BOSTON COLLEGE
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Dementia-Related Euthanasia:
A Catholic Contribution to Dialogue When Human Freedom Is at Stake

Thesis in Moral Theology
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Index

Introduction

On March 18, 2021, the Spanish Parliament passed a law legalizing euthanasia and guaranteeing free access to it within the national public health system. At the same time, the debate about approving euthanasia and physician-assisted suicide is ongoing in several other countries, such as France, the US, and Japan. The aging of populations around the globe contributes to this, as well as the increase in age-related diseases such as dementia. Dementia causes impairment and consequent suffering that is usually invoked as an argument in favor of legalizing euthanasia. In Spain, the law allows euthanasia for a patient with dementia who requests this in an advance directive document.

Given this situation, the present work has a twofold intention. Our thesis is that a person with dementia who requests euthanasia is not making a free decision. Our argument will rely on internal and external conditions which constrain the individual's freedom. Our purpose is to provide arguments that support our thesis as coherent with Catholic teaching without appealing to the concept of human dignity. We agree with the Catholic understanding of human dignity as children of God. However, "The word 'dignity' is not unambiguous. [...] the word therefore has very little ethical use, especially in bioethics [...]. If dignity can mean one thing to one person and another thing to another person then it cannot serve to resolve any ethical disputes."[1] For this reason, we will support our thesis without using the concept of dignity and will present our argument in five chapters.

The first chapter will present the state of the question. We will show the relevance of addressing the challenge of dementia due to its increasing prevalence and impact on the lives of

[1] Daniel P. Sulmasy, "The Varieties of Human Dignity: A Logical and Conceptual Analysis," *Medicine, Health Care and Philosophy* 16, no. 4 (November 2013): 937, accessed April 11, 2023, http://link.springer.com/10.1007/s11019-012-9400-1.

individuals and societies. Also, we will summarize the current legal and ethical debate about euthanasia, particularly in Spain.

The second chapter will present the anthropological theory of Pedro Laín Entralgo. This Spanish author is interesting because of his vast scientific publications about medical history, anthropology, and bioethics. He was a devout Catholic; still, his works always entered into dialogue with non-believers, thanks to his understanding of medical knowledge and contemporary philosophy. His stance on human freedom will help us realize how dementia undermines people's autonomy.

While the second chapter clarifies the internal conditioning factors relating to human freedom, the third examines inequity in healthcare access and social support. The focus is, therefore, on justice. Using Catholic Social Teaching, we will demonstrate how social injustice constrains human freedom.

The fourth chapter deals with the theological understanding of human freedom contained in Aquinas's *Prima Secundae*. We will use what was shown in the second chapter to complement Aquinas's understanding of the relationship between the will and the intellect concerning choice. We will also explain Aquinas's understanding of the virtue of prudence as explained in the *Secunda Secundae*. This virtue is essential for our decision-making process and, therefore, our freedom.

The fifth chapter will incorporate the above and offer some guidance to the healthcare provider facing a request for euthanasia from someone with dementia. To this end, we will rely on the principles of Catholic Social Teaching, particularly from the Spanish and American bishops' conferences.

1. Dementia-Related Euthanasia: State of the Question

The purpose of this chapter is not to form a moral judgment of euthanasia in general but to address a particular situation, such as euthanasia in cases of dementia, which does not represent the majority of euthanasia cases. For example, the number of euthanasia cases registered in the Netherlands in 2019 totaled 6,361,[2] only 162 of which were due to dementia.[3] Specifically, we will discuss those cases in which an advance directive document is signed after receiving the diagnosis of cognitive impairment and requests future euthanasia. The moral assessment of this possible euthanasia differs from those carried out based on a request made prior to the diagnosis, that is, in the absence of any pathology.

We will try to answer whether such a request for future euthanasia (a request made after receiving the diagnosis of dementia) is a free, autonomous decision. Our thesis is that it is not, due to internal and external conditioning factors limiting the subject's freedom at the time of the request.

Before going more directly into the possibility of euthanasia in cases of dementia, it is necessary first to clarify the concept of euthanasia and distinguish it from assisted suicide. Both terms are used interchangeably and loosely in public debate and the press. "Confusion commonly arises about legislation for euthanasia and assisted suicide. This outcome stems from the historical development of state law in the United States. Almost all state legislation uses the term 'assisted suicide' when euthanasia [...] is being discussed."[4] Furthermore, they are

[2] Antonie Stef Groenewoud et al., "Euthanasia in the Netherlands: A Claims Data Cross-Sectional Study of Geographical Variation," *BMJ Supportive & Palliative Care* 0 (January 14, 2021): 1, accessed January 20, 2023, https://spcare.bmj.com/lookup/doi/10.1136/bmjspcare-2020-002573.

[3] Antonie Stef Groenewoud et al., "The Ethics of Euthanasia in Dementia: A Qualitative Content Analysis of Case Summaries (2012–2020)," *Journal of the American Geriatrics Society* 70, no. 6 (June 2022): 1706, accessed January 20, 2023, https://onlinelibrary.wiley.com/doi/10.1111/jgs.17707.

[4] Peter B. Terry, "Euthanasia and Assisted Suicide," *Mayo Clinic Proceedings* 70, no. 2 (February 1995): 189, accessed January 24, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0025619611642894.

sometimes mixed with some ambiguity in academic articles, often under umbrella terms such as 'medical aid in dying' or 'medically assisted death.'[5]

However, in ethical debates of such importance, it is necessary to be precise and to delimit our moral evaluation. At the same time, we must always remember that "in working toward a comprehensive ethical and legal framework to guide practice we must remember that definitions are not morally neutral. They are not just innocent tools that allow us to describe reality. Rather, they shape our perception of reality –they select, they emphasize, they embody biases. Definitions constantly need refining if they are to aid our understanding and help ground law and policy."[6] In this sense, "Any attempt to define euthanasia rigidly immediately brings to mind qualifications or exceptions that seem to demand inclusion and thus lead to long, awkward definitions that still fall short of the mark."[7] Therefore, we will try to provide a definition consistent with the general medical consensus and with as much clarity and completion as is possible. As used here, euthanasia means: the intentional termination of a life by an act or method performed by a healthcare professional causing painless death to avoid unbearable suffering to a person with an incurable illness at their informed request and free consent. "Adding the modifiers active and passive, voluntary and involuntary, and direct and indirect to the word euthanasia often leads to confusion."[8] For this reason, we refrain from introducing such modifiers in the proposed definition to avoid confusion. In addition, not everyone accepts all these modifiers or qualifiers.[9]

[5] Cfr. Douglas M. Sawyer, John R. Williams, and Frederick Lowy, "Canadian Physicians and Euthanasia: 2. Definitions and Distinctions," *Canadian Medical Association Journal (CMAJ)* 148, no. 9 (1993): 1464.

[6] Maurice A. M. de Wachter, "Euthanasia in the Netherlands," *The Hastings Center Report* 22, no. 2 (March 1992): 23, accessed January 24, 2023, https://www.jstor.org/stable/3562561?origin=crossref.

[7] Sawyer, Williams, and Lowy, "Canadian Physicians and Euthanasia: 2. Definitions and Distinctions," 1463.

[8] Terry, "Euthanasia and Assisted Suicide," 189.

[9] Cfr. Sawyer, Williams, and Lowy, "Canadian Physicians and Euthanasia: 2. Definitions and Distinctions," 1463.

As for the agent performing euthanasia, it does not necessarily have to be a physician, and the fact that another person performs it, even someone outside the health profession, would not alter the definition. However, it is a unanimous condition in countries where euthanasia is legal, and a broad consensus among authors who defend the extension of its practice, that it must indeed be a physician who approves and performs euthanasia. It is also agreed that "The attending physician must consult with a colleague regarding the patient's condition and the genuineness and appropriateness of the request for euthanasia."[10]

Having defined euthanasia, let us now define 'assisted suicide' so that the differences between the two concepts are clearly illustrated. As used here, assisted suicide means: the intentional self-termination of a life by an act or method provisioned by an assisting party, causing painless death to avoid unbearable suffering to a person with an incurable illness at their informed request, free consent, and self-performance. Usually, we speak of physician-assisted suicide because the aforementioned assisting party is a medical doctor, but this does not necessarily have to be that way. For instance, in Switzerland, volunteers belonging to right-to-die organizations are the ones who accompany and assist the patient.[11]

Therefore, we can immediately appreciate the difference between one concept and the other. While in euthanasia it is another person who performs the act leading to the death of the patient, in assisted suicide it is the patient who performs the act. Although there is no unanimity among all authors, here we consider that the moral evaluation of both realities is different for several reasons. It is not our purpose to delve into this divergence. However, it is important to note both definitions and the immediate difference between them, after which we will focus exclusively on euthanasia, and more specifically on patients with dementia.

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[10] de Wachter, "Euthanasia in the Netherlands," 23.

[11] Cfr. Nicole Steck et al., "Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review," *Medical Care* 51, no. 10 (October 2013): 939, accessed January 25, 2023, https://journals.lww.com/00005650-201310000-00012.

Patients diagnosed with dementia considering euthanasia present a context in which it is necessary to consider various elements that play relevant roles. The increase in the prevalence of different types of dementia is explained by the progressive aging of the population, at least in the economically more developed West. However, an important consideration is the state of public debate and the legal situation in regards to euthanasia, to understand the arguments that come into play.

In this first chapter, we will begin by addressing the phenomenon of population aging and related social consequences. We will then present the global situation regarding dementia, pointing out the different dimensions of health that are affected by it. Thirdly, we will present the legal situation and the public debate surrounding euthanasia, particularly in Spain.

1.1. Population Ageing and Consequences

One of the most relevant demographic phenomena we have been facing globally for several years is the process of population aging. While it is true that "there remains considerable variation at both regional and country levels, with strong correlations to differing income level,"[12] we must, at the same time, acknowledge that "the population of virtually every country is aging rapidly."[13]

This population aging, along with the increase in absolute terms of the world's population, means that the number of people in the third and fourth ages will soon have to be expressed in billions. In fact, "the United Nations (UN) Population Division projects that the population over the age of 60 years will increase from more than 800 million today (representing 11% of the world population) to more than 2 billion in 2050 (representing 22% of the world population)."[14]

[12] David E. Bloom, David Canning, and Alyssa Lubet, "Global Population Aging: Facts, Challenges, Solutions & Perspectives," *Daedalus* 144, no. 2 (Spring 2015): 81.

[13] Ibid.

[14] Valentin Fuster, "Changing Demographics," *Journal of the American College of Cardiology* 69, no. 24 (June 2017): 3002, accessed January 23, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0735109717373278.

Nevertheless, this population aging is not only shown in the statistics that elaborate demographic projections, but it is a phenomenon that is already present. “In 2020, the number of people aged 60 years and older outnumbered children younger than 5 years.”[15] As the elderly population increases, “the proportion of people younger than 30 years was much lower and decreased more in high-, upper-middle-, and lower-middle-income countries [...] between 1990 and 2017.”[16]

This process is multifactorial, although most authors agree in relating the elements involved to two major factors, “declining fertility and increasing life expectancies.”[17] The most decisive element is, in fact, declining fertility. It results in “smaller youth cohorts, which create an imbalance in the age structure: older age groups become larger than their younger counterparts.”[18] The low birth rate is mainly due to the significant cultural changes that took place during the second half of the 20th century, but to this must be added the extension of “accessible and effective birth control [and the] increased child survival.”[19] In this sense, “A number of recent studies have also presented evidence that socioeconomic development leads to [...] fertility limitation.”[20] This socioeconomic development brings benefits in terms of offspring health, education and socioeconomic mobility. While these benefits increase child survival, they

[15] World Health Organization, “Ageing and Health,” www.who.int, October 1, 2022, accessed October 1, 2022, https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.

[16] Xunjie Cheng et al., “Population Ageing and Mortality during 1990–2017: A Global Decomposition Analysis,” ed. Sanjay Basu, *PLOS Medicine* 17, no. 6 (June 8, 2020): 6, accessed January 23, 2023, https://dx.plos.org/10.1371/journal.pmed.1003138.

[17] Wolfgang Lutz, Warren Sanderson, and Sergei Scherbov, “The Coming Acceleration of Global Population Ageing,” *Nature* 451, no. 7179 (February 2008): 716, accessed January 21, 2023, http://www.nature.com/articles/nature06516.

[18] Bloom, Canning, and Lubet, “Global Population Aging: Facts, Challenges, Solutions & Perspectives,” 80.

[19] Ibid.

[20] David W. Lawson, Alexandra Alvergne, and Mhairi A. Gibson, “The Life-History Trade-Off between Fertility and Child Survival,” *Proceedings of the Royal Society B: Biological Sciences* 279, no. 1748 (December 7, 2012): 4761, accessed February 14, 2023, https://royalsocietypublishing.org/doi/10.1098/rspb.2012.1635.

"may ultimately motivate further reductions in fertility in later stages of the demographic transition."[21]

The increase in life expectancy is also multifaceted, varying considerably from country to country. If we look at the case of the United States, cardiovascular diseases (both heart and cerebrovascular) and cancer were responsible for 59% of deaths in 2000.[22] Given this data, we can understand the impact of preventive medicine policies that seek to reduce exposure to these risk factors.[23] Thus, in high-income Western countries, life expectancy increases primarily due to the "improvement in effectiveness and coverage of health care, and [...] improvements in exposure to risk factors, particularly tobacco and blood pressure."[24] Similarly, higher-income countries generally have a larger proportion of the population with higher education, and "Almost universally, people with better education have better health."[25]

This population aging, in Western countries, has brought us to a point where we are surprised when we learn of the 'early' death of an acquaintance when he or she dies before the age of eighty. The world population of centenarians is multiplying yearly, having reached half a million in 2015, and is expected to reach 25 million in 2100.[26] Likewise, there is a succession of coverage in the press of older adults completing their fourth university degree or of retired

[21] Ibid.

[22] Cfr. Hiram Beltrán-Sánchez, Samuel H. Preston, and Vladimir Canudas-Romo, "An Integrated Approach to Cause-of-Death Analysis: Cause-Deleted Life Tables and Decompositions of Life Expectancy," *Demographic Research* 19 (July 25, 2008): 1330, accessed January 23, 2023, http://www.demographic-research.org/volumes/vol19/35/.

[23] Cheng et al., "Population Ageing and Mortality during 1990–2017," 2.

[24] Colin D Mathers et al., "Causes of International Increases in Older Age Life Expectancy," *The Lancet* 385, no. 9967 (February 2015): 546, accessed January 21, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0140673614605699.

[25] Wolfgang Lutz, "The Demography of Future Global Population Aging: Indicators, Uncertainty, and Educational Composition," *Population and Development Review* 35, no. 2 (June 2009): 362, accessed January 23, 2023, https://onlinelibrary.wiley.com/doi/10.1111/j.1728-4457.2009.00282.x.

[26] Cfr. Jean-Marie Robine and Sarah Cubaynes, "Worldwide Demography of Centenarians," *Mechanisms of Ageing and Development* 165 (July 2017): 59, accessed January 23, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0047637416302548.

people starting in the world of popular races or mass marathons. This circumstance, which some medical professionals present as an example of "successful aging,"[27] is undoubtedly positive.

However, it must be conceded that the increase in life expectancy, even if the final years are spent in much better conditions than only half a century ago, also has a negative consequence.

The first negative consequence is economic, as the reduction in the income of retired people logically leads to "older persons [having] lower per capita consumption than younger populations."[28] To this reduction in consumption, we must add "the difficulties this aging will cause for government programs for the elderly, and particularly public pensions."[29] However, this impact on the economy can be balanced if we consider that "there remains great scope for older people to contribute to society and to the economy, especially if they can remain healthy and active."[30] Many elderly people contribute to the economy in unrecognized ways, for example as caregivers (taking care of grandchildren while both parents are working, or of a family member with a disability), or as volunteers in many non-profit organizations that offer social services that are not provided by the government. We must also consider paid employment "that [is] not so physically demanding may see productivity increase alongside more years of experience."[31]

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[27] Michael A. Flatt et al., "Are 'Anti-Aging Medicine' and 'Successful Aging' Two Sides of the Same Coin? Views of Anti-Aging Practitioners," *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 68, no. 6 (November 1, 2013): 946, accessed January 23, 2023, https://academic.oup.com/psychsocgerontology/article-lookup/doi/10.1093/geronb/gbt086.

[28] Brian C. Thiede et al., "A Demographic Deficit? Local Population Aging and Access to Services in Rural America, 1990-2010: A Demographic Deficit? Local Population Aging," *Rural Sociology* 82, no. 1 (March 2017): 50, accessed January 23, 2023, https://onlinelibrary.wiley.com/doi/10.1111/ruso.12117.

[29] Ronald Lee and Andrew Mason, "Some Macroeconomic Aspects of Global Population Aging," *Demography* 47, no. Suppl 1 (March 1, 2010): 169, accessed January 23, 2023, https://read.dukeupress.edu/demography/article/47/Suppl%201/S151/169922/Some-macroeconomic-aspects-of-global-population.

[30] Jonathan Cylus et al., "Economic, Fiscal, and Societal Consequences of Population Aging – Looming Catastrophe or Fake News?," *Croatian Medical Journal* 61, no. 2 (April 2020): 190, accessed January 23, 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7230429/.

[31] Ibid., 190–191.

Despite the possibility of contributing to the labor market, if we look again at the public sector, this aging "threatens the sustainability of [...] health care systems, absent painful reforms."[32] We can consider the example of the United States, where "the Medicare program covers 95 % of the nation's aged population."[33] Translated in terms of people, "In 2009, 46.3 million people were covered by Medicare: 38.7 million of them were aged 65 years and older, and 7.6 million were disabled. By 2031, when the baby-boomer generation will be completely enrolled, Medicare is expected to reach 77 million individuals."[34] This increase in healthcare spending is due to the second of the consequences of population aging, i.e., those related to health. This aging "raises the prevalence of every ill that afflicts the elderly, such as activity limitations, chronic care needs, and dementia."[35]

Longer life expectancy necessarily implies an increase in the prevalence of age-related diseases, no matter how much modern medicine may develop. Dementia is among such diseases. "The epidemic is largely explained by the prevalence of dementia in persons 80 years of age or older. In most countries around the world, especially wealthy ones, this 'old old' population will continue to grow, and since it accounts for the largest proportion of dementia cases, the dementia epidemic will grow worldwide. The combined effects of longer lives and the dramatic bulge of baby boomers reaching old age will magnify the epidemic in future decades."[36]

In the following section, we will present some basic medical notions about dementia, which will allow us to assess the impact of this pathology in the elderly population, trying to focus on

[32] Lee and Mason, "Some Macroeconomic Aspects of Global Population Aging," 151.

[33] Anatoliy I. Yashin, Kenneth C. Land, and Eric Stallard, *Biodemography of Aging: Determinants of Healthy Life Span and Longevity*, 1st ed. 2016., The Springer Series on Demographic Methods and Population Analysis 40 (Dordrecht: Springer Netherlands: Imprint: Springer, 2016), 143.

[34] Ibid.

[35] Lee and Mason, "Some Macroeconomic Aspects of Global Population Aging," 151.

[36] Eric B. Larson, Kristine Yaffe, and Kenneth M. Langa, "New Insights into the Dementia Epidemic," *New England Journal of Medicine* 369, no. 24 (December 12, 2013): 2275, accessed January 21, 2023, http://www.nejm.org/doi/10.1056/NEJMp1311405.

one of the consequences of this disease, in addition to cognitive and physical impairment, namely: underdiagnosed dementia-related depression.

1.2. Dementia: An Introduction

The improvement that has taken place in so many dimensions of our life has been such that there is less and less tolerance to physical suffering, to the deterioration caused by age and illness. Attitudes of a cult of eternal youth have spread.[37] This circumstance is paired with a prejudice in favor of the new as ontologically and morally better than the old, and with the desire to prolong youth. These conceptions are incompatible with a family situation in which we have to care for a person with dementia, much less with seeing ourselves cared for in this way.

However, an increasing number of families have older members with dementia. Predictably, "as the global population ages, the number of people living with dementia is expected to triple from 50 million to 152 million by 2050."[38] The cognitive and behavioral deterioration associated with this pathology makes caregivers regret having 'lost their relative in life' since it is not only that they no longer recognize those close to them, but also that they do not recognize themselves.[39] These dramatic situations raise the question of their future senescence in many people. The possibility that old age may be accompanied by one of these dementias causes many to reject the idea of living in such conditions. In fact, the possibility of euthanasia and assisted suicide "in patients with psychiatric disorders, dementia, or an accumulation of health problems related to old age [...] has taken a prominent place in the public debate."[40]

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[37] Cfr. Marcel Danesi, *Forever Young: The "Teen-Aging" of Modern Culture* (Toronto: University of Toronto Press, 2003), 21–25.

