

On one cold December evening in 1976, Dr. Joan Owens walked through the doors of the Midwestern Medical Center. This time she was not there to treat one of her patients—Dr. Owens was, in fact, about to go into labor with her fourth child. She was aware that the periodic contractions she felt meant the process of delivering had begun, and she quickly went through the necessary paperwork in order to be admitted as a patient. At about 11:30 that night, much to the relief of Dr. Owens and her husband, a 4.5-pound baby girl was born. A bracelet around the baby’s wrist identified her as “Baby Owens.”

The attending obstetrician, Dr. Ziner, was immediately aware of an abnormality in the baby’s appearance. Dr. Owens, still groggy from the medication and the exhaustion of labor, also recognized the signs. It seemed almost certain that her baby had Down syndrome. After demanding that Dr. Ziner confirm her suspicions, she made her wishes perfectly clear: “Get rid of it. I don’t want a mongoloid child.”¹

To further complicate the matter it was revealed, upon examination, that Baby Owens had duodenal atresia, a congenital defect in which the passage through the small intestine is blocked. In the past such a condition would have resulted in starvation, though by 1976 the needed corrective surgery was considered relatively simple. The parents, however, unanimously refused to consent to the surgery. After all, they reasoned, it would be unfair to the other healthy children to have to grow up with all the difficulties that come with having a sibling with Down syndrome. At first, Dr. Ziner objected to the decision. He informed the couple that the necessary surgical procedure was very low risk and that the baby’s life could almost certainly be saved. Furthermore, he noted, Down syndrome children have a good capacity for forming relationships and are often very beloved members of their families.

¹ Ronald Munson, “Impaired Infants and Medical Futility,” *Intervention and Reflection: Basic Issues in Medical Ethics*, 7th ed. (California: Wadsworth/Thompson Learning, 2004) p. 144

Dr. Owens and her husband remained unmoved. It would not be fair to the other children to rob them of so much time and love in the effort of caring for a mentally handicapped child. The best thing to do, Dr. Owens thought, would be to let the child die. This would ensure that she, her husband, and her other children would not “lose out on many of life’s pleasures and possibilities.”²

Dr. Ziner felt unsure about the legality of refusing to perform a life-saving treatment on the child, so he called a meeting with the Midwestern Medical Center’s director, Dr. Entraglo, and the director of the center’s legal staff, Mr. Putnam. Over the course of a two-hour meeting, it was decided that the hospital would not be liable if Baby Owens was not treated and was allowed to die. Mr. Putnam argued that usually parents are expected to act for the sake of their child’s welfare, but that in this case, the situation was ambiguous. After all, Mr. Putnam questioned, “Is the Owens baby really a person in any legal or moral sense?”^{3,4}

Baby Owens died over the course of twelve days. The burden of care was shifted mainly onto the nursing staff in the obstetrics ward, which put many nurses in prolonged contact with the dying child. While some of the staff tried to avoid the baby altogether, others did their best to comfort Baby Owens throughout the ordeal. When death finally came, however, almost all were relieved. It seemed a needlessly cruel way to die, and it was difficult and frustrating to watch this baby—who was otherwise relatively healthy—slowly wither away.

Was the Owens baby really a person, in any legal or moral sense? The question, vocalized explicitly by Mr. Putnam, points to what I believe is a crucial question in medical

² *Ibid.*

³ *Ibid.*

⁴ Whether or not this suggestion was legally correct at that time is beyond the scope of this paper. The comment serves to illustrate the correlation between questioning the baby’s personhood and the subsequent decisions made.

ethics. It is crucial precisely because so often it is the deciding factor: we grant a *prima facie* right to life to “persons” but do not afford non-persons the same right.

The Owens baby, at the time of her birth, did not have the capacity for agency or self-expressiveness and was probably minimally self-aware. Furthermore, though the exact degree of mental retardation was not known, it was a fact that her Down syndrome condition would render her less cogitatively able than her healthy peers. Were these sufficient grounds upon which to question her personhood and, thus, her right to life-saving surgery? It is almost certain that any otherwise healthy child would have received corrective surgery for duodenal atresia, even if the hospital had been forced to obtain a court order. What, then, made Baby Owens an exception?

