

Do You Mind? The Anthropological Question Underlying Ultimate Reality and Meaning in Bioethical Discussions

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In his discourse to participants in an international congress on the vegetative state, Pope John Paul II proffered a rather definitive statement concerning life-sustaining treatments:

I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering (John Paul II, 2004).

Given its magisterial force as a papal pronouncement, yet startling because it seemed to come out of the blue, this teaching raised worldwide concern among bioethicists and moral theologians.

At stake here is the age-old principle that extraordinary means of preserving life need not necessarily be undertaken or continued. Generally accepted understanding and practice has been that life-sustaining treatments are not morally obligatory when the complexity of the procedure, degree of risk, or burden of cost make them disproportionate to the expected benefits. One wonders whether the former pope's new teaching departs from this concept in as much as it seems that he "substitutes a deontological principle for the traditional weighing of benefits to burdens" (Shannon and Walter 2004, p.19).

Beyond the immediate question of autonomy in end-of-life decisions, this debate comes to the fore in other areas of bioethics, such as embryonic stem cell research, the adoption of

biotechnology for human reproduction, the widespread increase in pharmaceutical usage, the enhancement of individuality through aesthetic surgery, and patient autonomy at the end of life (Dailey and Leonard 2004). Each of these issues generates its own interest and can be approached from several viewpoints. However, when considered together, these seemingly diverse subjects disclose a more coherent and ultimate concern about who we are and how we develop as human persons. For example, is pregnancy something more than the process of gestation? Is our identity reducible to molecular make-up? Is beauty limited by the reality of personal appearance? Does suffering negate the meaningfulness of our existence?

These and related questions about the meaning of human life reveal a central point in bioethical discussions, namely, the classic debate about the mind-body relationship. This debate concerns our understanding of the connectedness between mental processes and bodily states. In a healthcare context, the debate surfaces in questions about both beneficence and finitude. The former asks whether contemporary medicine admits of any limit to the extent to which it should intervene in its ambitious attempts to improve the quality of human life (Waters 2005). The latter questions whether or how we remain distinctly human when faced with debilitating illness or disease. Who answers these questions, and how one arrives at the answer, will lead to alternate views of human nature and the valuation of human life. Consequently, radically divergent conclusions emerge when it comes to decisions about healthcare and the use of biomedical technologies at life's various stages.

In this paper, we shall contend that the meaningfulness of human life lies not simply "out there" in the physical world that our bodies inhabit, nor "inside" the perception generated by the mind's eye (Bracken and Thomas 2002, pp. 1433-1434). In our view, the human being is

constituted as an “embodied self” (Kavanaugh 2001) or an “acting person” (Wojtyla 1979) whose body, mind, and soul are integrally connected and therefore wholly affected when it comes to healthcare matters. In more philosophical terms, we posit as characteristic of human being the dual reality that we are both immanent (inhabiting this physical life) and transcendent (exhibiting a spiritual character). As such, we concur with the viewpoint that "what is biological in man is not only biological, but an expression and fulfillment of our humanity" (Benedict XVI, 2005). From this position we assert that bioethical dialogue should begin with two principles, namely the *integrity* of a person (i.e., an inability to partition a person into body or mind or spirit) and the *permanence* of what makes us human (which remains without loss or degree). In sum, only when *personalism* triumphs over *physicalism* will decisions about healthcare and biotechnology be rightly ordered.

OVERVIEW OF THE ANTHROPOLOGICAL QUESTION

Science is, by definition, morally ambivalent and ethically neutral. Advances in biomedical science, and the biotechnology produced by it, can lead to good or evil, to health or death, to palliative care or destructive harm. For this reason, anthropological considerations that take into account the distinctive nature of who we are and what we do as human beings are not only valuable but necessary, for what is at stake in any bioethical discussion is, ultimately, the future of a human person and, consequently, the society of all human persons (Delumeau 2001, pp. 14-6). To make sound decisions about that future requires that we begin with an understanding of what a human person is, which leads us into the realm of philosophy.

In this realm, questions about personhood concern what is *essential* (i.e., what constitutes a being as human?) and what is *existential* (i.e., how is our humanness lived?). Far from settling

the perennial perplexities in these questions, we consider here only the relevant dichotomies that frame any bioethical dialogue.