[38] World Health Organization, "Dementia: Number of People Affected to Triple in Next 30 Years," *www.who.int*, December 7, 2017, accessed October 1, 2022, https://www.who.int/news/item/07-12-2017dementia-number-of-people-affected-to-triple-in-next-30-years.

[39] Cfr. Juliette Brown, "Self and Identity over Time: Dementia," *Journal of Evaluation in Clinical Practice* 23, no. 5 (October 2017): 1006, accessed January 25, 2023, https://onlinelibrary.wiley.com/doi/10.1111/jep.12643.

[40] Kirsten Evenblij et al., "Factors Associated with Requesting and Receiving Euthanasia: A Nationwide Mortality Follow-Back Study with a Focus on Patients with Psychiatric Disorders, Dementia, or an Accumulation of

It, therefore, seems appropriate to present a medical description of dementia that allows us to approach the possibility of euthanasia in such cases with a sufficient basis of knowledge about the disease. The contrary would lead us to speculate based on preconceived ideas and untested opinions, vitiating the moral assessment we pursue. A good Christian ethic starts from sound data, and it is fair to recognize that "our culture lacks understanding and awareness of the natural history of this illness. The dread of the end-game, the horror of the late stages, and fear of overwhelming need and dependency hang between us and our best thinking about the intervening years and the possibility of living better and dying better with dementia."[41]

So, let us begin by defining dementia as "a loss of mental functions. It is an acquired, persistent impairment in multiple areas of intellectual function not due to delirium."[42] Such chronic impairment must affect at least three "of the following nine spheres of mental activity: memory, language, perception (especially visuospatial), praxis, calculations, conceptual or semantic knowledge, executive functions, personality or social behavior, and emotional awareness or expression."[43]

This definition emphasizes the distinction between dementia and delirium, a condition with which it should not be confused. We define delirium as "a global disorder of cognition that develops over days to weeks and is characterised by fluctuations in alertness, changes in the sleep-wake cycle, poor concentration and memory, visual hallucinations and motor changes of restlessness or apathy,"[44] and is the most frequent neurobehavioral syndrome in hospitals.[45] The most common causative factors for delirium are "metabolic disturbances, major organ failure,

Health Problems Related to Old Age," *BMC Medicine* 17, no. 1 (December 2019): 2, accessed January 25, 2023, https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1276-y.

[41] Brown, "Self and Identity over Time," 1006.

[42] Mario F. Mendez, Jeffrey L. Cummings, and Jeffrey L. Cummings, *Dementia: A Clinical Approach*, 3rd ed. (Philadelphia, PA: Butterworth-Heinemann, 2003), 4.

[43] Ibid.

[44] Brian Draper, *Understanding Alzheimer's Disease and Other Dementias* (London: Jessica Kingsley Publishers, 2013), 115.

[45] Cfr. Mendez, Cummings, and Cummings, *Dementia*, 46.

strokes, infections, and drugs."[46] When the underlying cause is treated, mental function is usually recovered, even though some symptoms may last for months.[47]

The definition of dementia also allows us to distinguish it from other minor declines in intellectual capacity. It therefore breaks the myth that dementia is synonymous with senility or an inevitable part of aging. In this sense, we must distinguish between what can be qualified as normal and successful aging, the so-called age-associated memory impairment, age-associated cognitive decline, the concept of mild cognitive impairment, and dementia.

Normal and successful aging is one in which the person exhibits the typical behavioral changes that come with age, which can include "subtle declines in cognition,"[48] generally from 85 years of age onwards, even in otherwise optimally healthy individuals.[49]

Age-associated memory impairment defines the condition of people over 50 with a decline in memory function who nevertheless preserve their intellectual ability and do not meet the criteria for depression and dementia.[50]

Age-associated cognitive decline means the older individual exhibits a mild compromise "in multiple domains of cognition [...] relative to younger individuals."[51]

Mild cognitive impairment is described as "isolated and absolute memory deficits in the elderly."[52] The subjective memory complaints are demonstrable with testing, as it happens with age-associated memory impairment. However, in this case, test scores are below standard compared to younger populations and age-matched elderly. People suffering mild cognitive impairment do not present other defining features of dementia but have "also a lower baseline

[46] Ibid., 47.
[47] Cfr. Draper, *Understanding Alzheimer's Disease and Other Dementias*, 54.
[48] V. Olga B. Emery and Thomas E. Oxman, eds., *Dementia: Presentations, Differential Diagnosis, and Nosology*, 2nd ed. (Baltimore: Johns Hopkins University Press, 2003), 4.
[49] Cfr. Ibid.
[50] Cfr. Ibid., 5.
[51] Ibid.
[52] Mendez, Cummings, and Cummings, *Dementia*, 44.

score on all neuropsychological tests."[53] Despite the memory problems, at this stage, "social and occupational functioning are relatively preserved."[54] Mild cognitive impairment is "associated with increased neuropsychiatric symptoms and an increase risk of death,"[55] and is also "a potential early stage or precursor"[56] of Alzheimer's disease. Most studies show that people with mild cognitive impairment convert to Alzheimer's disease at a rate "in the range of 10–15 % per year [...]. This contrasts with the 1–2 % per year rate [...] in the normal elderly population,"[57] reaching up to 80 % of the individuals converting to Alzheimer's over the 9.5 years following the diagnosis of cognitive impairment.[58]

Once we have defined dementia and differentiated it from other conditions, the questions about its origin and cause arise. There are several types of dementia, up to over a hundred, but most are extremely rare. The four types of dementia most frequently seen in clinical practice are "[1] Alzheimer's disease, [2] vascular dementia, [3] frontotemporal dementia and [4] dementia with Lewy bodies – which account for 90 to 95 per cent of all cases."[59] Among them, in particular, Alzheimer's disease is the most frequent type, accounting for approximately 60 % of all causes,[60] and up to 80 % when it is present together with other causes.[61]

Alzheimer's disease typically has "an insidious onset with a slowly progressive and chronic course lasting many years."[62] The diagnosis is fundamentally clinical, and a series of tests and

[53] Ibid.
[54] Emery and Oxman, *Dementia*, 5.
[55] Mendez, Cummings, and Cummings, *Dementia*, 45.
[56] Ibid., 44.
[57] Emery and Oxman, *Dementia*, 6.
[58] Cfr. Ibid.
[59] Draper, *Understanding Alzheimer's Disease and Other Dementias*, 89.
[60] Cfr. Clive Holmes and Jay Amin, "Dementia," *Medicine* 48, no. 11 (November 2020): 743, accessed January 26, 2023, https://linkinghub.elsevier.com/retrieve/pii/S1357303920302073.
[61] Cfr. Morag E. Taylor and Jacqueline C.T. Close, "Dementia," in *Handbook of Clinical Neurology*, vol. 159 (Elsevier, 2018), 304, accessed January 27, 2023, https://linkinghub.elsevier.com/retrieve/pii/B9780444639165000197.
[62] Mendez, Cummings, and Cummings, *Dementia*, 51.

protocols are used to determine whether the subject meets the criteria for it.[63] Due to its clinical nature, we speak of "(1) Probable AD [Alzheimer's Disease] dementia, (2) Possible AD dementia, and (3) Probable or possible AD dementia with evidence of the AD pathophysiological process."[64] The latter case is the one in which there is evidence of brain injury in an image test, and these image tests (MRI or PET) are not usually requested except to include a patient study.[65] It is important to note that, at the time of clinical diagnosis, imaging is not considered necessary because by that time, "the neuropathological alterations are usually widespread"[66], anticipating that they will be encountered and do not provide relevant information for treatment and prognosis. That is to say, even before the diagnosis of the disease, the brain is immersed in a chronic degenerative process that causes its progressive atrophy and the intra- and extracellular accumulation of amyloid-beta and tau proteins.[67]

It is a disorder primarily of the elderly, but not exclusively. In cases of familial Alzheimer's disease, "onset as early as the fourth decade of life can occur."[68] "The presentation of AD with short-term memory difficulty is most common but impairment in expressive speech, visuospatial processing and executive (mental agility) functions also occurs."[69] Something that must be noticed is that "Dementia can manifest as personality or psychiatric changes rather than a clear

[63] Cfr. Guy M. McKhann et al., "The Diagnosis of Dementia Due to Alzheimer's Disease: Recommendations from the National Institute on Aging-Alzheimer's Association Workgroups on Diagnostic Guidelines for Alzheimer's Disease," *Alzheimer's & Dementia* 7, no. 3 (May 2011): 266, accessed January 28, 2023, https://onlinelibrary.wiley.com/doi/10.1016/j.jalz.2011.03.005.

[64] Ibid., 265.

[65] Cfr. Ibid.

[66] Gonzalo Rojas C. et al., "Neuroimágenes en Demencias," *Revista Médica Clínica Las Condes* 27, no. 3 (May 2016): 339, accessed January 28, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0716864016300359.

[67] Cfr. Miao-Kun Sun, ed., *Research Progress in Alzheimer's Disease and Dementia*, vol. 4 (New York: Nova Biomedical, Nova Science Publishers, 2007), 86.

[68] Mendez, Cummings, and Cummings, *Dementia*, 67.

[69] David S. Knopman et al., "Alzheimer Disease," *Nature Reviews Disease Primers* 7, no. 1 (May 13, 2021): 1, accessed January 27, 2023, https://www.nature.com/articles/s41572-021-00269-y.

cognitive decline."[70] In fact, when the frontal-subcortical region is affected, patients "may be more prone to depression and mood disorders."[71]

The difficulty in these cases is that "Sometimes the family doctor is consulted, though often nothing specific can be found. It is usually when other symptoms occur and the diagnosis of dementia is made that the family may become aware that the changed personality and behaviour is part of the dementia."[72] The relationship between dementia and depression is particularly important, as "depression is the most common differential diagnosis of dementia."[73] Moreover, paying attention to this relationship is crucial, as we see that "dementia may initially present with symptoms that mimic depression."[74] Depression must always be suspected in a person with dementia "if they wish to die or have suicidal ideas."[75]

Dementia's "progression varies significantly from patient to patient"[76] and even though the "average life expectancy is roughly 7 to 15 years after the clinical diagnosis,"[77] patients do not usually reach advanced stages because most die in fewer years due to comorbidity. When they do reach an advanced stage,

> the person with dementia is completely dependent on caregivers for all aspects of daily living and has almost certainly been in long-term residential care for some time. Language skills are lost and many are mute. Memory function is virtually impossible to test. Most are unable to stand or walk without assistance, many are unable to sit up properly. Due to their lack of activity, [...] contractures of arms and legs, and routine pressure care is required to prevent the development of bedsores. [...] Feeding difficulties are almost universal and many are unable to swallow safely. [...] Urinary and faecal incontinence is the rule. Most people with dementia die from infections (pneumonia, influenza), cardiac arrest or stroke.[78]

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[70] Mendez, Cummings, and Cummings, *Dementia*, 56.
[71] Ibid.
[72] Draper, *Understanding Alzheimer's Disease and Other Dementias*, 70.
[73] Emaad M. Abdel-Rahman, ed., *Depression in the Elderly*, Psychology of emotions, motivations and actions (New York: Nova Science Publishers, 2012), 141.
[74] Ibid., 142.
[75] Draper, *Understanding Alzheimer's Disease and Other Dementias*, 82.
[76] Sun, *Research Progress in Alzheimer's Disease and Dementia*, 4:86.
[77] Ibid.
[78] Draper, *Understanding Alzheimer's Disease and Other Dementias*, 88.

In the face of such a prognosis, dementia leads irrevocably to an agony that may extend more or less in time but that on every occasion presents great suffering that requires very intensive care. Therefore, it is easy to understand why people wonder, "If people have the right to live, then why can they not also have the right to die, especially when they are suffering immensely under such unbearable and terminal conditions?"[79] The question, therefore, arises as to the possibility of euthanasia in patients with dementia. Now, is it possible? What is the legal situation of euthanasia at the international level? What arguments are used in countries where it has been approved or will be approved? It is now necessary to briefly introduce the situation of euthanasia at the global level, with a particular mention of Spain, as this is the country from which we come and on which we will focus as this work progresses.

1.3. Euthanasia in the World

Let us begin by recalling that the subject of our work is euthanasia, which is clearly distinguished from assisted suicide, whose legality is different at the international level.[80] Euthanasia is legal in only eight countries worldwide. It was first introduced in the Netherlands and Belgium in 2002, Luxemburg in 2009, Colombia in 2015, Canada in 2016, and Spain and New Zealand in 2021. By the end of 2023, it will be legal in all the states of Australia.

The legislation of these countries exemplifies certain differences. Firstly, while in Australia and New Zealand the law requires that the patient has received a diagnosis of terminal illness (with an expected survival of less than 6-8 months), the other countries only require suffering not

[79] Jitender Jakhar, Saaniya Ambreen, and Shiv Prasad, "Right to Life or Right to Die in Advanced Dementia: Physician-Assisted Dying," *Frontiers in Psychiatry* 11 (January 21, 2021): 2, accessed November 6, 2022, https://www.frontiersin.org/articles/10.3389/fpsyt.2020.622446/full.

[80] By way of example, suffice it to cite the case of the USA, where euthanasia is illegal, while as of January 2023, ten states have legalized assisted suicide.

treatable by other means.[81] A second significant difference lies in the possibility of infant euthanasia. While it is legal in the Benelux countries and Colombia, it can only be applied to adults in the other countries.[82] Finally, only in the Benelux countries is euthanasia in cases of mental illness, including dementia, legal. "Most cases were reported as concurrent requests [...] by patients deemed competent in the 'early phases of dementia.' However, beginning in 2011, a small number of [...] requests based on written advance euthanasia directives have been granted."[83]

However, the possibility of legislating the end of life, and specifically legalizing euthanasia, is under public debate in several other countries, such as Germany, Italy, France, South Korea, and Portugal. In this debate, the arguments for and against such legalization are similar in different places.

Among the arguments used to defend the moral legitimacy of euthanasia, we can find "individual autonomy and the right to choose; loss of dignity and the right to maintain dignity; reduction of suffering; justice and the demand to be treated fairly."[84]

Arguments used to criticize the legalization of euthanasia and deny its moral legitimacy are based on "the sanctity of life doctrine; the possibility of misdiagnosis and recovery [...]; risk of abuse (by unscrupulous relatives [...]); non-necessity [...]; discrimination (treating some lives as less worthy than others) [...]; irrational or mistaken or imprudent choice [...]; the slippery slope argument."[85]

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[81] Cfr. Carmen Velasco Bernal and Jose Maria Trejo-Gabriel-Galan, "Leyes de Eutanasia en España y en el Mundo: Aspectos Médicos," *Atención Primaria* 54, no. 1 (January 2022): 4, accessed January 29, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0212656721002043.

[82] Ibid.

[83] Dominic R. Mangino et al., "Euthanasia and Assisted Suicide of Persons With Dementia in the Netherlands," *The American Journal of Geriatric Psychiatry* 28, no. 4 (April 2020): 467, accessed January 29, 2023, https://linkinghub.elsevier.com/retrieve/pii/S1064748119304889.

[84] Gail Tulloch, *Euthanasia, Choice and Death*, Contemporary ethical debates (Edinburgh: Edinburgh University Press, 2005), 34–35.

[85] Ibid., 35.

Given the above arguments, we easily realize that the reasons in favor of the moral legitimacy of euthanasia are basically two, namely: the autonomy of the subject who requests it, and the beneficence of politicians and professionals who make it available. The arguments against the approval of euthanasia are also twofold, namely: the dignity of human life, and the possibility of a moral slippery slope in society.

The above arguments are all highly relevant, and we will address them later in the text. However, we must first present the particular situation of euthanasia in Spain, specifically in cases of dementia.

1.3.1. Dementia-Related Euthanasia in Spain

The Organic Law for the Regulation of Euthanasia was approved in Spain by the national Parliament in March 2021. It was enacted in June of the same year, following its publication in the Official State Gazette.[86] Although the title of the law refers to euthanasia, the body of the text also includes assisted suicide.[87]

For the person who may request aid in dying, the first thing that is established is that "The decision to request assistance in dying must be an autonomous decision, meaning that it is based on the knowledge of the medical process, after having been adequately informed by the responsible health care team."[88] In other words, it must be an autonomous, competent person. It is also required that two requests have been "made voluntarily and in writing, or by other means that allow a record to be made, and that it is not the result of any external pressure."[89]

The mere request does not grant the possibility of euthanasia for the patient. He or she must suffer "a severe and incurable disease or a severe, chronic and incapacitating condition under the

[86] Cfr. *Ley Orgánica de Regulación de la Eutanasia*, *Boletín Oficial del Estado*, vol. 72, 2021.
[87] Ibid., 72:34040–34041.
[88] Ibid., 72:34041.
[89] Ibid.

terms established in this Law, certified by the responsible physician."[90] The body of the text itself explains what is meant by a severe and incurable disease, which is defined as "that which by its nature causes constant and unbearable physical or psychological suffering with no possibility of relief that the person considers tolerable, with a limited prognosis of life, in a context of progressive fragility."[91] Likewise, the law sets forth what is to be understood as a severe, chronic and disabling disease, which is defined as the

> situation that refers to limitations that directly affect physical autonomy and activities of daily living, in such a way that it is not possible to fend for oneself, as well as the capacity for expression and relationships, and that are associated with constant and intolerable physical or psychological suffering for the person who undergoes them, with the certainty or high probability that such limitations will persist over time without the possibility of cure or noticeable improvement.[92]

There are two relevant aspects of note. First, the law includes the possibility that the suffering to be ascertained in the patient is not only physical, but also recognizes the possibility of psychological suffering as a basis for the request for euthanasia. Secondly, we see that dementia meets the requirements of the law as a severe, incurable and incapacitating disease. However, the request must come from a competent adult subject, thus excluding euthanasia in cases of advanced dementia. However, subsequently the same law opens the door to the possibility which is the focal interest of this work. We read in the legal text that

> in those cases in which the responsible physician certifies that the patient is not in the full use of his or her faculties nor can give free, voluntary and conscious consent to make the requests, [...] and has previously signed a document of advance directive, living will, or legally recognized equivalent documents, [...] the provision of assistance in dying may be facilitated under the terms of such document. In the case of having named a representative in that document, he/she will be the valid representative to deal with the responsible physician.[93]

[90] Ibid.
[91] Ibid., 72:34040.
[92] Ibid.
[93] Ibid., 72:34042.

Thus, Spanish legislation on euthanasia allows a person diagnosed with dementia, but who has not yet reached an advanced stage where a judge has declared his or her legal incapacity, to write an advance directive document that includes his or her wish to receive euthanasia in the future. The person who is designated as the legal representative will be in charge of deciding at a later date whether the time has come to perform such euthanasia.

Faced with this possibility, the question arises: is such a request for future euthanasia made by an autonomous person? Is it a free decision whose moral legitimacy and legal consequences must be accepted? Our thesis is that it is not, due to a series of internal and external conditioning factors, and we will devote the following chapters to justifying this thesis.

To this end, in the next chapter, we will present the theory of freedom and choice of Pedro Laín, a prominent Spanish physician and philosopher of the twentieth century. We will begin by showing a non-theological understanding of the exercise of human will. In this way, the subsequent chapters, of a theological nature, will show that Catholic ethics is coherent with secular ethical reflection, making clear the possibility, on an equal level, for Catholic theology to enter into dialogue in public debate about human freedom, particularly concerning euthanasia.

2. Choice and Freedom in Pedro Laín Entralgo's Anthropology

In the first chapter, we introduced the context of our moral problem, which is euthanasia in patients with dementia. Due to an aging population, the prevalence of dementia is increasing and so is the debate about legalizing euthanasia in those cases.

Now we introduce the philosophy of Pedro Laín (1908-2001).[94] This author is relevant because throughout his life he combined thorough historical research with medicine and philosophy. If we focus on his philosophy, Laín published abundantly in anthropology. Moreover, he based his anthropological reflections on new findings in the science of medicine. The human being, as the culmination of evolution in cosmos, fascinated him.

From among the multitude of authors who could help us explore our thesis and serve the purpose of this work, Laín is the best choice for four reasons.

First, he had a profound Catholic faith and was committed to the laity's mission to transform the world's culture for God's greater glory.[95] He was also motivated by the desire to fulfill God's dream for humanity, specifically regarding healthcare for the vulnerable population.