What made Baby Owens an exception was her Down syndrome condition. Since the case of Baby Owens in 1976, we have learned more about children with Down syndrome, and the story presented above would sound outrageous to most contemporary readers. Yet in 1977 Dr. Anthony Shaw conducted a study in which he found that 77% of surveyed pediatric surgeons would have complied with the parents’ wishes.⁵ How could our moral sensibility change so significantly over the course of 40 years? Could it be that our visceral condemnation of the decision made in the Baby Owens case is so misplaced?

I will argue that it is not. In fact, it appears that many of the physicians involved in such cases, as well as advisors such as Mr. Putnam, relied on certain ontological presuppositions in their assessment of personhood. This is hardly surprising. Medical ethics, as applied ethics, must deal directly and practically with its subjects, which are *persons*. An ontological understanding of what *personhood* means thus lies at the root of any medical ethic, whether it admits this or not. It follows naturally that the first step in any argument denying a right to life begins, at least

⁵ Shaw A, Randolph J, Manard B, “Ethical issues in pediatric surgery: a national survey of pediatricians and pediatric surgeons,” *Pediatrics* 60 (1977): 588-589

implicitly, by questioning the personhood of the patient, or fetus, or neonate. What has changed in 40 years is not so much our moral sensibility as our view of personhood in the case of Down syndrome children.

There are various, elaborate ontological accounts of personhood. I propose to examine and compare two main views⁶ of the human person: first, a dualistic view, followed by a view that sees personhood as a psychosomatic unity that is inherently social in nature. Specifically, the former is most usually a variant of Cartesian dualism, whereas the latter I will approach from a Thomistic viewpoint. Ultimately, my goal is to show that a Cartesian-dualistic approach to personhood provides insufficient grounds upon which to base our ontology of personhood in medical ethics—and that the death of Baby Owens is an example of the isolating effect of this view’s overemphasis on a capacity for agency.

The dualistic account of personhood is largely inherited from the rationalist Rene Descartes, who could not reconcile two distinct concepts: 1) the body, which is spatial extension without thought and 2) the mind, which has thought without spatial extension. Since mind and body appeared to be totally distinct, Descartes could not explain the causal connection between them. The picture that this problem evokes is the well-known “ghost in a machine,” whereby the body and the mind are virtually alien to one another. Thus one of the implications of this ontological understanding of personhood is that there is no intrinsic connection between body and mind. In most cases, as with Baby Owens, this has meant that the mind has been given priority in indicating personhood.

One notable ethicist who uses a Cartesian approach to medical ethics is Joseph Fletcher. In his book *Morals and Medicine*, Fletcher identifies “personal integrity” or “moral status”—he

⁶ For the sake of brevity, I will not include a third, popular form of philosophical anthropology that approaches personhood from the perspective of biological reductionism.

uses both terms interchangeably—as dependent on two factors: 1) freedom of choice, or autonomy, and 2) knowledge. In a word, this means that he identifies personal integrity with informed consent; personhood is identified with autonomous and rational agency. In Fletcher’s own words: “... moral status... depends upon two things at least: first, freedom of choice, and second, knowledge of the facts and of the courses between which we may choose.”⁷ If, then, moral status is wholly dependent on freedom of choice and knowledge, the body has but little to contribute. Fletcher even goes so far as to say that “To be a person, to have moral being, is to have the capacity for intelligent, causal action. It means to be free of physiology!”⁸ The body is seen as limiting the freedom of a moral being, and personhood is identified entirely with the mind’s capacity for informed consent. Thus the body ultimately yields to the mind, so that the more explicit and deliberate an action is, the more ethically justifiable it is seen to be. To be free of physiology is, as it turns out, not radically unnatural but the *summum bonum* of our human “ghost.”