From an *essentialist* perspective, the question about what constitutes a human being is variously described as the “body-soul” or “mind-body” problem. In the former and historically earlier designation, the essence of humanness is characterized by both material and spiritual elements; even in the latter designation “the incorporeal realm has been seen as more enduring, efficacious and valued than the corporeal, which is often described as transient, of little value and even illusory” (Young, 1990, p. 702). Sharing a material body, like other living organisms, the human person is formed and defined by a spiritual soul; unlike other living organisms, this soul makes one capable of immaterial operations, such as intellectual thought, free choice, and reflective conscience. In this view, the soul is what animates the body, while at the same time transcending its physical limitations; it is what distinguishes us for who we are as persons and not just animals. These unseen properties are believed to determine who/what a person is; they are capacities that allow us to observe the self (Runes 1972).

Perhaps seeking to avoid religious overtones, the more contemporary designation contrasts body and mind. To speak of one’s “mind” rather than “soul” seems more scientific, as its reference is more readily grasped, especially when associated with the tangible and measurable reality of the brain (Gordon 2005). However, the change in nomenclature from “soul” to “mind” signals a shift toward a more functional view of human life, as, for example in the ethical position that suggests neocortical function is essential to humans (Fletcher 1975, pp. 5, 6). But, as Bishop Sgreccia argues, “These two modalities are not equivalent because whereas the phrase ‘body-soul’ refers to the concreteness of the individual being, to substance, to being,

the phrase ‘mind-body’ refers to function and is thus reductive” (Sgreccia 2004). Thus, while situating the essentially human in a functional realm seeks to account for our unique subjectivity, it also opens the door to utilitarian decision-making based upon a reductive approach to human essence that discounts the transcendent nature of the human person.

Specification of human functioning has also affected talk about the “soul” when this is further subdivided into its vegetative or sensory or rational parts (i.e., existing, experiencing, or thinking). Even so, this descriptive distinction need not negate the unitary character of the person’s spiritual constitution, for “(e)ven when rationality is impeded this does not mean that the rational soul is not present in a person who is still biologically alive” (ibid.). As others have argued, highly rational thought is not an essential marker for human experience (Post 2001, p. 10; Rudman 1997, p. 89). The unity of the person derives from the fact that one’s spiritual being is essential to one’s living (material) reality. In other words, the soul is “not only the seat of a human being’s rational capacities; it is also the principle of the body’s sensitive and vegetative capacities” (Eberl 2005, p. 29). Thus, in classic philosophical terms, now suggested also by embryological evidence, the unity of body and soul is substantial, not accidental: “Above all else it is required by the knowledge of biology and genetics that demonstrate a very specific organizational ‘form’ of the embryo from the first moment of conception. Compared to other forms, the human soul has specific to it the fact of being subsistent in its being and of communicating to the body the being that is specific to the body” (Sgreccia 2004).

This singular human being, whose spiritual and material realities are essentially united, lives historically, that is, within the limitations of terrestrial space and time. From this *existential*

perspective, the historical rootedness of human beings raises questions about identity and action as they relate to our distinctiveness as persons.

On the one hand, human identity is linked to what might be called a “reflexive awareness” of our self as being this particular person. Because who we are is not separable from the facticity of our bodily existence, our distinctive identity arises from the human ability to “turn back upon itself and [be] aware of itself in being aware of the world.” More than merely self-consciousness, understood as a mental capacity, reflexive awareness necessarily takes into account our physical functioning (Kavanaugh 2001, p. 43).

On the other hand, our sense of self is not limited by our material/physical existence. Human life in the world is related to, but not bound by, the actions in which our bodies are engaged. We experience dreams. We are able to contemplate. Our feelings are so complex that they cannot be fixed to any part of the body. In sum, as Kavanaugh argues, our existence as persons is ontologically distinct, rather than socially constructed: “our actions ... only *reveal* our personal nature; they do not *constitute* it” (ibid., p. 69, emphasis added).