Second, Laín knew how to translate his Christian values into philosophical terms while including the latest scientific advances, particularly in medicine.[96] This translation was motivated by his eagerness to facilitate dialogue between believers and non-believers, following the invitation of Vatican II. Thus, he satisfies the present work's purpose of using language and arguments capable of engaging non-believers.[97]

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[94] Cfr. Alejandro Goic, "Pedro Laín Entralgo, Physician and Humanist," *Revista Médica de Chile* 130, no. 1 (January 2002): 101–106.

[95] Cfr. Vatican Council II, Pastoral Constitution on The Church in the Modern World *Gaudium et Spes*, (7 December 1965) §43, at The Holy See. https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.

[96] Cfr. Ibid., §57.

[97] Cfr. Ibid., §92.

Third, Laín devoted his whole life to university teaching. In the university, Laín devoted himself to seeking knowledge and truth. However, he was always aware, using Pope Benedict's words, that "truth means more than knowledge: the purpose of knowing the truth is to know the good."[98] It thus seems appropriate to utilize his thought, since this is an academic thesis in an institution that likewise serves the true and the good.

Lastly, Laín is interesting because he is a Spanish author hardly known in the United States. Given the open and inclusive nature of ethical reflection at Boston College, it seems useful to introduce an author who has had significant influence on Hispanic medical ethics over the last 50 years.

However, when considering his anthropological understanding, we must realize that he gives considerable importance to philosophy of mind, a field that he described during the second half of the twentieth century. This description is still valid despite its age. During the last 25 years, there have been several discoveries about the way our brain works. Nevertheless, we are still waiting for a qualitative step forward concerning our understanding about how complex thinking is created, what we properly call our mind. We know much more about the brain but still very little about our mind. In that sense, we are in a similar situation to Laín's.

Thus we will introduce Laín's understanding of the human being, specifically that he understood the brain as the author of human behavior. As a result of this approach to his anthropology, we will explain his two main insights.

First, the whole human brain is involved in decision-making. Some functions are primarily rooted in specific cerebral nuclei but human freedom is a complex process involving the organ's

[98] Benedict XVI, Lecture at the University of Rome "La Sapienza," (17 January 2008), Vatican City. https://www.vatican.va/content/benedict-xvi/en/speeches/2008/january/documents/hf_ben-xvi_spe_20080117_la-sapienza.html.

entirety. For this reason, significant damage to any part of our brain will necessarily affect the decision-making process.

Second, we will introduce Laín's explanation of human freedom as a particular feature of the human brain due to evolution. Moreover, we will see how he understands human freedom as a moment within the human project.

These two insights will serve to show the capacity of Catholic moral theology to incorporate medical knowledge in its reflection and debate on equal terms with secular philosophy. This chapter will thus demonstrate our thesis that a person with dementia who requests euthanasia is not free. This is because understanding freedom as part of the human project will show that social injustice may limit our freedom to the point of constraining it. Our third chapter will introduce Catholic social teaching, particularly regarding inequity in healthcare access, to prove this point.

Also, because dementia-related damage in the brain affects our intellect and consequently our freedom to the point of constraining it, the fourth chapter will show how Aquinas explains the connection between intellect and will.

2.1. The Mind-Body Relationship in Pedro Laín Entralgo's Anthropology: Structurism

As we begin approaching Laín's anthropology, we must understand his reflections as part of the classic philosophical problem concerning the relationship between the human soul and body. The philosophy of mind has now taken up this issue again, although from another perspective. Laín, like many other contemporary authors, refers to this in terms of the mind-brain relationship.[99] He distinguishes what, in his opinion, are the eight main viewpoints on this

[99] Carlos Beorlegui, "Los Emergentismos Sistémicos: Un Modelo Fructífero para el Problema Mente-Cuerpo," *Pensamiento* 62, no. 234 (2006): 391–392.

question.[100] These eight can ultimately be reduced to two main positions: monism (mind and body are one and the same thing) and dualism (mind and body are two independent realities that interact).

Faced with this dichotomy, our author centers his thought in a monism similar to emergentism, although with some nuances that differentiate them. “The concept of emergence has been used to characterize certain phenomena as ‘novel,’ [...] in the theoretical sense of being unexplainable, or unpredictable, on the basis of information concerning the spatial parts or other constituents of the systems in which the phenomena occur.”[101] We can think about some of the features of water, such as its transparency and liquidity; they could not have been expected from a knowledge of the properties of hydrogen and oxygen nor predicted by their simple addition to one another.

Classical British emergentism is a cosmological doctrine that, applied to philosophy of mind, would imply a materialism that considers human behavior as the motor expression of events occurring in the central nervous system (thus comprising more than just the brain), whose explanation involves biological laws containing new predicates. Therefore, mental activity is the biological activity of plastic subsystems of the central nervous system, explicable through biological laws containing these new predicates.[102]

As in emergentism, the concept of evolution is fundamental for Laín. He defines the brain as “a system of cellular subsystems that by gradual emergent evolution arose in the biosphere and is the earthly culmination of the process that goes from the organism of the first cell to the human

[100] Cfr. Pedro Laín Entralgo, *Alma, Cuerpo, Persona*, 1st ed. (Barcelona: Galaxia Gutenberg - Círculo de Lectores, 1995), 145–146.

[101] Mark Bedau and Paul Humphreys, *Emergence: Contemporary Readings in Philosophy and Science* (Cambridge, Mass.: MIT Press, 2008), 62.

[102] Cfr. Mario Bunge, *Matter and Mind: A Philosophical Inquiry*, Boston Studies in The Philosophy of Science v. 287 (Dordrecht: Springer Verlag, 2010), 144–145.

organism."[103] In other words, the human brain is a radically new entity whose functions are qualitatively different from the ones of previous evolutionary stages. These brain functions or mental acts, "are not, therefore, acts of the mind communicated to the body, they are the result of the combination of the biological activities [...] of several brain subsystems [...]."[104] Therefore, the brain is a structure whose functioning is caused by the interaction of the substructures that constitute it. At the same time, the brain is also a substructure "within the total structure of the human body."[105] Thus, everything that physically affects the individual affects the mental act too, since it necessarily affects the brain.

Laín's structurist proposal takes its name from the importance of this notion of structure, which is understood to be the dynamic and evolutionary mode of reality. However, what does he mean by 'structure'? For Laín, every structure implies a qualitative leap in evolution with respect to everything that precedes it. It supposes a systematic, closed, and cyclical set of notes or characteristics in which the whole is always of a complexity superior to that given by the sum of its parts. These notes can be additive (they are explained by the sum of the properties of the components) or constitutional, that is, proper to the structure and arising from it.[106]

For Laín, it is also crucial to understand that "material structures are essentially dynamic. Not because they possess a dynamism, but because they are dynamic in themselves, they are dynamism."[107] It is not a matter of thinking of the brain as possessing certain functions but rather that the brain is a function itself. The brain is permanently operative. Even during our sleep, the brain keeps running several processes at the same time. This functioning is part of the broader functions of the wider human body.

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[103] Pedro Laín Entralgo, *Cuerpo y Alma: Estructura Dinámica del Cuerpo Humano* (Madrid: Espasa Calpe, 1991), 257.
[104] Ibid.
[105] Ibid., 259.
[106] Cfr. Ibid., 88–100.
[107] Ibid., 101.

Understanding the dynamism of material structures, such as the brain, implies recognizing that the electrophysiology of neuronal activity and the biochemistry of axon-dendritic synapses "constitute the inescapable basis of any theory of brain activity and function."[108] Thus, understanding the phenomenon we call 'mind' involves studying the anatomy and physiology of the brain. Accordingly, this means that we cannot abstractly speculate about how the brain acts. Instead, our philosophical reflection must be based on medical facts.

In this task, thanks to the data provided by medical science, within brain activity we can distinguish functions that can be attributed to specific locations in the anatomy of the organ (such as vision arising in the occipital cortex, for instance) and functions that require the intervention of the whole brain (such as consciousness and memory).[109] We can see these differences thanks to functional magnetic resonance imaging (fMRI) and electroencephalogram (EEG). FMRI shows changes in the amount of oxygen in the blood and in the blood flow to the areas of the brain that get activated. EEG records the electrical activity in the brain using electrodes attached to the scalp. This is possible because brain cells communicate through electrical impulses that create a pattern of wavy lines. Thus both tests show which parts of the brain are active. In this way they help us find what cerebral parts are involved in specific activities. Some examples will help us understand the principles involved.

For instance, hearing is rooted in the Heschl area, located in the temporal cortex (the exterior part of the brain, on both sides, around the top of the ears). If we check the brain activity with fMRI and EEG, we see how this area gets activated when a person hears some noises. This is the way ENT physicians test the hearing ability of newborn babies, for example. In the same way, if we stimulate this area through electrodes, a patient will hear some rustling, buzzing, or

[108] Ibid., 273.

[109] Cfr. Pedro Laín Entralgo, *Idea Del Hombre*, 1. ed. (Barcelona: Galaxia Gutenberg - Círculo de Lectores, 1996), 142.

tapping.[110] We can thus see the connection between a brain area and its operation in both directions.

Let us now consider a more complex brain function. Suppose we ask a subject to elaborate on deep thinking or recall a memory and imagine an alternative outcome. In that case, both fMRI and EEG will show the activation of several brain areas. Even in a decision seemingly as simple as choosing between two cards of different colors, several centers of the cerebral cortex are active. On the contrary, if we stimulate those same brain areas, the subject neither elaborates a deep thought, reproduces a memory, nor even decides which card to choose. In this case, we cannot see the connection between the brain areas and their operation in both directions. Thus, the difference between basic brain activities and more complex ones becomes clear.[111]

In this sense, the brain as a whole is the agent of complex thinking (self-consciousness, conceptualization, symbolic and abstract thought). This is not due to the association of the messages from the various functional areas of the cerebral cortex. We can reproduce the same electrical impulses in the same brain areas and still the output will not be the same. Human complex thinking is produced by the coordinated functioning of the brain's structural totality.[112]

Within these higher mental activities, the phenomenon of consciousness stands out for its complexity, which Laín calls 'personal consciousness.' This form of consciousness is opposed to the neural consciousness of a higher primate or the trial-and-error pattern present in lower living beings.[113] This personal consciousness implies a qualitative step forward from neural

[110] Cfr. Christoph Mathys et al., "Non-Invasive Brain Stimulation Applied to Heschl's Gyrus Modulates Pitch Discrimination," *Frontiers in Psychology* 1 (2010): 2–3, accessed February 27, 2023, http://journal.frontiersin.org/article/10.3389/fpsyg.2010.00193/abstract.

[111] Cfr. Markus Thimm et al., "Neural Mechanisms Underlying Freedom to Choose an Object," *Human Brain Mapping* 33, no. 11 (November 2012): 2689–2691, accessed February 15, 2023, https://onlinelibrary.wiley.com/doi/10.1002/hbm.21393.

[112] Cfr. György Buzsáki, *Rhythms of the Brain* (New York: Oxford University Press, 2006), 46.

[113] Cfr. Pedro Laín Entralgo, *Qué es el Hombre: Evolución y Sentido de la Vida*, Colección Jovellanos de Ensayo 17 (Oviedo: Ediciones Nobel, 1999), 190–191.

consciousness insofar as it is based on the projective capacity (which implies the capacity of symbolization and always conditioned freedom), as opposed to the "quisitive life"[114] (which ultimately remains in the trial-and-error pattern) that is implied by the neural consciousness of the higher primates.[115] That is, between animal and human consciousness, there is an ontological gap, a qualitative difference. Again, this is explained by the greater evolutionary complexity of the human brain.

Therefore, personal consciousness is a constitutional operation of the human brain, a characteristic that arose through evolution as a novelty present only in our brain. It is not a property that the organ possesses alone, but is an act of the brain in conjunction with the totality of the human body. Consciousness, closely linked to human wakefulness, is a mode of being of certain psycho-organic acts. "The so-called contents of consciousness are the various psycho-organic acts that have become conscious."[116] Our body, directed by the brain, is continuously active, carrying out different operations. Think of our digestive process after a meal. It is a psycho-organic act because the brain coordinates the various systems and apparatus involved (respiratory, circulatory, or digestive). We are not usually aware of this process, but this does not alter it. This psycho-organic act becomes a content of our consciousness when, for example, we have overeaten during a copious Christmas meal. Our digestion becomes heavy, and we become conscious of it. We turn it into a conscious thought.

Thus, to simplify Laín's position, he explains the mind as a function of the brain. According to him, the human mind is not something that happens *in* the brain but *because of* the brain. At the same time, however, it should be clear that not all brain activity is mental. Many of the brain's minor activities are also executed by the brains of animals that are not properly

[114] José Peña González and Antonio Piñas Mesa, eds., *La Antropología Médica de Pedro Laín Entralgo* (Madrid: CEU Ediciones, 2014), 102.

[115] Cfr. Laín Entralgo, *Idea Del Hombre*, 142–146.

[116] Pedro Laín Entralgo, *Antropología Médica para Clínicos*, [1a. ed.]. (Barcelona: Salvat, 1984), 30.

'conscious.' "Only in the case of the activities proper to the whole system can one speak of mind and mental states, the subject of such states being the whole system of the brain."[117] Thus Laín does not consider a reflex movement or the way the brain takes part in the hearing sense, for example, as mental operations. When he speaks of the human mind or mental activity, he refers to sophisticated thinking, such as mental mathematical calculation, introspective reflection, or fond memories, for example.

We have briefly explored Laín's understanding of the brain as a complex structure arising from the dynamism of evolution. Therefore, from his point of view freedom is nothing but a higher function of the brain itself. "The free act is the work of the whole brain, of the brain as a unity."[118] This shows how our author avoids resorting to metaphysical notions, always adhering to a philosophical field in which medical science is also comfortable.

The question then arises, how does Laín conceive of human freedom? How does he explain it from the premises of his structurist doctrine? We will now present his understanding of human freedom.

2.2. Human Freedom in Pedro Laín Entralgo's Structurism

One of the arguments heard most frequently in the debate on the ethical legitimacy and legal possibility of euthanasia appeals to freedom as the specific condition of humanity, as a dimension whose exercise constitutes us properly as persons. In this sense, the maximum exercise of freedom would be the disposition over our own life. Human life is not such when the possibility of freedom, understood in terms of autonomy, is completely lost.

Bearing in mind the importance of what is at stake in whatever notion of freedom we adopt, we will explore the concept proposed by Laín. After presenting the idea of the brain as the author

[117] Beorlegui, "Los Emergentismos Sistémicos: Un Modelo Fructífero para el Problema Mente-Cuerpo," 400.
[118] Laín Entralgo, *Cuerpo y Alma*, 302.

of human behavior, and not merely as an actor in it, we will compare the animal way of living –proleptic– and the human way of living –projective–. Thus, we arrive at the central idea in Laín's thinking about freedom: his conception of it as a structural moment of the human project.

To Laín, there is no freedom without consciousness and wakefulness. "Consciousness [...] is a quality of the psycho-organic acts that by their nature or by their intensity become 'conscious,' and [...] the acquisition of this quality requires as a prior condition the actuality of the psycho-organic state that we call wakefulness. In wakefulness, [...] certain psycho-organic acts [...] become conscious and, by this, become part of a deliberate act."[119] Because people are aware of a specific psycho-organic state of their bodies, they can undertake free actions. For instance, if we are not awake and conscious of thirst, we cannot decide to get out of bed and get a glass of water at midnight. Without the freedom to initiate or set it aside, a person would not undertake an action. Now, freedom is not uniform but can take on very diverse modes.

The first distinction to be made regarding freedom is between "freedom 'from' all external and internal obstacles that prevent or hinder one from being effectively free"[120] and the "freedom 'for' moving towards the goals one has set out to achieve."[121] That is, the first stage of freedom is "to be free with respect to that which prevents one from being free"[122] and a second stage where we can more appropriately speak of human freedom is "to be free for wanting or not wanting this or that thing."[123]

Having established this distinction, Laín considers that there are four constitutive moments of this freedom 'for':

> 1. The freedom of choice or preference, the *facultas electiva* of which the classic definition speaks. I can choose between moving or not moving, [...] between reading one book or another.

[119] Pedro Laín Entralgo, *El Cuerpo Humano: Teoría Actual* (Madrid: Espasa Calpe, 1989), 306.
[120] Laín Entralgo, *Antropología Médica para Clínicos*, 146.
[121] Ibid.
[122] Laín Entralgo, *El Cuerpo Humano*, 307.
[123] Ibid.

> 2. The freedom of acceptance or rejection. I act freely when, under the pressure of a particular social usage or the suggestion of such and such an offer, I can accept or reject it by myself [...].
> 3. Freedom of imagination and creation. The option can sometimes take a very singular form: when the subject decides to be free not by choosing among the various possibilities offered but by coming out of the situation through the invention of a new possibility: to conceive an unprecedented artifact, [...] Creation is the consequence, then, of a supreme act of freedom and places the creator before another subsequent and distinct free act: to accept as their own the created work or to altogether deny it and the actions that led to it [...].
> 4. The freedom of offering and donation. By lovingly offering and donating what is 'mine' – to a specific person, to a cause, to the whole of humanity, to God– I act freely and affirm my reality by appropriating what I offer in a very subtle and sometimes sublime way: the way of generosity, self-denial, or sacrifice [...].[124]

These four constituent moments of what human freedom properly is involve how people confront the reality surrounding them, their world.[125] 'World' is not just any word in Laín's philosophy. Following Ortega and Zubiri, he understands that "Unlike the animal, for which the environment is not a set of things that are, but a diversely formalized series of stimuli that solicit or attack it, the human being makes and lives their conduct"[126] in the world. An animal lives in the environment that surrounds it. Human beings live in a world they appropriate through their freedom. As Laín explains, "Human intelligence qualitatively surpasses the afference of pure stimulus and installs the human being in reality."[127] We can better understand this with an example.

Imagine a dog who has not been fed for two days. As soon as a piece of meat is offered, the dog will eat it. Perhaps he has been trained for a long time and has learned not to do so because the subsequent reward is more appealing, or to avoid punishment. In any case, the dog feels the stimulus of hunger and the visual stimulus of a piece of meat. Eating such meat or the alternate

[124] Laín Entralgo, *Antropología Médica para Clínicos*, 146.
[125] Cfr. Pedro Laín Entralgo, *Ser y Conducta Del Hombre* (Madrid: Espasa Calpe, 1996), 420.
[126] Laín Entralgo, *El Cuerpo Humano*, 226.
[127] Ibid., 169.

reward will satiate his appetite. In the dog's brain, there is nothing more than a succession of stimuli that he knows how to connect by trial and error.

Now, let us think about a person. After a prolonged fast, someone may decide to eat the whole piece when faced with delectable meat, or choose to eat only a bit and reserve another part just in case. They may also decide to abstain because they are on a diet, even if hunger torments them. Then again, they may choose not to eat due to a vegetarian lifestyle commitment, or for religiously motivated abstinence. Alternately, hunger may overcome all ideas and beliefs, and the subject may eat the meat and later regret it and feel guilt and remorse. They may also decide not to eat that portion publicly out of pride or shame but try to eat it later on the sly. Thus, a person receives the same stimulus of hunger and the food portion as the dog, but both are inserted in a larger frame of reference, which is the more expansive human world. In this, there are not only stimuli but also personal history, social usages, religious beliefs, ideological commitments, good or bad moods, feelings of shame or guilt, and a long series of other variables. It is not just a quantitative increase in the knowledge acquired by the person through trial and error; it is a qualitative difference in the capacity to face reality.

In the human world, we discover a paradox. A person is not free not to be free. "Human beings are inevitably free, whether they want to be or not, [...] when as true human beings we exist."[128] People have no choice but to develop in the world by exercising their freedom. For this reason, human freedom always has a responsorial character rather than a spontaneous one. "Every human act, including the freest and most innovative creation, is a response to the psycho-organic situation in which and from which it arises."[129] To develop the above example, the way a

[128] Laín Entralgo, *Cuerpo y alma*, 303.
[129] Ibid., 301.

hungry person behaves in front of the portion of food is always a response conditioned by the stimulus of hunger and the larger background inherited in that person's world.

This responsorial character is a necessary condition of human freedom. However, this does not make Laín deny freedom. On the contrary, he considers that the explanation of freedom starts from three fundamental conditions, namely, "that in human behavior there is no absolute spontaneity; that persons are genuinely and truly free, although with conditioned freedom; that life in general, and in a very particular way human life, tends constitutively towards the future."[130] Therefore, if human action is conceived as primarily responsorial while, at the same time, such freedom is real and true, what is the relationship between the antecedents –that is, the psycho-organic states– and the effectively free act?

