is so completely and unalterably removed from the way the incompetent person experiences the condition.

Compassion, in a way, is too easy. It does not require the intense effort necessary to understand the needs and desires of the suffering person as that person. Rather it suggests an understanding of what your needs and desires would be if you found yourself in that condition. What would you want? Of course, you don't have to live with the actual consequences of the

⁵⁵ See generally SPELMAN, *supra* note 38, at 113–32 (discussing the comparison made by white suffragists of the nineteenth century to the experiences of African American slaves). Spelman acknowledges that the experiences of others may be appropriated in an exploitative way, but insists that the identification of the subject with the object of compassion is important nonetheless.

[T]he paradox in appropriation reminds us that seeing one's own experience in the experience of others can all too easily lend itself to the expropriation of the experiences of others, to putting their experiences to one's own use while erasing the fact of their having been subjects of those experiences. But at the same time, our thinking of one another as possible subjects of the same kinds of experiences can be an important piece of our thinking of one another as members of the same human community.

Id. at 120–21.

actions taken on the basis of this imaginative dwelling. Surely it is easier to say that you would not want to continue living in a certain condition if your life is not the one at stake. The State of Oregon discovered this problem several years ago when it sought to restructure its Medicaid eligibility and coverage rules.⁵⁶ The restructuring process included telephone polls of the state's residents asking their opinions on the value of certain treatments.⁵⁷ The healthy and able-bodied placed a low priority on lifesaving medical assistance to people who had incurred a serious physical disability, such as paraplegia.⁵⁸ When they

⁵⁶ See generally Timothy B. Flanagan, *ADA Analysis of the Oregon Health Care Plan*, 9 ISSUES L. & MED. 397 (1994) (including several formerly unpublished documents relating to the Oregon Medicaid proposal). Oregon, in 1989, approved a plan to provide health care coverage to a larger number of people than at that time were covered by the state's Medicaid program, but increasing the number of people covered would require rationing some care. A commission was thus established to prioritize individual health services, to list services "from the most important to the least important." *Id.* at 397 (quoting Oregon Basic Health Care Act, ch. 836, § 4a(3), 1989 Or. Laws (enacting S.B. 27)). In any particular year Oregon's Medicaid program would cover those services on the list above a line to correspond with legislative appropriations. A waiver from the federal government was required for this departure from Medicaid coverage rules. Initially, Oregon's proposed list of prioritized treatments was compiled on the basis of express appraisals of the "quality of life" of people following those various treatments. The Department of Health and Human Services denied the waiver because it violated the Americans with Disabilities Act. In a second attempt at creating a plan in compliance with the ADA, the state compiled the list without the quality of life measurements of specific conditions, but still downranked treatments that left individuals with symptomatic conditions. *Id.* at 398. This revised plan was approved on the condition that a reranking again take place that would not consider "whether treatment returned an individual to an asymptomatic state." *Id.* at 399 (quoting Letter from William Toby, Jr., Acting Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, to Kevin W. Concanon, Director, Oregon Department of Human Resources (Mar. 19, 1993) (enclosing Health Care Financing Administration Special Terms and Conditions)). Rationing that discriminates against persons with disabilities can also take subtler forms, for example, when treatment is denied on the basis of medical futility. See generally Mary A. Crossley, *Medical Futility and Disability Discrimination*, 81 IOWA L. REV. 179 (1995) (assessing futility-based rationing schemes under the Americans with Disabilities Act).

⁵⁷ Flanagan, *supra* note 56, at 401-02.

⁵⁸ The National Legal Center for the Medically Dependent & Disabled, Inc., explained how the proposal would have discriminated against people with disabilities in a letter to Representative Christopher Smith, published in a volume of *Issues in Law and Medicine*:

Patient A and Patient B are both injured in an accident. Treatment A is recommended for Patient A, while Treatment B is recommended for Patient B. Both treatments cost the same. However, Treatment A will sustain Patient A's life but will not restore the abilities A has lost after the

imagined themselves suffering a severe loss of capabilities, they imagined that they would not want to continue living. People living with such severe disabilities quite naturally thought differently; they indeed did value the medical and other assistance necessary for continued life.⁵⁹

Compassion understood this way, where we try to imagine the experience of another as happening to us, seems to ignore what we know about the transformative effect of certain life experiences. We know, for example, that many people who prior to becoming disabled, insisted that they would not want to live if disabled in the way they eventually were disabled, changed their minds and want to continue living. Similarly, when people are young and healthy, they do not think that expensive medical treatments should be used to prolong their lives when they reach their elderly years, yet the elderly seek these treatments. Rebecca Dresser, John Robertson, and others have focused needed attention on this important question of transformation through illness or disability by asking what should guide decision making in the event of a substantial and permanent transformation from competency to incompetency.⁶⁰ Should the desires of the person expressed prior to incompetency be

accident (such as the ability to walk), while Treatment B will sustain B's life and restore his ability to walk. If the basis for funding B but not A is a quality of life judgment that being able to walk is of greater benefit than not being able to walk, for example, then a decision to deny treatment for A would be discrimination based on A's resulting level of disability. In effect, B's life would be considered more valuable than A's life because B will regain an additional function, while A would not. Under [this] scenario, a distinction between two effective treatments would be based not on treatment effectiveness, because both treatments would sustain life, but on an inappropriate assessment of the underlying quality of life each patient will have after treatment. This scenario describes the Oregon Plan.

Id. at 405-06.

⁵⁹ *See id.*

⁶⁰ *See, e.g.,* Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 *LAW MED. & HEALTH CARE* 234, 236-37 (1989). Dresser and Robertson write:

When people become incompetent and seriously ill, . . . their interests may radically change. With their reduced mental and physical capacities, what was once of extreme importance to them no longer matters, while things that were previously of little moment assume much greater significance. An existence that seems demeaning and unacceptable to the competent person may still be of value to the incompetent patient, whose abilities, desires and interests have so greatly narrowed.

Id. at 236; *see also* DEREK PARFIT, *REASONS AND PERSONS* 302-06 (1984) (explaining that a person's life may be a series of identities, or successive selves).

respected, or does that person in a sense no longer exist and another person stand before us? Does it make sense to distinguish between the then person and the now person? Looking to imaginative dwelling to answer how to ethically respond to someone else's situation denies our growing awareness of the transformative effect of changing circumstances and conditions.

Finally, we must wonder whether this imagining response contributes to fears that fuel prejudicial attitudes. As explained above, scholars often describe the experience of compassion as involving an element of fear, due to the sudden awareness that the unfortunate condition could also happen to the person observing it.⁶¹ Fear is a common response to people with severe disabilities. According to a 1991 poll, forty-seven percent of respondents said they reacted with fear when they met people with severe disabilities "because what happened to the disabled person might happen to them."⁶² As Paul Steven Miller, commissioner of the Equal Employment Opportunity Commission, has written, "Many able-bodied persons are tremendously fearful about becoming disabled. This fear is based upon the notion that a disabled person's life is inferior to, and less precious than, an able-bodied person's life."⁶³ According to Miller, this fear is a primary source of prejudice against persons with disabilities.⁶⁴ To the extent that a compassionate response involves fear, it may have the unfortunate and unintended effect of contributing to prejudice.⁶⁵

c. *Compassion May "Thematize" the Person Who Suffers*

Compassion has been praised for focusing on the unfortunate condition rather than on the unfortunate person.⁶⁶

⁶¹ See *supra* text accompanying note 32.

⁶² Milani, *supra* note 48, at 202 n.247 (citing and quoting JOSEPH P. SHAPIRO, NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT 328 (1993)).

⁶³ Paul Steven Miller, *The Impact of Assisted Suicide on Persons with Disabilities—Is It a Right Without Freedom?*, 9 ISSUES L. & MED. 47, 49 (1993).

⁶⁴ *Id.* at 48–49.

⁶⁵ See Longmore, *supra* note 18, at 141–42 (stating that the "unacknowledged and unconscious fear and prejudice of many nonhandicapped persons toward people with disabilities" at times "burst out in violent words and deeds, but usually, and perhaps even more dangerously, they are masked by an avowed compassion, contempt cloaking itself in paternalism").

⁶⁶ See *supra* text accompanying notes 41–42.

This is seen as laudable because persons are not thereby discounted, devalued, or dismissed, but are still seen as equally deserving of respect and attention. Put this way, focusing on the condition does seem preferable to focusing on the person; it's better than pity. On the other hand, however, focusing on the condition carries the risk of what Levinas calls "thematization."⁶⁷ If the condition stands in for the person in evoking the right ethical response, i.e., compassion, then the condition may stand in for the person in other respects as well. In other words, the condition is the person, and thus we need to know nothing more about the person than the existence of the condition. Indeed, this is one of the central criticisms scholars like Adrienne Asch, Eric Parens, and others within the "disability rights" critique of prenatal genetic testing make of current practices of genetic screening and abortion.⁶⁸ These scholars object that when decisions are made to abort a fetus on the basis of a positive diagnosis of, for example, Down syndrome, the condition, Down syndrome, stands in for the entire person who would have been born.⁶⁹ Nothing else is known about the potential child except this one quality. We know nothing about her preferences, her dreams, her actual abilities or disabilities, or her capacity to love and be loved. Instead, she has been essentialized, or thematized, into a single attribute.

The risk of thematization is especially high in situations of disability, old age, or the loss of certain bodily functions. These are also often the conditions that are involved in situations in which the hastening of someone's death is contemplated. In much of the literature about the rights of persons to hasten their deaths, and indeed the legal cases that have addressed the topic,

⁶⁷ EMMANUEL LEVINAS, *OTHERWISE THAN BEING OR BEYOND ESSENCE* 6, 153 (1981).

⁶⁸ See Erik Parens & Adrienne Asch, *The Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations*, 29 no.5 HASTINGS CTR. REP. 51, 525 (Special Supp. 1999).

⁶⁹ *Id.* at S2, S5-S6. Michael Berube's book about his son Jamie, a child with Down syndrome, provides a compelling counterpoint to this societal inclination to categorize and thematize people with disabilities. He writes:

I have tried. Almost as a form of emotional exercise, I have tried, on occasion, to step back and see him as others might see him, as an instance of a category, one item on the long list of human subgroups. This is a child with *Down syndrome* I say to myself. *This is a child with a developmental disability.* It never works: Jamie remains Jamie to me.

MICHAEL BERUBE, *LIFE AS WE KNOW IT* xi-xii (1998).

a dependency on others for toileting needs takes on unparalleled importance.⁷⁰ Lack of independent toileting appears to be equated with a person who lacks dignity. Furthermore, a life without dignity is often translated into a life not worth living. This, however, ignores the fact that elderly people near death, even suffering from dementia, may still find pleasure in visiting with relatives, in having their hair brushed, having lotion rubbed into their hands, rediscovering long lost childhood memories. Instead, the tendency is to focus only on the inability of such people to use the bathroom by themselves.⁷¹

A compassionate response that focuses on the condition of a person in a way that permits us to see her in terms of a theme can result in unfair prejudice and discrimination. Even when less noxious results follow, such a response inappropriately shortcuts the more intense inquiry that is required to determine the needs and desires of that individual and can prevent the ethical response that is due. As we all know, sometimes a compassionate response is offered to a person who is not actually suffering, but whose condition has simply been traditionally understood as equated with suffering. Indeed, Marsha Saxton tells us that on the whole people with disabilities do not suffer any more than people without disabilities.⁷² For example, studies show that deaf people, on the whole, live happier lives than hearing people.⁷³ When people with disabilities do suffer, it is often not from their physical impairment but from the societal reaction to that impairment—whether of indifference or discrimination or disparagement. A compassionate response that thematizes a person as disabled can cause an

⁷⁰ See *infra* notes 175–77 and accompanying text.

⁷¹ And if we do, I submit, they do. One of the top reasons listed by people who seek to hasten their deaths through physician assistance is losing control of their bodily functions. See Off. Disease Prevention & Epidemiology, Or. Dep't. Hum. Servs., Fifth Annual Report on Oregon's Death with Dignity Act 20 (2003) (compiling results of interviews with physicians prescribing lethal medications under Oregon's Death with Dignity Act; while physicians listed multiple end-of-life concerns that may have contributed to patients' requests for lethal medication, one of the most frequently reported concerns was losing control of bodily functions (fifty-eight percent of the patients who died after ingesting a lethal dose of medication in the years 1998–2001 were identified by physicians as being motivated in part by this concern)).

⁷² Saxton, *supra* note 54, at 222.

⁷³ See LANE, *supra* note 54, at 9; see also NAT'L COUNCIL ON DISABILITY, *supra* note 54, at 284–86.

underestimation of what that person can achieve and can thereby cut off opportunities for success, expression, respect, and self-worth. It can also result in alienation of people with disabilities as others cannot see beyond the apparent physical condition. The emphasis that advocates for people with disabilities place on language captures this concern that the focus of attention is properly placed on the person rather than the condition; advocates encourage the use of terms such as "person with a disability" rather than "the disabled person" so that the person comes first.

d. Whose Suffering Is Being Relieved?

Finally, if we are actually successful in imagining the suffering of the other person, so accurately that we too suffer, then to the extent our imagining is causing us to "suffer with," we might be trying to relieve our own actual, although vicarious, suffering rather than the other person's. This, too, has especially troubling consequences for situations in which the hastening of someone's death might be contemplated. To the extent that it pains us to see and, upon seeing to imagine the experience for ourselves of another person—such as a person with severe disabilities or an elderly person with Alzheimer's Disease—then actions we might take to assist in hastening their death appear to be for the self, rather than the other person—or at the least the motives are mixed, which is troubling in itself.⁷⁴

One of my criticisms of advocacy on behalf of a right to physician assisted suicide is that it seems facile to think of any purported right to assisted suicide to be based in autonomy, for the action of two rather than one is required by definition.⁷⁵ Understanding that the action of two is required brings home

⁷⁴ See *Compassion*, *supra* note 13, at 32–35. Martha Nussbaum acknowledges that there is a debate in the traditional work on compassion about how the process of identifying with the sufferer actually works. Thus she points out that certain passages from Adam Smith's work that suggest that a compassionate observer actually does, at the time he feels compassion, believe that he *is* the sufferer, and points to the work of Arthur Schopenhauer which suggests that the compassionate observer's responses are "*fused* in some mysterious way with those of the sufferer." *Id.* She rejects these views, arguing that a compassionate observer is always aware of his "*separateness* from the sufferer." *Id.* Otherwise, "If one really had the experience of feeling the pain in one's own body, then one would precisely have failed to comprehend the pain of another *as other*." *Id.*

⁷⁵ Lois Shepherd, *Sophie's Choices: Medical and Legal Responses to Suffering*, 72 NOTRE DAME L. REV. 103, 119–26 (1996).

the fact that the opinion of the assistant in death regarding the experience of the suffering of the other is critically important and is, in fact, the linchpin. The assistant in death must believe that the other person's suffering is so awful that suicide is the answer.⁷⁶ If the assistant experiences suffering by her contact with the other person, by seeing or caring for that person, then the action of two is not simply relying on the opinion of two about the depth of the person's suffering but also the experience of two who are suffering, the person seeking death, and the person who is asked to assist in it. The suffering of the assistant, then, rather than the suffering of the ill person can have a determinative effect on the answer given to a request for assisted suicide.

