

Should the state support the 'right to die'?

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Euthanasia and physician-assisted suicide (hereafter E/PAS) is a practice with a long history. It was a frequent occurrence in the Ancient World, despite the prohibitions of the Hippocratic Oath (which had no legal standing and was supported by a minority of Greco-Roman physicians). It was condemned as murder by the Christian community and prohibited in Christian Europe (though – like abortion – was no doubt practised secretly). Strong support and advocacy for E/PAS re-emerged in the 19th century in Europe and North America. The first attempts to legalise it, in a number of states in the USA, were defeated in the early 1900s, though voluntary euthanasia societies advocating for reform of existing laws proliferated there and throughout Europe.¹ Although not legal, cases brought before the courts – particularly in the USA, Britain and The Netherlands – were treated with remarkable leniency.

Today, E/PAS has been legalised in a few countries and is treated with leniency or even a 'blind eye' in many others. It is the subject of fierce legal and moral debate.² Religions are divided over whether it can ever be justified. Secular physicians, politicians and ethicists are also engaged in the conflict on both sides. While support for E/PAS is strongest in the north, with surveys showing support ranging from 57% (USA) to 92% (The Netherlands), talk of introducing E/PAS legislation in South Africa shows that it has become a global issue. With the ever-present financial and logistical pressures on the public health service, particularly in developing countries like South Africa, E/PAS takes on a new dimension that gives the question added urgency.

In this paper we ask whether states should support 'right to die' practices. In particular we examine:

- whether E/PAS should be legalised in certain circumstances; and
- whether physicians in the public health service should be required to practise E/PAS if it is legalised.

Definition of terms

Before we debate E/PAS it is necessary to clarify our terms, particularly to distinguish active and passive, direct and indirect, voluntary and non-voluntary euthanasia, as well as physician-assisted suicide.

- *Euthanasia*, from the Greek meaning 'happy death', is 'one person's deliberate killing of another, not because they are threatening injury or have committed a crime, but because their lives are reckoned not to be worth living.'³ It is usually associated in medical situations with patients with terminal illness and no hope of recovery, where the patient experiences great suffering, sometimes accompanied by physical pain that can no longer be properly treated with palliative care.
- *Voluntary euthanasia* occurs at the request, or by consent, of the person/ patient in this situation.
- *Non-voluntary euthanasia* occurs without the request or consent

of the person, where another person – often the physician or relative – considers that it would be the person's wish for their life to be ended.

- *Involuntary euthanasia* occurs against the person's wishes, sometimes out of another's belief that such a step is economically efficient or socially 'hygienic'. It is widely rejected, even by defenders of E/PAS, as murder and is historically associated with the 'euthanasia' atrocities of the Nazi regime in Germany (1933 - 1945).
- *Assisted suicide* occurs when a person helps another to kill him or herself, whether by providing information or means. If the helper is a doctor it is called *physician-assisted suicide*.
- *Active euthanasia* is euthanasia by commission.³
- *Passive euthanasia* is euthanasia by omission. Whether this is the same as 'letting die'⁴ is disputed. Biggar³ says that by withholding treatment we might be practising passive euthanasia; conversely '[w]e might instead be recognising the futility of further treatment and allowing the dying person to turn their limited reserves of energy from striving to stay alive to living as well as possible in the time that remains.'

It might be useful at this stage to try to conflate our understandings of voluntary euthanasia and physician-assisted suicide. Ethicist Willem Landman⁵ has formulated a definition that seeks to include physician-assisted suicide into a definition of voluntary euthanasia: 'The intentional bringing about of an individual's death for that individual's sake, where a positive act of a person other than that individual, and not merely withholding or withdrawal of life-sustaining treatment, is either a contributory cause or a proximate cause of death.'

States that support euthanasia and physician-assisted suicide

Few countries in the world have legalised E/PAS. As we mentioned above, it is widely regarded as a form of murder and remains a criminal offence. It is legal, however, in Belgium, The Netherlands, Colombia and the state of Oregon in the USA, and was briefly legalised in the Northern Territory of Australia. Its legal status is not clear in other places, notably Japan where in 1995 a Yokohama District Court ruled that 'mercy killing' could be justified if all medical conditions coincided with the expressed desire of a patient to shorten his or her life.