Laín's thesis is that free acts are strictly stipulated by their antecedents; however, he preserves freedom by the fact that these antecedents are in some way set by the person and, therefore, "are out of the precedent-consequent pattern."[131] According to the example above again, subjects can decide whether to skip their diet, violate their conscience concerning vegetarianism, or remain faithful to their religiously inspired abstinence. And the next day, the same person can decide the opposite. We may now understand what Laín means when he explains that the human being decides how to introduce the antecedents and their subsequent role. Thus, discarding environmental determinism, Laín understands that humans have actual freedom because their life looks, by its very nature, towards the future.

We find, therefore, a qualitative difference between humans and animals. The animal relates to its environment in a proleptic way, in anticipation by instinct. In humans, in whom there are also proleptic acts, the novelty of the projective act emerges.[132] Herein lies the key to Laín's

[130] Ibid., 300.
[131] Ibid., 302.
[132] Ibid.

thinking about our freedom. The human project has, in effect, freedom as a structural moment of itself: "By devising and executing projects that are responses, constantly feeling within themselves that their freedom is conditioned, humans move freely towards their personal and historical future."[133] Faced with a portion of food, our example's dog does not devise a life project. He eats the food or not according to what he has learned as more convenient by trial and error. This conduct is characteristic of proleptic life. A person, on the other hand, may abstain, with much regret, because they need to lose weight. In the prospect of their life, they have a clear objective towards which all their decisions point. This person's goal to enter West Point military academy requires that they not allow themselves to fail the necessary fitness assessment. This conduct is characteristic of projective life.

In the free ideation and execution of the human project, sensory, memory, and psychomotor moments come into play, so the whole structure of the brain is involved. This participation is corroborated by neurophysiology, which shows that decision-making always requires the participation of a complex network of neural centers in inner decisions and those requiring the participation of the motor apparatus.[134] This complexity becomes more actual the more complicated the decision is, the more we move from the simple decisions often used in laboratory studies (choosing between two color cards, or pressing one or the other button, for instance) to vocational choices that involve a whole life story, a project in constant revision.

Clearly, therefore, there is no such thing as a 'center of freedom' in the brain. As we have just noted, "The free act is the work of the whole brain, of the brain as a totality."[135] This aspect is fundamental to Laín's anthropology, which is based on medical science and tries to avoid any possibility of dualism. That means the brain is not a mere actor but the author of human freedom.

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[133] Ibid.
[134] Cfr. Thimm et al., "Neural Mechanisms Underlying Freedom to Choose an Object," 2691.
[135] Laín Entralgo, *Cuerpo y Alma*, 302.

At the same time, we should not forget Laín's structurist understanding. The cerebral structure is, as a unit, the author and executor of higher thinking, including human freedom. However, at the same time, the brain is a subsystem within the larger structure which is the totality of the human body.[136] We have seen this with the example of the hungry person. The mental process of decision-making is related to a physical condition.

Therefore, it is clear the role the entire brain and body play in human freedom. At the same time, we noted above that Laín considers that two elements preserve freedom. First, the relation of human action concerning the antecedents is not one of direct causality. Second, people themselves somehow bring these antecedents into play by how they situate themselves in their world. The fact of being hungry does not imply that a person will necessarily eat the portion of food. Being a vegetarian does not forbid them to eat a piece of meat and then regret it or not. Being Catholic does not necessitate that someone abstains from meat on Fridays in Lent. The person consciously introduces those factors in the decision-making process, and their free decision will always be, in one way or another, a response to all of them. This responsorial nature of our freedom means that, for Laín, the person is necessarily influenced by the stimuli they receive in their body, their beliefs, and their social and economic status, because, all of these different circumstances play a role in their life. However, Laín still considers human freedom to be true and real because it is the person who, in each decision, takes into consideration and gives greater or lesser importance to these circumstances as they make different decisions.

However, Laín mostly guarantees human freedom because of the unconcluded condition of human conduct, its constant tension and openness towards the future. That is, human freedom is not expressed in its most meaningful way in a decision like the one we have used as an example

[136] Cfr. Laín Entralgo, *Idea del Hombre*, 139.

throughout this section. To continue with the possibility mentioned above, let us assume that the hungry subject is a high school student who desires to be admitted to West Point. She comes from a family with a long military tradition, and her great dream is to become a high-ranking officer, like her father and grandfather. Her life project is to become an army officer, marry a man from a military family, and raise a large family. She wants to become President of the United States, like General Eisenhower. That is her life project, and all her decisions point towards that goal. However, it is an open horizon constantly being adjusted as some of her prognoses are fulfilled while others are not. Some unforeseen variables might come into play. Perhaps she falls in love for the first time in high school with a girl who does not come from a military family, and so adjusts her project to include the girlfriend and the new discovery of her own identity. Alternately her physical condition may not be as strong as she would need. She may thus require more will to stick to her project, more study, and harder training. That situation may change next month or year because new motivations appear. In any case, this student's freedom unfolds into the future, constantly being readapted.

The situation we have described, hunger in front of food, requires a free but conditioned decision. Such a decision is part of a larger picture, the student's project for the current academic year, with more complex conditions. At the same time, the current academic year is only part of the student's life project for the future, with additional and more complex conditioning elements.

Thus, people direct themselves through a project toward their personal future, as we saw in the example of this student. It is now necessary to explain how Laín conceives the human project and why it is crucial to understand his idea of freedom.

2.3. Project and Freedom in the Human Being

By learning through trial and error, the animal can instinctively anticipate the various stimuli in its environment, in what has been called proleptic life.[137] Consider a cat's ability to anticipate falls and land on all fours. Beyond this activity, which we also share with animals, humans give a specific response to the situations that happen to them in life, in their world. This response is a conscious and personal anticipation; it is the aforementioned human project, which gives name to the 'projective life' of humans,[138] such as the student who wants to attend West Point.

Not all events in a person's life are, logically, projects such as the one introduced above; consider the case of accidents, for example. "There is a project only in the psychic and organic activity of a person when they carry out their life –their biography– proposing a personal goal and moving actively towards it."[139] Moreover, it is precisely in such projects that human freedom is at stake, not in accidents or reflex decisions.

In the conception and execution of a project, various moments must be distinguished, connected both successively and in a more complex way, with advances and reverses that are not necessarily linear. Such moments include desire, the idea of oneself, the idea of one's world, imagination, freedom, effort, and the conclusion.

First, desire is the starting point, the impulsive moment when the project begins. People move towards a horizon of reality that manifests itself to them as the object of their desire or impulse –sex, money, power, career progression– modulated to a large extent by the historical and social context and the possibilities offered by the environment.[140]

Second is the idea of oneself, of one's possibilities and capabilities. For example, a person of short stature and weak physical constitution may wish to be an offensive lineman on a football

[137] Cfr. Laín Entralgo, *Qué Es El Hombre*, 123.
[138] Cfr. Laín Entralgo, *Cuerpo y Alma*, 172.
[139] Laín Entralgo, *Alma, Cuerpo, Persona*, 271.
[140] Cfr. Laín Entralgo, *El Cuerpo Humano*, 162–163.

team but not project it (as long as they have an accurate idea about themselves). We all have our limits, although the line between what we can and cannot do is not always sharp and fixed.[141]

Third is the idea of the world in which one exists. As with the idea of oneself, every person has a particular idea of the world in which he or she lives and acts. This idea can be more or less precise, which will condition the future project. This idea of the world also necessarily includes the understanding that one has of others and of "the historical and social significance of their actions and works."[142] For instance, a person can dream of being the next Queen of England, but she cannot realistically conceive this if she is neither an English national nor a member of the British royal family.

Fourth, imagination is the ability to consider future possibilities that are not present realities. Imagination plays a crucial role in the human project, both in its initial conception and the path leading to the projected goal. Imagination, "a specifically human activity, allows us to discover that the human world is essentially open to the limitless."[143] Projecting implies imagining, even when what is imagined is fallacious and alternative solutions must be sought.

Fifth, human freedom is involved in the project in the four senses mentioned above, and not only as a choice, as we usually believe; freedom is involved in the project as a choice of means for its implementation;[144] but also freedom as abstention, since in the pursuit of the project multiple options are rejected; freedom as perseverance; freedom as creation, which would be the highest degree of freedom, as conception and effective execution of life projects.[145]

Sixth is the effort, which inserts our will into the project from the first moment, in its conception and execution. In fact, "human life is always effort [...] the first fact of consciousness

[141] Cfr. Laín Entralgo, *Ser y Conducta del Hombre*, 430.
[142] Laín Entralgo, *Qué Es El Hombre*, 165.
[143] Laín Entralgo, *Idea del Hombre*, 147.
[144] Cfr. *Eth. Nic.*, III, 3, 1112b, 11-12 in Aristotle, *The Nicomachean Ethics*, ed. H. Rackham, Second edition., Loeb Classical Library 73 (Cambridge, Massachusetts: Harvard University Press, 1934), 137.
[145] Cfr. Laín Entralgo, *Antropología Médica para Clínicos*, 146.

is an effort [...] interpreted as the will acting on the organism."[146] Our effort is required from the minimum level of abstaining from a piece of meat for religious beliefs to the higher level necessary to devote six years of toil to write a dissertation, for instance.

Lastly, consider our openness or infinitude, either by understanding humans as open to reality or because we never finish projecting ourselves and always have a trace of dissatisfaction. In this sense, "the end of a human action is incompletion, followed by choice between two possibilities: 'to do more' along the lines of what has already been done [...] or to do something far apart from what has already been done."[147] Thus, incompletion affects all human actions since "All the tendencies, all the impulses and all the desires of humans are in essence unconcluded."[148] This incompletion is evident "if we take into account that the end of all human actions is ultimately happiness,"[149] and this always seems impossible to us since we always live "wanting something else and wanting more."[150] Such insatiability is a truth that we all recognize in ourselves. Before finishing a current book, the reader usually already has the next in mind. A runner will strive for a personal best; an artist will mentally compose a new piece of art. Once a thesis has been defended, doctoral students will aspire to find positions at prestigious universities. Likewise, a retired person will seek to rest after a long life of professional effort and enjoy time with their loved ones and undertake new personal projects. Furthermore, at the end of each day, every person will have new projects in mind for the next. Whether big or small, human projects are always open to new directions, requiring new steps.

Now that we have examined the structure of the human project, as conceived by Laín, a question arises: What happens in the living body of a person, and especially in their brain, when

[146] Laín Entralgo, *Alma, Cuerpo, Persona*, 274.
[147] Laín Entralgo, *Cuerpo y Alma*, 173.
[148] Laín Entralgo, *El Cuerpo Humano*, 311.
[149] Ibid., 310.
[150] Laín Entralgo, *Alma, Cuerpo, Persona*, 274.

they desire something, imagine how to achieve their goal, forge an appropriate project and embark on the adventure of achieving it?

As already noted, humans can project into the future thanks to the coordination or interrelation between different parts of their brain, and between this and the rest of the body. More than one area supports our capacity to project. In the human brain, there is nothing like a neuronal center of freedom.

At this point, let us introduce the famous case of Phineas P. Gage. He was a 25-year-old railroad construction supervisor in Vermont. After drilling a pilot hole into the rock and partially filling it with gunpowder, he instructed an assistant to pour sand into the hole atop the powder. Assuming the sand had been added, he dropped the end of an iron rod into the hole. The iron struck the interior of the hole, causing a spark to ignite the powder, which launched the pointed iron rod upwards, through the left cheek of Mr. Gage, passing behind his left eyeball, piercing his cranial vault, passing through his brain, and exiting the top and front of his skull. A large amount of frontal lobe tissue was expelled, but surprisingly Mr. Gage survived and was able to recover sufficiently from his physical injuries and return to his family. However, profound personality changes happened, and he could not return to his previous job, while co-workers and relatives commented that he was 'no longer Gage.'

Following this case from the mid-nineteenth century,[151] advances in neurophysiology, thanks to diagnostic image techniques, have allowed us to know the predominant role of the frontal lobe (although at least the corpus callosum, the short axon neurons of the cranial base, and the cerebellum are also involved). Several studies have shown that patients with lesions in this lobe

[151] Cfr. John Darrell Van Horn et al., "Mapping Connectivity Damage in the Case of Phineas Gage," ed. Olaf Sporns, *PLoS ONE* 7, no. 5 (May 16, 2012): 1–2, accessed February 16, 2023, https://dx.plos.org/10.1371/journal.pone.0037454.

are unable to elaborate projects and consciously execute their freedom.[152] The consequences of such lesions are, among others, dysfunctions in attention and short-term memory, affective disorders (indifference or disinhibition), and the inability to think about the future and make decisions about it, so subjects with such an impairment live only in the present.[153] Progress in neuroanatomy and neurophysiology has revealed that "the frontal lobe is the place where the anticipation of the future from the present and the corresponding recollection of the past are fused."[154] In this sense, the human project, as an operation of freedom, is born from the past and tends towards future possibilities.

This human project's connection to both the past and the future is proven by the fact that patients with severe frontal lesions are incapable of feeling regret for their past acts.[155] Neurophysiology shows our past is fundamental to our freedom. The impact on an area (frontal lobe) of such importance for our perceptions of the past also disrupts our future decision-making ability. The role played by our perception of the past is relevant when considering our topic of dementia. In this disease, memory is one of the first functions to be affected, even before the disease has been diagnosed. In fact, its loss usually triggers a visit to the doctor and the subsequent diagnosis. Impaired memory suggests frontal lobe damage (among other regions). The alteration of our perception of the past will affect, and may even nullify, our ability to project into the future.

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[152] Cfr. Lesley K. Fellows, "Deciding How to Decide: Ventromedial Frontal Lobe Damage Affects Information Acquisition in Multi-Attribute Decision Making," *Brain* 129, no. 4 (April 1, 2006): 944–952, accessed February 16, 2023, http://academic.oup.com/brain/article/129/4/944/371178/Deciding-how-to-decide-ventromedial-frontal-lobe.

[153] Cfr. Ildefonso Rodríguez-Leyva et al., "Demencia Frontotemporal: Revisión y Nuestro Punto de Vista," *Revista Mexicana de Neurociencia* 19, no. 6 (October 22, 2019): 26, accessed February 16, 2023, http://www.revmexneurociencia.com/frame_esp.php?id=16.

[154] Laín Entralgo, *Alma, Cuerpo, Persona*, 279.

[155] Cfr. Brandon M. Wagar and Paul Thagard, "Spiking Phineas Gage: A Neurocomputational Theory of Cognitive-Affective Integration in Decision Making," *Psychological Review* 111, no. 1 (2004): 68, accessed February 16, 2023, http://doi.apa.org/getdoi.cfm?doi=10.1037/0033-295X.111.1.67.

We have seen that the brain, in its totality, coordinated by the frontal lobes, is what imagines, projects, and unfolds human freedom. The brain brings into deliberation the antecedents from the idea that we have of ourselves and our world. This process is always limited because there is a bias in the variables we allow to enter the picture. That is why our freedom is always conditioned. Dementia necessarily limits the ability people have to understand themselves and the world. This limitation can abort the very possibility of the human project before it can reach the structural moment in which freedom comes into play.

It is the brain as a unit, and in dialogue with the body as a whole, that constructs future possibilities. Imagination has almost infinite possibilities, so freedom is almost unlimited. Thus, we see the paradox of our nearly unlimited freedom which is always conditioned and, for that reason, limited. Moreover, the fewer future possibilities our imagination opens up, the more limited human freedom is.

Thus, we see how, according to Laín's proposal, the brain is not just one actor among others when it comes to unfolding human freedom toward the future. "In sum: the brain is not the instrument of the human way of advancing into the future, it is the immediate agent of that advancement; humans project and realize their lives in their brains and with their brains."[156] Accepting that the circumstances of our life always condition our freedom, an impairment of the brain that alters our vision of ourselves and the world, and our perception of the past and the future, is not just one more among other conditioning elements. Such impairment of the brain implies an alteration of another nature. It involves a qualitative difference in terms of conditioning. Such impairment may mean that there is no room left for personal freedom. Suffering from dementia is not just another antecedent. Since the brain is affected and it brings the antecedents into the scene, our freedom will thus be constrained.

[156] Laín Entralgo, *Alma, Cuerpo, Persona*, 280.

At this point, it is worth recapitulating the entire argument. We have briefly approached Laín's structurist approach. His anthropology is inserted into a cosmological understanding similar, with some nuances, to emergentism. In its course, evolution gives rise to the appearance of increasingly complex structures, whose properties and functions represent a qualitative leap with respect to lower structures. Within this evolution, humans emerge as such complex structures that include a brain that endows us with the possibilities that most radically distinguish us from the world of animals.

Laín thus does not leave room for a dualistic understanding of the human being. We may disagree with him and regard such monism as reductionistic anthropology, yet the opposite of such monism is not only and necessarily an irrational dualism. Nevertheless, remaining within that framework is worthwhile for our purpose of creating a dialogue between theology, medical science, and secular philosophy. In an increasing part of our Western society, such dialogue does not allow any reference to anything other than mere physicalist anthropology. Remembering our Catholic comprehension of human nature, we can engage in such a dialogue and translate our understanding into a secular language.

Thus, according to Laín's understanding, the brain is the actual author of mental acts. Within the most complex mental acts or higher thinking, we find freedom, a function in which the whole brain intervenes and constitutes the most determining structural moment of a person's project. From Laín's point of view, a life intentionally oriented towards the future makes us properly human. Free indeed, but always conditioned.

So if the brain is properly the author of our projects and is where human freedom unfolds, to what extent does dementia limit our projects and freedom? As we have seen, Laín's thought brings us two insights in this regard:

First, the human brain functions as a whole in making decisions. Some functions are rooted in specific brain nuclei, but human freedom is a complex process involving the entirety of the organ. For this reason, the damage caused by dementia in one part of the brain affects the whole structure and, therefore, our decision-making ability. This point will help us later when we examine the relationship between intellect and human will in Aquinas. Thus, Laín's proposal helps us see that secular philosophy and medical knowledge do not contradict but reinforce Aquinas's theology of human freedom. Laín helps us rely on Aquinas's proposal as an argument in our thesis: the absence of freedom in the subject with dementia who requests future euthanasia. We will devote the fourth chapter to this.

Second, we introduced the different structural moments involved in the human project according to Laín's proposal. Moreover, we explained that human freedom is maximally expressed as a moment of a broader project, a life project with a dimension of openness to the future. Among such moments, we find the people's idea of themselves and of their world. Both ideas are antecedents that necessarily condition our freedom as part of the human project. This understanding of Laín helps us present social injustice as a determining factor of a person's idea of themselves and their world. Social injustice, particularly in people with dementia facing inequity in access to social resources and healthcare, can abort any possibility of setting a project before reaching the moment of freedom. Thus, Laín's proposal on human freedom shows that Catholic Social Teaching, and particularly the role it gives to social justice, grounds our thesis: the absence of freedom in the subject with dementia who requests future euthanasia. We will devote the following chapter to this purpose.

3. Dementia-Related Healthcare Access and Catholic Social Teaching

> Some people are born into economically stable families, receive a fine education, grow up well nourished, or naturally possess great talent. They will certainly not need a proactive state; they need only claim their freedom. Yet the same rule clearly does not apply to a disabled person, to someone born in dire poverty, to those lacking a good education and with little access to adequate health care. If a society is governed primarily by the criteria of market freedom and efficiency, there is no place for such persons, and fraternity will remain just another vague ideal.[157]

This quote from Pope Francis's latest encyclical letter forces us to confront the manifest reality of social inequity, including disparity in access to affordable healthcare. This problem is particularly notable regarding the care and assistance of people with dementia. Due to its degenerative and constraining nature, this disease entails a very high economic cost. "An estimate of annual per-person costs for 2019, which includes health care and the value of unpaid care provided to persons with Alzheimer's disease, is approximately $81,000 ($31,000 is the value of the unpaid care) [...]. This estimate is about four times higher than the costs of the same care provided to similarly aged persons without the disease."[158] Given this fact, let us recall the thesis defended in this paper. Once diagnosed with dementia, the person who signs an advance directive document requesting future euthanasia is not making a free decision. We base this assertion on the fact that the external and internal conditions of the person in this situation constrain his or her freedom.

We will address the internal conditioning factors later in the fourth chapter. Our third chapter will focus on the main external conditioning factor: inequity in access to the social and healthcare resources required for treating dementia. That is, how the economic costs of dementia

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[157] Francis, Encyclical on Fraternity and Social Friendship *Fratelli Tutti* (3 October 2020) §109, at The Holy See, https://www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20201003_enciclica-fratelli-tutti.html.