The first problem with such a view of personhood is that it serves to isolate the individual. Ultimately, a person in the Cartesian sense is almost as alienated from his community as he is from his own body. Fletcher’s “personalism” holds that “personality is a unique quality in every human being, and that it is both the highest good and the chief medium of our knowledge of the good.”⁹ Since this unique quality in each individual is both its own end and the medium to our knowledge of this end, the human being with whom this ethic is concerned is only accidentally related to the community of which he is a part. There is, in fact, little or no common ground between persons save that they all have this quality of personality.

⁷ Joseph Fletcher, *Morals and Medicine* (Boston: Beacon Press, 1954) p. 35

⁸ *Ibid.* p. 218

⁹ Joseph Fletcher, *Morals and Medicine* (Boston: Beacon Press, 1954) p. xx

Practically, such a view has dangerous consequences. It is clear that in most cases patients are not the rational and autonomous persons that such an ontology would have them be; in fact, patients are often deeply affected by their environments. External stressors play a large role in patient decisions, and this is where the Cartesian-dualist account of personhood ceases to do justice to human persons. Take as an example the case of HIV and poor women in Haiti. Paul Farmer, noted physician and anthropologist, writes that: “In Haiti... young women are driven into domestic service and unfavorable unions by poverty... they have little choice about their acceptance of risk. Indeed, their testimony calls into question facile notions of ‘consensual sex’.”¹⁰ Farmer points out that some women are from the very beginning more vulnerable to HIV infections due to factors that result, indirectly, from their socioeconomic environment. Taking such factors into consideration might, for example, make one “question the utility of condoms in settings in which women’s ability to insist on ‘safe sex’ is undermined by a host of less easily confronted forces.”¹¹ The point is that the autonomy assumed by the Cartesian-dualist view of personhood is not tenable in the real world: a poor woman in Haiti—who is repeatedly exposed to high-risk sexual relationships due to her socioeconomic position—has a radically different opportunity for rational, autonomous action than the proponent of dualism has in mind.

A further objection to the Cartesian-dualist account of personhood is that its extreme emphasis on agency leads to conclusions that are instinctively unacceptable to most. Indeed, Michael Tooley’s famous paper “Abortion and Infanticide” makes a case for infanticide precisely on the grounds that neonates are minimally, if at all, self-aware. Tooley writes: “if one is going to defend infanticide, one has to get very clear about what makes something a person,

¹⁰ Paul Farmer, “Women, Poverty, and AIDS,” *Partner to the Poor: a Paul Farmer Reader* (California: University of California Press, 2010) p. 312

¹¹ *Ibid.* p. 315

what gives something a right to life.”¹² He goes on to argue that “An organism possesses a serious right to life only if it possesses the concept of a self as a continuing subject of experiences and other mental states, and believes that it is itself such a continuing entity.”¹³ The emphasis on the “mind” of the mind-body dichotomy in Cartesian ontology is clear here. Certainly Baby Owens would not be justified as having a right to life according to Tooley’s view of personhood; in fact, a full-grown animal with a vague sense of self would have more of a right to life than a human neonate, a conclusion that Tooley implies in his paper.¹⁴ The extreme example of infanticide serves to highlight the inadequacy of a sole emphasis on agency in medical ethics.

Against Cartesian dualism stands the ontology of personhood developed by Thomas Aquinas. His appropriation and development of Aristotelian metaphysics represents a unique insight into the ontological constitution of personhood: one that reconciles the mind with the body and recognizes the interconnectedness in being. I ask that the reader bear with me through a few technical points—all the while keeping the case of Baby Owens in mind. For if it is to be contrasted with a Cartesian dualism, it must be shown that the superiority of hylomorphism in ethics lies in the very ontological understanding which provides the basis for its subsequent approach to practical ethics.