In The Netherlands, various forms of E/PAS were widely practised by the late 1990s although it was technically still illegal, despite over 90% of the Dutch public supporting E/PAS. The Termination of Life on Request and Assisted Suicide Act (2001) that went into force on 1 April 2002 was 'generally considered as the codification of the norms and procedures that [had] governed the practice of euthanasia in The Netherlands for almost three decades'.⁶ Under this law 'euthanasia' and 'physician-assisted suicide'

were treated more or less the same. E/PAS was available to any terminally ill adult person (broadly defined) experiencing unbearable suffering with no hope of improvement who voluntarily and repeatedly requested an ending of his/her life. Advance directives were also taken into account. The physician involved in the process had to be known to the patient for some time, had to agree that the patient's situation was hopeless, and had to consult with another doctor, relatives and the caring team of the patient. A full written record of the case and a report to the authorities also had to be made. In effect the intention was to prevent rushed, uninformed or secretive end-of-life decisions.

The Northern Territory of Australia presents an interesting case study. In 1995 the state legislature legalised active euthanasia under certain restricted conditions: terminal illness, intractable pain and suffering, and repeated and expressed desire of an adult patient for euthanasia. Two persons availed themselves of the legislation before the Australian Senate overruled and disallowed the legislation by a narrow majority (38 votes to 33) in March 1997. This was despite the fact that a vast majority of Australians surveyed (roughly 81%) supported voluntary E/PAS.

In South Africa a 1997 discussion paper of the South African Law Commission introduced a Draft Bill on the Rights of the Terminally Ill that included a number of provisions that would have legalised aspects of E/PAS. However reactions from the public were generally negative. Despite finding in a members' survey that 12% of physicians had already helped terminal patients to die, 9% had performed physician-assisted suicide, and 60% had practised passive euthanasia by withholding medication or procedures, the South African Medical Association in 1999 requested that proposed legislation be put on hold. Numerous groups – Doctors for Life, Christians for Life and the National Alliance for Life – lobbied vigorously against reform in the law. To date, no E/PAS legislation has been passed in South Africa. Yet it remains an issue in the background and a source of contention.

What makes the South African case particularly complex are conflicting themes in the Bill of Rights of the Constitution and a series of significant legal cases regarding assisted suicide and the withholding of medical treatment. Under South African law suicide and attempted suicide are legal^{7,8} but euthanasia and assisted suicide are not. Fundamental to the debate is whether a suicide was the direct result of assistance, or whether it constituted a *novus actus*, a new act. A number of conflicting legal judgments⁹⁻¹¹ were resolved in an Appellate Court decision (*Ex Parte Min. of Justice: S v. Grojahn*, 1970 2SA 355 (A))¹² which held that directly assisting or inciting someone to commit suicide was indeed a crime – though circumstances may find it to be murder, attempted murder or culpable homicide. Subsequent cases have confirmed this ruling, though some scholars⁸ have argued for more lenient treatment of such cases according to circumstances.

A further tension in the law has subsequently arisen in terms of conflicting human rights claims in the Bill of Rights of the new Constitution. The Bill of Rights emphasises personal liberty, the right to life and the right to emergency medical treatment. In 1997 the *Soobramoney* case¹³ came before the Constitutional Court. A terminally ill chronic renal patient was refused dialysis by a state hospital, which led ultimately to his death. The plaintiffs for *Soobramoney* argued that he had a constitutional right to life and to emergency medical treatment. Recognising that the treatment was futile and represented an unjustifiable burden on limited state medical resources the Court ruled in favour of the hospital service.

This clarified the sense in which the emergency care clause of the Bill of Rights was interpreted: the right to emergency care was not absolute but conditional on there being a reasonable hope that a patient might recover. It mirrored the common medical practice of triage in hospital emergency rooms. Doctors were not obligated to use what they considered to be extraordinary means to keep patients alive in what they professionally judged to be hopeless situations.

In the medical profession the Bill of Rights has also led to a much stronger defence of patient autonomy. 'Medical paternalism', a global source of concern for decades, has been successfully challenged by the growing movement for human rights for patients. Where patients are able to do so, they have the right to decide for themselves whether to undergo or refuse treatment. Increasingly, too, where they are physically unable to make such decisions for themselves, other persons who know them are able to stand in for them and make proxy decisions. Although as yet they have no legal standing, 'living wills' are also used as a source of direction for doctors as to their desire for certain forms of medical treatment.

Arguments presented for and against E/PAS^{14,15}

For 'assisted' death

Two major arguments are frequently advanced.