2. Equality

a. *Compassion Appears Based on a Sense of Equality That Is False*

As discussed above, compassion, which is considered good, is often distinguished from pity, which is bad, because compassion is based on a sense of the shared, common experience of being

⁷⁶ Or, we might say, "rational." In fact, a Michigan Circuit Court in *Michigan v. Kevorkian*, No. 93-11482, 1993 WL 603212 (Mich. Ct. App. Dec. 13, 1993), *rev'd* 527 N.W.2d 714 (Mich. 1994), held that criminalizing physician-assisted suicide was unconstitutional because it violated a person's right to commit "rational" suicide, suggesting that the decision is not entirely autonomous, but subject to review. *Id.* at *18. The Court found "that when a person's quality of life is significantly impaired by a medical condition . . . causing the quality of life to be significantly impaired, and the decision to end one's life is freely made without undue influence, such a person has a constitutionally protected right to commit suicide." *Id.* at *19.

We also have to be aware that, without strict safeguards, physicians might be the dominating actor in the pair. The power imbalance in the relationship between physician and patient is well-documented. See, e.g., JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 198-99 (1984); see also Bernard Lo, *Improving Care Near the End of Life: Why is it So Hard?* 274 *JAMA* 1634, 1635 (1995) (revealing that only 41% of patients in a study reported discussing CPR or their prognosis with their physicians; physicians misunderstood patients' preferences with respect to CPR in 80% of cases); Patricia Wesley, *Dying Safely*, 8 *ISSUES IN L. & MED.* 467, 480-85 (1993) (suggesting that Dr. Timothy Quill was not simply respecting his patient's autonomy when providing her with a lethal prescription, but was a "powerful actor," injecting his own values into her medical decisions). The latter reference is to Dr. Quill's now famous letter to the *New England Journal of Medicine*, in which he described his assistance in a patient's suicide. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 *NEW ENG. J. MED.* 691, 691-94 (1991).

human, whereas pity is the response of one who is distant and superior. Yet it seems a mistake in many situations where one is suffering to emphasize the equality of the persons involved. Of course, at some very basic level the persons involved are, as human beings, entitled to equal respect, but I think as a matter of common usage, in the way we normally think about compassion, we think of the compassionate response coming from the stronger person, the person who, at the time in question, has more resources—whether they be emotional, financial, or physical—than the person who suffers. This can be illustrated by the fact that we do not usually think of fellow sufferers as having compassion for each other.

This inherent inequality that exists in our typical conception of the situation in which compassion takes place was evident on the walls of an elementary school I recently visited. The concept of compassion in many debates and, in particular, the debate over physician-assisted suicide entails no detailed or philosophical definition for us, making it helpful to look at common usage. I was interested in what the third-graders had to say on their assignment labeled “compassion.” They were asked to fill in a four-square grid with a picture and a one sentence description in each section of the grid describing a way in which they had acted compassionately toward other people. The most common situation depicted in the papers by far was that of another child hurting himself and the author or artist providing the other child with aid. This, to me, more than the descriptions of scholars who might focus on the equality-basis of compassion, captures what we mean in lay terms by compassion. The relationship depicted is not one of equality; rather the one person who is standing has the resources or ability to help the other who has fallen down. This inequality is emphasized because it is important with respect to the expectations for action.⁷⁷ Parenthetically, the relationship depicted is also not one of shared suffering. The child rescuer was not feeling equally bad as the child who was hurt. She might have felt sad

⁷⁷ See *supra* text accompanying note 40. I appreciate the fact that when Lawrence Blum, quoted above, speaks about the equality basis of compassion, he is referring to the shared humanity of all and that he is not suggesting that compassion suggests anything about social, financial, or physical inequality. At the same time, my point here is that the inequality is what makes the situation so commonly understood as ripe for compassion (one person *should* feel compassion for the other), as much or more than the equal human status of both people.

because the other child was hurting, but she did not seem to feel the same kind of pain or feel it with the same intensity. There was usually only one child crying in each picture, the child who had fallen down. Sometimes the rescuer child was smiling in the picture because she was able to help.

There is much that is positive flowing from the general liberal philosophy that all humans are equal and that they are entitled to equal rights and equal respect. But if the ethical response toward people in need that we are going to hold as an ideal is rooted in equality, then we may risk the subject's failure to recognize her greater—not equal, but greater—ability to ease the suffering of the person for whom compassion is felt. In other words, emphasize equality too much and, in our society, it becomes fend for yourself. We should, instead, want the subject to understand how much more she has; to appreciate the fact that she is not an equal sufferer, she does not truly "suffer with"; and she can do something to relieve the condition of the one who does suffer.

b. Compassion as Based in Equality Is Inadequate

Thus, it appears that we want to recognize, or we want the subject in a situation of compassion to recognize, that she has greater resources by which to aid the suffering object of compassion, but there is another way in which the emphasis within scholarly circles on the equality basis of compassion is problematic. Equality is inadequate to describe the relationship of obligation that exists between two persons when one is suffering and the other is not. Rather than a situation of equality, we might instead see the suffering person as having an unequal or greater claim for relief.

Suppose for a moment that we had a situation in which a physician encounters a stranger who needs immediate life-saving care. In responding to the need of the stranger, to this stranger here and now, who stands or lies before the physician, the physician must not accept as a fundamental tenet the equality between himself and the patient. Rather he must accept the priority of the patient. That recognition of the priority of the patient means that the physician put his own interests aside and provide the care that is needed.

3. No Duty

Finally, compassion does not require acts of care. This is for two reasons. First, compassion may not be experienced by the subject in the situation where our moral intuition understands that care should be given. Second, even if compassion is experienced, it does not require any action on the basis of it. Compassion may be a motivator, but it is not a master.

This failure of compassion can be seen by further considering the physician who encounters the stranger needing immediate care. This situation is one in which many of us would believe the physician should provide care. In fact, the American Medical Association has adopted a principle of medical ethics that requires the physician to provide care in an emergency situation.⁷⁸ Yet relying on the emotional/ethical response of compassion would not get us to the same place as this principle of medical ethics. Most obviously, the physician, even if he is a good and caring individual, at the moment may not feel compassion for the stranger. Perhaps he has a number of other pressing matters on his mind. The emotional state required for compassion may elude him at the moment. Similarly, he might not be particularly inclined to like or respect this particular stranger before her. Perhaps he cannot imagine himself in this situation or this kind of emergency ever happening to him. Secondly, even if he does feel compassion, that feeling does not require him to act. Other feelings may compete within the physician to make him turn away from the stranger.

It is not mere compassion that we seek from the physician; it is action assumed upon acknowledgement of an obligation. We would not think the physician especially noble or philanthropic to aid the stranger; we would think of him as bound to do so.

If we did not have this expectation, then we might see the physician as only bound to that for which he has contracted. This, indeed, is the law, even in the case of an emergency.⁷⁹ As a

⁷⁸ "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve . . ." See Council on Ethical and Judicial Affairs, American Medical Association, Code of Medical Ethics: Current Opinions with Annotations, Chicago, Ill.: AMA, 1998, Principle VI.

⁷⁹ Generally, physicians have no duty to treat an individual with whom they are not in a physician-patient relationship. The relationship between physician and patient has largely been defined as a contractual one. See, e.g., *Oliver v. Brock*, 342 So. 2d 1, 3 (Ala. 1976) ("The relationship between a physician and patient may result from an express or implied contract, either general or special, and the rights

general matter, doctors are obligated to provide care only to those to whom they have promised it.⁸⁰ They may decide, if they like, to take on certain patients out of compassion or philanthropy, but they are not required to do so. The duties they do assume may be assumed conditionally, such as the condition of payment, which seems reasonable for most situations, but also the condition of about anything, and services may be terminated with adequate notice.⁸¹

Under this legal system, a doctor may, for example, refuse to provide care to pregnant women unless they agree to be sterilized after delivery. The physician in the 1977 case of *Walker v. Pierce* testified regarding his policy requiring women who were incapable of self support to agree to voluntary sterilization upon the birth of their third child or if they did not wish to cede to that request, to require that they seek care elsewhere.⁸² The court upheld the physician's right to condition

and liabilities of the parties thereto are governed by the general law of contract . . ."); *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) (finding that physician's refusal to render aid to decedent not actionable; physician, by obtaining state license, does not obligate himself to practice on any terms he does not choose to accept); *Childs v. Weis*, 440 S.W. 2d 104, 106-07 (Tex. Ct. App. 1969) ("The relation of physician and patient is contractual and wholly voluntary, created by argument, express or implied."); see also WILLIAM J. CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 128-29 (5th ed.) (1998) (explaining that *Hurley* still represents the prevailing law for physicians).

The existence of an emergency does not generally alter the legal right of the physician to refuse treatment. See Karen M. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 25-33 (1989). Those few legal cases that have found an obligation on the part of physicians to provide emergency care have found a *contractual* basis for doing so. The contract is not one between the patient and the doctor, but between the doctor and the medical care facility (for example, an agreement in which the physician agrees to be on-call for an emergency room), see *Hiser v. Randolph*, 617 P.2d 774, 777-78 (Ariz. 1980); *Millard v. Corrado*, 14 S.W. 3d 42, 47-48 (Mo. Ct. App. 1999), or between the doctor and health maintenance organization (where the doctor has again agreed with the organization to provide care in particular circumstances, see *Hand v. Tavera*, 864 S.W.2d 678, 679-80 (Tex. Ct. App. 1993). Thus, even in emergencies, the physician has a duty only insofar as he or she has *ex ante* voluntarily assumed one, if not to the patient directly then to another party who undertakes (for a fee or not) to provide care. No obligation to provide care devolves upon the physician as a matter of course.

⁸⁰ Again, excepting the professional but not legal obligation to provide care in the case of emergencies.

⁸¹ See *Ricks v. Budge*, 64 P.2d 208, 211-12 (Utah 1937) (explaining obligation of continuing attention in the absence of reasonable notice of termination of relationship).

⁸² 560 F.2d 609, 611 (4th. Cir. 1977), *cert. denied*, 434 U.S. 1075 (1978).

his delivery of a patient's fourth child on her agreement to be sterilized.⁸³ The court could "perceive no reason why Dr. Pierce could not establish and pursue the policy he has publicly and freely announced."⁸⁴

This case does not appear to be an aberration with respect to its statement of the law. Doctors may and have legally refuse care to strangers in emergencies, to lawyers because they are lawyers, to spouses of lawyers because they are spouses of lawyers, and to lesbians and gays because of their sexual orientation.⁸⁵ Thankfully, most do not. They generally believe they have an ethical responsibility, even though not a contractual or legal responsibility, to provide care in emergencies and to provide care without imposing inappropriate conditions. This responsibility cannot be explained as compassion. Doctors may or may not feel compassion for a particular stranger; and if that is all they feel, they could turn away and deny the stranger entry into the doctor-patient contract.

Compassion is merely an overlay of contract. It is a response voluntarily assumed—or not. Within the world of

⁸³ *Id.* at 613. The condition here was not imposed while the woman was in active labor, so there was not the additional complication of a situation of duress or need for immediate care. The plaintiff, Virgil Walker, was informed of the defendant physician's policy of sterilization approximately four months before she delivered her baby. *Id.* at 611.

⁸⁴ *Id.* at 613. Not all conditions imposed by physicians for treatment receive such disinterested approval. In another case, a court found that the condition imposed was not acceptable. In *Tunkl v. Regents*, the court refused to enforce a waiver of liability signed by a patient as a condition to receiving charitable care from a research hospital. 383 P.2d 441, 442, 447 (Cal. 1963). The court ruled the release unenforceable because the release condition varied the legal standard of care owed to patients and was thus an unacceptable "exculpatory clause." *Id.* The court did not reject the condition at issue in *Tunkl* because of any particular distaste for the idea that a physician can impose conditions upon a patient for either the beginning or continuation of care. Such ability is a natural consequence of the "no duty" rule, and if courts were to scrutinize conditions as a general matter, the "no duty" rule would be directly assailed. *See id.*

⁸⁵ *See* *Hiser v. Randolph*, 617 P.2d 774, 776 (Ariz. 1980) (stating that evidence suggested that refusal of on call physician in emergency room to see patient arriving in semi-comatose condition was due to personal animosity toward the patient or to the fact that the patient's husband was a lawyer); Jane E. Allen, *Invisible Women; Many Lesbians Avoid Doctors for Fear of a Backlash from Judgmental Practitioners*, L.A. TIMES, June 21, 1999, at S1 (relating experiences of lesbian women). *See generally* MICHELE ELIASON, WHO CARES: INSTITUTIONAL BARRIERS TO HEALTH CARE FOR LESBIAN, GAY AND BISEXUAL PERSONS (NLN Press 1996) (describing numerous studies that document negative attitudes towards gays and lesbians among health care providers).

contract, the response of compassion may be put on like a physician's white coat or not. Compassion, like contractual obligations, may be conditional; it may be conditioned on the appearance of the stranger, on her number of children; on her financial capacity; on her sexual orientation; and even on her gender, skin color, race, ethnicity, religion, or disability—all factors that may cause identification with the suffering person to be more attenuated.

If we look no further than compassion to determine our duties to one another, then we seek no more than contract. We assume that everyone is equal and has the equal ability to enter into contracts for his benefit. No one has a greater claim; no one has a greater responsibility. By contrast, an ethics of radical responsibility, to which I now turn, means that whether or not I feel compassion for the other person I have a responsibility for another's suffering.⁸⁶ Responsibility does not have the voluntary nature of compassion.