[158] Committee on the Decadal Survey of Behavioral and Social Science Research on Alzheimer's Disease and Alzheimer's Disease-Related Dementias et al., *Reducing the Impact of Dementia in America: A Decadal Survey of the Behavioral and Social Sciences* (Washington, D.C.: National Academies Press, 2021), 210, accessed February 20, 2023, https://www.nap.edu/catalog/26175.

treatment are so high that they can lead economically disadvantaged people to see no other way out of their suffering but to advance their death because of the impossibility of paying for appropriate care. To what extent does this external factor limit our freedom?

Let us recall the anthropology of freedom presented in the preceding chapter. Freedom is expressed as a structural moment of the human project, not in minor acts. Moreover, in the conception of the human project that we described, there are two crucial moments after the initial impulse of desire: the ideas a person has of themselves and their world. Situations of social injustice can undermine both ideas to the point of clouding the subject's judgment. If these ideas do not open up possibilities to the subject's imagination but are presented as necessarily closed paths, the vital project is aborted before reaching the moment of freedom.

In the present chapter, therefore, we will begin by explaining the value of justice in the broader framework of Catholic Social Teaching, showing how it plays an essential role. We will then show how inequity in access to social and health resources is one of the primary indicators of the absence of social justice. Next, we will demonstrate how the lack of social justice concerning the living conditions of patients with dementia cancels their freedom if they are economically disadvantaged. In this way, we will have proven our thesis from a social perspective: we cannot speak of freedom in the request for euthanasia of a person with dementia insofar as they all are not offered the healthcare that would enable them to face this disease on equal terms with well-off patients who possess a secure social and familiar network.

3.1. The Value of Justice in Catholic Social Teaching

While it is true that "The Church does not assume responsibility for every aspect of life in society,"[159] we must acknowledge that "The object of the Church's social doctrine is essentially

[159] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (Vatican City, 2005), §68,

the same that constitutes the reason for its existence: the human person called to salvation, and as such entrusted by Christ to the Church's care and responsibility."[160] Because of this entrustment, the Church feels she "has the right to be a teacher for mankind, a teacher of the truth of faith: the truth not only of dogmas but also of morals whose source lies in human nature itself and in the Gospel."[161] But this right to offer her moral proposal is "is at the same time a duty."[162] Thus, the Church finds herself responsible for proclaiming what is right and denouncing what is wrong regarding human behavior, and "she cannot forsake this responsibility without denying herself and her fidelity to Christ."[163] Following the desire to serve humanity after the love that inspired Jesus's ministry among people, "the Church's social doctrine becomes judge and defender of unrecognized and violated rights, especially those of the poor, the least and the weak."[164] The Church devotes herself to the poor as Jesus Christ himself did.

The principle around which the Church carries out such defense of persons whose rights are disregarded is "Caritas in veritate", charity in truth. This principle takes on form in a series of criteria, two of which are particularly relevant to our argument: the common good and justice.[165]

We may define the common good as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily."[166] In this sense, the common good is not reduced to the sum of the individual goods (social, political, economic, etc.) of the subjects that are part of a human group or society. On the contrary, it is an

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https://www.vatican.va/roman_curia/pontifical_councils/justpeace/documents/rc_pc_justpeace_doc_20060526_compendio-dott-soc_en.html#Social%20doctrine,%20evangelization%20and%20human%20promotion.

[160] Ibid., §81.

[161] Ibid., §70.

[162] Ibid., §71.

[163] Ibid.

[164] Ibid., §81.

[165] Cfr. Benedict XVI, Encyclical on Integral Human Development in Charity and Truth *Caritas in Veritate* (29 June 2009) §6, at The Holy See, https://www.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html.

[166] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, §164.

intangible, indivisible good that belongs to society as a whole and can only be sought and increased as a community.

The common good thus becomes a requirement for every society (from the basic level of a family, through the levels of city or country, to the supreme level of humanity as a whole), without which its members cannot achieve their own development, since "The human person cannot find fulfillment in himself, that is, apart from the fact that he exists 'with' others and 'for' others."[167] This impossibility of achieving our fulfillment without seeking at the same time the common good implies that "no one is exempt from cooperating, according to each one's possibilities, in attaining [the common good] and developing it."[168] This necessity means that States must seek the common good too, not only for their citizens but also at an international level in their relations with other countries. "In view of the increasingly close ties of mutual dependence today between all the inhabitants and peoples of the earth, the apt pursuit and efficacious attainment of the universal common good now require of the community of nations that it organize itself in a manner suited to its present responsibilities, especially toward the many parts of the world which are still suffering from unbearable want."[169] This principle of the common good goes hand in hand with another principle of Catholic Social Teaching: the universal destination of goods.

The universal destination of goods is imperative because "God gave the earth to the whole human race for the sustenance of all its members, without excluding or favoring anyone."[170] The earth is fruitful and capable of satisfying human needs, so everyone has the right to use these

[167] Ibid., §165.
[168] Ibid., §167.
[169] Vatican Council II, Pastoral Constitution on the Church in the Modern World *Gaudium et Spes*, (7 December 1965) §84, at The Holy See. https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.
[170] John Paul II, Encyclical on the Hundredth Anniversary of Rerum Novarum *Centesimus Annus* (1 May 1991) §171, at The Holy See, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus.html.

goods. This right is the "first principle of the whole ethical and social order."[171] At the same time, together with this right comes "the responsibility not to hinder others from having their own part of God's gift."[172] This responsibility involves "a common effort to obtain for every person and for all peoples the conditions necessary for integral development, so that everyone can contribute to making a more humane world, in which each individual can give and receive, and in which the progress of some will no longer be an obstacle to the development of others."[173] Furthermore, when we talk about sharing earth's goods, it also "includes the latest developments brought about by economic and technological progress. The ownership of these new goods — the results of knowledge, technology and know-how — becomes ever more decisive."[174] Medical knowledge and technology are essential parts of the goods we are called to share. When people or institutions do not assume responsibility to share earthly goods according to their universal destination, we can speak of this as social sin. This can be seen through the consumption and accumulation of resources and disregard for the common good. "Social sin is every sin committed against the justice due in relations between individuals, between the individual and the community, and also between the community and the individual. Social too is every sin against the rights of the human person."[175]

Therefore, when we speak of the responsibility to seek the common good and contribute to making the universal destination of goods an effective reality, we appeal to the second of the criteria above: justice.

However, the term "justice" risks being reduced to a great word empty of any meaning.[176] To prevent justice from being "bent and shaped to serve as tools for domination, as meaningless tags

[171] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, §172.
[172] John Paul II, *Centesimus Annus*, §31.
[173] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, §175.
[174] Ibid., §179.
[175] Ibid., §118.
[176] Cfr. Francis, *Fratelli Tutti*, §14.

that can be used to justify any action,"[177] we must ask, "what is justice? The problem is one of practical reason; but if reason is to be exercised properly, it must undergo constant purification, since it can never be completely free of the danger of a certain ethical blindness caused by the dazzling effect of power and special interests."[178] Justice, therefore, not only implies "recognition and respect for the legitimate rights of individuals and peoples"[179] but actually requires striving "to secure a common good corresponding to the real needs of our neighbors."[180] Justice "consists in the constant and firm will to give their respective due to God and neighbor. From a subjective point of view, justice is translated into behavior that is based on the will to recognize the other as a person, while, from an objective point of view, it constitutes the decisive criteria of morality in the intersubjective and social sphere."[181] Thus we see that justice is a practical principle, not merely a theoretical one.

When speaking of justice, we must remember that we generally distinguish various forms of it. "The five forms of justice to be taken into account [...] are: distributive justice, commutative justice, restorative justice, retributive justice and procedural justice."[182] Distributive justice requires granting everybody equal access to goods and services. Commutative justice requires an appropriate valuation and fair compensation for the goods or services provided. Restorative justice is a newer concept that implies taking corrective actions to balance social and historical oppression and unfairness. Both retributive and procedural justice are dimensions of legal

[177] Ibid.

[178] Benedict XVI, Encyclical on Christian Love *Deus Caritas Est* (25 December 2005) §28, at The Holy See, https://www.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est.html.

[179] Benedict XVI, *Caritas in Veritate*, §6.

[180] Ibid., §7.

[181] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, §201.

[182] Alexandra Aragão, Sander Jacobs, and An Cliquet, "What's Law Got to Do with It? Why Environmental Justice Is Essential to Ecosystem Service Valuation," *Ecosystem Services* 22 (December 2016): 222, accessed February 24, 2023, https://linkinghub.elsevier.com/retrieve/pii/S2212041616303369.

justice. Retributive justice requires a legal consequence for any significant influence on society. Procedural justice refers to the legitimacy of legal procedures.[183]

Among these forms of justice, the Church constantly stresses the importance, in every society, of commutative, distributive, and legal justice. However, the Church gives greater value to the concept of social justice, which she proposes as "a requirement related to the social question which today is worldwide in scope, [and] concerns the social, political and economic aspects and, above all, the structural dimension of problems and their respective solutions."[184] This greater importance is due to the fact that social justice includes and goes beyond the other forms of justice. Thus, social justice avoids being considered in a reductionistic manner based on criteria of utility and ownership, which constitute a serious threat to the value of the person and their rights.[185] At the same time, social justice goes beyond the other forms of justice because it is not reduced to a contractualistic vision but is open to solidarity and love.[186]

Christian love, or charity, "goes beyond justice, because to love is to give, to offer what is 'mine' to the other; but it never lacks justice, which prompts us to give the other what is 'his', what is due to him by reason of his being or his acting."[187] Thus, according to Catholic Social Teaching, we recognize the deep connection between social justice and love. In fact, "Not only is justice not extraneous to charity, not only is it not an alternative or parallel path to charity: justice is inseparable from charity, and intrinsic to it."[188] Hence, charity fulfills social justice and "calls for an effective process of historical change that embraces everything: institutions, law, technology, experience, professional expertise, scientific analysis, administrative procedures,

[183] Cfr. Ibid., 222–223.
[184] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, §201.
[185] Cfr. Ibid., §202.
[186] Cfr. Ibid., §203.
[187] Benedict XVI, *Caritas in Veritate*, §6.
[188] Ibid.

and so forth."[189] This historical change that social justice aspires to achieve implies a preferential option for the poor because they are excluded from their share of the common good.[190] In this sense, when we speak about the preferential option for the poor, we must remember that it is not an exclusively economic concept but refers to every dimension of reality that makes persons vulnerable. One dimension that plays a role in considering individuals as beneficiaries of such a preferential option is the ability to access quality healthcare.

This relationship between healthcare access and poverty inevitably means that equity in healthcare access is part of the common good and, therefore, a fundamental goal of social justice. As the World Health Organization reminds us, "Poverty and ill-health are intertwined. Poor countries tend to have worse health outcomes than better-off countries. Within countries, poor people have worse health outcomes than better-off people. The association between poverty and ill-health reflects causality running in both directions."[191] The Church is also concerned with the direct relationship between economic poverty and poor health. Pope Francis insists on this when he affirms that "the fundamental right to the preservation of health pertains to the value of justice, whereby there are no distinctions between peoples and ethnic groups, taking into account their objective living situations and stages of development, in pursuing the common good."[192] Thus, Pope Francis points us to the next section of our chapter, where we will show in more detail how inequity in healthcare access is a determining factor of social injustice, thus limiting people's freedom even in countries such as Spain or others in Western Europe that possess a public health system.

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[189] Francis, *Fratelli Tutti*, §164.

[190] Cfr. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, §182.

[191] Adam Wagstaff, "Poverty and Health Sector Inequalities," *Bulletin of the World Health Organization* 80, no. 2 (2002): 97.

[192] Francis, Message to the Participants in the 32nd International Conference on the Theme: "Addressing Global Health Inequalities" (18 November 2017) at The Holy See, https://www.vatican.va/content/francesco/en/messages/pont-messages/2017/documents/papa-francesco_20171118_conferenza-disparita-salute.html.

3.2. Social Inequity in Public Healthcare Access

"Do people have a *right* to health care? If so, to what exactly are they entitled? To a guarantee of a state of well-being equal to that of everyone else? To an equal share of health care resources? To the best health care available? Or to something more modest—a decent minimum amount of health care? And what, exactly, is a decent minimum?"[193] All these questions relate to the same issue: where do we as a society draw the line between what we consider to be sufficient or inadequate healthcare access?

These questions should first be asked when addressing the relationship between healthcare access and social justice. As mentioned earlier, healthcare-related disparities are an element of the multidimensional reality of poverty and, therefore, a factor in social inequity. At the same time, however, we realize that there will always be people with better or worse healthcare access, without this necessarily implying the presence of social injustice.

Health, like housing and education, is a good to which access must be guaranteed for every human being. There is extensive agreement on this universality of access, which can be seen, for example, in the fact that these goods are all included in the Universal Declaration of Human Rights. For this reason, they cannot always and in all circumstances be governed by the logic of the capitalist market, based solely on supply and demand. At the same time, however, there is also general agreement that, beyond a certain minimum level, it is morally permissible for access to these goods to be subject to the rules of the said market.[194]

We can easily understand this by comparing health to a similar good, namely, transportation. "While society provides roads and public transportation, we accept the fact that not everyone

[193] Lewis Vaughn, *Bioethics: Principles, Issues, and Cases*, 2nd ed. (New York: Oxford University Press, 2013), 681.

[194] Cfr. John Frederic Kilner, C. Christopher Hook, and Diane B. Uustal, eds., *Cutting-Edge Bioethics: A Christian Exploration of Technologies And Trends*, A Horizon in Bioethics Series Book (Grand Rapids, MI: W.B. Eerdmans Pub. Co., 2002), 110.

gets to ride in the same comfort. Some drive ordinary cars, others drive luxury vehicles, while still others take public transit."[195] If we translate this into health terms, we can understand, for example, that society should not let a person die if he or she has had an accident of any kind or has suffered a heart attack. That does not imply, for instance, that everyone should be guaranteed bariatric surgery, although obesity is a severe health condition related to low-income status.

However, we cannot make the mistake of thinking that between the extreme of not ensuring minimum healthcare access and attempting to satisfy every demand, the solution will come from "the narrow contractual conception all too common today."[196] On the contrary, "healthcare has been viewed by the Christian tradition as an entitlement in justice – but under a view of justice which is about right relations between persons and an imaginative, generous, merciful application of the Golden Rule (Mt 7:12)."[197] The Christian perspective will always be more inclined to the aforementioned decent minimum to be generous, but to be more *decent* than *minimum*.

This generosity is rooted in the Christian understanding that "persons are bound together as a community by birth [...] and by redemption [...]."[198] This unity of origin implies that each individual deserves "uncompromising reverence and respect."[199] The model for this attitude of reverence and respect "is, of course, Jesus, who 'went about doing good and healing everyone.' Care for the sick and the weak, the suffering and the sinful, was a major focus of his life."[200] In line with Jesus' example, "then, any healthcare system must be consistent with respect for and indeed positively serve [...] all human life and the life of each and every human being."[201] Some

[195] John Mark Freeman and Kevin McDonnell, *Tough Decisions: Cases in Medical Ethics*, 2nd ed. (Oxford; New York: Oxford University Press, 2001), 175.
[196] M. Therese Lysaught, ed., *On Moral Medicine: Theological Perspectives in Medical Ethics*, 3rd ed. (Grand Rapids, MI: W.B. Eerdmans Pub. Co., 2012), 134.
[197] Ibid.
[198] Ibid., 132.
[199] Ibid.
[200] Ibid., 132–133.
[201] Ibid., 132.

people may think that a public health system, which guarantees universal and free healthcare access, meets these standards of generosity demanded by the Christian understanding of care for the sick, as opposed to a model such as the American one. However, is this idea accurate? We may look, for instance, at the model of universal access that most European countries, and Spain in particular, have. Can we say it is consistent with the social justice ideal promoted by Catholic Social Teaching, or is there some distance between them?

In response to this question, "We first need to admit that the supply of resources available for health care is insufficient to meet the need because it is limited by other priorities. In the 1980s and early 1990s there was consensus that health care costs were spiraling out of control, and that if they were not contained, they would constitute a disproportionate share of society's resources."[202] Given this inevitable limitation in the resources that can be allocated to a public health system, such a system cannot be expected to be perfect.

Public health systems in Western Europe, particularly in Spain, are generally well regarded by public opinion and are seen as a significant factor in promoting social cohesion.[203] Taxes from businesses and citizens fund such systems, which are crucial in redistributing income and wealth. However, if we consider more specifically the issue of care for people with dementia, usually the elderly, we must bear in mind that

> Older persons with advanced dementia consistently manifest a range of comorbidities and frailty associated with dementia, requiring intensive long-term care. The authors also assert that palliative care is valuable and relevant support for the needs of people with advanced dementia. As it is a syndrome with diverse characteristics that can vary from months to years, in an advanced stage and facing installed chronicity, palliative approaches specific to dementia are necessary to allow the person to live as well as possible.[204]

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[202] Kilner, Hook, and Uustal, *Cutting-Edge Bioethics*, 109.

[203] Cfr. M. Arrazola-Vacas, J. de Hevia-Payá, and L. Rodríguez-Esteban, "¿Qué Factores Ayudan a Explicar la Satisfacción con la Atención Primaria en España?," *Revista de Calidad Asistencial* 30, no. 5 (September 2015): 235, accessed March 14, 2023, https://linkinghub.elsevier.com/retrieve/pii/S1134282X15000858.

[204] Rogério Donizeti Reis et al., "Cuidados Paliativos a Pessoa Idosa Com Demência: Sentimentos Emergentes Com Reflexões Bioéticas," *Revista Iberoamericana de Bioética*, no. 12 (February 27, 2020): 3–4, accessed March 14, 2023, https://revistas.comillas.edu/index.php/bioetica-revista-iberoamericana/article/view/12091.

In other words, it is necessary to consider access to intensive long-term care and palliative care. These are not the only elements to be assessed concerning dementia care, of course, but they are essential because they concern people in a state of utmost suffering and vulnerability.[205] Because of their suffering and proximity to death, people with dementia, like other similarly disadvantaged persons, deserve the preferential love of God and the Church for the poor.[206]

Thus, if we look specifically at the situation of intensive long-term care and palliative care access in Spain and neighboring countries, we learn that

> Today the coverage of palliative care does not reach 100% in any of the countries [...] In Spain, 50% of the people who need palliative care die in physical pain and 75% in emotional pain. [...] In 2019, in Spain, 80,000 people will die without any palliative care, according to the Atlas of Palliative Care in Europe 2019. Spain is descending in the European ranking of palliative care [...] (31st place out of 51). In 2016, in France, palliative care only reached 20% of patients.[207]

Therefore, although a broad overview of the public health system in countries such as Spain and the neighboring region shows a positive balance, a closer look at the issue of access to intensive long-term care and palliative care shows a lack of availability. We can go a step further and affirm that this deficiency of access exemplifies a great social injustice. In the particular case of Spain, this is because there is no national palliative care law to ensure fair access to all citizens, so a significant part of the population ends up without access to home care or long-stay hospitals for chronic conditions.[208] The result is that specific population groups are excluded from critical care.

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[205] Cfr. Joseph Tham, Alberto Garcia, and Gonzalo Miranda, eds., *Religious Perspectives on Human Vulnerability in Bioethics*, Advancing Global Bioethics (New York: Springer, 2014), 53.

[206] Cfr. Lysaught, *On Moral Medicine*, 133.

[207] Javier de la Torre Díaz, "Eutanasia: Los Factores Sociales del Deseo de Morir," *Revista Iberoamericana de Bioética*, no. 11 (October 28, 2019): 10, accessed March 14, 2023, https://revistas.comillas.edu/index.php/bioetica-revista-iberoamericana/article/view/11599.

[208] Cfr. Gloria Rabanaque Mallén et al., "Actitud de los Médicos de Familia ante los Cuidados Paliativos en Zonas Rurales sin Cobertura de Unidad de Hospitalización a Domicilio," *Medicina Paliativa* 25, no. 2 (April 2018): 100, accessed March 14, 2023, https://linkinghub.elsevier.com/retrieve/pii/S1134248X17300848.