Argument from respect for autonomy

This is based on the fundamental principle that patients as human beings have certain rights to decide for themselves what is good for them. (This is the first of the four basic principles of contemporary medical ethics. The others are: beneficence (the obligation to act for the benefit of others), non-maleficence (the obligation not to harm) and justice (most difficult to define, but broadly the obligation to treat the person/patient fairly within the norms of the given society)). It is an argument based on human freedom and choice, one that is fundamental to biomedical ethics, but which is also problematic since 'little agreement exists about its nature and strength or about *specific* rights'¹⁶ (my italics) that it entails. Simply put, it would argue that, since physicians should (within reason) respect the wishes of morally autonomous (i.e. adult) patients, the request for E/PAS should be honoured if their condition is hopeless and they experience great suffering, including pain that cannot reasonably be alleviated.

Argument from mercy

No one, it is argued, ought to be compelled to endure extreme suffering if terminally ill and if pain cannot be relieved by other means. E/PAS is the acceptable, indeed merciful, alternative.

Against 'assisted' death

Here we might consider three arguments.

Killing is intrinsically wrong

The basic commandment in all religions and ethical systems is 'Thou shalt not kill.' Even given that this Judeo-Christian formulation of the commandment is commonly taken to mean 'Do not murder', the fundamental assumption is that it is always wrong to directly kill the innocent. Therefore E/PAS, particularly in its active and direct forms, is intrinsically wrong.

The danger of a 'slippery slope'

Another argument against E/PAS is that by allowing it we will be on a slippery slope from voluntary euthanasia through non-voluntary forms to allowing involuntary euthanasia of a kind akin to the Nazi programme in the 1930s to purge Germany of 'defectives'. If it is allowed, it is argued, doctors will feel able to do what they like and – acting out of laziness, indifference to patients, the pressures of medical expenditures (particularly in state health care) or out of greed for more lucrative procedures than terminal care – take decisions for themselves.

The physician's role argument

A third argument is that E/PAS explicitly violates the principle of doing no harm enshrined in the Hippocratic Oath, the medical ethics of Moses Maimonides, and subsequent developments (e.g. the 1948 Geneva Declaration). Following on from that, it is argued that E/PAS would violate patient-physician trust and undermine the essentially curative role of the physician.¹⁷

Moral tensions: autonomy, suffering and conscience

To tease out this problem further we need to consider what might be three conflicting moral paradigms or principles.

Autonomy

The principle of autonomy, mentioned above, is a central theme in contemporary biomedical ethics. Given the often shocking history of treatment of patients by some medical professionals – subtle and less subtle coercion into sometimes expensive and/or dangerous treatments (in the doctors' interests of medical research or personal gain), treating patients without sufficient explanation or simply a patronising 'doctor knows best' attitude – the principle that a patient has considerable, if not final, say in his/her treatment is not to be taken lightly. This is particularly pertinent in a country like South Africa where for decades public health care was for the majority of our citizens characterised by powerlessness: powerlessness, often, in seeking the best available treatment; powerlessness in having often to make do with inadequate treatment and inferior equipment provided by doctors, some of whom were apartheid 'bureaucrats in white coats' with little knowledge of or sensitivity to the medical needs of their patients or to the complexities of African culture.

Autonomy is also important socially to a liberal democratic society based on individual liberties as enshrined in the Bill of Rights. In a liberal democracy the liberty of the individual to make one's own decisions without coercion (subject of course to the law) is crucial. This too, in South Africa's case is particularly significant given the scandalous degree to which the disenfranchised majority were subjected to a swathe of petty and gross restrictions on their lives – where they could live, work and study; what they were allowed to say or read; even who they could marry.

But, unless one is an extreme libertarian, autonomy is not unlimited. People are constrained in their freedom by circumstances, abilities, family, customs, culture and the laws that (should at least) fairly govern behaviour so that no person's rights and liberties are infringed or destroyed by another (including an over-reaching state).

Can we then use autonomy as a justification for legalising E/PAS? Can we really claim that one has an *absolute* right over

one's own body? Religious communities reject such a claim, claiming that our absolute right to ourselves is overridden by God. Life is a gift of God given to human beings under a condition of stewardship. We do not own our lives but live them for God, who ultimately has the decision about when life shall end. The fundamental principle of not killing an innocent person extends to a rejection of suicide and by further extension to E/PAS.^{3,18-20} Many religious traditions accept the principle that preserving life is not an absolute duty – indeed, that it may be legitimate to withhold futile treatment, not use extraordinary means to keep people alive, or indeed to administer potentially lethal doses of painkiller even if possible death is foreseen though not intended. Few however accept in principle E/PAS.