II. AN ETHICS OF RADICAL RESPONSIBILITY

Levinas, a Holocaust survivor, philosopher, and theologian,⁸⁷ finds the condition of ethics to be in the originary, primordial,

⁸⁶ And how is such responsibility justified? For Levinas, as we will see below, it is not directly or simply justified by the needs of the stranger. It is acknowledged instead as an essential part of being human, of existing. This may be more apparent in the case of physicians and their patients than in other relationships. For it is for physicians the stranger, who may or may not have any particular qualities of endearment or interest, that is essential for the physician's existence, that provides the basis for the physician's existence. The physician's existence depends upon the stranger or patient calling for healing or comfort. William F. May tells us that a physician needs his patients for his own professional and emotional well-being: "No one can watch a physician nervously approach retirement without realizing how much he has needed his patients to be himself." William F. May, *Code, Covenant, Contract, or Philanthropy*, HASTINGS CTR. REP., Dec. 1975 at 29, 33. Their acts of care are not the gifts of a philanthropist but the responsibility of an obligor.

⁸⁷ Adriaan Peperzak explains that while Levinas has also written what might more properly be considered theological works, his philosophical works are pure philosophy and do not stand on a religious basis. See PEPERZAK, *supra* note 1, at 210. Peperzak writes:

The stress that Levinas lays on morality and religion has caused some misunderstandings. Some readers consider his philosophy to be too pious or even to be a sort of theology. Yet few contemporary philosophers have criticized the praxis and the idea of traditional theology more radically than has Levinas; and, although no philosophy can or may free itself from its prephilosophical, and therefore naive, convictions, Levinas has stressed more than once the fact that he is not a theologian but a philosopher . . .

face-to-face encounter between two human beings.⁸⁸ When we look into the face of another person, we are compelled to respond, whether with a smile, a gesture of greeting, an invitation, an apology, a helping hand, pity, mercy, a cold stare, a deliberate disregard, or an angry glare. We cannot avoid some response, Levinas tells us, even if it is the response of indifference; a response of indifference is a response. We are trapped, captured, "held hostage" by the face of another person whose presence commands some response.⁸⁹ The command to respond to the face of another person comes before everything else, before the subject's knowledge of himself, even before the subject's own existence or "beingness." For this reason, Levinas considers ethics as "first philosophy," prior to the philosophy of ontology, the study of being; rather than the "I" coming first and knowledge and relations with others coming second, it is only the presence of others that allows the "I" or the "subject" to exist.⁹⁰ Other people and their needs, their claims on us, and our responses, determine who we actually are. For Levinas, those claims must be answered rather than ignored; actions taken in generous response to other people is what constitutes the human being.⁹¹

Id.

⁸⁸ EMMANUEL LEVINAS, *TOTALITY AND INFINITY* 35–40 (Alphonso Lingis trans., 1969) [hereinafter *TOTALITY AND INFINITY*].

⁸⁹ Levinas writes:

A human being is the sole being which I am unable to encounter without expressing this very encounter to him. It is precisely in this that the encounter distinguishes itself from knowledge. In every attitude in regard to the human there is a greeting—if only in the refusal of greeting.

Emmanuel Levinas, *Is Ontology Fundamental?*, in EMMANUEL LEVINAS, *BASIC PHILOSOPHICAL WRITINGS* 1, 7 (Adriaan T. Peperzak et al. eds., 1996).

⁹⁰ *TOTALITY AND INFINITY*, *supra* note 88, at 43–48. It is important to mention that "the other," for Levinas does not mean a marginalized group. Common references in current legal scholarship to "the other" or "otherness," or "othering" are used to criticize the ways in which practices, laws, or legal decisions treat some people as different (and inferior) from some norm in a way that leads to unjustified and therefore unfair discrimination. Whether used by liberal or critical scholars, the focus seems to be on greater comprehension of the "other" or the "outsider" in order that he might be treated equally with members of the majority group. The liberal project does this by assimilation, pointing out the similarities between the other and the normative group, while the critical project recognizes and sometimes celebrates the differences between them but appeals to equal respect for all just the same. Neither generally emphasizes how an experience with the "other" in order to be genuinely ethical must alter the subject, or the normative group. Nor does either generally insist on the subject's responsibility to the other person.

⁹¹ For Levinas, "being human is a concrete and physical sensitivity to the

In this part of the Article, I draw on the work of Emmanuel Levinas to construct an alternative to the compassionate response, one that shares with compassion a concern and care for others, but that avoids some of compassion's weaknesses. This alternative I call an "ethics of radical responsibility." Levinas's work does not provide a system of principles or rules that might apply to a given situation, but suggests instead an orientation. It is an orientation in which the other person takes precedence or priority over the subject. Indeed, if rules or principles could be derived from this orientation, they could not possibly be fulfilled because at essence the orientation is that expressed by Dostoevsky when he claims responsibility for everything and everyone. One approach in studying Levinas's work for the insights that might be found there regarding questions of social policy, justice, and law, is to consider in what ways the orientation he describes presents a challenge or interruption to existing practices and norms. In the following sections I identify four central concepts found in Levinas's work that bear on the ethical relationship between persons and that have particular relevance to the relationship between a subject and another person who suffers—the situation we commonly think of as appropriate for compassion. These four concepts are welcome, alterity, rupture, and responsibility.

A. *Welcome or Desire*

"A flock of wild geese had settled to rest on a pond. One of the flock had been captured by a gardener, who had clipped its wings before releasing it. When the geese started to resume their flight, this one tried frantically, but vainly, to lift itself into the air. The others, observing his struggles, flew about in obvious efforts to encourage him; but it was no use. Thereupon, the entire flock settled back on the pond and waited, even though the urge to go on was strong within them. For several days they waited until the damaged feather had grown sufficiently to permit the goose to fly. Meanwhile, the unethical gardener, having been converted by the ethical geese, gladly

claims revealed by the Other, a being-delivered to the Other and a substitute." PEPPERZAK, *supra* note 1, at 26. Peperzak also explains, "The Other's existence reveals to me the uniqueness of a task that constitutes the meaning of my life." *Id.* at 28.

watched them as they finally rose together, and all resumed their long flight."⁹²

For Levinas, the subject exists only because of and for the other. The expression "I" means "here I am," *for you*.⁹³ One of the ways "I" can be "here for you" is to welcome you into my home, to sit at my table, into my life.⁹⁴ Welcome, however, is not merely being a good host. A good host may have invited a guest grudgingly, out of mere obligation, such as the heavy-drinking spouse of a good friend or the host's boss. Such tolerance is not sufficient; ethics begin with an orientation of true welcome, of true desire for the presence of the other person.⁹⁵

This orientation of welcome is especially insightful when it is considered in challenge to, or interruption of, current social attitudes and practices toward people with disabilities, who often feel unwelcomed—and not without justification. When a person who uses a wheelchair is confronted with stairs as his only

⁹² ALBERT SCHWEITZER, *REVERENCE FOR LIFE* 48 (Thomas Kiernan ed., 1965).

⁹³ EMMANUEL LEVINAS, *OTHERWISE THAN BEING OR BEYOND ESSENCE* 114 (Alphonso Lingis trans., 1981). Levinas writes, "The word *I* means *here I am*, answering for everything and for everyone." *Id.*

⁹⁴ TOTALITY AND INFINITY, *supra* note 88, at 77. According to Peperzak:

I must feed my body and arrange my house in order to receive the foreigner knocking at my door; if I possess a home, it is not for me alone. Expressions such as 'After you' or 'Make yourself at home' say quite well that the person who enters is respected as Other. 'Here I am' does not, then, signify that I am the most important being of the world but, on the contrary, that I am at your disposal.

PEPERZAK, *supra* note 1, at 24–25.

⁹⁵ TOTALITY AND INFINITY, *supra* note 88, at 33–52. Levinas sees in the face-to-face relationship, between an "I" and a stranger, the experience of desire. Human desire (not *need*, which may be for necessities such as food, but *desire*) is a desire for that which is absolutely other than itself, for something that cannot be contained by it, for something that cannot even be comprehended, for something beyond any idea or concept we can have of it, something that "overflows" its idea; it is a desire for the "infinite," which for Descartes meant "God," but for Levinas means the human other. He finds the originary face-to-face relationship between two individuals to be the situation in which that desire appears.

The relationship between an "I" and another person is grounded in language, and when one speaks, one gives oneself over to the other. Thus, the original social relation is not one of knowledge of the other, comprehension and therefore assimilation and possession, but of speaking to him. And the expression of speech invites its return. "To approach the Other in conversation is to welcome his expression." *Id.* at 51. The lost memory of the originary encounter with the other does not reveal a relation between individuals where each is primarily concerned with protection of his or her own freedom, a concern that leads to resistance and ultimately war, but a radically different relation, one of welcome, hospitality, and generosity. *Id.*; see also PEPERZAK, *supra* note 1, at 30–31, 120–30.

access inside a building, he is not to be faulted for believing his presence is not welcomed. As some writers have well pointed out, people with disabilities often suffer more from the lack of welcome, respect, and care that they experience rather than from their actual impairments.⁹⁶ In fact, it has taken a statute, imperfectly, the Americans with Disabilities Act⁹⁷ to force the able-bodied community to *act* as if they welcome people with disabilities into a full and equal participation within the community.

It is not, however, the outward manifestations of welcome, as it is not the mere invitation to the dinner party, that satisfy the orientation of welcome within the ethics of radical responsibility. It is not sufficient to engage in welcoming behavior as a solution to the alienation that people with disabilities sometimes experience. Taking up the welcoming banner may be sufficient under an ethics of compassion—the response of welcoming behavior is chosen to alleviate the condition of exclusion, in the same way that a painkiller may be offered to alleviate pain. Such welcoming acts, however, do not tell us that the existence of the person with a disability is desired, just as the offer of a painkiller does not tell us that the existence of the person in pain is desired. An ethics of radical responsibility is based, at its root, in a desire for the other person. The aim, therefore, is true desire, true welcome for the other person. Mere acts of welcome that derive from compassion prompted by someone's experience of alienation are not likely to fool many into believing that a true welcome has been offered.

Thus, while not immediately obvious, compassionate feelings toward another person do not necessarily, and may in fact not, signal welcome or desire for another person. In fact, compassion does not really tell us anything about how the compassionate person feels about the suffering person's

⁹⁶ See, e.g., Adrienne Asch, *Disability Equality and Prenatal Testing: Contradictory or Compatible?* 30 FLA. ST. U. L. REV. 315, 318 (2003) (discussing that the "social model" of disability and "minority group model" of disability both, in contrast to the traditional "medical model," do not "ascrib[e] the major difficulties of people with disabilities to their physical, cognitive, or emotional make-up. Instead, the theorists assert that the difficulties should be ascribed to the mismatch between the range of people actually in the world and the institutional practices, physical structures, modes of communication, and social attitudes that assume a much narrower range of human beings than exist."); Saxton, *supra* note 54, at 222.

⁹⁷ Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (1994).

continued existence. The focus is not on welcoming the existence of the suffering person or desiring interaction with him but is instead on empathic feelings regarding the condition being endured. One may in fact be indifferent to the presence or even existence of the other person.

For example, it is possible to feel compassion for a person who is suffering from a grave illness or severe disability but at the same time lack the desire that such person be alive and in the world—especially in my world where I have to encounter her suffering. Of course, compassionate responses may militate against the elimination of such a person because she does in fact exist and have feelings, but that does not mean her presence is welcomed or sought or desired.

The fact that compassionate responses to the living can be consistent with, or at least not obviously antithetical to, indifference to the existence of people with severe disabilities is one thing. But what is more startling is that a compassionate response to the condition of people with disabilities or serious illness is often thought to justify the avoidance of the lives of such people, or even to counsel the end of their lives for those unfortunate enough to exist. Here I refer to prenatal screening to avoid the births of children with disabilities and patterns of advocacy for physician assisted suicide that consistently refer to patients with severe disabilities as examples of candidates in need of such practices.⁹⁸

Looking first at current and likely future prenatal screening practices, it is in large part our imaginative dwelling on the kind of life a potential child with a disability would have that leads us to support selective abortion to avoid such lives.⁹⁹ If they arrive,

⁹⁸ As an example of the latter, Geoffrey Fieger, when he represented Jack Kevorkian in defense of his acts of assisting suicide, cited Christopher Reeve as the sort of patient his client would help commit suicide. Milani, *supra* note 48, at 199–200 n.243.

⁹⁹ Adrienne Asch, along with others, has pointed out how mistaken common assumptions about life with a disability can be. In a recent article, she points out that most people with prenatally detectable disabilities are not hindered from leading fulfilling lives merely by virtue of the characteristics that distinguish them from people without disabilities. See Asch, *supra* note 96, at 322–27. She also directly addresses the question of the good of having a capacity and the presumptive bad of not having it. Having a capacity may be good, she writes, “but the absence of capacity is simply an absence.” *Id.* at 326. It is not, for one thing, a “loss” (as might be experienced by someone who had a capacity, but lost it), nor is it necessarily an absence of something of intrinsic value, as opposed to a “means to an end”—as

they will be treated with care, but wouldn't it be better, the prevailing ethics in prenatal practice tell us, if they never arrived?¹⁰⁰ It is important to emphasize that our current medical technology, except perhaps in rare instances, allows us only to avoid the births of such children once detected rather than to correct the abnormality in utero, so it is clearly lives avoided rather than disabilities corrected that constitutes the current goal of such practices. We cannot justify the lack of welcome for most of these children who would have been born on the grounds that they would have suffered if they were in fact born. While it is true that prenatal screening detects some conditions from which children will horribly suffer, such as Tay Sachs disease,¹⁰¹ the most common use of such testing is to identify and select against Down syndrome,¹⁰² a condition which

visual capacity is a means to (but not the only means to) aesthetic pleasure. *Id.* at 324–27. She writes, “Brief acquaintance with people who have disabilities and who work, play, study, love, and enjoy the world should demonstrate that very few conditions preclude participating in the basic activities of life, even if some conditions limit some classes of them, or methods of engaging in them.” *Id.* at 324; see also National Council on Disability, *supra* note 54, at 284–88 (discussing both the underestimation of the life quality of people with disabilities and the fallibility of medical predictions).

¹⁰⁰ “For whom?” of course, is the critical and often unasked question, although courts challenged by wrongful life claims have been unable to avoid this issue. In the wrongful life cause of action, the child alleges injury on the basis of having been born because of the negligence of a health care provider in the delivery of carrier screening or prenatal care. The perceived impossibility of determining that no life would be preferable to life, and birth thus causing injury, has caused most jurisdictions to reject the wrongful life cause of action. See, e.g., *Elliott v. Brown*, 361 So.2d 546, 547 (Ala. 1978) (“The infant plaintiff would have us measure the difference between his life with defects against the utter void of nonexistence, but it is impossible to make such a determination.” (quoting *Gleitman v. Cosgrove*, 227 A.2d 689, 692 (N.J. 1967)). But see ALLEN BUCHANAN ET AL., FROM CHANCE TO CHOICE: GENETICS AND JUSTICE 242–56 (2000) (arguing that a wrong may be done by bringing a child with a disability into the world even if the harm is not done to that child).