For Aquinas, *a being* meant *that which is*, where the “is” denotes an *act of existence*. This is the first important ontological realization, because it prevents us from thinking of existence as a static state; rather, *to be* is to act and to be acted upon. The very intelligibility of a being comes from its action upon us. This is what separates it from non-being, and includes it in

¹² Michael Tooley, “Abortion and Infanticide,” *The Rights and Wrongs of Abortion: a Philosophy & Public Affairs Reader* (New Jersey: Princeton University Press, 1974) p. 53

¹³ *Ibid.* p. 59

¹⁴ *Ibid.* pp. 79-80

the world of the real to us. Being is thus self-communicative by its very act of existence: a concept that Aquinas encompassed by the Latin word *esse*.

The *act of existence* is then one of the two metaphysical “co-principles”¹⁵ of being, and is that which all being has in common. The second “co-principle” is a being’s *essence*, or nature, by which it is distinct from other beings. In this way all beings are alike, in that they all *exist*, or partake in the act of existence; yet different, in that one being is this particular being and not that one. Thus all beings partake in the same act of existence (*that* they are), but in different modes of existence, whereby they differ in essence (*what* they are).

To speak of the *act of existence* is to imply an action *upon* something: either the observer himself or another being. This is the only reason we are able to *do* ontology, because being reaches out, so to speak, and touches us. Because of this, being is inherently *relational*, as is explained by Fr. Norris Clarke, S.J., in his book *Person and Being*. He writes that: “While all relations are not generated by action, still all action and passion necessarily generate relations.”¹⁶ What’s more, we can deduce from this relation that both beings *must* contain substance in order for the relation to exist in the first place, “For the very meaning of relation implies that it is *between* two terms that it is connecting...”¹⁷ Thus a Thomistic understanding of being both affirms the individual and recognizes that relationships flow naturally from being. It turns out that, “To be fully is to be *substance-in-relation*.”¹⁸

If one takes the time to pause and consider, one can already see how this ontological approach excludes the possibility of isolation that was so sharply evident in the Cartesian

¹⁵ For an expanded definition of these metaphysical “co-principles,” see W. Norris Clarke, S.J., *The One and the Many: a Contemporary Thomistic Metaphysics* (Indiana: University of Notre Dame Press: 2001) pp. 83-84

¹⁶ W. Norris Clarke, S.J., *Person and Being* (Milwaukee: Marquette University Press: 1993) p. 14

¹⁷ *Ibid.*

¹⁸ *Ibid.*

approach to ethics. An individual can never simply *be* just an individual, for existence is active self-communication. This is true of all beings and therefore also especially of persons. If being means to be a *substance-in-relation*, then all of reality is really a complex web of self-communication, of giving and of receiving. This realization, which is grounded in the nature of being itself, prevents us both from simply isolating the individual as a “rational agent” and from accepting any ethic that leaves out considerations of community. Baby Owens may not have been able to exercise her rational agency, but she was certainly a member of the community of being.

Viewing *relationality* as an intrinsic aspect of the ontological make-up of personhood thus provides a safeguard against the isolating effects of Cartesian dualism. The “facile notions” earlier alluded to by Paul Farmer stem from the Cartesian assumption that individuals act as fully autonomous, rational agents that are not intrinsically related to other beings. Another example of this implicit assumption lies in the use of “informed consent” as the only rubric by which to proceed in medical ethics. Farmer writes: “When someone living in destitution ‘opts’ to sell a kidney and signs all the informed-consent forms in front of multiple witnesses, is the term ‘informed consent’ really meaningful?”¹⁹ The answer, evidently, is “not really.” It seems very probable that a man living in destitution is being acted upon by socioeconomic stressors that make him much more likely to sell a kidney than someone who does not have these stressors present. It is not enough, therefore, to simply guarantee the act of free informed consent in some way, any way. If medical ethics truly did believe that this was sufficient, then the world would be a cold, hostile battleground between the individual and “the rest.” It would be a world where, as long as the appearance of autonomy was maintained—to say nothing of those incapable of self-