Such an objection is viable, in a secular and religiously pluralist society, only for those who share these beliefs. A secular state which has to act in the interests of all citizens of all religions and none cannot use this as an argument against legalising E/PAS, however much they wish to respect citizens' religious beliefs. Nor do all believers, moreover, share the convictions of their religious tradition; some are ignorant, others dissent.

More convincing is the sociological and psychological fact that people are in fact *not* as autonomous as they might imagine. Human beings are a product of, and are shaped to varying degrees by, their society and culture. Seemingly autonomous, the human being is constantly being pressurised by a range of sometimes conflicting messages in the environment. It is conceivable, then, that a person may seek E/PAS for motives less than the conventional reason (longstanding and incurable pain and suffering caused by a terminal illness). They may feel (directly or indirectly) pressurised into seeking an end to life by feelings of being a physical, mental or financial burden to family and friends. Sickness may simply be a pretext.

Does this exclude autonomy as a justification for legalising E/PAS? Religious claims aside, it does not. What it emphasises is the need for profound caution if E/PAS is legalised. It clearly excludes medical professionals from arbitrarily ending patients' lives that they may consider futile. Similarly it excludes any simplistic 'E/PAS on demand' approach to ending life: given the deep-seated concern for respect for life that marks the principles of medicine and social life. Patient autonomy in this case is seen for what it is – limited.

Under a system that legalises E/PAS, while patient autonomy to *seek* E/PAS may be guaranteed it can never be the sole grounds for *receiving* it. One does not simply get what one wants when it is something so final that has such a personal and social impact. There need to be serious grounds for justification. As we have noted above, the strongest reason for seeking E/PAS is suffering.

Suffering

The fundamental reason advanced for seeking – and for legalising – E/PAS is unbearable pain and suffering. Few if any seek 'death on demand'. Among advocates of E/PAS unbearable pain and suffering is understood as a situation where existing medical treatments for terminal illnesses are futile, where pain control may not be sufficiently effective, or where the illness leads to a slow, debilitating death. Suffering is understood as more than physical pain but also severe mental anguish – as distinguished from depression – leading to a sense that one's quality of life is so dimin-

ished as to be non-existent or virtually non-existent. Such suffering that destroys one's quality of life – sometimes understood as one's biographical life – is seen as grounds for a person to seek E/PAS.

This raises a number of controversies, many of them rooted in religious traditions but with direct relevance to secular people. Should suffering be allowed? Should we not try to fight suffering – and if so, to what lengths should one go?

Many religious traditions hold, in varying ways, that suffering is the will of God. This can have two meanings: that God *will*s suffering or that God *allows* it. If one claims that suffering is the will of God the implication is that God may demand it, possibly for sin. Such a claim, even for a believer, is problematic: at best, if suffering is a punishment for sin, God is a punishing God; at worst, if God simply demands it God is a sadist.²¹ The latter image seems incoherent and unbelievable, given most religions have firm belief in a loving God. The former image raises a range of theological issues that cannot adequately be addressed here and moreover does not address the age-old question of why bad things happen to good people.

More often religions may claim that God *allows* suffering. Suffering is a part of human life, often the consequence of free human actions or, in the case of illness, combinations of bad luck, negligence or unfortunate genetic defects. God allows suffering and human beings are faced with how they deal with it. In the Christian tradition there is the classic example of the suffering of Jesus of Nazareth whose course of action led to his death – and the examples of countless Christian martyrs who died for the faith. This is true too for many secular martyrs and leaders who have suffered for their convictions.

A frequent religious claim is that suffering is best avoided, if it can be, but if it cannot, it should be endured. Suffering too, many religions claim, can also be an opportunity for a deepening faith in a compassionate God – and the dying process, if it leads to death, can be an opportunity for strengthening relationships with others, and for reconciliation of differences between people. True, too, for secular people who come together around a dying family member or friend.

This is not the whole picture, however. A slow death accompanied by great suffering can also be a time of trauma for everyone – whether they are believers or not. Time and again, physicians, therapists and clergy are confronted with people, the dying and assorted relatives and friends alike, emotionally shattered by experiencing such a terrible end to a life. Religious faith, too, may be shattered rather than deepened.