¹⁰¹ Within the first year of life children with Tay-Sachs disease, who at birth appear “[n]ormal . . . begin to regress and lose contact with their families and environment . . . , declining inexorably toward a totally vegetative state.” Madeleine J. Goodman & Lenn E. Goodman, *The Overselling of Genetic Anxiety*, HASTINGS CTR. REP., Oct. 1982, at 20. “[M]ental retardation, . . . convulsions, . . . blindness, . . . gross physical deformit[ies], . . . [and] pain” characterize the remainder of the child’s life. *Curlender v. Bio-Science Labs.*, 165 Cal. Rptr. 477, 480–81 (Cal. Ct. App. 1980). The life span of children with Tay-Sachs is two to four years. Goodman & Goodman, *supra*, at 20.

¹⁰² Mary Mahowald, *Are’n We All Eugenicists? Commentary on Paul Lombardo’s “Taking Eugenics Seriously,”* 30 FLA. ST. U. L. REV. 219, 221 (2003). Mahowald argues that social attitudes and practices relating to prenatal testing for

comes with no more suffering than the average lot.¹⁰³ Moreover, not only does the practice of prenatal selection suggest that children with genetic disabilities are not welcome but also, as a number of scholars writing in this area have pointed out, the routine selection against fetuses or embryos with disabilities signals a lack of welcome to people who are currently living with disabilities.¹⁰⁴

As the welcome of children born with disabilities is suspect in our current practices of prenatal screening, so is the welcome of other people with severe disabilities in our current openness to consider assisted suicide for them and in our readiness to accept a withdrawal of life-sustaining treatment for such individuals. Our compassion, by which we imagine and perhaps even fear the tragic condition of the other person befalling us, tells us that the person with a severe disability is rational to want to end his life. In fact, that conclusion—that life is not worth living in such a condition—is constantly thrust in the face of people with severe disabilities. For example, Adam Milani reminds us that when Christopher Reeves was interviewed on television in 1995 following the riding accident that caused him to become quadriplegic, he said that he had briefly considered suicide after his accident.¹⁰⁵ While this was only a passing remark in an hour-long interview, “that sound bite appeared in almost every commercial advertising the interview, in the introductory piece

Down syndrome illustrate “bad eugenics” for a number of reasons, one of which is the “deep seated ableism on the part of society’s leaders.” *Id.* at 234. “This ethos of ableism no doubt influences individual women and couples to conform to its standard by avoiding the birth of a child who is disabled.” *Id.*

¹⁰³ *Id.* at 232.

¹⁰⁴ Adrienne Asch writes that societal promotion of prenatal selection to avoid disabilities inherently conflicts with the goal of social inclusion of persons with disabilities: assumptions that underlie the social endorsement of prenatal selection—assumptions (which she critiques as uninformed and narrowly conceived) about the quality of life of people born with disabilities—undermine the welcome of people with disabilities that laws such as the Americans with Disabilities Act purport to provide. The necessary, if unintended, consequences of institutional promotion of prenatal selection against disabilities are a devaluation of the lives of persons who live now and will live in the future with disabilities. Asch, *supra* note 96, at 332–39; see also David Wasserman, *A Choice of Evils in Prenatal Testing*, 30 FLA. ST. U. L. REV. 295, 299 (2003) (preferring the “evil” of allowing prenatal selection for any trait parents wish to test for, with the potential risk of degrading the parent-child relationship and commodifying children, to the “evil” of allowing testing only for certain disabling traits, with the effect of stigmatizing people with disabilities).

¹⁰⁵ Milani, *supra* note 48, at 199–200 n.243.

preceding it, in the lead of the Associate Press piece about it, and in several headlines reporting it."¹⁰⁶ Other people with substantial and visible disabilities report similar experiences.¹⁰⁷

One of the many problems with assisted suicide is the confluence of motives of the people who may be involved. Assisted suicide, whether by a spouse or a physician, would be somewhat less troubling if the assistant truly desired the continued presence in the world of the individual for whom death is sought, and truly desired the presence of that individual in her current and perhaps future deteriorating condition, rather than holding onto some vague wish for the way she used to be. In such a case, the assistant's agreement to help her spouse, friend, or patient toward death would be antithetical to her own wishes, rather than in conformity with her similar appraisal of the situation: that non-existence of the suffering person is better than this existence. Only then might we be able to argue legitimately that permitting assisted suicide respects the individual patient's autonomy.¹⁰⁸

Compassion seeks to end—in its better form, to end the suffering of the other person; in its less laudable form, to end the sorrowful feelings we ourselves experience when faced with someone else's suffering. If we can end or avoid suffering without ending or avoiding lives then perhaps welcome can be achieved as well as compassion, but it is a fundamentally different orientation. Welcome says, "Come as you are." You are welcome here and everywhere without regard to any impairment or dependency.

B. *Alterity and Rupture*

*"A life is not important except in the impact
it has on other lives."¹⁰⁹*

As with welcome, the concepts within Levinas's work of alterity and rupture offer ways of approaching the suffering

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ Autonomy is the primary principle upon which advocates for physician-assisted suicide rely. See generally Lois Shepherd, *Dignity and Autonomy after Washington v. Glucksberg*, 7 CORNELL J. L. & PUB. POL'Y 43 (1998).

¹⁰⁹ This quote from Jackie Robinson is found on his grave. Find A Grave, Jackie Robinson's headstone, at <http://www.findagrave.com/photos/101c/222/robinson1.jpg> (last visited Mar. 20, 2003).

person or the person in need of care that can be contrasted with some of the more problematic aspects of a compassionate response. Compassion may allow the object of compassion to remain simply that—an object that is understood by reference to the observer and who is in a sense possessed by the observer. The idea of alterity is that the other person is uniquely outside of the observer and cannot be understood by reference to the self. Rather, the self is to be understood by reference to the other person. Rupture captures the idea that the ethical encounter with the other person ruptures the observer's world; he is no longer a mere observer, but instead is someone who is in conversation and relation with the other person.

1. Alterity

As we have already seen, Levinas's work calls for a radical reorientation from the self to other people. He challenges the primacy of the ego, or the I, or what he calls "egology"¹¹⁰ in Western philosophy. When "I" am first, he tells us, when truths and values are determined by reference to myself and I understand other people primarily by their usefulness to me or even merely by way of comparison to myself, a totality is achieved.¹¹¹ The other person is "neutraliz[ed],"¹¹² reduced to nothing that can alter or affect me. John Wild has explained Levinas's conception of such "totalizers" as "satisfied with themselves and with the systems they can organize around themselves as they already are."¹¹³

¹¹⁰ TOTALITY AND INFINITY, *supra* note 88, at 44.

¹¹¹ John Wild, *Introduction to TOTALITY AND INFINITY*, *supra* note 88, at 12. Hence the title, "Totality and Infinity." For Levinas, infinity, which is what we desire that is truly outside of ourselves, *other* than ourselves, is found in the other person. *See supra* note 98.

¹¹² TOTALITY AND INFINITY, *supra* note 88, at 45–46.

¹¹³ Wild, *supra* note 111, at 17. The traditional assumption that we know, understand, and experience others by reference to the self is not merely, in Levinas' view, an orientation troubling at the level of individual relationships, but is the orientation of violence, war, and politics. PEPPERZAK, *supra* note 1, at 123. Thus, while Levinas' work in *Totality and Infinity* focuses on how an individual subject, or I, must treat other people, rather than describing the rules that should govern states or communities, his eye is ultimately on the world scene. The question Levinas tells us he seeks to answer in this work is no less than how do we replace war with peace? *Id.* at 122. The classic answer to this question is that we achieve peace through expectations of universal behaviors, "objective" organizations that treat all people equally, requirements that individuals "limit[] the range of their desires" in exchange for the *satisfaction* of their needs, and a political order that

According to Levinas, this way of understanding the world only through the self is a perspective promoted by Socrates' teaching and all of Western philosophy. To be free in this tradition is to "receive nothing of the Other," but what is already in me and that I possessed as though from all eternity.¹¹⁴ Freedom in the Western tradition means "the reduction of all Otherness to the Same,"¹¹⁵ and thus Levinas calls this philosophical tradition "the primacy of the same."¹¹⁶ The "primacy of the same" is the philosophy of power, where other people are suppressed or possessed in order to maintain the I unchanged.

Levinas rejects this Western focus on autonomy. Rather than focusing on the self, ethics requires that we focus on the other. This re-orientation is not merely about who comes first, whose claims are precedent—a subject that will be addressed below¹¹⁷—but is also a way of relating to others. Other people are not to be understood as another instance of the self. They

represents a "compromise of interested forces." *Id.* at 127. This answer is unsatisfactory to Levinas as totalizing, impersonal, neglectful of the individual's "unicity," and ultimately tyrannical. TOTALITY AND INFINITY, *supra* note 88, at 47; PEPPERZAK, *supra* note 1, at 127. In such a system, individuals are overcome; they become singular instances of a universe, with "roles and functional definitions," PEPPERZAK, *supra* note 1, at 127, and eventually "bearers of forces that command them unbeknown to themselves." TOTALITY AND INFINITY, *supra* note 88, at 21. According to scholar Adriaan Peperzak, "Levinas' search is oriented to another peace." PEPPERZAK, *supra* note 1, at 127. Rather than the uncertain and unstable peace of totalization, Levinas looks to the originary peace found in the face to face relationship between an individual and a stranger. This is a relation that has been generally neglected by the Western tradition. *Id.* at 128. It is like a "lost memory." *Id.*

¹¹⁴ TOTALITY AND INFINITY, *supra* note 88, at 43.

¹¹⁵ *Id.* at 45.

¹¹⁶ *Id.* Levinas writes:

Cognition [in Western philosophy] consists in grasping the individual, which alone exists, not in its singularity which does not count, but in its generality, of which alone there is science. And here every power begins. The surrender of exterior things to human freedom through their generality does not only mean, in all innocence, their comprehension, but also their being taken in hand, their domestication, their possession. Only in possession does the I complete the identification of the diverse In a civilization which the philosophy of the Same reflects, freedom is realized as a wealth. Reason, which reduced the other, is appropriation and power.

Emmanuel Levinas, *A Commentary on Philosophy and the Idea of the Infinite*, in PEPPERZAK, *supra* note 1, at 88, 97–98 [hereinafter "*Philosophy and the Idea of the Infinite*"]. This essay preceded the larger work, *Totality and Infinity*, and is a precursor to it. PEPPERZAK, *supra* note 1, at 38.

¹¹⁷ See *infra* text accompanying notes 136–52.

are not to become a "theme and an object," falling "into the network of a priori ideas, which I bring to bear so as to capture it."¹¹⁸ The human other is not reducible to a form of the self and in this sense is not capable of being comprehended and thus not capable of being possessed or used. Levinas contrasts the way we experience the other person with the way we comprehend objects. "An object, we know, is integrated into the identity of the Same; the I makes of it its theme, and then its property, its booty, its prey, or its victim."¹¹⁹ Rather than as an object, the other person must be encountered as something completely exterior to one's self, a radical alterity, an enigma, never truly understood.¹²⁰

John Wild explains the basic differences between the Western philosophical tradition's emphasis on the "I" and Levinas's emphasis on the "Other" as one of orientation:

The basic difference is between a mode of thought which tries to gather all things around the mind, or self, of the thinker, and an externally oriented mode which attempts to penetrate into what is radically other than the mind that is thinking it. This difference emerges with peculiar clarity in the case of my meeting with the other person. I may either decide to remain within myself, assimilating the other and trying to make use of him, or I may take the risk of going out of my way and trying to speak and to give to him. This does not fulfill a *need*. I can satisfy my needs more adequately by keeping to myself and the members of the in-group with which I am identified. And yet it is the expression of a *desire*, as Levinas calls it, for that which transcends me and my self-centered categories.¹²¹

How does compassion as commonly understood measure up to the ideals of an appreciation of the alterity of the other person? Imaginative dwelling, seeing others as like us means

¹¹⁸ *Philosophy and the Idea of the Infinite*, *supra* note 116, at 97.

¹¹⁹ *Id.* at 109. According to Francis Dominic Degnin, "the very definition and condition for violence is to ignore, reduce, attack, or dismiss the irreducible moral singularity of another person. Most often this is done through treating a person in terms of one's own needs, categories, or principles." Francis Dominic Degnin, *Levinas and the Hippocratic Oath: A Discussion of Physician-Assisted Suicide*, 22 J. MED. & PHIL. 99, 104 (1997).

¹²⁰ *Philosophy and the Idea of the Infinite*, *supra* note 116, at 97; PEPERZAK, *supra* note 1, at 21–22 ("Since the other cannot become a moment of such a totality, it is not a phenomenon but rather an 'enigma' not to be defined in phenomenological terms. If visibility, in a broad and metaphorical sense, is a feature of every being that can become a phenomenon, Levinas may even call the other 'invisible.'").

¹²¹ Wild, *supra* note 111, at 16.

that we will presume to know more than we do or can about their suffering, that we will appropriate the other person's suffering, that we will comprehend her as a theme rather than a person, and that we may choose to act to relieve the other person's suffering out of mixed motives that include a need to relieve our own suffering caused by viewing and being in the presence of the object of our compassionate feelings. These are failures to appreciate that the person whose suffering is contemplated is a uniquely other person than the one who observes the suffering. Rather than looking inward to relate to another person, one must look to that person. As Levinas writes, "One does not question oneself concerning him; one questions him."¹²²

Therefore, in the examples considered in the critique of compassion relating to people with disabilities, the ethical orientation Levinas provides would require that we do a number of things differently. For one, we would not try to use our imagination as a primary measure—or even as a reliable measure—of how someone who is suffering feels or what she needs or desires.¹²³ We would instead listen to the person for whom we might experience empathic feelings in order to appreciate her perspective. The comparison of the two right to die cases discussed in Part IV of this Article reveals how important this difference in approach can be. In the case of Elizabeth Bouvia, the justices of the California appeals court imagined for themselves what Bouvia's life must be like and essentially declared it to be without value.¹²⁴ In the case of Ms. B, the court took great care to let Ms. B speak for herself, and while approving the removal of life support on the basis of autonomous choice, concluded that Ms. B had much to live for and much to contribute to society.¹²⁵

Secondly, orienting ourselves to the alterity of the other person would mean that we take care not to act in ways to relieve our own suffering by way of association but to focus instead on the other person's needs. The compassionate

¹²² TOTALITY AND INFINITY, *supra* note 88, at 47.

¹²³ In this vein, consider the work of Adrienne Asch on the issue of whether a person born with a physical impairment experiences that impairment in the same way as someone who has lost an ability through trauma or sickness. See Asch, *supra* note 96, at 324–27.