¹⁹ Paul Farmer, “Rethinking Medical Ethics: A View from Below,” *Partner to the Poor: a Paul Farmer Reader* (California: University of California Press, 2010) p. 476

determination like Baby Owens—travesties could be perpetrated upon an individual. It is possible, after all, to violate one’s own integrity: we do not invariably choose our own good all the time. Paul Ramsey, ethicist at Princeton University, has written that: “There are more ways to violate man-womanhood than to violate the *freedom* of the parties; and... something voluntarily adopted can still be wrong.”²⁰ Thus, the Thomistic realization of the inherently communal nature of being is paramount to safeguarding the individual. We must attend to the social context of individual actions as much as to the actions themselves.²¹

The hylomorphic view also restores equity to the ethical claims held by both the mind and body. Far from the Cartesian dualism that could not reconcile the body and the mind, the philosophical anthropology set forth by Aristotle in the *De Anima* posits that to be a human person means to be *both* body and soul. The soul is the first principle of life in the human body—a concept echoed by Aquinas when he wrote that “the intellect... is the form of the human body.”²² The very essence of a human being makes it necessary that he or she be a composition of mind and body—and neither one can be without the other.

The importance of this ontological synthesis of body and mind in medical ethics is profound. For as we have seen in Fletcher’s dualism, it is quite easy to conclude that “to be a person means to be free of physiology” when one has refused to solve the paradox of mind and body—to marry the form and the matter. If we take up once more the example given to us by Paul Farmer concerning the destitute man who decides to sell his kidney, we see that the decision is justifiable if we opined that the kidney was, after all, no part of *who that man was*. There

²⁰ Paul Ramsey, *Fabricated Man* (New Haven: Yale University Press, 1970), p. 87 as cited in Verhey, *Reading the Bible in the Strange World of Medicine* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2003) p. 76

²¹ Allan Verhey, *Reading the Bible in the Strange World of Medicine* (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2003) p. 242

²² St. Thomas Aquinas, *Summa Theologica* [I, 76, 2] as cited in *Summa of the Summa*, ed. Peter Kreeft (San Francisco: Ignatius Press, 1990) p. 253

seems to be no ethical problem with a man in financial hardship selling property that he owns—it may be unfortunate, but it does not appear to be intrinsically *wrong*—so why not also a part of his body, which is, in the Cartesian model, only secondary in importance? Hylomorphism, on the other hand, accounts for the feeling that what is done *to our bodies* is done *to us* as persons.

Such an ontology of human personhood thus leads us to understand that a destitute man voluntarily selling his own kidney is somehow still in violation of his personhood. Not only is the man's body a part of who he *is*, but we also have the responsibility of adopting an ethical system that does not pretend that he is unaffected by the wider community of beings in which he exists. Likewise, in the case of Baby Owens, a relational ontology of personhood might have meant that her cognitive deficit alone would not have been sufficient to cast doubt upon her right to life. Down syndrome children form a part of the community of being as much as other children. Their capacity for rational agency might be diminished, but an ontological view that rejects identifying personhood solely with this capacity does not exclude them from possessing a right to life. Had such a *relational* and *hylomorphic* ontology of personhood been present to the minds of Mr. Putnam, Dr. Ziner, or even the baby's parents—instead of the implicit dualism at work in their rationale—Baby Owens might have had a life filled with relationships, happiness, and love.

Finally, it serves to note that the decision to omit Baby Owens' simple life-saving procedure was made largely with her future cognitive problems in view. Keeping this in mind, one might argue that employing the same premise—that agency *is* personhood—in other circumstances might disqualify most neonates from a right to life, as Tooley does. After all, the capacity for agency that dualism equates with personhood is hardly present at the first few weeks of life. Fortunately, this position is instinctively unappealing to most. It would be beneficial,

however, if we explicitly moved away from the implicit Cartesian mind-body dichotomy that justifies such reasoning in favor of a more relational and hylomorphic ontology of personhood. Doing so, and basing our ethical positions on a sound ontology of person and being, may enable us to respond to Mr. Putnam's question: "Is the Owens baby really a person...?" in the affirmative. In the moral sense, at least, we may answer with a resounding "yes."