First, there is an unfair situation in that rural populations still need guaranteed access under the same conditions as urban areas. Doctors in rural areas often find "patients living alone [...], elderly, deteriorated, with no family involved, and with inadequate homes."[209] In addition, doctors do not have the appropriate knowledge because they face so few cases, are unaware of the resources available to them, cannot coordinate with specialists in urban centers, and often their patients have little or no health literacy.[210] Thus, "palliative care becomes a lost ground for family physicians who delegate it to specialized units. Instead of playing a supporting role, these units become substitutes, providing care that does not reach everyone and placing patients in a situation of inequity and inefficiency."[211] A specialized unit in the main regional city is of little use if it is almost impossible for the inhabitants of the region's periphery to get to it.

Second, "over 80 years of age [...] there are more women who, compared with men, have [...] more cognitive impairment, less partners as primary caregivers and more caregivers who are professional."[212] We must consider that, although demographics are changing, women are usually widowed earlier, so they often reach an older age alone, and "dementia is amongst common causes of death in women in the very elderly group and will be, alongside cancer, the main drivers of a marked increase in the demand for palliative care."[213] In this situation, women have less family support and are more dependent on the economic resources they may have to access professional care. Recall the figure provided in the first chapter, which puts the annual cost of non-professional care for people with dementia at around $31,000. Older women, therefore, face a significant economic, social, and familiar disadvantage.

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[209] Ibid., 99.
[210] Cfr. Ibid., 100.
[211] Ibid., 103.
[212] Xavier Busquet-Duran et al., "Gender and Observed Complexity in Palliative Home Care: A Prospective Multicentre Study Using the HexCom Model," *International Journal of Environmental Research and Public Health* 18, no. 23 (November 23, 2021): 6, accessed March 14, 2023, https://www.mdpi.com/1660-4601/18/23/12307.
[213] Ibid.

Third, different studies show that "Discrimination and identity concealment also put LGBT older adults at elevated risk for social isolation and loneliness [...], which have been linked to poorer physical and mental health [...], increased mortality [...], and increased risk for developing cognitive impairment or dementia [...]."[214] LGBT older adults not only have an increased risk of dementia, but they are in a disadvantaged situation regarding healthcare access. We must remember that the public health system does not guarantee such care, so "Many older adults rely on immediate family members for care and support, but LGBT older adults are less likely than heterosexuals to have children or be married and are more likely to live alone."[215] In addition to this reduced opportunity to receive informal care, there is the difficulty of accessing professional care, including that provided by the public healthcare system. "Due to past discrimination and ongoing marginalization of LGBT older adults, there remains a lack of consistent and affirming communication between health service agencies and LGBT communities."[216] This situation regarding LGBT older adults is a clear example of the obstacles to healthcare access which result from non-economic factors.

Fourth, there is an evident inequality in healthcare access for immigrants. On the one hand, immigrants who have an irregular status by lacking a residence permit or citizenship may receive emergency care in hospitals belonging to the public health system but are not granted the right to regular care. In the case of dementia, they will only be treated for physical complications that cause a health emergency, not for the underlying dementia. On the other hand, there are "a number of barriers to early and correct diagnosis of cognitive impairment/dementia in persons with diverse cultural and linguistic backgrounds [...]. One of the barriers is related to health

[214] Karen I. Fredriksen-Goldsen et al., "Cognitive Impairment, Alzheimer's Disease, and Other Dementias in the Lives of Lesbian, Gay, Bisexual and Transgender (LGBT) Older Adults and Their Caregivers: Needs and Competencies," *Journal of Applied Gerontology* 37, no. 5 (May 2018): 550, accessed March 14, 2023, http://journals.sagepub.com/doi/10.1177/0733464816672047.

[215] Ibid.

[216] Ibid., 559.

professionals' interpretation of cultural norms or preferences for family care, thus preventing or delaying health-seeking behaviour, diagnosis, and treatment and care."[217] To these cultural and linguistic barriers that immigrants face, we can add the racist prejudices growing in Europe as immigration has increased in recent decades. Different studies have shown that people from racial and ethnic minorities "were less satisfied with the quality of end-of-life care and more often reported concerns about provider communication. Similarly in other studies, [they] report less satisfaction with the quality of communication, including the extent to which providers listen and share information, with greater disparities in racially discordant patient-provider relationships."[218] Therefore, in the case of immigrants, barriers accompany the entire disease process, hindering diagnosis and frequently preventing access to treatment.

Fifth, several studies show the substantial disadvantage for people with scarce economic means in regards to healthcare access, including those in countries with a public health system, such as Spain. Poverty corresponds to a higher prevalence of dementia and a lower quality of life in such cases.[219] This lower quality of life is due to a later diagnosis, the fact that poverty-related lower health literacy is associated with higher comorbidity and lower treatment adherence,[220] and the fact that low income makes it impossible to supplement public care with private care.[221]

Thus, we see that much of the population is disadvantaged where healthcare access is concerned, particularly intensive long-term care and palliative care. Such care is essential to

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[217] Mette Sagbakken, Ragnhild Storstein Spilker, and T. Rune Nielsen, "Dementia and Immigrant Groups: A Qualitative Study of Challenges Related to Identifying, Assessing, and Diagnosing Dementia," *BMC Health Services Research* 18, no. 1 (December 2018): 9, accessed March 14, 2023, https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3720-7.

[218] Kimberly S. Johnson, "Racial and Ethnic Disparities in Palliative Care," *Journal of Palliative Medicine* 16, no. 11 (November 2013): 1329, accessed March 14, 2023, http://www.liebertpub.com/doi/10.1089/jpm.2013.9468.

[219] Cfr. Mónica Machón et al., "Desigualdades Socioeconómicas en la Salud de la Población Mayor en España," *Gaceta Sanitaria* 34, no. 3 (May 2020): 284, accessed March 15, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0213911119301785.

[220] Cfr. Rebecca L. Sudore et al., "Limited Literacy in Older People and Disparities in Health and Healthcare Access," *Journal of the American Geriatrics Society* 54, no. 5 (May 2006): 772, accessed March 15, 2023, https://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2006.00691.x.

[221] Cfr. Machón et al., "Desigualdades Socioeconómicas en la Salud de la Población Mayor en España," 284.

maintain an appropriate quality of life as dementia worsens. This situation represents a flagrant social injustice as the lack of access is the result not of people's choices, but of circumstances over which they have no control. Furthermore, this situation "is a very large challenge no matter the development of the countries,"[222] because it affects residents in countries with a universal public health system, such as Spain, where "The healthcare system is prepared for responsive care in acute problems, exacerbations, and complications but not for proactive care of the chronically ill."[223]

As we pointed out above, economic resources are necessarily limited; therefore, a public health system can never be perfect. No predefined formula tells us how much of the budget should be devoted to guaranteeing healthcare access. There must be restrictions on spending, and our aim is not to show how to allocate such limited resources, nor to propose what is the decent minimum that should be provided for each citizen.

"Unlike some other issues in health care ethics, no consensus has arisen about allocation."[224] There is no consensus because there are those who advocate treating health as a commodity subject to market rules and, from a Catholic perspective, "making the ability to pay the basis for providing or denying essential health services seems to be a failure in distributive justice."[225] Others consider that allocation should be based on "the merit or goodness of persons and their usefulness to society,"[226] which is similarly incompatible with the radical equality of every person proclaimed by Christian morality. However, even within those positions consistent with

[222] Tham, Garcia, and Miranda, *Religious Perspectives on Human Vulnerability in Bioethics*, 139.

[223] G. Rubiera López and J.R Riera Velasco, "Programa para Mejorar la Atención de las Enfermedades Crónicas. Aplicación del Modelo de Cuidados para Enfermedades Crónicas," *Atención Primaria* 34, no. 4 (2004): 207, accessed March 15, 2023, https://linkinghub.elsevier.com/retrieve/pii/S0212656704789106.

[224] David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington, D.C: Georgetown University Press, 2004), 270.

[225] Philip S. Keane, *Catholicism and Health-Care Justice: Problems, Potential, and Solutions* (New York: Paulist Press, 2002), 7.

[226] Ibid.

Catholic ethics, there is a disagreement between the allocation of healthcare "according to need, or distributing it in a way that assures that all people are treated the same in terms of their basic health-care needs."[227] In any case, what seems evident is that, no matter how many resources are assigned to fund a public health system, social injustice exists when where people with conditions such as dementia are not treated merely because they are poor, women, LGBT or immigrants.

How does this social injustice affect the freedom of people diagnosed with dementia? To what extent does such inequity constrain the freedom of persons considering euthanasia? In the following section, we will briefly show the relation between healthcare access disparity and freedom according to the concept of the human project we introduced in the previous chapter.

3.3 Social Injustice Concerning Human Freedom and Dementia-Related Euthanasia

Human freedom, usually expressed in terms of autonomy, "is understood to be exercised in any decision made by an individual who gives informed consent."[228] According to this understanding of autonomy, which is the most widespread in Western society today, "If a patient understands the reality of his or her medical condition, appreciates the certain and/or likely ramifications of a potential choice, and after due reflection decides to execute a choice, then this choice is autonomous."[229] This approach, however, seems reductionistic. Let us consider why.

When assessing freedom in a person's decision-making, we must always consider the circumstances surrounding the action, not just the substance of the action itself. Following Thomas Aquinas, we believe that circumstances crucially affect the decision. "Whatever conditions are outside the substance of an act, and yet in some way touch the human act, are

[227] Ibid.
[228] Christopher Kaczor, *Disputes in Bioethics: Abortion, Euthanasia, and Other Controversies*, Notre Dame Studies in Medical Ethics (Notre Dame, IN: University of Notre Dame Press, 2020), 130.
[229] Ibid.

called circumstances."[230] The same decision, depending on its circumstances, can be free or not, and we can be responsible for it or not. Because the circumstances remain outside the substance of the action, but they touch and modify it. We can illustrate this with an example.

Two different people steal two packages of rice and a bag of oranges from a grocery store. The first is a young man who does it for fun and then throws the stolen goods in the trash because he does not want them, just the thrill of stealing without being caught. The second is an unemployed mother with no money to feed her three children and no knowledge of social resources which could help her. She feels ashamed of what she has done. The substance of both decisions is the same: stealing food from a grocery store. We easily understand how distinct the circumstances of the two cases are. Furthermore, the degree of freedom in making such a decision, and the responsibility for it, are very different too.

According to Aquinas, the circumstances in which we make decisions are related to our actions in two ways, "For some circumstances that have a relation to acts, belong to the agent otherwise than through the act; as place and condition of person; whereas others belong to the agent by reason of the act, as the manner in which the act is done."[231] The first type of circumstances, those belonging to the agent otherwise than through the act, include the antecedents of the agent, i.e., their conditioning factors in life. And these latter are fundamental and do not seem to be taken up by the definition of autonomy that we presented at the beginning of this section. The disease is not the only conditioning factor of a person with dementia. At the same time, the ramifications of an action point to the future, to consequences. Where are the causes pushing a person to decide one thing or another? Where are the social conditions of a person in the definition given above?

[230] *S. Th.* I-II, q. 7, a. 1, co. See in Thomas Aquinas, *Summa Theologiae* (Green Bay, WI: Aquinas Institute, 2020), https://aquinas.cc.

[231] *S. Th.* I-II, q. 7, a. 1, ad. 3.

As we have seen in the first section of this chapter, social justice is crucial in our lives because, without it, we cannot flourish; we cannot establish and strive to achieve a human project, according to Laín's terminology. And we have seen in the second section how in Spain, the country we focus on for having a universal public health system and for allowing euthanasia in cases of dementia, there is a significant disparity in healthcare access. A disparity that penalizes certain people who are part of vulnerable groups. Let us look at this issue from the perspective of Laín's theory of human freedom, i.e., his explanation of the human project.

After the initial impulse of desire, the next moments of the human project are the ideas of oneself and the world in which one exists. Next comes the moment of imagination and, only afterward, in fifth place, the structural moment of human freedom. Thus, we see how social injustice in healthcare access prevents patients with dementia from actually having freedom of choice, because such people see all their options closed off before they even get to the structural moment of freedom. Again, let us use an example to explain this.

Suppose two persons have been recently diagnosed with dementia due to Alzheimer's disease. The first is a 75-year-old married man with five married children and a close-knit family. His income is high, and he owns several properties. The whole family lives close by, in the center of Madrid, in an upper-class residential area, near a primary care center with a palliative home care unit. The referral hospital is a twenty-minute drive away. He can also supplement this public care by paying for 24-hour private assistance and the non-professional but constant and adequate care provided by his wife, children, and children-in-laws.

The second patient is a 75-year-old widow with a single daughter who herself is the divorced mother of a teenage boy. The elderly lady lives in a small village in a rural region in western Spain. Her only income is a modest pension; her only property is the old family house. The daughter, for professional reasons, lives in a city that is a ten-hour drive away. The town's

primary care center depends on another municipality, so a doctor is available only twice weekly. There is no palliative home care unit; nursing service is only twice a week. The referral hospital is in the main regional city, an hour and a half drive away.

Neither case is an imaginary and extreme situation, but both represent thousands of cases of dementia in Spain and throughout the world. Now let us consider how both persons face dementia. Both can request euthanasia, since it is a right recognized by Spanish law, and the health system guarantees it for free. What alternatives does the man have? What alternatives does the woman have?

Both may have the same desire to cope with the progressive impairment caused by the disease. However, their idea of themselves and the world differ significantly. He can manage his illness in the best possible way, despite the suffering, thanks to the care, non-professional and professional, public and private, that is accessible to him. Therefore, according to Laín's idea of the human project, the man can get to the moment of freedom and choose between euthanasia or continuing his life until its natural end.

If we consider now the circumstances of the woman, what alternatives does she have? She is unable to afford minimum care, but euthanasia is accessible and free. Can she imagine diverse alternatives for the future? Is she actually free to choose any alternative other than the easy and more accessible possibility of euthanasia? Our thesis is that it is not possible to speak of true freedom in her case.

The woman is a victim of social sin, as defined above. The lady is not really free because she is not given equal opportunities to imagine and set up a personal project for her future. Her social conditioning factors constrain her freedom.

Recall the quotation which opened this chapter. The person in a privileged situation may claim the right to decide about his or her own life, specifically about ending it. But as long as

vulnerable people may lose their freedom to live and die on an equitable basis, the State and society must be proactive and guarantee, on the principle of fraternity, justice in healthcare access. It could be argued that the lady always has the option of continuing with her life and enduring her progressive psychological and physical deterioration. However, the Church has never demanded heroic virtues from everyone. And the State cannot expect ethical heroism from its most disadvantaged citizens in order to please the most privileged.

Therefore, we have proven the relevance of justice in Catholic Social Teaching and how healthcare access is an integral part of this principle. We have also demonstrated how a public health system does not necessarily avoid inequity of access. This inequity, combined with accessible and free euthanasia, creates an imbalance in the understanding that dementia patients in vulnerable situations may have of themselves and their world. This imbalance constrains the human project and prevents it from getting to the structural moment of freedom.

Along with this external constraint on freedom, we will address an internal constraint in the next chapter. Based on Aquinas, we will show the relationship between the intellect and the human will, which will help us understand that an intellect damaged by dementia negatively impacts the will, to the point of eliminating freedom. This understanding will reinforce our thesis that there is no freedom in the dementia patient who requests euthanasia.

4. Human Freedom in Aquinas regarding Brain Impairment Due to Dementia

In the preceding chapter, we have shown the importance of social justice regarding human freedom. Healthcare access stands out as crucial within the diversity of elements that constitute social justice. In this sense, we have seen substantial disparities in the care needed to meet the progressive decline that comes with dementia. Despite living in a country with a public health system, a significant portion of the population cannot access such care in Spain.

When faced with a diagnosis of dementia, a person in a socially disadvantaged situation does not find it possible to access chronic treatment and adequate care at home or in a nearby public facility. At the same time, however, the system guarantees rapid and free access to euthanasia. As we have argued, this external pressure so conditions the human project of the person with dementia that we can go so far as to say that it constrains his or her freedom.

When some people appeal to beneficence as a principle for granting the request for euthanasia, we can refute that beneficence can only properly exist if the principle of justice is first honored. Although we may differ regarding how far our duty of beneficence must go, there is common agreement that "the principle of positive beneficence supports an array of prima facie rules of obligation."[232] Among these rules, we may consider the duty to protect the rights of others and to remove the conditions that cause harm to others.[233] When society offers its members no other way to cope with dementia than by requesting euthanasia, granting it is not beneficence. On the contrary, beneficence implies a commitment to social justice and the provision of alternatives.

At the same time, however, we must acknowledge that patients may be aware of their status as victims of social injustice and, despite it,

[232] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013), 204.

[233] Cfr. Ibid.

> When patients are at their life's end and suffering from terminal illnesses like dementia, they frequently express the desire to not live any further. Life is often viewed as meaningless, and they often express the opinion that they are held captive under their mental prisons. They often consider themselves to be a burden on their family members. As dementia progresses, all their activity of daily living and instrumental activities get impaired. This loss of personal autonomy results in guilt and shame among patients. This raises important ethical questions in mind: If people have the right to live, then why can they not also have the right to die?[234]

In this argument, we see at stake the second of the two principles mentioned earlier that are appealed to in the debate in favor of euthanasia, namely, autonomy. Moreover, as we have already pointed out, personal autonomy is invoked as the expression of human freedom, so both terms, autonomy and freedom, are often used interchangeably in the debate on euthanasia. In this debate, some people appeal to the alleged right to decide on one's death as the ultimate expression of personal freedom.

Nonetheless, we must carefully pay attention to the entire quoted argument. Indeed, we frequently express our desires regarding how we want to end our lives. We frequently have an opinion about the disgraceful condition of many people at the end of their lives. We often hear that older persons are considered a burden to their caregivers (most frequently close relatives). However, are such statements the expression of a genuine human will? Are they indeed a rational consideration of the intellect? Are they valid expressions of human freedom? As we have been proposing, our thesis is that we cannot consider these requests of euthanasia a true expression of human freedom in a person with dementia.

We base our thesis on Laín's explanation of the human brain's interconnection and activity, as introduced in the second chapter. Furthermore, we use Laín's explanation to complement our main argument regarding human freedom, that is, the theology of Thomas Aquinas.

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[234] Jitender Jakhar, Saaniya Ambreen, and Shiv Prasad, "Right to Life or Right to Die in Advanced Dementia: Physician-Assisted Dying," *Frontiers in Psychiatry* 11 (January 21, 2021): 3, accessed November 6, 2022, https://www.frontiersin.org/articles/10.3389/fpsyt.2020.622446/full.

Thus, in this fourth chapter, we will briefly introduce Aquinas's theology regarding the purpose of human life. Then we will focus on the human will in our actions and its relationship with the intellect. This way, we will finally introduce Aquinas's theology about choice and prudence to enforce our thesis.

4.1. The Last End of Human Life: Happiness

"The last end of human life is stated to be happiness."[235] For Aquinas, it is evident that human life must have an end in teleological terms, in terms of its meaning and purpose. Our human life aims at a purpose, which is none other than the achievement of happiness. Human life is necessarily oriented. "This teleological fact is expressed as a motion in the will toward the universal good and in the intellect toward the universal truth, both of which are found only in God."[236] As we see, Aquinas understands that both our will and our intellect move us toward happiness, which can only be found in God, "in Whom alone true happiness consists."[237]

The reason for this identity of our happiness with God is that we also have our origin in him: "All things are treated of under the aspect of God: either because they are God Himself or because they refer to God as their beginning and end."[238] Now, by happiness Thomas is not referring to a feeling or an emotion, in the sense this concept is usually understood today, but to a state of personal realization, of completeness.

This completeness or happiness cannot be attained by our own means. We need God's grace and the example of Jesus Christ.[239] However, "it is Aquinas's firm conviction, reiterated in many

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[235] *S. Th.* I-II, q. 1, pr.

[236] Mark D. Jordan, "The Good That Draws the Will," in *Teaching Bodies: Moral Formation in the Summa of Thomas Aquinas* (New York: Fordham University Press, 2017), 112, accessed May 12, 2022, http://www.jstor.org/stable/j.ctt1g2kn06.14.

[237] *S. Th.* I, q. 82, a. 2, co.

[238] *S. Th.* I, q. 1, a. 7, co.