From these dual perspectives on what it means to be and to live as humans, two key issues arise for bioethical consideration. The first concerns the distinction or separation of the personal and the physical. On the one hand, our “self” is clearly more than our bodily make-up; even while possessing higher-level mental traits than others, neither the human mind nor the body can be completely explained in scientific terms. As Nancey Murphy contends, “[T]here are no 'mental' events that are without a physical realization in the brain, yet neurophysiological analysis will never give an adequate account of those events” (Brown 1998, p. 26). On the other hand, if who we are is not somehow connected to physical reality, then one’s humanness would

be called into question when the person lacks complete consciousness or loses independent bodily functioning.

The second issue concerns the basis for making decisions about the human person. If, on the one hand, human beings enjoy an “intrinsic constitution (as) persons” (Kavanaugh 2001, p. 93), then healthcare decisions cannot be limited by observable benchmarks of action or function or achievement. On the other hand, if who we are is reduced to the mind or the body, then either the priority of internal dispositions or the maximizing of physical outcomes will guide decisions; either way, these utilitarian approaches would assume differing degrees of humanness depending on the medical condition of one’s mind or body.

THE VANTAGE POINT OF PERSONALISM

Thus, a necessary first step for understanding sound bioethical discussions is that we come to terms with the anthropological dichotomies of mind/soul and body, and of human identity and action. In our view, the resolution of these primary questions by way of personalism, rather than physicalism, offers the best approach to bioethics.

Physicalism, as the name suggests, “is the view that actuality is exhausted by physical reality” (Sturgeon 1998, p. 426); in this perspective, human nature is identified with our material existence. What is true about humans, and what we can know about ourselves, is that which is tangible, observable, and measurable, whether in mental or physical states. Even in psychiatry, for example, this view leads to the operationalizing of inner mental states by measurable cognitive and affective scales; in other words, it tends to appreciate the fullness of the mind only in terms of what is quantifiable. The obvious limitation of the physicalist perspective, as Kevin

Augustine explains, is that it “renders accounts of the world which appeal to supernatural forces obsolete because nothing beyond nature is required to explain the natural world if physicalism is true” (Augustine 2000).

For bioethical discussions, this approach to human life is decidedly reductive. Limiting our “self” to the physical and material realities of our existence is to deny the spiritual reality that makes us distinct as persons. “If human beings evolved from other organisms and are different from them only in degree – as evolution implies – and physiological psychology reveals that we have no substantial soul that makes us different *in kind* from other animals, then we seem to be nothing more than highly complex animals” (ibid.). A purely physicalist approach would even deny the immaterial dimension of the “mind” by reducing it “to a mere epiphenomenon of the neurobiological workings of the brain” (Haag 2005, p. 37). Partitioning the person in this way, by limiting the human to the physical, healthcare decisions are reduced to medically observable outcomes.

The personalistic approach, on the other hand, affirms “man’s proper and primordial nature, the ‘nature of the human person,’ which is the person himself” (John Paul II, 1993, no. 50.1). The person is who he/she is, not because of what the person can do, in terms of mental or physical capacities or actions (both of which, in the physicalist perspective, are “material”), but because of the very constitution of that which we know to be a distinctly human life. Understanding that make-up requires distinguishing body and soul without separating them.

In the personalistic view humans are “acting persons” (Wojtyla 1979). In summary form, this means that a person is “a self-determining agent that realizes itself through free and responsible action” (Dulles 2004, p. 12). Who a person is (identity) and what a person does

(action) are distinct but necessarily correlated. “Activity is not something strictly other than the person; it is the person coming to expression and constituting itself” (ibid.). For healthcare considerations, this means that, while the acts that are proper to our physical or mental functioning are distinguishable in terms of medical analysis and treatment, they nonetheless are not separable from our personhood.

Participants at the international congress on vegetative states heard specifically what this means for bioethics: “[T]he intrinsic value and personal dignity of every human being do not change, no matter what the concrete circumstances of his or her life. A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man, and he will never become a ‘vegetable’ or an ‘animal’” (John Paul II 2004, no. 3). Even in Kantian ethics, the human being is special enough to be treated as an end in his or her self rather than a means to an end, which is not always the case with animals (Green 2001). In addition, considerations about so-called “quality of life,” whether referring to one’s own health or in terms of interaction with others, cannot take precedence over the fact of living. As the pope continues, “to admit that decisions regarding man's life can be based on the external acknowledgment of its quality, is the same as acknowledging that increasing and decreasing levels of quality of life, and therefore of human dignity, can be attributed from an external perspective to any subject, thus introducing into social relations a discriminatory and eugenic principle” (John Paul II 2004, no. 5). In terms of healthcare decisions, what the pope means is that “the value of man’s life cannot be made subordinate to any judgment of its quality expressed by other men” (John Paul II 2004, no. 6), be they medically trained professionals or personally vested family members.