¹²⁴ See *infra* text accompanying notes 172–87.

¹²⁵ See *infra* text accompanying notes 196–223.

approach gives the appearance of this latter focus, but its adoption of imaginative dwelling as the mechanism for producing a caring response allows for a mixture of motives that the orientation toward alterity would not.

Focus on the other person as other rather than as a form of ourselves also makes us open to evaluating and perhaps changing some of the social norms and legal rules that may work for us and in which we may feel comfortable but which do not appropriately accommodate, respect, and care for the other. Thus, for example, while the able-bodied, white, educated population tends to approve of courts' allowing persons with disabilities to be removed from life support measures on the basis of their expression of autonomous choice alone, people with disabilities often decry such practices as not providing the same kind of protection against suicidal impulses to the disabled as to the abled.¹²⁶

2. Rupture

Rupture means, at a minimum, that we are changed by our experience of our face-to-face encounter with the other person. Because we see the other person outside our own referential

¹²⁶ In August of 1995, Oregon's Death with Dignity Act (allowing physician-assisted suicide) was declared unconstitutional and enjoined by the United States District Court in Oregon because the Act denied terminally ill patients the equal protection of the laws regarding suicide and physician malpractice as are granted to persons who are not terminally ill. See *Lee v. Oregon*, 891 F. Supp. 1439, 1439 (D. Ore. 1995) (granting plaintiffs' motion for summary judgment as to Equal Protection Clause claim and granting permanent injunction against recognition of the Act), *vacated by* 107 F.3d 1382 (9th Cir. 1997).

Similar arguments about the lack of equal treatment regarding the suicidal impulses of the healthy and the disabled have been made in other contexts. See, e.g., *McKay v. Bergstedt*, 801 P.2d 617, 632 (Nev. 1990) (Springer, J., dissenting) (disagreeing with majority's confirmation of right of man with quadriplegia to remove life-sustaining respirator). Justice Springer concluded that majority's willingness to allow Mr. Bergstedt's ventilator to be removed, when he was not dying, constituted a "prejudicial treatment of Mr. Bergstedt because his assisted suicide was sanctioned and facilitated only because of his disabled condition." *Id.* at 635 (Springer, J., dissenting). The dissent also quotes with approval from the *amicus curiae* brief submitted in the case by Thomas J. Marzen, general counsel of the National Legal Center for the Medically Dependent and Disabled: "[V]alue judgments . . . about the worth of Mr. Bergstedt's life have clouded [the] ability to properly assess the suicidal basis for Mr. Bergstedt's request to die. . . ." *Id.* at 633-34 (Springer, J., dissenting). Justice Springer referred to the *amicus* brief even though it had been rejected by the court because of late filing because "it is the only argument to be found in this case that favors life instead of death." *Id.* at 634 n.6 (Springer, J., dissenting).

framework, the experience of rupture goes far beyond the experience of attempting to comprehend the other person. For example:

Another comes to the fore *as other* if and only if his or her 'appearance' breaks, pierces, destroys the horizon of my egocentric monism, that is, when the other's invasion of my world destroys the empire in which all phenomena are, from the outset, a priori, condemned to function as moments of my universe.¹²⁷

The other person is not merely to be understood by me as an object that I might possess but is to be recognized as someone with whom I am engaged.¹²⁸ Within this ethical orientation, one is transformed by the encounter with the stranger.

By contrast, the compassionate response requires no such transformation, no "transcendence" from the self. We may be compassionate yet see other people as functioning as mere "moments in our universe." In the *DeShaney* case, Joshua appears to have been such a mere moment in the Court's universe.

It is not adequate or ethical to be a justice on the Supreme Court and to hear the *DeShaney* case and to respond, simply and by reference to precedent, that the law does not require the state to protect Joshua from his abusive father. If I am that justice, then Joshua's story, his legal issue, becomes part of my own castle of the law. I require that Joshua himself stay outside of my castle, and I refuse to consider what kind of structure of law he needs for shelter and protection. Operating on compassion, I can say that I was moved,¹²⁹ that I found the child's story moving, but I need not move. Under the ethics of radical responsibility, I am moved by this case to move. I am changed. I cannot be who I was. Because this child's call was made upon me, I cannot be the person I was before that call was made.

¹²⁷ PEPPERZAK, *supra* note 1, at 19–20.

¹²⁸ As Peperzak explains, my response to the other person can be to see her as instrumental to my needs, or to observe her from an aesthetic perspective, having such and such color hair, eyes, and other features, but neither of these responses allows the other to reveal herself as other. They merely incorporate the other as a part of self. *Id.* at 19.

¹²⁹ As the Chief Justice wrote, "Judges and lawyers, like other humans, are moved by natural sympathy in a case like this . . ." *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 202 (1989).

This is the idea of rupture, and it is, under Levinas's work, a necessary step for the self to exist. It is our answering the call of the other that calls us into being; the ethical relationship of responsibility is prior to existence. Without the other person and communication with the other person, there is no thought available to us. We are without awareness, thought, or beingness. We only exist because of other people and their claims upon us. It is as if the phone is ringing. If you answer it, you are there, and if you do not, you are, for the person calling, in every way, "not there."

If Joshua calls and I do not answer that call then I am not there. It is as if the judge is sitting at home and the phone rings and he knows it is Joshua and he knows Joshua is in trouble and he says "I know that, but I can't answer it because of precedents and rules that tell me when I can and can't answer the phone. I feel bad for that child who is calling; I feel compassion for him, but I cannot answer." If I am the judge and I do not answer, I may as well not be there.

We can contrast that response with the judge who hears the phone ringing and knows it is Joshua calling and that he is in trouble, but who says, "I know the precedents and rules tell me the state has no duty here, but I have to pick up the phone. I don't know what to do, I don't know the answer, but I will pick up the phone." This is the rupture. I am brought into a relationship with the child where I must, in effect, look into his face and answer for the suffering that is found there. It is a relationship of responsibility. I have to "face" my responsibility. The first step in acting on that responsibility is to answer the phone.

In the *DeShaney* case, Joshua called upon the justices of the Supreme Court, as he called upon state workers to protect him, and the justices—in particular Chief Justice Rehnquist, Justice White, Justice Stevens, Justice O'Connor, Justice Scalia, and Justice Kennedy¹³⁰—were not there. I do not know how the Supreme Court should have defined the duties of the state or whether or not those duties were properly met in this case, but the point here is that the Court did not understand itself to be in a relationship with this child. The Court was grossly dismissive of the child's claim. In fact, its expression of sympathy was not

¹³⁰ *DeShaney*, 489 U.S. at 190.

offered from the Court itself but was in fact carefully removed from it. The opinion tells us that other people—" [j]udges and lawyers, like other humans, are moved by natural sympathy in a case like this . . ." ¹³¹—not that the justices themselves were so moved. In addition, the Justices chose language to deny in effect their own role in the decision to offer Joshua no aid.¹³² The Court, in describing the relevant precedent cases, wrote: "But these cases afford petitioners no help. Taken together, they stand only for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being."¹³³ Benjamin Zipursky insightfully writes:

By making 'cases' the subject of the first sentence, the Court obscured the fact that it was the Justices who decided to offer Joshua no help. Moreover, the Court aspired to report on what these cases 'stand for,' suggesting that their meaning exists independently of the Court's interpretation of them. Yet, as the Justices' disagreement in *DeShaney* indicates [Justices Brennan and Blackmun argued in dissent that the earlier cases did allow the Court room to find for Joshua and his mother], these cases can be read in different ways.¹³⁴

If a father is beating his son and nobody helps him or tries to help him or has a duty to help him, that is wrong. Joshua in effect asked for help all the way to the Supreme Court. When he got there, the place was empty.

C. *Responsibility and Action*

*"Every gun [that is] made, every warship [built], every rocket fired signifies, in the final sense, a theft from those who hunger and are not fed, those who are cold and not clothed."*¹³⁵

Answering the call when it is made is the first step towards fulfilling the responsibility we have towards one another. For Levinas, it is what makes us human. Our existence, not only

¹³¹ *Id.* at 202.

¹³² Zipursky, *supra* note 15, at 1118.

¹³³ *Id.* (quoting *DeShaney*, 489 U.S. at 199–200).

¹³⁴ *Id.*

¹³⁵ Dwight D. Eisenhower, *Toward a Golden Age of Peace, Address Before the Am. Soc. of Newspaper Editors* (Apr. 16, 1953), in *PEACE WITH JUSTICE* 34, 37 (1961).

who we are specifically but also just our very being, depends upon the other people to whom we are responsible. This responsibility means that we are obligated to respond to the suffering and needs of others, and we are responsible to everyone, for everything. The subject's responsibility to the other is infinite in that it is never satisfied. At no time may the subject rest, comfortable that she has given enough, that the claims placed upon her by the other person are satisfied. Under Levinas's account of ethics,¹³⁶ "I can never do enough."¹³⁷

¹³⁶ See ROBERT BERNASCONI & EMMANUEL LEVINAS, *ENCYCLOPEDIA OF PHILOSOPHY* 580 (Paul Edwards ed., 1972). "Levinas has readily conceded that he does not provide an ethics but only an account of the conditions of ethics." *Id.*

¹³⁷ *Id.* The combination of Levinas' idea of rupture and responsibility might appear to overrun the individual. Within the context of the caregiving responsibilities of nurses, some scholars have rejected the relational feminists' "ethics of care" on this ground, namely, that the nurse is overrun—she gives and gives until she is a non-person, an entity engaged in "slave-caring." Nelson, *supra* note 19, at 10. This possibility—that caring reduces the caregiver to nothing—is especially troubling when we acknowledge that caregiving has traditionally been the province of women. As Robin West has written, the "selfless" woman may be so out of genuine empathy for others, or (and this is what we must be wary of) out of a "harmful and injurious lack of regard for oneself: a sense of self-loathing, a lack of self-esteem or self-respect, and at root a failure to give oneself one's 'due': a quite general, massive denial of the importance, equality, and dignity of oneself." WEST, *supra* note 12, at 79. Relational feminists, taking the cue from Carol Gilligan, have tended to answer the criticism of self-abnegation by appealing to the other moral orientation, that of justice, and emphasizing its equal importance to care. See *id.* at 79–84; Bookman & Aboulafia, *supra* note 19, at 172–73.

Levinas, by contrast, does not counterpose care (or for him, responsibility for the other) with justice, as if they are separate moral demands with separate origins. While it is true that for Levinas concerns about justice (which works by rules that apply to all) might be seen as a corrective to the ethics of the face-to-face relation and vice versa, justice is also a required dimension, a necessary conclusion, an outgrowth of (rather than a counterpoint to), the responsibility the subject has to one other—because the subject has a responsibility not just to those within a "zone of care" or with whom the subject has a particular relationship (in contrast to typical formulations of the feminist ethic of care) but to all others, and even to himself as an other (to others). Moreover, the personal ethic of openness to the other in encounter is not relieved by the subject's awareness that he is also an "other." Nor is it relieved by the appreciation that universal rules of justice may be necessary for ordered relations between the many. Levinas does not relinquish his claim that the subject to be in ethical orientation toward the other must be altered by the encounter with the other's alterity. He counsels that the rupture that occurs in that ethical encounter with the other does not cause us to be "eaten up." The idea of rupture is not that the other has power over us, willing us to do what is commanded, reducing us to nothing, rather that we are not able to exercise our power over him. The other's "alterity is manifested in a mastery that does not conquer, but teaches. Teaching is not a species of a genus called domination . . ." TOTALITY AND INFINITY, *supra* note 88, at 171.

Furthermore, there is no reciprocity of claims. There is no semblance of contract, either imaginarily negotiated, as in some social contract theory, or in terms of an imposed *quid pro quo*. There is not even a consideration by the subject of what the subject's treatment of the other person might prompt by way of reciprocal generosity, as the golden rule might at times suggest—this other person is like me, therefore I will treat him like I would like him to treat me.¹³⁸

You cannot learn much of Levinas's ideas before asking what such an account of ethics can mean as a practical matter. Levinas has little to say on that question. He says even less on what his theory of ethics and existence might offer with respect to our approach to law, to what extent we might be influenced by his thought in our expectations of social behavior in the legal context. When he mentions law, he speaks of it as outside the realm of his concern.¹³⁹ Because the ethical writings of Levinas expect so much of a person, perhaps we should just dismiss their relevance to law or considerations of social policy. I think we should not for the following reasons.

First, we must acknowledge that there has been and continues to be support for a role in the law and considerations of social policy for a caring or fellow feeling response to people that is not encompassed within systems of rules or principles based simply upon a recognition of the equal right of every

¹³⁸ The subject's responsibility to the other is *asymmetrical* in that the subject has no claim to reciprocity from the other. I have no right to ask of the other person what the other person asks of me. BERNASCONI & LEVINAS, *supra* note 136, at 580. Bernasconi writes: "My obligations to the Other are not contracted by me. They not only precede any debts I incur, but also go beyond anything I could possibly satisfy. . . ." *Id.* at 579.

¹³⁹ "Responsibility for the neighbor is precisely what goes beyond the legal and obliges beyond contracts; it comes to me from what is prior to my freedom, from a nonpresent, an immemorial." Emmanuel Levinas, *God and Philosophy*, in EMMANUEL LEVINAS: BASIC PHILOSOPHICAL WRITINGS 129, 142 (Adriaan T. Peperzak et al. eds., 1996). See generally PEPERZAK, *supra* note 1, at 166–84, concerning Levinas' discussions of social justice, a consideration required by the introduction of "the third," the third person who is not accounted for in the face-to-face relation between the self and the other. The existence of the third, or other others, limits our ultimate ability to make only *one* other prior to all else; instead, we must have a system of justice that does have universal rules of application, and that recognizes that the subject is an other for other people, thus treating all as equal. But such universal rules bring "universalization, objectification, totality, and even calculus," *id.* at 180, the ways of human interaction that Levinas has revealed as violent. In this way, ethics and justice might be said to pose constant challenges to one another. See *infra* note 148.

person to be free from unjustified interference with their person or what we have decided is their property. The examples are abundant: from laws passed providing aid to the poor,¹⁴⁰ requiring hospitals to provide emergency care,¹⁴¹ and funding programs to prevent premature births, to judicial decisions wrestling with abortion rights, particularly those of minors,¹⁴² or with the education rights of children,¹⁴³ or with the rights of terminally ill individuals seeking a withdrawal of life-support measures¹⁴⁴ or physician assisted suicide.¹⁴⁵ Many legal contexts

¹⁴⁰ This reference is not to suggest that such programs are adequate.