[239] Cfr. Jean-Pierre Torrell, *Aquinas's Summa: Background, Structure, and Reception*, 1st ed. (Washington, D.C: Catholic University of America Press, 2005), 29, https://www.jstor.org/stable/10.2307/j.ctt284xr1.

passages, that God moves the will only in accord with its nature and not against it. According to Aquinas, then, his account of grace should not alter the conclusions we reach about his theory of the nature of the will, independently considered."[240] This understanding of the relationship between God's grace and our will comes together with Aquinas's being aware that human happiness necessarily has a dimension, albeit an incomplete one, in this life. "For imperfect happiness, such as can be had in this life, external goods are necessary, not as belonging to the essence of happiness, but by serving as instruments to happiness."[241] As we see in this text, Aquinas exposes the need we have for external goods to achieve certain happiness in this life. However, it is vital that we realize that such goods are a means to attain happiness; happiness can never be identified with external goods, including goods of the body such as health.[242]

Although we cannot identify happiness with health or other goods of the body, our body plays a crucial role in achieving happiness. "If we speak of that happiness which man can acquire in this life, it is evident that a well-disposed body is of necessity required for it. For this happiness consists [...] in an operation according to perfect virtue; and it is clear that man can be hindered, by indisposition of the body, from every operation of virtue."[243] As we see, dementia may eventually end up preventing a patient from being happy in this life, clouding the goal of our life.

Thus, we have introduced Aquinas's teleological conception of human existence. We live to be happy. Reason and will aim at this happiness "as an arrow is directed to a target by an archer."[244] Nevertheless, this happiness can only be fulfilled in God, for which we need God's

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[240] Eleonore Stump, "Aquinas's Account of Freedom: Intellect and Will," *The Monist* 80, no. 4 (1997): 577, http://www.jstor.org/stable/27903551.

[241] *S. Th.* I-II, q. 4, a. 7, co.

[242] Cfr. *S. Th.* I-II, q. 2, a. 5, co.

[243] *S. Th.* I-II, q. 4, a. 6, co.

[244] Edward J. Gratsch, *Aquinas' Summa: An Introduction and Interpretation* (New York: Alba House, 1985), 75.

grace. This grace does not act against our nature but enhances it. This way, a certain degree of happiness is possible for our will and intellect. However, a series of conditions must be present, a series of external goods, for instance, wealth, social status, pleasure, and health.

We can realize that this vision of human life oriented towards a goal, as presented by Aquinas, shows a remarkable similarity with the proposal of the human project that we saw in Laín in a sort of secularized version. According to Laín, the human project has a dimension of infinitude or openness in the end; in the same way, for Aquinas, the happiness we strive for in this life comes up against the impossibility of being fully achieved while we live.

In Laín's human project, the initial impulse springs from desire, from the will, but then the intellect intervenes by developing the ideas that one has of oneself and one's world. These ideas are partially based on the external goods we have or believe we have.

Thus, both authors understand that our ultimate good is somehow within our reach. However, "While the human good is attainable, something must be done to reach it."[245] Here is where freedom comes into play, as we choose the means to achieve our good.[246]

We saw how Laín distinguished between proleptic life (animal life based on reactions to a stimulus) and projective life. This projective life, where our decisions point to an aim, is what makes us humans, where we properly see our freedom in action. Similarly, Aquinas affirms that not every action is a human action. We also react to a stimulus, while only "those [actions] are properly called human, which are proper to man as man. […] Wherefore those actions alone are properly called human, of which man is master. Now man is master of his actions through his reason and will; whence, too, the free-will is defined as the faculty of will and reason. Therefore those actions are properly called human which proceed from a deliberate will."[247] Consequently,

[245] Jordan, "The Good That Draws the Will," 109.
[246] Cfr. *S. Th.* I, q. 82, a.1, ad 3.
[247] *S. Th.* I-II, q. 1, a. 1, co.

both the will and the intellect have been involved and related in the origin of a genuinely human action, an action where our freedom truly comes into play. Let us now see how Aquinas understands this relationship to take place.

4.2. The Will and the Intellect

"Aquinas believes that investigation into the general nature of human acts needs to begin with an examination of which acts are voluntary and which are involuntary. Voluntary acts are the most distinctive of human beings—and, not incidentally, the ones most closely connected to our happiness."[248] As we see, when we come to discuss human acts, we first must distinguish those acts that are voluntary from involuntary ones, because voluntary acts are the ones properly human. So, what is a voluntary act?

According to Aquinas, a voluntary act is one "which has its principle within itself"[249] and must also be oriented to an end. "Now in order for a thing to be done for an end, some knowledge of the end is necessary. […] But those things which have a knowledge of the end are said to move themselves because there is in them a principle by which they not only act but also act for an end. […] the voluntary is defined not only as having a principle within the agent, but also as implying knowledge."[250] As we see in the definition, the role of the intellect is crucial because we can only talk of voluntariness with the participation of our reason and will. Indeed, "we can succinctly define the will as the power or capacity by which a rational being […] freely directs his actions to his good or perfection."[251] In directing our actions to a good, we must face some external factors that can oppose our reason and will, such as violence, fear, or ignorance.

[248] Thomas Williams and Christina Van Dyke, *The Treatise on Happiness: The Treatise on Human Acts: Summa Theologiae I-II 1/21* (Indianapolis; Cambridge: Hackett Publishing Company, Inc, 2016), 290.
[249] *S. Th.* I-II, q. 6, a. 1, obj. 1.
[250] *S. Th.* I-II, q. 6, a. 1, co.
[251] Stephen J. Pope, ed., *The Ethics of Aquinas*, Moral Traditions Series (Washington, D.C: Georgetown University Press, 2002), 73.

For Aquinas, it is evident that violence prevents us from being free:

> Violence is directly opposed to the voluntary, as likewise to the natural. For the voluntary and the natural have this in common, that both are from an intrinsic principle; whereas violence is from an extrinsic principle [...] so in things endowed with knowledge, [violence] effects something against the will. Now that which is against nature is said to be unnatural; and in like manner that which is against the will is said to be involuntary. Therefore violence causes involuntariness.[252]

We can explain this idea with an easily understandable example. Suppose a political prisoner is in jail in a non-democratic country. They want to incriminate her in the organization of a coup d'état in order to discount her as an agent opposing the regime. If she is physically tortured with great violence and cruelty, she will quickly confess to whatever crime her custodians want her to confess. There is no voluntariness in such a confession because it is only the fruit of desire and need to avoid the suffering and violence inflicted on her.

After showing that violence causes involuntariness because of the way it acts as an extrinsic principle against our will and the natural, Aquinas draws a parallel between violence and fear. Nevertheless, fear cannot be said to cause involuntariness simply, as violence does. Aquinas explains it by saying that "what is done through fear, becomes voluntary, because the will is moved towards it, albeit not for its own sake, but on account of something else, that is, in order to avoid an evil which is feared. […] since the voluntary is not only what we wish, for its own sake, as an end, but also what we wish for the sake of something else, as an end. […] because the will of him that is in fear, does concur somewhat in that which he does through fear."[253] So, in this sense, what we do under the influence of fear is of a mixed character. However, "If we consider what is done through fear, as outside this particular case, and inasmuch as it is repugnant to the will, [...] consequently what is done through fear is involuntary, considered in

[252] *S. Th.* I-II, q. 6, a. 5, co.
[253] *S. Th.* I-II, q. 6, a. 6, ad 1.

that respect, that is to say, outside the actual circumstances of the case."[254] Thus, what we do under the influence of fear is mainly on the side of involuntariness.

Again, we can explain this with an example to make it easier to understand. Suppose an 80-year-old lady whose health is fragile, and she is a devout Catholic who used to attend Mass every day. With the pandemic, the churches were closed, and the Church offered the faithful to follow Mass thanks to new technologies. Even though the worst of the pandemic is now over, the lady is still highly fearful of the possibility of being infected in an enclosed place with a large gathering of people. Not attending Mass in person causes her great sadness and moral distress, but her fear is stronger than her will. She does not want to stop attending her parish. Nothing prevents her from attending church; in that sense, her decision to stay at home is voluntary. However, in circumstances other than the terrible pandemic of the last few years, she would never stop attending daily Mass, least of all on Sundays.

Regarding ignorance, we must first acknowledge that we cannot go very deep into this complicated issue here because "the relationship between ignorance and involuntariness is quite complex"[255] in Aquinas. Ignorance causes involuntariness only "insofar as it deprives one of knowledge, [...] But it is not every ignorance that deprives one of this knowledge."[256] So ignorance affects the will, but this does not mean that it is a cause of involuntariness in every case. Aquinas affirms that "we must take note that ignorance has a threefold relationship to the act of the will: in one way, concomitantly; in another, consequently; in a third way, antecedently."[257] Among these three types of ignorance, concomitant and consequent ignorance do not make the act involuntary. Since they are not so relevant to our subject –dementia– suffice it to say first that concomitant ignorance causes non-voluntariness (which falls outside the

[254] *S. Th.* I-II, q. 6, a. 6, co.
[255] Williams and Van Dyke, *The Treatise on Happiness*, 305.
[256] *S. Th.* I-II, q. 6, a. 8, co.
[257] Ibid.

voluntary/involuntary disjunctive).[258] As for consequent ignorance, second, Aquinas distinguishes different types within it. Still, we will only point out that it is a voluntary kind of ignorance and, therefore, cannot lead to an involuntary act.[259] Aquinas reminds us that we can be held responsible for not knowing, acting, and willing.[260]

The third type of ignorance is the most relevant concerning dementia. It is antecedent ignorance. Such ignorance "is not voluntary, and yet is the cause of man's willing what he would not will otherwise. Thus a man may be ignorant of some circumstance of his act, which he was not bound to know, the result being that he does that which he would not do, if he knew of that circumstance; […] Such ignorance causes involuntariness simply."[261] As we see, antecedent ignorance is the only kind that causes involuntariness in an absolute sense because, in this case, the ignorance is neither desired nor sought by the subject (as opposed to consequent) and because the final result is not desired either if the circumstances involved were known (as opposed to concomitant).

Suppose the example of a hunter. She is a very peaceful person in her dealings with people. She would never, under any circumstances, harm a person, much less think of killing anyone. On a hunting day, she shoots what she believes is a deer in her range. She was utterly unaware that the apparent deer was a nature photographer disguised as a deer to get closer and take pictures of different animals. As a result of the shot, the photographer died on the spot. In no way was it the hunter's will that this would have happened.

When we consider the role that ignorance, fear, or violence play in human acts, we see the importance of the intellect and the will. We cannot speak of voluntariness without knowledge of the different circumstances involved in our actions. At the same time, we need knowledge of the

[258] Cfr. Williams and Van Dyke, *The Treatise on Happiness*, 306.
[259] Gratsch, *Aquinas' Summa*, 79.
[260] Cfr. *S. Th.* I-II, q. 6, a. 3, ad 3.
[261] *S. Th.* I-II, q. 6, a. 8, co.

end towards which we direct our actions. This teleological dimension of our action is essential. Let us remember that the voluntary act requires an end towards which to be directed. Some means may or may not lead us toward this end.[262] Thus, the will can be directed towards the end and the means that aim at it, or "the will sometimes wills the end, and yet does not proceed to will the means."[263] Take the example of a girl who wants to become a professional soccer player but is unwilling to train hard four days a week for years and work hard at her studies in the little free time that soccer leaves her. She does not will the means to achieve her end.

The intellect plays a leading role in this direction of the will towards the end and the means. "The systematic rigor of Aquinas's approach to action theory can be seen from his presupposition that morality is generally a domain of reason […] A further background assumption is Aquinas's doctrine of the *human act* or *moral act*, which states that any action that is performed by a human being as the *master of her own act* is a product of an interaction of reason and will."[264] Therefore, let us present this interaction now.

In the *Pars Prima*, Aquinas has already told us that, in a certain sense, the intellect moves the will (as an end), while, in another sense, it is the will that moves the intellect "as what alters moves what is altered, and what impels moves what is impelled."[265] This idea can initially seem contradictory. Nevertheless, "Because the will *moves* the intellect with regard to its exercise and *is moved by* the intellect with regard to its determination, it is clear that the will is something moved in a way that is quite distinct from how it is a mover, such that there is no contradiction

[262] Cfr. *S. Th.* I-II, q. 8, a. 2, co.
[263] *S. Th.* I-II, q. 8, a. 3, ad 3.
[264] Jeffrey Hause, ed., *Aquinas's: Summa Theologiae, A Critical Guide*, Cambridge Critical Guides (New York: Cambridge University Press, 2018), 153.
[265] *S. Th.* I, q. 82, a. 4, co.

between the two claims."[266] Not only is there no contradiction in the will being both moved by and mover of the intellect, but we may think that there is a primacy of the will over intelligence.

In this sense, Aquinas affirms that "it would seem that the will is a higher power than the intellect. For the object of the will is good and the end. But the end is the first and highest cause. Therefore the will is the first and highest power."[267] However, this preeminence of the will over the intellect is not true because "the more simple and the more abstract a thing is, the nobler and higher it is in itself; and therefore the object of the intellect is higher than the object of the will. Therefore, since the proper nature of a power is in its order to its object, it follows that the intellect in itself and absolutely is higher and nobler than the will."[268] According to this statement, there is an asymmetry between the will and the intellect, an asymmetry by which the intellect would prove itself superior.

The intellect has this preeminence because the will can never come to possess the ultimate end to which it tends, its most proper and definitive object, which is the good. All the acts of the will incline towards its object but not possess it. Unlike the will, the intellect does not incline but possesses.[269] When the intellect knows, it is always in possession of its object, its end, which is the truth, in such a way that its object cannot be separated from the act of knowing, as the end is from the act of willing proper to the will.[270] However, this asymmetry does not imply that the

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[266] Frederick Christian Bauerschmidt, *The Essential Summa Theologiae: A Reader and Commentary*, Second ed. (Grand Rapids: Baker Academic, 2021), 131.

[267] *S. Th.* I, q. 82, a. 3, obj. 1.

[268] *S. Th.* I, q. 82, a. 3, co.

[269] Cfr. *D. V.*, q. 22, a. 10, rº. See in Thomas Aquinas, *De Veritate* (Green Bay, WI: Aquinas Institute, 2020), https://www.aquinas.cc/la/la/~QDeVer. [Et sic obiectum animae est aliquid dupliciter. Uno modo in quantum natum est esse in anima non secundum esse proprium, sed secundum modum animae, id est spiritualiter; et haec est ratio cognoscibilis in quantum est cognoscibile. Alio modo est aliquid obiectum animae secundum quod ad ipsum anima inclinatur et ordinatur secundum modum ipsius rei in seipsa existentis; et haec est ratio appetibilis in quantum est appetibile.]

[270] Cfr. Javier García-Valiño Abós, "La Voluntad Humana en Tomás de Aquino. Un Estudio desde sus Fuentes Griegas, Patrísticas y Escolásticas" (PhD Dissertation, Universidad de Málaga, 2010), 235–236, http://hdl.handle.net/10630/4983.

intellect is superior to the will. There is no intellectual determinism.[271] We need to realize what it means for Aquinas to move. To move something is to bring it from potentiality to actuality.

The will is in potentiality, so it needs something to move it. There are two ways in which the will, like other powers of the soul, is in potentiality: regarding acting and not acting (the exercise of the act) and regarding doing this or that (the determination of the act). Thus, "the object moves, by determining the act, after the manner of a formal principle […] Now the first formal principle is universal being and truth, which is the object of the intellect. And therefore by this kind of motion the intellect moves the will, as presenting its object to it."[272] As we can easily understand, it is first necessary to know something in order to desire it.

At the same time, the will is also a motor of itself in another sense. "The will is moved by the intellect, otherwise than by itself. By the intellect it is moved on the part of the object: whereas it is moved by itself, as to the exercise of its act, in respect of the end."[273] That is, the will moves itself insofar as it chooses the acts conducive to its object, happiness.

Thus, we have seen how the intellect and the will necessarily act together in voluntary acts that genuinely define us as persons and in which our freedom is displayed. This consideration is of utmost importance when the issue at hand is a disease such as dementia, in which intellectual ability progressively deteriorates.

At the same time, we have seen how certain elements significantly condition our actions and can determine the total or partial involuntariness in our decisions, as we have noted about violence, fear, and ignorance.

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[271] Cfr. James Keenan, *Goodness and Rightness in Thomas Aquinas's Summa Theologiae* (Washington, D.C: Georgetown University Press, 1992), 45–47.

[272] *S. Th.* I-II, q. 9, a. 1, co.

[273] *S. Th.* I-II, q. 9, a. 3, ad 3.

Since we are considering the freedom of a person with dementia in requesting euthanasia as the means to avoid suffering and end their life, we must approach Aquinas's comprehension of choice as an act of the will concerning the means.

4.3. The Choice

As Aquinas states, "choice implies comparison, whereby one is given preference to another."[274] To compare is an act of reason, as are "to form a syllogism, and to draw the conclusion."[275] Although this assertion could lead us to think that the choice rests with reason, this is not the case, for "choice is the desire of things in our power. But desire is an act of will. Therefore choice is too."[276] Aquinas explains this further when he declares, "That act whereby the will tends to something proposed to it as being good, through being ordained to the end by the reason, is materially an act of the will, but formally an act of the reason. Now in such like matters the substance of the act is as the matter in comparison to the order imposed by the higher power. Wherefore choice is substantially not an act of the reason but of the will."[277] After having made it clear that the choice falls on the side of the will, Aquinas argues that the choice does not apply to the ultimate end since, for every human, it is necessarily happiness.[278] The choice concerns only the goods or ends oriented toward the ultimate end. That is, the choice is about the means.[279]

In addition, the choice can only be of the possible,[280] although "sometimes the will tends to something which is apprehended as good, and yet is not really good; so is choice sometimes

[274] *S. Th.* I-II, q. 13, a. 1, obj. 1.
[275] *S. Th.* I-II, q. 13, a. 1, obj. 2.
[276] *S. Th.* I-II, q. 13, a. 1, s.c.
[277] *S. Th.* I-II, q. 13, a. 1, co.
[278] Cfr. *S. Th.* I-II, q. 13, a. 3, ad 1.
[279] Cfr. *S. Th.* I-II, q. 13, a. 3, ad 2.
[280] Cfr. *S. Th.* I-II, q. 13, a. 5, co.

made of something apprehended as possible to the chooser, and yet impossible to him."[281] This contingency means that we do not choose out of necessity but freely.[282] Moreover, we can fail in our choices for this reason. We can think of Laín's understanding of the human project. If the individual's ideas of herself and her world are wrong, the possibility of making wrong choices will be high, since she starts her project based on erroneous assumptions.

Similarly, the will can apprehend something as evil, despite being good, and consequently avoid it: "The will can tend to whatever the reason can apprehend as good. […] Again, in all particular goods, the reason can consider an aspect of some good, and the lack of some good, which has the aspect of evil: and in this respect, it can apprehend any single one of such goods as to be chosen or to be avoided."[283] Here again, the importance of the intellect can be appreciated.

4.3.1. The Choice in the Case of Dementia

Once we consider the relevance of the intellect in its interaction with our will, a question arises. What happens to our choices and our will when the intellect is impaired by dementia?

In answering this question, we will relate the theology of Aquinas that we have introduced, and the medical and philosophical knowledge previously presented.

First, we should recall what medicine allows us to know about cognitive impairment in patients with dementia. As we pointed out in the first chapter, the patient is diagnosed through clinical tests, that is, thanks to the observation of the patient's signs and symptoms. Diagnostic imaging techniques are not generally used. However, when they are, these techniques show that there is already extensive damage in different brain regions. This damage will progressively increase, causing clinical decline with new symptoms and aggravation of existing ones.

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[281] *S. Th.* I-II, q. 13, a. 5, ad 2.

[282] Cfr. Matthew Knell, "Thomas Aquinas on Free Will," in *Sin, Grace and Free Will - Vol. 2: A Historical Survey of Christian Thought*, 1st ed., vol. 2: From Anselm to the Reformation (Cambridge: James Clarke & Co, 2018), 168, http://www.jstor.org/stable/10.2307/j.ctvhrd1q9.

[283] *S. Th.* I-II, q. 13, a. 6, co.

Second, it is worth recalling what was said in the second chapter about the unity of action of the brain in complex thinking. Laín insists that mental higher abilities, among which are complex and abstract thinking, the exercise of freedom, or the elaboration of a human project, for instance, are not a property of a specific brain region but are systemic properties of the brain as a whole. It is the whole brain as a unit that elaborates such higher thinking. Not only is this a fundamental point in Laín's emergentism as a philosophical doctrine, but our medical knowledge so far supports the idea that there is no brain center of freedom. On the contrary, exercising our freedom, although only at the theoretical level before action, depends on a complex interaction between different brain regions. This connectivity implies that the whole system is necessarily compromised when one area is affected.