We now turn to a consideration of some of the more contentious issues in science and healthcare. Modern technology is having an increasingly direct impact on the beginning, the development, and the end of human lives in the twenty-first century and, as such, generates extensive bioethical and philosophical discussion.

IMPLICATIONS FOR BIOETHICAL DISCUSSIONS

Issues Affecting the Beginning of Human Life

The development of embryonic stem cell technology has enabled scientists to take a human embryo that was fertilized five days prior and disaggregate the cells at a point in development before specialization has occurred. The technology, as first reported in the journal *Science*, utilized “excess” human embryos that were donated by couples who had participated in *in vitro* fertilization (Thomson 1998, p. 1145). Since the cells were removed from the embryo before differentiation occurred, it was predicted they could be directed developmentally to serve as a source for replacement tissues in adult humans. While the development of this type of technology is the work of scientists as “acting persons,” its much sought after progress stems from an approach that seems to devalue the human embryo from which the cells are derived, since it precludes that living human embryo from ever developing into an “acting person.” Thus the potential flourishing of an adult is pursued at the expense of the demise of another human (Doerflinger 1999, p. 138), through a reductive consideration that an embryo lacks the status of personhood since it has not yet developed neocortical functioning and cannot develop independently of a biologically nurturing environment.

The recent completion of the Human Genome Initiative has produced a publicly available database as well as a privately owned database containing the complete sequence of DNA bases

derived in part from nine different individuals (Campbell and Heyer 2003, p.17). This technology will ultimately offer access to the complete biological “blueprint” of the human race. This technology promises a future ability to replace certain existing gene sequences with other sequences that are potentially more desirable, thus personalizing different types of healthcare for individuals based on their genetic constitution. But the technology in itself does not provide any insight about the attributes that would be considered more desirable than others. While the curing of genetic illness seems attractive, the definition of genetic illness seems illusive. For example, is low intelligence really a genetic disease? And if so, should we genetically re-engineer our children in order to produce a race that is more intelligent? This technology clearly has the potential to lead to a eugenic principle and the philosophical problem of situating our value as persons in the inherent “quality” of our genes.

While the first successful frog cloning experiments, conducted by Gurdon and his associates, were generally well known to biologists during the 1960s, the emergence of mammalian cloning technology at the Roslin Institute in Scotland during the 1990s created renewed interest in the popular culture toward the prospect of cloning human beings (Petersen 2001, pp. 1265-6; Wilmut 1997, p. 811). In this technology, the DNA blueprint contained in the nucleus of an adult body (somatic) cell is extracted and transplanted to a human egg in which the native DNA has been removed or obliterated. The egg is artificially stimulated to begin development in the absence of sperm contact and is then implanted into a surrogate mother. The individual who is produced would have the biological constitution of an identical twin to the original adult. Similar to the considerations above involving genetic engineering, cloning technology leaves important philosophical questions unanswered, for example, will the cloned individual behave the same as the donor adult, which would imply some form of genetic

determinism? But there are important questions arising from the fact that policy decisions involve more than one person, namely, whose genetic material should we clone and is the genetic material from one individual more desirable than that of another? This will again lead, ultimately, to ethical decisions based upon eugenic principles.

Each of the above issues is predicated upon a biological technology that in itself is morally and ethically neutral. But the philosophical consideration that undergirds the use of such technology is morally and ethically essential. The question that considers the “subject” of the biomedical promise – namely, a human being – must be posed before the technology is put to work. When body and soul are separated, or when the soul is reduced merely to the mind or to molecules, the lack of regard for what makes a person distinctively human leads to an ethic based upon physicalism; more broadly, it betrays the ideology of scientism, with its belief that only what is scientific is legitimate, and that real progress is the result of technological advancement. Human stem cell research and eugenics-based technologies both offer the materialist illusion that an individual is the sum total of his/her genes and that the autonomous pursuit of an individual’s bodily perfection can take place through the use of, or at the expense of, another person’s genes, whether it is by the use of a single gene or an entire genome.