¹⁴¹ See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000).

¹⁴² See Lois Shepherd, *Looking Forward with the Right of Privacy*, 49 U. KAN. L. REV. 251, 294–95, 306–07 (2001) (arguing that the requirement of a judicial bypass option to avoid consent or notice to parents reveals some sensitivity to the needs of pregnant teenagers, and does not merely respect their autonomy). In *Bellotti v. Baird*, the Supreme Court writes, “the potentially severe detriment facing a pregnant woman is not mitigated by her minority. Indeed, considering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor.” 443 U.S. 622, 642 (1979) (citations omitted).

¹⁴³ See Henderson, *supra* note 14, at 1593–1609 (identifying *Brown v. Board of Education*, 347 U.S. 483 (1954), as illustrating empathic understanding, “leading to a transformation of legal understanding, an opening of opportunities for new legal categories and interpretations”).

¹⁴⁴ The early cases regarding the rights of terminally ill individuals to be removed from life support measures gave considerable attention to the quality of life that could be prolonged, see, e.g., *In re Quinlan*, 355 A.2d 647, 656–57, 659, 663–64 (N.J. 1976) *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976). Later cases have focused primarily on the patient's preferences, see, e.g., *In re Conroy*, 486 A.2d 1209, 1221–37 (N.J. 1985). With respect to the withdrawal of life-sustaining treatment for people who are not terminally ill, see *McKay v. Bergstedt*, 801 P.2d 617, 622–23 (Nev. 1990), where a discussion of quality of life still takes place. In particular, note the expression of the dissenting justice, who disapproved of the majority's agreement to allow withdrawal of life support, but nevertheless writes, “I have agonized over this case. At one moment I am haunted by the picture of a hopeless, wretched and tortured person who has no desire except to end his suffering by ending his life . . . How can any one who can help him possibly turn down his plaint?” *Id.* at 637 (Springer, J., dissenting).

¹⁴⁵ See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790, 799, 836–39 (9th. Cir. 1996) (finding that the degree of suffering of terminally ill patients determined both the strength of their liberty interest in pursuing physician-assisted suicide and the relative weakness of the state's interests in prohibiting such practices), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997). Prior to reaching *en banc* review, the panel of the appellate court had also wrestled with the role of compassion in consideration of the plaintiffs' claims. See *Compassion in Dying v. Washington*, 49 F.3d 586, 594 (9th. Cir. 1995); see also Shepherd, *supra* note 142, at 288–99 (discussing petitioners' briefs in the Supreme Court case that relied on a constellation of liberty interests to support a constitutional right to

require consideration of the ethical response due from one person or group—and from the court itself in the context of adjudication—to another person that goes beyond principles of respect for autonomy of the person or equality. Sometimes consideration of the ethical response is discussed outright, as appeals to compassion for the suffering of the terminally ill were made in the Supreme Court cases regarding physician-assisted suicide.¹⁴⁶ At other times the effect of such considerations seem apparent, but there is little discussion about them. In still other cases, the apparent lack of such consideration—consideration of what kind of treatment or response is due one person by another or society as a whole other than simply non-interference or equal treatment—opens the court to widespread criticism, as in the *DeShaney* case.

This caring or fellow feeling response is often described as compassion, yet as we have seen, compassion has serious shortcomings, not the least of which is that it does not entail responsibility. Beside an ethics of radical responsibility, an ethics of compassion is a dim impulse. There is a place in law and social policy for the caring response; although, as I acknowledged in the beginning of the Article, that place may be properly bounded by concerns for autonomy and the rule of law. Compassion does not adequately fill that place. An ethics of radical responsibility may. Its emphasis on responsibility requires us to ask hard questions about what should be done by the state or society as a whole or what should be expected in the interactions between individual people, even if full assessment of the situation does not require that action be taken. Compassion is too often viewed as a mere emotion that stands outside the law and any considerations of duty. No one must move as a result of it. The ethics of radical responsibility in its insistence on welcome, an appreciation of alterity and an openness to being changed by our encounters with one another, in addition to its insistence on responsibility, provides an approach that is distinctively different from compassion and that avoids some of its weaknesses.

The second reason why we should not dismiss the potential contribution that Levinas's philosophical works might have to

physician-assisted suicide, that constellation including the avoidance of suffering, decisional autonomy, and bodily integrity).

¹⁴⁶ See Shepherd, *supra* note 142, at 308–10.

legal and social theory is that they provide an interruption to our usual ways of thinking, for example, to our uncritical acceptance of compassion as the right ethical response to someone who is suffering. While Levinas's work does not provide us with principles or rules that we might follow,¹⁴⁷ it offers an orientation by which we might measure the humanity of our social institutions and legal decisions.¹⁴⁸ We might ask, how and in what ways do our existing social expectations differ from an orientation of radical responsibility and how and in what ways do those social expectations appear inadequate against such an orientation?¹⁴⁹ There is a radical difference between starting with the question, "What am I to do here and now, in answer to the call of the other person?" and the question that libertarian and, indeed, most liberal theory begins with, which is, "What is my realm of freedom, what are my rights?" With Levinas, as

¹⁴⁷ Levinas does not offer *principles* of ethics, but instead an experience of obligation. See Degnin, *supra* note 119, at 105. This experience of obligation is, according to Francis Dominic Degnin, "an affective relation and not a principle after all." *Id.*

Obligation is experienced as an absolute call, an *absolute demand*, but it is also without cognitive content. This suggests that although we can argue principles until the cows come home, we will come no closer to understanding the nature of morality—or of our distinctly human nature—until we recognize that at the heart of obligation is an affective relation and not a principle after all. Again, this does not mean that one could or should dispense with moral principles—they are absolutely essential for the sort of justice which allows communities and societies to function and flourish. But their regulative and guiding functions must not replace or obscure the concrete, singular call of obligation which is at their origin.

Id.

¹⁴⁸ The ethics of Levinas requires the subject to answer the call of the Other, even every other, but the rules of justice must order the relations not only between those others and the subject, but also between all such others, with rules of general applicability. Ethics and justice might be said to pose constant corrective challenges to each other, or "interruptions." "Ethics in Levinas' sense," writes Robert Bernasconi, "keeps justice from being satisfied with itself," but justice also serves as a corrective to ethics. BERNASCONI & LEVINAS, *supra* note 136, at 580. Ethics would appear to pose a constant challenge to the general just rule in that it brings to the foreground the case of the particular other in the face to face encounter, in the here and now. Likewise, a constant challenge to the ethical relation (the face to face, here and now encounter) is the requirements of justice, the requirements of a just set of affairs, rules, schemata, and so on. See *supra* note 139.

¹⁴⁹ According to Robert Bernasconi, while Levinas' work has often been criticized as having little to offer to political theory, "his challenge to the good conscience of ethics applies equally well to politics." BERNASCONI & LEVINAS, *supra* note 136, at 580.

with Kant,¹⁵⁰ our duty to help another in any particular situation may be imperfect in that it may not be the strongest moral imperative of the moment, and we may not always be held accountable for living up to it. Indeed, we can't be. Because under the ethics of radical responsibility, the phone is ringing off the hook. Calls are made from every direction, by everyone, and they can't all be answered. Levinas's work provides a moral foundation to understanding that answering those calls is an urgent duty nonetheless. This terrain of ethics is "fractured, uncertain, and unsafe,"¹⁵¹ yet according to Francis Degrin, "[t]he power of Levinas' thought is found precisely in his willingness to live within this uneasiness."¹⁵²

Another lesson we might take from an ethics of radical responsibility is to appreciate the relationship between every one of us and that any action or inaction on our part affects each other person, and that a responsibility for such actions or inactions attaches. Indeed, every act of kindness toward one is as an act of violence toward another.¹⁵³ Choices to allocate funds or energies for one purpose are choices not to allocate them for other purposes. Our actions are never without effect or cost on other people; an ethics of radical responsibility highlights that fact.

This might be illustrated by looking again at prenatal testing and selection practices. In general, the primary emphasis in any evaluation of the practice of prenatal testing and selection is on respecting the autonomy of the prospective parents to make reproductive decisions. Where responsibility is

¹⁵⁰ JEFFRIE G. MURPHY, *KANT: THE PHILOSOPHY OF RIGHT* 51 (1970). Murphy writes:

A duty is imperfect if no one is in a position to demand by *right* that it be complied with. I have, according to Kant, a duty to promote human happiness. This duty is imperfect, however, because no one can demand by right that I make him happy, can regard himself as wronged if I fail to make him happy.

Id. An "imperfect duty," such as the duty of benevolence, is "not constantly and universally binding; that is, we are not obligated or duty-bound to help everyone all the time." *Id.* The same is not quite true for Levinas, because while the duties cannot possibly all be met, they remain obligations nonetheless.

¹⁵¹ Degrin, *supra* note 119, at 106.

¹⁵² *Id.* Degrin further explains, "The ethical life is not an escape from uncertainty, but a responsibility carried out in fear and trembling, without adequate resources or knowledge, knowing that even though the best one can do is rarely enough, one must act nonetheless." *Id.* at 118.

¹⁵³ *Id.* at 104.

recognized, it is only in the doctor's responsibility to provide sufficient and accurate information to prospective parents about their risks of having a child with a condition society considers disabling—to enable them to exercise their autonomy to choose whether to bear a child with a disability.¹⁵⁴ There is virtually no recognition, even among scholars writing within the disability rights critique of prenatal testing,¹⁵⁵ of the responsibility that parents have in making these difficult choices to people living or who will later live with a similar disability. There is, again, little or no recognition that every decision that every parent makes to abort a fetus because of its disability has an effect on the reproductive decisions of the parents to come. While such individual parents do not intend their individual acts to be messages to anyone else,¹⁵⁶ messages are nevertheless received by people living with disabilities similar to those for which abortions take place that it would have been better if they had not been born and by people who are contemplating a pregnancy that these are the conditions they should likewise wish to avoid in their offspring. The ethics of radical responsibility does not mean that these parents are wrong in making the decisions that they do, but it does point out that those decisions have consequences to other people in ways that are not typically acknowledged or considered.

Finally, it seems to me that we do have certain moral intuitions about the responsibilities that certain people have for others in given contexts. Sometimes these responsibilities become legal responsibilities, as when the parties have entered into a contract or a special relationship of trust, such as a fiduciary relationship, or because of family bonds, such as

¹⁵⁴ See, e.g., *Becker v. Schwartz*, 46 N.Y.2d 401, 412–14, 386 N.E.2d 807, 813, 413 N.Y.S.2d 895, 901–02 (1978) (considering a wrongful birth cause of action). Plaintiffs alleged they were never advised by defendants of increased risk of Down syndrome in children born to women over thirty-five years of age or of availability of amniocentesis test. *Id.* at 808–09.

¹⁵⁵ Generally, scholars writing within what has become known as the disability rights perspective take pains to make clear that they are not offering criticism of the individual choices of parents, but of the social and institutional practices that influence those choices. See, e.g., *Asch*, *supra* note 96, at 332–34. However, other scholars have countered that if there is not a problem with the individual choices, then it is difficult to conclude that there is a problem with the collection of those individual choices, which is what we might see as the societal response. See *BUCHANAN ET AL.*, *supra* note 100, at 53–54.

¹⁵⁶ *Asch*, *supra* note 96, at 333.

between a parent and child. Oftentimes, however, there is no legal duty, or the legal duties have been fulfilled. Nevertheless, we still generally understand someone as having had a moral responsibility to do something more or something differently. At those times, while the moral responsibility may not be legally enforced, recognition that it exists may nevertheless have an effect on a legal determination of a different sort. In addition, a judicial or other means of state urging that such responsibilities be fulfilled, without legally requiring it, may improve the quality of people's lives. An example of both of these phenomena can be found in the Supreme Court's opinion in the physician-assisted suicide case of *Washington v. Glucksberg*¹⁵⁷ with respect to the availability of palliative care for the terminally ill. Recognizing that terminally ill patients in pain should be receiving adequate palliative care from their physicians without undue state interference influenced some of the justices in determining that there was no constitutional right to physician-assisted suicide.¹⁵⁸ Moreover, the emphasis within the opinion that such care should be provided, even aggressively, may have influenced the medical profession's improved attention to the matter and to cause some states to review laws that might inhibit appropriate pain relief.¹⁵⁹

It is therefore appropriate to examine moral responsibilities to each other, even if the law does not directly or expressly enforce those responsibilities. Thus, a court, rather than simply feeling compassion for a person who seeks to end his life, should examine the ways in which government programs, institutional systems, individual caregivers, and the prejudices of society against the dependent and the disabled have contributed to or perhaps created this desire. The following discussion of two right to die cases examines, among other things, the courts'

¹⁵⁷ 521 U.S. 702 (1997).

¹⁵⁸ See *id.* at 736 (O'Connor, J., concurring); *id.* at 789-91 (Breyer, J., concurring); Robert Burt, *The Supreme Court Speak: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1234 (1997) (suggesting that the opinions of the court in *Glucksberg* may reflect a willingness to recognize a constitutional right to palliative care), see also Shepherd, *supra* note 142, at 315-17 (discussing the justices' concern that palliative care be available to people who are terminally ill and suffering).

¹⁵⁹ See Alan Meisel, *Pharmacists, Physician-Assisted Suicide, and Pain Control*, 2 J. HEALTH CARE L. & POL'Y 211, 214-26 (1999) (noting statutory and judicial efforts to spur improvements in end-of-life care, especially in pain control).

willingness to inquire into the care received by the petitioners from those who bore responsibility for it.

III. TWO CASES: *IN RE BOUVIA* AND *IN RE MS. B*

The two cases discussed in this Part reveal contrasting approaches towards an individual with severe disabilities who seeks the withdrawal of life-sustaining treatment.¹⁶⁰ In both cases, intelligent, articulate women, experiencing severe paralysis, sought a court order granting the withdrawal of life-sustaining treatment; in the case of Ms. Bouvia case, it was withdrawal of a feeding tube;¹⁶¹ in the case of Ms. B, it was withdrawal of a ventilator.¹⁶² In both cases, the court¹⁶³ agreed that the petitioner was entitled, on the basis of the exercise of her autonomy, to have the unwanted medical treatment discontinued. Yet the two courts adopt very different approaches in the inquiry undertaken prior to approval of the discontinuance of medical treatment and in their respect and concern for the patient. While the legal outcomes were essentially the same, the courts' discussions of the cases before them differ on the fundamental issue, what care is due the stranger? The Bouvia case suggests that little care is due while at the same time revealing similarities with a compassionate approach—a disconcerting combination. The case of Ms. B is more aligned with an orientation of responsibility.