As to those who suffer and/or die for a noble cause, this much might be said: whether consciously or as a result of their actions, they embraced the possibility or reality of their suffering. They may have found it redemptive or for a greater good, but to varying degrees it was chosen, not imposed upon them.

Moreover the *value* of suffering is not the only dimension to great religious traditions. In most religions suffering, particularly the unjust suffering of the innocent, is a moral challenge to *end* or *reduce* suffering. All great religions precisely because they value the human being so highly have developed moral teachings that defend human life, dignity, social and economic justice. Religions act, often heroically, on behalf of those who suffer, demonstrating great compassion for them. Mercy is a theme of all great faiths. Indeed these values are common to secular people and organisa-

tions too. The question is: to what degree should mercy cause them to rethink E/PAS? Similarly, if God is not a sadist and *allows* rather than demands suffering, should this same God – who is universally understood as loving and compassionate by the great faiths – not also allow means to alleviate excessive suffering, even to the point of E/PAS?

Believers or not, suffering offers us a strong challenge. In itself, the value of suffering does not offer us a clear argument against E/PAS. If anything it offers a stronger case for legalising E/PAS, though this does in itself raise a further problem.

If, for argument's sake, E/PAS was legalised in South Africa, what criteria would be used – apart from respecting the autonomous will of a patient – to proceed? In The Netherlands since 2002 a strict process has been in place. The patient requests euthanasia from his/her doctor, who must be known to them for at least a few years. The doctor examines the case carefully, in particular to be certain that the patient's suffering is indeed unbearable and not motivated by depression or social factors. If there seem to be grounds, the doctor consults another physician who must concur. Relatives must be informed of the patient's decision before E/PAS proceeds. The whole case must be carefully documented and reported to the Ministry of Health. Failure to conform to any part of the process results in the prosecution of the doctor.

Whether this method or a variation (like leaving the decision to an ethics committee, cf. Landman)⁵ were to be adopted in South Africa, and although it reflects both patient autonomy and the key factor of suffering, a further key factor – conscience – would still have to be addressed.

Conscience

E/PAS, however rational the reason, entails a terrible choice – participating in the direct ending of a human life. Even if it were legal, E/PAS entails for almost any normal person a terrible moral dilemma, a problem of conscience. This is particularly acute for those actively involved in administering E/PAS, the medical professionals.

To follow one's conscience – one's formed and informed conscience – is the core of moral activity. Ethicist Martin Prozesky²² defines conscience as 'the inner voice of ethics, of right and wrong, of good and evil. We can think of it as our built-in guidance system in the search for the good life. It is the uncomfortable feeling we get, or should get, when we lie, speak cruelly, cheat on somebody ... or do any of the many things we know are wrong. It is also the warm and noble feeling that comes when we do the right thing ... especially when it costs us something to do these things.'

Conscience is 'the whole person's commitment to value and the judgment one makes in light of who one ought to be and what one ought to do and not do.'²³ It can be understood psychologically as 'decisions or judgments based on an internal sense of oughtness (how I should live and what I must do) that is the result of a life history that incorporates who I am, who I am becoming, and who I desire to be.'²⁴ Conscience is both the inwardly directed and ongoing search for my deepest, most authentic self – a self which includes a fundamental moral option, towards good or evil – and outwardly directed towards making the right decisions; in short, doing the good thing.

Since such decisions, if one is to be an authentic person, must ultimately come from within – from a realist moral perspective – following one's conscience must take note of what a sense of moral-

ity requires. One does not have to deny that an objective moral order exists, but one has to see how we appropriate for ourselves the values, principles or paradigms that constitute the moral order. Indeed, Josef Fuchs²⁵ – one of the greatest 20th century Catholic ethicists – insists that it is ‘not possible to learn about objective and morally correct behaviour and conduct in the world from external norms only but also from one’s own convictions embedded in the conscience.’