Issues Affecting Human Development

Bioethical questions also arise concerning medical interventions that can be targeted to either the mind or the body. At stake is the distinction between therapy and enhancement.

The development of various psychoactive drugs during the past two decades has led to a cultural sense that the human mind can be enhanced chemically by the administration of a broad spectrum of agents. Our contemporary culture has coined an entire idiom around terms ranging

from dependency to addiction. Many individuals commonly refer to their ongoing relationships with their psychotherapist as simply a way of life. Scientists pursue neurological investigations driven by an ongoing sense that our brains are merely a series of complex chemical reactions, which when completely understood, will result in world free from suffering, self-doubt and conflict. We are promised that all of this can be achieved by the attainment of an illusive state called “chemical balance.” Yet are we simply the product of the interaction of our neurotransmitters? If so, then what is the role of our experiences? Is suffering a transformative experience or something to be obliterated?

Regarding interventions targeted to the body, the number of surgical procedures aimed at aesthetic enhancement has increased dramatically as well (and is rendered even more popular through television shows that celebrate such makeovers). According to the American Society of Plastic Surgeons, over 225,000 breast augmentations were paid for in 2002, while demand for implants and lifts has risen 584% in the last decade (Seigel 2004). Our desire to correct for disfigurement, or to improve upon perceived blemish, is based upon an assumption that one appearance is more desirable than another within a population. Our desire to turn back the effects of aging is based upon an assumption that being young is more desirable than being old. Our desire to pursue surgical and medicinal means of correcting obesity is based upon a sense that we are not able to master our own passions and desires. With these interventions, more and more resources are being expended in search of preserving or perfecting a “normal” body.

Yet each of the above enhancements, whether of mind or body, extends biomedical technology well beyond its therapeutic promise to the realm of aesthetic preference. In doing so, the technological makeovers threaten to leave behind any sense of the unique role of our life

experiences. This conceptually reductive separation of the mind or spirit from our physical existence tempts us to alter ourselves in a way that diminishes our distinctiveness while we pursue either an “ideology of normalcy” (Koch 2005) or some better-than-myself ideal, both of which result from an undefined social standard. Kavanaugh’s concept of personal identity as reflexive awareness is replaced with an awareness based on the image of others as more desirable than who we actually are.

Issues Affecting the End of Human Life

Perhaps most contentious are biological discussions regarding the final stages of human life. Questions about whether and how to sustain or to end life draw us into the depths of understanding the meaning of our lives.

The rapid emergence of physician assisted suicide in many cultures attests to a shift that has occurred which equates the value of our human existence with our self-perceptions of our bodily health. Autonomy of our bodily existence is maximized at the expense of a more inherent, personal value that transcends physical make-up. The sense of a soul that animates the body is replaced with a body that is separate from or devoid of a soul. Suffering becomes meaningless because it is ultimately not contextualized in the series of events that gives our human experiences a higher meaning. Death is no longer accepted, but imposed; care-giving love changes to care-denying utilitarianism as a “characteristic of the excesses of the individual” (Lawler 2005, p. 11).

Life sustaining technologies, which often successfully enable the acutely affected patient to survive, have also challenged us to face a condition often referred to as “permanent vegetative state.” The mere term “vegetative” seems to refute most commonly accepted biological

definitions of humans who remain animals no matter their state of consciousness. Nonetheless, the key philosophical question under consideration for humans experiencing this condition is whether neocortical function is necessary for personhood. If one considers the soul to be separate from the body, or that the soul is predicated on the functioning of a mind, then those who lack consciousness are no longer persons. Yet, an integrated, personalistic understanding, rather than a physicalist approach, will lead to a very different conclusion.