A. *In re Bouvia*

According to the California Court of Appeal, in 1986 Elizabeth Bouvia was 28 years old, quadriplegic, confined to bed,

¹⁶⁰ See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 298 (Cal. Ct. App. 1986); *Re B*, 2 All E.R. 449, 452 (Fam. 2002). The case of Elizabeth Bouvia, from the 1980s and the recent 2002 case of a British woman, Ms. B, although reaching similar legal outcomes, reveal stark differences in the way the courts approach their task. Whether the differences in the approaches of the two courts might be explained by the different times in which they took place, or the different legal systems or cultures, or the varying sensitivities of the particular justices, is not the issue here; rather, I offer the cases to contrast and to judge their approaches and in particular, to note that the more recent British case reveals a much closer affinity to Levinasian concerns than the *Bouvia* case, which is dismally inhuman, and yet arguably displays some aspects of a compassionate response.

¹⁶¹ *Bouvia*, 225 Cal. Rptr. at 298.

¹⁶² *Re B*, 2 All ER at 452.

¹⁶³ The case of Ms. B was heard before a trial court and the case of Elizabeth Bouvia before the appellate court.

in continual pain, had suffered from severe cerebral palsy since birth, and lived with degenerative arthritis.¹⁶⁴ The court also recognized that she was intelligent; had earned a college degree; had married, although her husband had left her; and had been pregnant but suffered a miscarriage.¹⁶⁵ She was without a permanent place to live and without financial means to support herself.¹⁶⁶ At the time of her petition she was a patient at a public hospital maintained by the County of Los Angeles. It appears from the court's opinion that Ms. Bouvia did not necessarily require hospital care but ended up in the public hospital simply because it had been difficult to find another suitable place for her.¹⁶⁷ Because she had little ability to move,¹⁶⁸ she was spoon fed. Because Ms. Bouvia would stop eating when she felt she could not eat more without nausea and vomiting,¹⁶⁹ the medical and dietary staff were concerned that she was not consuming enough nutrients. They were also aware that she had in the past announced a resolve to starve herself.¹⁷⁰ Accordingly, they inserted a nasogastric tube, against her wishes, which she sought to have removed by court order.¹⁷¹

In its opinion, the court discussed at length the inviolability of the right of a mentally competent patient to refuse medical treatment.¹⁷² If the court had stopped there and concluded that because Ms. Bouvia was considered competent she could have the feeding tube withdrawn at her request, perhaps its opinion

¹⁶⁴ *Bouvia*, 225 Cal. Rptr. at 299–300. Note that Paul Longmore has provided a more complete rendering of the facts, and disputes many of the findings of fact accepted by the court. See Longmore, *supra* note 18, at 152–59. For example, Longmore states that Bouvia had never been formally diagnosed as having arthritis, and the court's suggestion that her cerebral palsy and quadriplegia were progressive could not have been true since cerebral palsy is not a progressive condition and her quadriplegia was the result of her cerebral palsy. *Id.* at 157. She had not become "bedridden" until she had become depressed four years earlier and refused to get out of bed. *Id.*

¹⁶⁵ *Bouvia*, 225 Cal. Rptr. at 300.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* ("Efforts by the staff of real party in interest County of Los Angeles and its social workers to find her an apartment of her own with publicly paid live-in help or regular visiting nurses to care for her, or some other suitable facility have proved fruitless.").

¹⁶⁸ *Id.* ("[A] few fingers of one hand and some slight head and facial movements.").

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.* at 300–04.

would not have taken on the offensive tone that it did. Because the hospital¹⁷³ argued that previous decisions permitting the withdrawal of life-support procedures involved only a hastening of death in terminal situations and Ms. Bouvia's condition was not terminal, the court entered an evaluation of Elizabeth Bouvia's quality of life.¹⁷⁴ This portion of the court's opinion is so shockingly insensitive from any ethical standpoint that it does not take a French philosopher to point out its problems. Moreover, to the extent it might be considered at all compassionate, it should serve as a warning to the effects of at least that kind of compassion. Quoted here are the most offensive passages:

In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding.¹⁷⁵

Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone?¹⁷⁶

Here, if force fed, . . . [p]etitioner would have to be fed, cleaned, turned, bedded, toileted by others for 15 to 20 years! Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness.¹⁷⁷

The statements quoted above from the court's opinion were unnecessary if we are to believe the court that the decision to forego life-support "is a moral and philosophical decision that,

¹⁷³ "The real parties in interest" were the county hospital, its physicians, and its administrators. *Id.* at 304.

¹⁷⁴ It did so in response to the hospital's argument that certain state interests should prevail over the right to refuse treatment, namely, the state's interests in preserving life, preventing suicide, and maintaining the ethical standards of the medical profession. *Id.* at 304-07. The other state interest often asserted in these cases, protecting innocent third parties, was not an issue.

¹⁷⁵ *Id.* at 304.

¹⁷⁶ *Id.* at 305.

¹⁷⁷ *Id.*

being a competent adult, is hers alone.”¹⁷⁸ These quotes are much more troubling, however, than simply being gratuitous. Their presence in the opinion, taken together with the opinion’s failure to express interest in or concern about the quality of care Ms. Bouvia has received, express presumptions about Ms. Bouvia’s suffering and reveal appropriations of that suffering. Moreover, the quotes reveal a thematization of Ms. Bouvia as someone lacking dignity, a lack of welcome, and a denial of responsibility on the part of society, her caregivers, and the court itself. Each of these shortcomings in the opinion are not necessarily inconsistent with the compassionate approach as commonly understood. They will be discussed in turn.

The court’s venture into Ms. Bouvia’s life presumes to know what she suffers by reference to the judges’ own experiences. As compared to the case of Ms. B, discussed below, the court does not quote any of the relevant testimony of Ms. Bouvia, but instead tells us in the court’s words how Ms. Bouvia views her own life.¹⁷⁹ Then it tells us that the court agrees with what it has described as Ms. Bouvia’s view of herself and goes further and tells us what Ms. Bouvia may be thinking (perhaps *should* be thinking?) when it states, “She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding.”¹⁸⁰ Clearly, the judges believe that a life such as Ms. Bouvia’s would be intolerable for them. To the extent that this imaginative dwelling on the condition of Ms. Bouvia might be understood as compassion, it is not clear that compassion serves Ms. Bouvia well. The sort of compassion the court may be expressing towards Ms. Bouvia simply serves the purpose of confirming her own dismal view of her own life. Whereas the positive aspects of compassion include prompting aid, as represented by a child’s drawing of a sister getting a bandage for

¹⁷⁸ *Id.* And this, indeed, for better or worse, has become the fairly well-established law on the issue of the withdrawal of life-sustaining treatment. For a critical appraisal of this approach, especially as it applies to people with disabilities, see *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (Springer, J., dissenting), which disagrees with the majority’s confirmation of the right of a man with quadriplegia to remove a life-sustaining respirator.

¹⁷⁹ *Bouvia*, 225 Cal. Rptr. at 304. (“In Elizabeth Bouvia’s view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration.”).

¹⁸⁰ *Id.*

a little brother, it is not clear that compassion in this case—if that is what it is—has prompted anything for Ms. Bouvia to take away and understand as care.

Secondly, the emphasis in the opinion on Ms. Bouvia's toileting needs thematizes her as a person with no remaining dignity. Incontinence and toileting dependency signify, without any apparent need for further discussion, an individual's lack of dignity. Lack of dignity today further signifies a life not worth living. Other courts have expressed similar views. In a decision by the Court of Appeals for the Ninth Circuit that found a constitutional right to physician assisted suicide—later reversed in *Washington v. Glucksberg*¹⁸¹—the court gave considerable weight to a person's interest in avoiding dependency on others for toileting, recognizing "a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent."¹⁸² This thematization has the consequence of permitting society to define a person who is dependent on others for toileting needs as such primarily, *that* is who they are, "a person dependent on others for toileting needs," and nothing more. It ignores any talents, wants, and relationships the person might have. This is further troubling because one of the primary reasons cited by people for seeking physician-assisted suicide in Oregon under that state's Death with Dignity Act is dependencies of just this sort.¹⁸³

Thirdly, the court devalues Ms. Bouvia as a person and in doing so conveys a lack of welcome for her presence in the world when it writes, "She . . . may consider her existence meaningless. She cannot be faulted for so concluding."¹⁸⁴ Recognizing that someone is suffering from a difficult condition does not need to result in a discounting of that person's value, a questioning of the meaning of that person's existence. The court's own assessment of the lack of meaning of Bouvia's life reveals its readiness to view Ms. Bouvia's continued existence as less important than other people's and by implication less important than the lives of the members of the court itself. It is true the

¹⁸¹ *Compassion in Dying v. Washington*, 79 F. 3d 790, 814 (1996), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁸² *Id.*

¹⁸³ See *supra* note 71.

¹⁸⁴ *Bouvia*, 225 Cal. Rptr. at 305.

court describes her as “alert, bright, sensitive, perhaps even brave and feisty,”¹⁸⁵ but such descriptions are overshadowed by the descriptions of her need for being “fed, cleaned, turned, bedded, toileted”¹⁸⁶ and the resulting “ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness.”¹⁸⁷ Even the term “feisty” is problematic, having the connotation of someone who asserts an endearing, perhaps almost amusing, protest against higher authorities that is inevitably ineffective. I have never heard the word “feisty” used to describe, for example, a healthy, young, white adult male.

These descriptions of Ms. Bouvia and the life she would lead if the feeding tube was not removed reveal that the court does not care whether such a person lives; the judges cannot understand why she might want to live, for they imagine themselves in such situations as wanting to die and do not care whether Ms. Bouvia decides to live or die.

Finally, the court almost willfully refuses to inquire whether anyone might bear responsibility for the situation in which Ms. Bouvia now finds herself, focusing instead on the purely physical nature of her suffering and the fact that she is freely exercising her will in seeking to avoid that suffering. The court, in its opinion, makes no inquiry into the quality of care and, in particular, the quality of the interpersonal relationships Ms. Bouvia experienced at the hospital with her physicians and other medical staff. The court understands and accepts the primary concern of the hospital, physicians, and administrators to be their wish not to participate in a suicide, which they believe is illegal. This concern, at least as the court portrays it, appears to stem from fear of criminal or civil liability¹⁸⁸ rather than any care or concern for anybody’s life, much less care or concern for Ms. Bouvia herself. The court accepts matter-of-factly that “[Ms. Bouvia] is without [the] means to go to a private hospital and . . . [the] hospital as a public facility was required to accept her.”¹⁸⁹ In other words, the court was not concerned with whether Ms. Bouvia was cared for, liked, or respected, by anyone who was

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ After discussing how Ms. Bouvia’s request differed from suicide, the court wrote, “No criminal or civil liability attaches to honoring a competent, informed patient’s refusal of medical service.” *Id.* at 306.

¹⁸⁹ *Id.*

responsible for her physical care or, for that matter, by anyone at all.

The court further failed to recognize that our society may have had responsibilities to Ms. Bouvia that it did not fulfill. The court tells us that efforts to find Ms. Bouvia an apartment with appropriate live-in assistance had been unsuccessful.¹⁹⁰ While we must give the court some credit for relating to us these facts, revealing some recognition that they may be important in this controversy, the court does not connect the fact that Ms. Bouvia wants to die with the fact that she has nowhere to live.¹⁹¹ Who wants to live in a hospital? Further, who wants to live in a hospital which has accepted you only because it is required to do so and which places a nasogastric tube in your nose because it is worried about liability should you die there of malnourishment? The court should have recognized that Elizabeth Bouvia's hospitalization, when she did not require hospital care, was deeply troubling. It was deeply troubling in its denial of care for Ms. Bouvia, who sought to die in those circumstances, and also as an example of the way in which our society generally fails people with disabilities.¹⁹²

Finally, the court failed to see its own responsibility to Ms. Bouvia. Its members failed to see that they were not simply deciding a question of law but that they were in a relationship of responsibility to Ms. Bouvia. This relationship existed not merely in the sense that their decision would permit her to starve herself, but also in the sense that their words might matter, that their dismissal of the meaningfulness of Ms.

¹⁹⁰ *Id.* at 300.

¹⁹¹ As Paul Longmore has suggested, there were other factors in Ms. Bouvia's life besides her physical disability that may have contributed to her request to die. She had been institutionalized by her mother when she was ten years old, thereafter moved from one facility to another, with only rare visits from her mother. As a young adult she earned a college degree and began a master's degree but was not given the "reasonable accommodations" needed for her field experience and dropped out. She married and became pregnant. Before her hospitalization she had suffered a series of personal misfortunes. Her brother drowned, she suffered a miscarriage, and she separated from her husband. While Ms. Bouvia reported these experiences to the psychiatric professionals who evaluated her at her lawyers' request, they ignored the part these experiences may have played in her wish to die and concluded that her disability was the reason she requested death. Longmore, *supra* note 18, at 153-57.

¹⁹² The court was not completely heartless. It did suggest that the hospital and medical staff had a duty to alleviate Ms. Bouvia's pain and suffering, as she refused food. *Bouvia*, 225 Cal. Rptr. at 306.

Bouvia's life might hurt her.¹⁹³ The court further ignored the fact that its decision, particularly the discussion of the worthlessness of Ms. Bouvia's life, might have harmful effects on other people with disabilities.

B. *In re B*

The court in the recent British case of *Ms. B*¹⁹⁴ approached in a very different way a similar request for withdrawal of treatment.¹⁹⁵ Ms. B, who had recently become quadriplegic as a result of an illness, sought permission to have her ventilator removed while she was in the hospital under a doctor's care. Apparently she could not shut off the ventilator herself, nor did she wish it to be discontinued slowly through a weaning process, which would have to take place without the sedation necessary to ease the pain of dying from lack of oxygen. In a sensitive and thorough examination of the issues, the judge explained her decision to permit Ms. B to have her ventilator withdrawn. As in the *Bouvia* case, the decision rested on the right of a patient with the requisite mental capacity to refuse unwanted medical treatment even if doing so would cause her death.¹⁹⁶ However, unlike the *Bouvia* case, the court did not find it necessary to consider whether an end to life would be in the patient's best interests.¹⁹⁷ Instead the court was careful to base the right to have the ventilator removed solely on the patient's autonomy to "determine what shall be done with one's own body."¹⁹⁸ Thus the

¹⁹³ With respect to the need for judges to resist distancing themselves from the people governed by them, see Martha L. Minow & Elizabeth V. Spelman, *Passion for Justice*, 10 CARDOZO L. REV. 37, 57-60 (1988).

¹⁹⁴ *In re B*, 2 All ER 449 (Fam. 2002).