Some doctors support E/PAS; some allow exceptions to a general opposition to it; others are strongly pro-life and cannot in good conscience countenance it. This is an important point because ultimately it’s the doctor who will directly or indirectly perform PAS – and they must live with themselves afterwards. Doctors have rights as well as a range of beliefs – and in this debate they need to be heard, respected and as far as possible protected. If PAS and euthanasia are to be legalised in South Africa, what space should doctors have to conscientiously *object* to performing PAS? We have seen with the abortion bills how, though doctors in theory have a ‘right to conscience’, these rights are frequently ridden roughshod over through a combination of pressures on young doctors (interns and community service doctors) and physicians in public health care – bullying administrators and senior physicians, threat of no career advancement and sometimes the shortage of available practitioners in a hospital – to act against their consciences. In traditional moral theology, in no less an orthodox theologian as Thomas Aquinas, an informed conscience trumps all rules. In a South Africa with pro-PAS, pro-euthanasia legislation, can pro-life doctors be guaranteed not to be slaves to law?

Legalisation?

Short of an appeal to the sanctity of life as a ‘gift’, are there any strong grounds for not legalising E/PAS? Probably not. But will legal clarification change the problem? Does law make a moral dilemma right?

I don’t think so. At best a law makes some things permissible, other things culpable. To take a few examples:

1. Apartheid law made marriage and/or sex across the ‘colour line’ illegal, restricted the majority of South Africans’ freedom of movement – and even citizenship – while giving security forces immense powers to violate generally accepted notions of civil and political liberty in the name of ‘national security’. South Africa in fact functioned for the most part as a *rechtstaat* with democratic elections, parliament and an independent judiciary. Yet – it was a fundamentally immoral system, so immoral that it had to be overthrown.
2. Conscription of adult, white males was compulsory under the old order – yet many young South Africans chose to conscientiously object to service in the South African Defence Force, whether for universal religious or secular pacifist or political reasons. To those who fought against apartheid – including those now in government – they were heroes because they did not put their beliefs ‘on hold’.
3. Under our new democracy the abortion laws were considerably liberalised, while the death penalty was abolished – but repeated surveys suggest that the majority of South Africans believe that the abortion laws should be repealed while capital punishment should be reinstated. While I don’t want to debate the merits of my fellow citizens’ views on these issues, let me

point out that here we find a situation where law-making does not resolve any moral issues, but is merely an expression of public policy.

In short, at best the law does not *make morality* – it makes laws or policies. Even if the state legalises euthanasia on demand, legislation cannot replace each one of us making a moral decision as to the rightness or wrongness of what we do. In the proposed bill that was shelved, apart from a directive as to who might perform euthanasia or assisted suicide, there was, as exists in abortion situations, a clear ‘conscience clause’ – no doctor could be forced to perform PAS/euthanasia.

And here lies a problem. The Ethics Institute of South Africa²⁶ found in 2001 in an admittedly small pilot survey that a majority of doctors were opposed to euthanasia (51%) and PAS (52%), although an overwhelming majority (73%) were sympathetic to the legalisation of patients’ advance directives clarifying the degree to which doctors were asked to preserve lives. Forty-three per cent were sympathetic to legalisation of provision of lethal drugs to patients seeking PAS (39% opposed, 18% neutral), while 44% were sympathetic to voluntary euthanasia (47% against, 9% neutral). These somewhat confused and confusing results suggest that even if E/PAS were legalised, medical practitioners would be divided as to the morality of the law.

Medical practitioners will have to make up their minds whether they are prepared to participate in E/PAS. Of course following one’s conscience sometimes comes with a price. People of conscience have suffered ridicule, ostracism, intimidation, imprisonment, torture and death for their convictions. We may think of the Hebrew prophets, of Jesus, of Muhammad, of the early Christians, of medieval scientists and doctors persecuted for ‘witchcraft’, of the socialist movement, of Soviet dissidents and those who resisted fascism in its many forms. We may think of Gandhi, Martin Luther King, Dietrich Bonhoeffer and – closer to home – of Steve Biko, Bram Fischer and Nelson Mandela. All of them can echo the words of Martin Luther: ‘Here I stand. I can do none other.’

Individual conscience is not narcissism, nor is it bourgeois ideology. We are social beings, interacting in many and various ways with each other, with our ancestors, with future generations. We have obligations to each, to society and to history – but also to ourselves. What we are is a product of certain social classes, ideologies, religions, privileges (or lack of them). But if we are to stop thinking of ourselves as victims of history and rather as agents of history, people making history in relationship with others, we have to think of ourselves as persons *making* history by bringing *ourselves* into the historical process. All these forces and persons are poured into our carbon-based life forms and give each one of us a particularity – personhood, personality, soul. Developing and living according to conscience is what makes us human. But it never makes decisions easy.

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