Personalistic considerations of both physician-assisted suicide and permanent vegetative state reverse the reductive tendencies of a physicalist approach. We exist in the world as “acting persons” whose identity begins with the endowment of life itself; we then become who we are through the complexity of self-determined, consequential actions in our lives. Even in the presence of suffering and in the absence of neocortical functioning, each human person uniquely relates to others. Consciousness is not required for this relating to occur. We each have a personal existence in this world with which we have been gifted, and an ability to act that is distinct but necessarily related to the gift of life we have received. Thus, the issues we face at the end of life are personal and not merely physical; in this sense, they are expressions of our soul as much, if not more than, conditions of our body. Consequently, the actions we undertake when faced with crippling challenges are most fully expressive of our personhood in as much as they also manifest this “transcendent” or “spiritual” dimension of our being; appreciating this reality, which grounds the equal dignity of all persons, leads to the basic principle that we should never aim at or intend the death of another (Meilaender 2005, p. 17). By contrast, bioethical choices that fail to consider and manifest the fullness of our personhood ultimately devalue our dignity by reducing our lives to a purely mental or merely physical existence.

THE ULTIMATE QUESTION IN BIOETHICAL DISCUSSIONS

The contemporary situations and metaphysical considerations reviewed above lead ethicists to a question that looms larger than the technologies involved, yet is more foundational to the scientific research to be undertaken and the healthcare decisions being to be made. The question is ultimately an anthropological one: what and how is a being human, and a human a person? How one approaches this twofold question becomes decisive for bioethical discussions.

When physicalism acts as the prism through which life is understood and lived, the human question is reduced to a materialistic level. This reduction, in which “the sorts of questions that avail themselves of empirical inquiry become the only questions worth asking” now dominates the training of aspiring physicians, resulting in a “scientific enterprise [that] pares down the scope of inquiry so radically that it is hard to imagine a worse education for a young soul: material, devoid of spirit, and instrumental; yet also powerful, sophisticated, and unabashed in its absence of self-understanding” (Overby 2005, p. 24). In the end, what it means to be a human is de-valued in the sense that the spiritual or transcendent dimension that makes us unique as persons is lessened to the point of being irrelevant. Life comes to be manufactured from a non-personal, yet actually human, clump of cells. Growth and development are engineered by pharmacological or surgical enhancements. Death becomes the cessation of qualitative functioning, chosen when physical or mental capacities diminish to a point no longer operationally acceptable by an individual.

However, a personalist approach to the key question sees humans for who and what they are, as this is linked to what they do (or cannot do) and what they become. Realizing that our identity as persons transcends the material realm, personalism considers a human to be an

“embodied self” – one whose spirit or “soul” is more than mindful consciousness, yet is expressed in and through our bodily existence, both mental and physical. In this respect, dignity inheres in every human simply by virtue of being human. As “acting persons” we have the ability to live in ways that affect our dignity – whether to fulfill or diminish it – but we cannot lose it, for we cannot change our identity as being human and, by extension, our existence as persons. An embryo, and the genes it possesses, does not have the potential for life; it is a human life that has the potential to develop into an adult. Mental or physical enhancements do not change who we are; our identity as human persons is given, not self-selected or self-determined. Death is not merely an autonomous choice in the face of suffering or a proxy decision absent a person’s consciousness; rather, it discloses the mortality that characterizes our human condition and serves as the natural end to a person’s earthly existence – in the totality of body, mind, and soul.

CONCLUSION

Contrasting understandings about the essential relationship between life and death have opened up divisions within modern medicine and continue to generate discord in bioethical discussions (Fiori 2005). Yet, if we fail to affirm the inherent dignity and value of human life, those discussions risk being reduced to utilitarian equations. If our humanity depends only on our physical reality, in terms of the health of our brain or our body, then our distinctiveness as persons no longer plays a part in decisions about the future health of that very person. What we risk, according to John Paul II, is a “pulverization” of the fundamental uniqueness of the person, and when this occurs, the evil of our socio-political times reaches down to the biological level and degrades the ethical decision-making process in healthcare matters (Weigel 1999). Only

when we construct bioethical discussions on the foundation of what it means to be a human person, which necessarily includes that “adventure of transcendence” that takes us beyond the perception of the senses and scientific verification (Benedict XVI, 2006), can we be certain that the house of our body-soul continuum will not crumble.

Thus, to the reader the ultimate question is “Do you mind?” whether human reality is physical or personal. In our view, we must respond with a “yes” ... for the answer is a matter of life and death to someone.

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