¹⁹⁵ For criticisms of the approach of the court, see D. Coleman & S. Drake, *A Disability Perspective from the United States on the Case of Ms. B*, 28 J. MED. ETHICS 240 (2002) which discusses concerns about lack of informed consent and denial of desired treatment alternatives and J. Keown, *The Case of Ms. B: Suicide's Slippery Slope?* 28 J. MED ETHICS 238 (2002), which suggests that the court's right to refuse treatment may actually include a right to commit suicide or be assisted in suicide by having treatment withdrawn.

¹⁹⁶ *In re B*, 2 All ER at 450 (holding that the key issue was the mental capacity of the patient and not the grave consequences the decision may have).

¹⁹⁷ The *Bouvia* court, of course, does not expressly or directly assume this task. However, in concluding that she should be allowed to have the feeding tube withdrawn even though she was not terminally ill, the court entered into an evaluation of the quality of her life, as we have seen. *Bouvia*, 225 Cal. Rptr. at 305-06.

¹⁹⁸ *In re B*, 2 All ER at 455 (quoting *Malette v. Shulman*, [1990] DLR 321, 336).

court's opinion dealt primarily with an examination of the patient's mental capacity, including fairly sophisticated analyses of some of the components of that capacity, for example, how one should handle evidence of ambivalence on the part of the patient¹⁹⁹ and whether the patient was capable of assessing the quality of her future life while she was still in an intensive care unit, which carries more of an ethos of death, as opposed to a rehabilitation unit, where patients are coping with their disabilities and working to become self-sufficient.²⁰⁰

At the same time that it focused on assuring a true and accurate expression of autonomous choice, the court also treated Ms. B with respect, care, appreciation, and welcome. Some might consider the opinion to be compassionate. Instead, I think that it avoids some of the more problematic aspects of compassion that have been outlined above and adopts an orientation more in line with an ethics of radical responsibility. It took care not to make presumptions about Ms. B's suffering or to appropriate or allow others to appropriate her suffering. The court did not thematize Ms. B by letting her condition stand in for the person. Finally, it answered Ms. B's call for help and evaluated how responsibly others had answered her calls.

First, the court is careful to avoid itself and to avoid sanctioning on the part of others compassion that appropriates the experiences of the patient. The court quotes with approval from an article written by Dr. Kim Atkins and published in the *Journal of Applied Philosophy*: " 'While we can imagine, we cannot know objectively 'what it is like to be' another person, no matter how many facts we are in possession of . . . ' " ²⁰¹ The article explains that the irreducibility of the differences between people means that we must move away from being objective and move toward understanding the experience of another as it is subjectively experienced. The court adopts Atkins' language for this case:

¹⁹⁹ See *id.* at 459–460 (discussing a patient's ambivalence as being relevant only if it affects mental capacity and applying it to Ms. B); *id.* at 464 (comparing situation to Mr. G); *id.* at 472 (concluding Ms. B is not ambivalent).

²⁰⁰ See *id.* at 461, 464–65, 472 (demonstrating how Ms. B and others could not make an informed decision without experiencing life beyond a hospital room).

²⁰¹ *Id.* at 469 (quoting Kim Atkins, *Autonomy and the Subjective Character of Experience*, 17 J. APPLIED PHIL. 71, 75 (2000)).

'However disturbing it is to see someone, especially one's loved one, on something like [a ventilator], it is essential that one tries to imagine what it is like to be *that particular* person on [a ventilator] if one is to attempt to act from respect for *that person's* autonomy. The difficulty here lies not in becoming *more* objective, but in being appropriately subjective. . . . I need to imagine not just what it would be like to *me* to be on [a ventilator], but what it would be like for [Ms B].'²⁰²

While the court, in quoting the language of Dr. Atkins' article, embraces imagination as a way of understanding Ms. B's experience, the sort of imaginative dwelling approved is unlike typical formulations of compassion and unlike the appropriate expressions of the *Bowvia* court. For one, the court acknowledges the limitations of that imagination,²⁰³ and secondly, it insists that the point of reference should not be the observer but the person who is suffering.²⁰⁴ Thirdly, the court approves the language of the article not in the context of determining what is in Ms. B's best interests but in the context of affirming that she is exercising an autonomous choice. Thus, the court quotes at length the testimony of Ms. B herself, rather than explaining how the court believes that she must feel. For example, the opinion includes statements, written and oral, from Ms. B about why she was not willing to be weaned from the ventilator, which would also eventuate in her death, although not as quickly as sudden removal. She stated that such a death would be slow and painful, that she would "feel robbed of a certain amount of dignity," and that such a death would be more distressing for her loved ones.²⁰⁵ During her oral testimony, Ms. B was also asked about her views on attempting rehabilitation and on whether she wished to die or not to remain alive in her present condition.²⁰⁶ In one of her written statements, she set out her understanding of her situation in the context of her faith.²⁰⁷ On the basis of

²⁰² *Id.* at 469 (quoting Atkins, *supra* note 201, at 78).

²⁰³ *Id.* at 469 (quoting Atkins, *supra* note 201, at 75).

²⁰⁴ *Id.* at 469 (quoting Atkins, *supra* note 201, at 75) (emphasis added).

²⁰⁵ *Id.* at 460–61. According to the court, Ms. B "provided two written statements and gave oral evidence for about an hour and a half." *Id.* at 459.

²⁰⁶ *Id.* at 460–62. While these questions were asked by the representative for the hospital, they are included in the opinion of the court in its discussion of Ms. B's mental capacity.

²⁰⁷ *Id.* at 462. The court stated:

The dominant view in the church is that I should wait for God to heal me. Withdrawing ventilation would be seen as throwing in the towel. I have

these expressions, the court determined that Ms. B's "wishes were clear and well-expressed."²⁰⁸ Together with the evidence of the consultant psychiatrists, they formed a substantial part of the evidence that Ms. B had the requisite mental capacity to make the decision to have the ventilator withdrawn. In relating Ms. B's testimony about her decision, the court did not agree or disagree with Ms. B's assessment of the prospects for her life, but let her speak for herself.

With respect to the potential for thematizing, Ms. B's condition was in many ways like Ms. Bouvia's. Both, for example, were highly dependent on others for personal care, such as bathing and toileting.²⁰⁹ The *Bouvia* court, however, equated such dependency with embarrassment, humiliation, and ignominy that make life not worth living, while the court in Ms. B's case described such care as "intimate."²¹⁰ It neither suggested that such dependency was horrifying nor even placed much emphasis upon it. When it was mentioned,²¹¹ it was primarily in the context of the relationship of care that had developed between Ms. B and the hospital staff. The court understood that the hospital staff had experienced difficulty in acceding to Ms. B's request that the ventilator be withdrawn because they had become emotionally involved in the case.²¹² "That situation was entirely understandable," the court concluded. "They [the clinicians] had with the nursing staff kept

questioned myself about this and it has challenged my integrity. It has been a very difficult process to rationalise what I am doing in the context of my faith but I feel there is no alternative, as I do not have any realistic hope of recovery. I have come to believe that people die and become disabled and God does not always intervene.

Id.

²⁰⁸ *Id.* at 449, 462.

²⁰⁹ The court tells us in the case of Ms. B, "She is totally dependent on her carers, who feed, clothe and wash her and assist with her bodily functions." *Id.* at 459.

²¹⁰ *Id.* at 463.

²¹¹ There are three references to these matters in the opinion. First, within a paragraph describing in some detail Ms. B's physical condition, we are told that "[s]he is totally dependent on her carers, who feed, clothe and wash her and assist with her bodily functions." *Id.* at 459. Later, in recording the testimony of Dr. C, the lead clinician in the case, the court tells us that Dr. C testified that "[s]he did not feel able to agree with simply switching off Ms. B's ventilation. She would not be able to do it. She felt she was being asked to kill Ms. B. They had all been looking after Ms. B for a long time on a very intimate level." *Id.* at 463. The third reference is discussed in the text.

²¹² *Id.* at 473-74.

Ms. B alive and looked after her in every respect including her most intimate requirements.”²¹³ The court saw the dependency that Ms. B had on others for assistance with her private bodily functions not as something she should feel shame about, but as something that drew Ms. B and her health care providers into a close relationship of care. Intimacy or ignominy? Ms. B and Ms. Bouvia both required assistance with toileting and other bodily functions. The court in Ms. B’s case did not let the condition of such dependency stand in for or define her.

Finally, the British court took very seriously the responsibilities that Ms. B’s physicians had towards her and the responsibilities that the court itself had toward Ms. B, and understood both sets of responsibilities to include an obligation of welcome.

The court’s opinion revealed a very caring relationship on the part of the physicians toward Ms. B. Their reluctance or refusal to participate in the withdrawal of the ventilator treatment was not wholly an egocentric one, based on their understanding of their professional role to preserve life and to heal,²¹⁴ nor did they consider Ms. B’s fate in terms of their success story or failure, another egocentric hazard of practicing medicine. Similarly, their primary concern was not their potential legal liability. Rather, as the court recognized, the treating doctors had a strong desire for Ms. B to live; over the course of a year, they had come to know, like and care for her as a unique human being. The court wrote:

It was clear from their evidence that both the treating clinicians were deeply distressed by the dilemma which had faced them over the year that Ms B had spent in the ICU. They knew her well and respected and liked her. They considered her to be competent to make decisions about her medical treatment. They could not, however, bring themselves to contemplate that they should be part of bringing Ms. B’s life to an end by the dramatic . . . step of turning off the ventilator. As I listened to the evidence of each of them I had the greatest possible sympathy for their position.²¹⁵

²¹³ *Id.* at 473.

²¹⁴ *See id.* at 463, 473 (noting that Ms. B’s carers had an emotional attachment that made them compelled to see her live).

²¹⁵ *Id.* at 463–64.

The doctors desired her presence in the world. I must emphasize that they desired *her* presence. The doctors were not simply holding onto an objective principle that they should preserve any life, but actually wanted Ms. B, not just some objectively described patient, to live. Dr. C, the lead clinician, gave oral evidence in the case that she believed that the physicians had treated Ms. B as if competent to make decisions but that they felt she shouldn't make the decision to discontinue ventilation until she had left the environment of the intensive care unit and experienced a spinal rehabilitation unit.²¹⁶ According to the court, Dr. C's "dilemma was not to be against the wishes of Ms. B but to offer her anything to make her want to live."²¹⁷ Even the consulting psychiatrist on the case, who had not spent as much time caring for Ms. B, expressed a desire for her to live, while recognizing that she had capacity to refuse medical treatment. The court wrote: "He accepted that intellectually there was no inconsistency between Ms. B's vitality and her wish to die, although emotionally it grieved him, which was not too strong a word."²¹⁸

The court's emphasis on and approval of the caring feelings that the doctors had for Ms. B establish such feelings as an important part of the medical care she was receiving. Good care is not impersonal but embodies a face-to-face relationship between doctor and patient. Indeed, the court was sympathetic to the physicians as well, recognizing them also as human beings in this dilemma and believing they had been placed in the untenable situation of both caring for Ms. B and being asked to accede to her request to die. "Obviously," the court wrote, "a relationship built up and it was, in my view, unjust to the team in the ICU that the burden of decision and responsibility for Ms. B largely remained in their hands."²¹⁹ It was the hospital trust

²¹⁶ See *id.* at 463-64.

²¹⁷ *Id.* at 463 (emphasis added). The court's decision further relates the following with respect to Dr. C's testimony:

She did not feel able to agree with simply switching off Ms B's ventilation. She would not be able to do it. She felt she was being asked to kill Ms B. They had all been looking after Ms B for a long time on a very intimate level. She felt that a lot more needed to be done for these patients.

Id.

²¹⁸ *Id.* at 466.

²¹⁹ *Id.* at 473.

that had a duty to resolve the dilemma "and to do so with some degree of urgency for the sake of all concerned."²²⁰

Finally, the court did not see itself as distant from or outside of the events unfolding in the case but saw itself in a relationship with Ms. B and with the hospital staff as well. Courts are institutions but the decisions made by them are made by persons, in this case, one person, the Right Honorable Dame Elizabeth Butler-Sloss. This court, through this judge, expressed a human response to the call of Ms. B. In Levinasian terms, Ms. B had called, and the judge heard the call and answered it. While the law required Dame Butler-Sloss to allow Ms. B to be removed from the ventilator under the principle of autonomy, and indeed Butler-Sloss had no quarrel with this principle of law, she nevertheless expressed her own respect and care for Ms. B. She did this in a number of ways. As earlier explained, the judge let Ms. B speak for herself by quoting extensive portions of her testimony, including some in which Ms. B spoke about her faith. The judge, in accepting that testimony as positive evidence of Ms. B's mental capacity to choose to have the ventilator removed, commented on Ms. B's humor, her articulateness, her insight, and her intelligence, calling her an "exceptionally impressive witness."²²¹ In the portion of the opinion in which she concludes that Ms. B does have the right to have the ventilator removed, Dame Butler-Sloss took care to point out that her decision was not a decision that Ms. B will have the ventilator removed but only a decision that recognized that the power to decide resides with Ms. B in the future and that the possibility remains that Ms. B might decide to accept rehabilitation and continue life.²²² Indeed, the judge would have liked to see Ms. B make that decision for continued life:

I would like to add how impressed I am with her as a person, with the great courage, strength of will and determination she has shown in the last year, with her sense of humour, and her understanding of the dilemma she has posed to the hospital. She is clearly a splendid person and it is tragic that someone of her ability has been struck down so cruelly. I hope she will

²²⁰ *Id.* at 474 (differentiating between what should be expected of individual carers and the hospital trust as a whole).

²²¹ *Id.* at 462 (remarking that Ms. B had done a great deal of investigation and was well informed about her decision).

²²² *See id.* at 472-73 (stating that Ms. B is not bound by her past decision and that she should rethink her choice).

forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large.²²³

The judge desired that Ms. B live. She welcomed her.

CONCLUSION

Because of the problems associated with compassion's imaginative dwelling, its basis in equality, and the lack of any moral duty associated with it, we must be wary of thinking that compassion can be that caring response that many of us believe has a legitimate role in questions of law and social policy. If compassion is the best we can do, we must be alert, suspicious, and watchful in our use of it. Compassion has the potential to discount, devalue, and ignore people who are in need.

The work of Emmanuel Levinas poses challenges to our current ways of thinking about law and social policy, especially in relation to issues of suffering and need but also in relation to people who are not suffering but commonly thought to be so, such as people with disabilities. The orientation of welcome, alterity, rupture, and responsibility that characterizes an ethics of radical responsibility provides a compelling interruption to the traditional egocentric foundations of American law and the dim impulse of compassion that sometimes softens it.

²²³ *Id.* at 473.