Third, and connected to the previous point, we have explained in this chapter the relationship between the intellect and the will in Aquinas's theology. We have seen that the intellect moves the will in a certain sense because it offers the end toward which to incline. "The sensitive appetite, as also the intellective or rational appetite, which we call the will, follows from an apprehended form. Therefore, just as the natural appetite tends to the good existing in a thing; so the animal or voluntary appetite tends to a good which is apprehended. Consequently, in order that the will tend to anything, it is requisite, not that this be good in very truth, but that it be apprehended as good."[284] The will is inclined towards what it finds to be good, guided by the intellect. In this sense, the intellect must perform its function properly because otherwise it will not guide the will correctly. In such a case, the intellect would present to the will as good objects those that are not.

Therefore, considering these three points we have presented, we can insist on our thesis: the subject with dementia who requests euthanasia is not free. Such a subject may be competent for

[284] *S. Th.* I-II, q. 8, a. 1, co.

minor decisions of ordinary life at an early stage. However, the brain affliction already present at the time of diagnosis implies that systemic properties of the brain are compromised, including freedom. Complex thinking, such as freedom, is severely impaired. A brain with dementia is incapable of free human acts for the following reasons:

First, the will is offered as good something that it is not, in this case ending suffering by ending one's own life. That is to say, the impulse of desire, from which the whole human project starts, is already affected from the very beginning insofar as the will perceives as desirable something that it is not, such as death. Let us recall Aquinas's and Laín's teleological perspectives. We can only desire a good and direct our freedom toward happiness. So, when we are wrong, and we consider as good something that it is not so, we are not properly free because we are not heading to actual happiness.

Second, and again following Laín's theory of the human project, before we reach the point of choice, which belongs to the structural moment of freedom, the intellect affected by dementia is already conditioning our project. An affected intellect will be unable to elaborate an adequate idea about oneself or one's world. We have already seen that social injustice can nullify the project from its roots without allowing us to reach the moment of freedom, because it determines the idea of oneself and one's world. Social injustice exerts particular violence on the victim, provokes fear, and causes ignorance and uncertainty about the future. Aquinas has shown us how these circumstances prevent us from speaking of true voluntariness in a person's decisions in such a condition. The intellect is not able to correctly process and elaborate the information that comes to it about the person and their world.

Third, at the moment of choice, which belongs to the structural moment of freedom, according to Laín, an affected intellect will not be able to correctly carry out the operation of comparison between different means that choice requires, according to Aquinas.

Thus, we can understand that an intellect compromised by dementia determines the will in a way that makes it impossible for a human project to develop. Furthermore, as we have already mentioned, the freedom of the human being is not at stake in the small acts of which perhaps a patient with initial dementia is capable, but in conceiving, advancing, correcting, and finally bringing to completion a human project. A human project that, as mentioned above, is necessarily open and always leads to new projects because our striving for happiness is never satisfied in this life.

Human freedom consists of the continuous pursuit of happiness, so we cannot speak of freedom in the case at hand. In this pursuit, the person should choose the means that will lead her to happiness by exercising prudence. As Aquinas reminds us, "Prudence is a virtue most necessary for human life."[285] Therefore, let us briefly explore the virtue of prudence as Aquinas explains it, so that we can understand the way it is affected by dementia.

4.4. The Virtue of Prudence in Aquinas

The approach to prudence in Aquinas is comprehensive, but we will offer only some of the most relevant aspects which relate to our theme. We begin by following the theologian in situating prudence as an intellectual virtue: "To that which is suitably ordained to the due end man needs to be rightly disposed by a habit in his reason, because counsel and choice, which are about things ordained to the end, are acts of the reason. Consequently an intellectual virtue is needed in the reason, to perfect the reason, and make it suitably affected towards things ordained to the end; and this virtue is prudence."[286] Along with art, from which it is distinct, prudence is seated in practical reason.[287] Prudence is necessary for us to live well because moral virtues

[285] *S. Th.* I-II, q. 57, a. 5, s.c.
[286] *S. Th.* I-II, q. 57, a. 5, co.
[287] Cfr. Gratsch, *Aquinas' Summa*, 107.

cannot exist without it and understanding.[288] In the same way, any action guidance we offer should be based on this virtue.

> In order that a choice be good, two things are required. First, that the intention be directed to a due end; and this is done by moral virtue, which inclines the appetitive faculty to the good that is in accord with reason, which is a due end. Second, that man take rightly those things which have reference to the end: and this he cannot do unless his reason counsel, judge and command aright, which is the function of prudence […] Wherefore there can be no moral virtue without prudence: and consequently neither can there be without understanding.[289]

In other words, our choices cannot be good without moral virtues, which direct us correctly toward the desired goal. Our reason offers this goal to our will. At the same time, prudence, which resides in reason, allows us to put these virtues into practice. If we lose our reason or intellect, we cannot be prudent; without prudence, there can be no moral virtues, and therefore no ability to make good choices.

Aquinas offers a very clear idea of prudence when he explores the virtues in general in the *Prima Secundae*. However, in the *Secunda Secundae* he focuses specifically on prudence again, devoting questions 47 to 56 to it. He begins by recalling and arguing that prudence does not lie in the will but the understanding,[290] and specifically in the practical understanding, as we noted above.[291] Thus, prudence helps our will keep track of its object, happiness. "The will is the faculty responsible for safeguarding the overall good of the person; through its mediation, all actions spring from a unitary source and possess a common point of reference."[292] While the will is responsible for our good, this responsibility is expressed in different decisions mediated by prudence.

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[288] Andrew Kim, "Progress in the Good: A Defense of the Thomistic Unity Thesis," *Journal of Moral Theology* 3, no. 1 (2014): 168, https://jmt.scholasticahq.com/api/v1/articles/11288-progress-in-the-good-a-defense-of-the-thomistic-unity-thesis.pdf.

[289] *S. Th.* I-II, q. 58, a. 4, co.

[290] Cfr. *S. Th.* II-II, q. 47, a. 1, co.

[291] Cfr. *S. Th.* II-II, q. 47, a. 2, co.

[292] Pope, *The Ethics of Aquinas*, 155.

Aquinas reiterates that prudence is a virtue, a special one indeed, although relating to all moral virtues.[293] "Prudence helps all the virtues, and works in all of them; but this does not suffice to prove that it is not a special virtue; for nothing prevents a certain genus from containing a species which is operative in every other species of that same genus."[294] In its relationship with moral virtues, prudence does not impose itself on them regarding the end, since it is concerned only with the means.

Aquinas analyzes how prudence is present in various situations and conditions, after which he considers the parts of prudence in four questions. Aquinas thoroughly explains the various dimensions which constitute prudence, but we should concentrate on one of these parts: foresight. "Future contingents, insofar as they can be directed by man to the end of human life, are the matter of prudence: and each of these things is implied in the word foresight, for it implies the notion of something distant, to which that which occurs in the present has to be directed. Therefore, foresight is part of prudence."[295] Moreover, if foresight seeks future goods, it necessarily goes hand in hand with caution, which seeks to avoid future evils.[296]

It is also worth mentioning the three virtues that necessarily are paired with prudence, namely: "*eubulia* by which a person is led to take counsel; *synesis* by which a person exercises good judgement in practical matters; and *gnome* by which one judges according to the higher principles of human conduct especially in extraordinary affairs."[297] We say they are necessarily linked to prudence because it is impossible to speak of it if we lack good advice, good judgment, or the virtue of being guided in situations outside ordinary laws.

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[293] Cfr. *S. Th.* II-II, q. 47, a. 3, s.c.
[294] *S. Th.* II-II, q. 47, a. 5, ad 2.
[295] *S. Th.* II-II, q. 49, a. 6, co.
[296] Cfr. *S. Th.* II-II, q. 49, a. 8, ad 2.
[297] Gratsch, *Aquinas' Summa*, 169.

Thus, Aquinas demonstrates that a dementia patient, having lost her reason or intellect, cannot be prudent and, therefore, she cannot make good choices toward her happiness.

Given our thesis and the situation described in the preceding chapters regarding the aging population, the increase in the prevalence of dementia, and the social injustice that occurs in countries where euthanasia is legal or may soon become so, what response can be offered? We are dealing with dementia, which notably affects our intellect. Aquinas has shown us how this affliction has a determining repercussion on our will because it impairs our prudence and, therefore, constrains freedom. In the following chapter, we will offer some action guidance, seeking to safeguard the freedom of vulnerable people.

5. Catholic Moral Guidance Regarding Dementia-related Euthanasia

"There are three stages which should normally be followed in the reduction of social principles into practice. First, one reviews the concrete situation; secondly, one forms a judgment on it in the light of these same principles; thirdly, one decides what in the circumstances can and should be done to implement these principles. These are the three stages that are usually expressed in the three terms: look, judge, act."[298] This quotation from Pope John XXIII lets us conclude the course of our present work. We began by providing an overview that allowed us to understand the ethical complexity surrounding euthanasia in patients with dementia. We continued by exposing the elements of judgment that support our thesis: the subject with dementia who requests future euthanasia is not free. In this sense, we based our thesis on an element external to the patient, social injustice in healthcare access, and on an element internal to the patient, namely, the relationship between the intellect and the will and how the will is irremediably constrained when cognitive ability is impaired. We now come, therefore, to the third verb that Catholic Social Teaching proposes: to act.

When we consider what guidance we can offer in such a complicated issue, we must be aware that euthanasia has tremendous ethical, social, cultural, and economic implications. The burden it places on patients and their friends and family, particularly caregivers, also takes a tremendous emotional toll. We should place the concrete suffering person at the center of our reflection, rather than theoretical and abstract ideas. In this regard, it is worth recalling the centrality of the person that Pope Francis always emphasizes in his moral approach. This centrality is important not only because recent popes have insisted on it but also because it is consistent with the importance of the personal and social circumstances of each person, in line

[298] John XXIII, Encyclical on Christianity and Social Progress *Mater et Magistra* (15 May 1961) §236, at The Holy See, https://www.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_15051961_mater.html.

with the moral theology of Aquinas and Laín's proposal of the human project. "Although Pope Francis has not used the term 'personalism,' his approach is decidedly personalist. First, he asserts the moral primacy of the person over ideology. Throughout his writings, he gives the existing person epistemological priority over ideas about the person's nature. [...] His focus remains on the existing person and her relationship with God, and he does not turn to discussions of human nature or other abstractions."[299] This centrality of the person is not only crucial for the theologian but also for the healthcare professional or caregiver who deals with dementia patients daily, since "Sickness is not the only thing a physician deals with: she deals with people who feel sick; for sickness is one thing, and feeling sick is another (because I can be sick and not feel sick, just as I can feel sick without being sick)."[300] The experience of dementia in each individual and family is very different from that lived by others. We must bear this in mind now that we proceed to offer some action guidance regarding dementia-related euthanasia.

5.1. Catholic Social Teaching on Healthcare Services

In offering such guidance, we begin at the broadest level of advocacy and then narrow our focus to the concrete situation at the patient's bedside. We cannot exhaust all the possible guidelines that could be given, but should remember that we insisted on the primacy of the concrete person in most recent Catholic ethics. This primacy leads to a casuistry that is impossible to explore exhaustively. However, by appealing to prudence and giving a few hints, we may help advance the debate.

First, regarding public outreach, we must consider that we are discussing euthanasia in Spain, where it is legal. Spain is a parliamentary democracy in which secularization is advancing

[299] Daniel J. Daly, *The Structures of Virtue and Vice*, Moral Traditions (Washington: Georgetown University Press, 2021), 103.

[300] Peña González and Piñas Mesa, *La Antropología Médica de Pedro Laín Entralgo*, 74.

rapidly. We do not contradict Catholic teaching on the absolute prohibition of euthanasia, which we agree is "a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person. This doctrine is based upon the natural law and upon the written word of God, is transmitted by the Church's Tradition and taught by the ordinary and universal Magisterium."[301] However, the purpose of this paper is not to assess euthanasia per se but the freedom of the person with dementia requesting it. For this reason, we believe it is more appropriate for Catholic advocacy to take gradual steps to encourage the development of a "culture of life and encounter, rejecting the culture of throwaway and exclusion."[302] By gradual steps, we mean seeking first to improve the present law so that euthanasia for persons with dementia is no longer legal, rather than taking maximalist positions from the very beginning, seeking the abolition of euthanasia directly. This advocacy should be twofold. On the one hand, "by being present in the mass media and other forums influencing public opinion,"[303] and on the other hand, "by participating in institutions and political life, both through voting and active participation in political parties, institutions, and administrations."[304] At the same time, Catholic advocacy would not be genuine if it focused only on the specific issue of euthanasia without addressing the life circumstances that lead people to see no other possibility when suffering overwhelms them. Thus, promoting a culture of life involves advocacy for eradicating the conditions of social injustice and discrimination alluded to in the third chapter. As a society, we cannot close our eyes to the likelihood that women, immigrants, LGBT people, or people of socioeconomically limited status, just because they are such, are more inclined to request

[301] John Paul II, Encyclical on the Value and Inviolability of Human Life *Evangelium Vitae* (25 March 1995) §65, at The Holy See, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.

[302] Conferencia Episcopal Española, "Sembradores de Esperanza. Acoger, Proteger y Acompañar en la Etapa Final de esta Vida" (CEE, November 1, 2019), n. 54, https://www.conferenciaepiscopal.es/wp-content/uploads/2020/02/2019-Familia-Vida-Sembradores-esperanza.pdf.

[303] Ibid.

[304] Ibid.

euthanasia than upper-class heterosexual white men. If this discrimination is ignored, to what other discriminations are we leaving the gate open for? Similarly, it may be useful to refer to the Dutch experience. After legalizing euthanasia twenty years ago, 5% of all Dutch deaths are currently due to euthanasia, a trend on the rise.[305] We do not intend to appeal to the slippery slope as a definitive argument. We agree with Prof. Keenan that "Invoking the slippery slope argument to foreclose discussion is often a sign of intransigence. One can look on the slippery slope, however, not to forecast the future, but to express concern about the present. When a slippery slope argument is used to close debate it is nothing but an authoritarian tool; but it can legitimately suggest that necessary standards need to be in place before the public can be confident in a proponent's proposal."[306] Therefore, we must discuss these issues.

Second, we should consider the vast network of hospitals the Church runs direct or indirectly. One way of public testimony of commitment to the faith is consistency with Catholic Social Teaching. In this sense, "Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination."[307] This service implies that Catholic hospitals must actively pursue social justice concerning health, where literacy and healthcare access for vulnerable populations are concerned. At the same time, consistent with supporting people's health knowledge, particularly those most vulnerable, Catholic hospitals should "make available to patients information about their rights, [...] to make an advance directive for their

[305] Radboud M. Marijnissen, Kenneth Chambaere, and Richard C. Oude Voshaar, "Euthanasia in Dementia: A Narrative Review of Legislation and Practices in the Netherlands and Belgium," *Frontiers in Psychiatry* 13 (June 2, 2022): 7, accessed April 10, 2023, https://www.frontiersin.org/articles/10.3389/fpsyt.2022.857131/full.

[306] James Keenan, "Casuistry, Virtue, and the Slippery Slope: Major Problems with Producing Human Embryonic Life for Research Purposes," in *Cloning and the Future of Human Embryo Research*, ed. Paul Lauritzen (Oxford; New York: Oxford University Press, 2001), 78.

[307] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: United States Conference of Catholic Bishops, 2018), 9, https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf.

medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored."[308]

This mention of advance directives brings us to a third recommendation. We cannot accept these when written by dementia patients requesting euthanasia. A Catholic hospital or professional should never collaborate with a request for euthanasia.[309] Moreover, consistent with our thesis, we cannot accept such request out of respect for the patient's freedom, which we argue is compromised in the case of dementia. For this reason, the third recommendation is that Catholic primary care physicians and hospitals actively encourage their patients to prepare conscious and knowledgeable advance directives while their health is still good, as soon as the doctor-patient relationship starts. These documents should be thorough, comprehensive, and reviewed as often as the law requires. In order to help the patient prepare them with adequate information, it will be necessary to help the sick understand all medical and technical aspects, as well as help them be aware of the social resources at their disposal in case they need them. Similarly, "Hospital chaplains should intensify the spiritual and moral formation of the healthcare workers, including physicians and nursing staff, as well as hospital volunteers, in order to prepare them to provide the human and psychological assistance necessary."[310] In a Catholic context, preparing such an important document is not a mere legal or technical formality but must include the possibility of spiritual accompaniment, regardless of the patient's faith.

[308] Ibid., 13–14.

[309] Cfr. Congregation for the Doctrine of the Faith, Letter on the Care of Persons in the Critical and Terminal Phases of Life *Samaritanus Bonus* (29 September 2020) §9, Rome, https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2020/09/22/200922a.html.

[310] Cfr. Ibid., §12.

Nevertheless, what happens if the patient, before any diagnosis, leaves a written request for euthanasia in case of future dementia? This question brings us to the fourth recommendation. As we have said, neither a Catholic institution nor a Catholic professional will be able to accept such a request. Again, we recall what was said above regarding the symptoms of dementia. One of the earliest manifestations is memory loss. This clinical sign indicates damage to the frontal lobe, which also makes it impossible, as we mentioned, to assess the future adequately. Foresight ability and, thus, prudent reasoning, are constrained. This constraint on the patient's prudence is coherent with the understanding of prudence in Aquinas that we explored and reinforces our thesis that there is no freedom in a patient with dementia making a decision of such magnitude. However, neither can we force the patient against her conscience, regardless of how impaired it may be or whether we believe she is wrong.

Assuming that Spain is a democratic system with a great diversity of values and that euthanasia is legal, it will be necessary to guide the patient honestly so that they are aware of the social and health resources that are available to them and where they will be able to have their requests attended to. The Catholic hospital or professional that faces a request for euthanasia should adequately explain what palliative care is and how it helps alleviate the physical decline caused by dementia. In addition, they should coordinate with social workers to ensure that the patient fully understands the possibilities for assisted living, preferably at their home. In collaboration with social workers, we should help the patient know if they are entitled to any benefits. Similarly, it is essential to ensure that the patient knows and participates in community programs of cognitive stimulation, which also help avoid dementia-related social isolation. All this information can provide the patient with alternatives to euthanasia that they had not previously considered. If, on the contrary, the patient persists in their decision to request euthanasia, the Catholic hospital or professional must make available to them the information

concerning the right to receive euthanasia established by law. However, providing this information should never mean that the Catholic hospital or professional take the initiative to inform the patient about euthanasia as equal to other alternatives. Catholic hospitals and professionals should also not take the initiative to facilitate the procedure or to establish direct contact with another institution or professional willing to perform it. The patient is entitled to our honesty in providing information regarding the end of their life, not to our collaboration with euthanasia.

In this case of a request for euthanasia that the Catholic institution or professional cannot comply with, the fifth recommendation is that human and spiritual accompaniment for the patient must always be ensured. The attitude of listening together in discernment, and good advice, while never trying to force the person's conscience, can bring new hope that the patient may discover alternatives previously not contemplated. Again, consistent with Aquinas's understanding, the healthcare professional, caregiver, or chaplain must accompany the patient with prudence. Such accompaniment can be very demanding. Their Catholic conscience, when confronted with the request of a person whose suffering inspires compassion, may cause significant moral distress.

For this reason, the sixth recommendation is that "healthcare and assistance organizations must arrange for models of psychological and spiritual aid to healthcare workers who care for the terminally ill. To show care for those who care is essential so that healthcare workers and physicians do not bear all of the weight of the suffering and of the death of incurable patients."[311] This support for healthcare professionals and non-professional caregivers is essential to help

[311] Ibid.

them understand and live that "their own mission is a true vocation to accompany the mystery of life and grace in the painful and terminal stages of existence."[312]

Thus, we have presented some action guidance consistent with the values or principles of Catholic Social Teaching. This guidance does not mean giving rigid rules of obligatory compliance in every case of a patient with dementia, except for the essential prohibition of not carrying out the voluntary death of a patient. On the contrary, prudence should help discern how to proceed in each case, consistently placing the concrete person who suffers before us at the center of the decision. These recommendations seek to emphasize three aspects above all.

First, the patient with dementia is not isolated from her social circumstances, so Catholic institutions and healthcare professionals must strive to promote a culture of fraternity and social justice that does not incline disadvantaged people to final decisions they would not otherwise make. The preferential option for the poor is a mandate of Christ to his Church that must include the sick.

Second, commitment to the value of each person means advocating that decisions be made in true freedom, not with just the mere appearance of freedom. It is an imperative of prudence, given the medical data described, not to consider as free the decision of a patient who has dementia since their brain is already severely compromised.

Third, the Church, incarnate in her institutions and lay professionals, can never afford to abandon those in extreme suffering, even if they have made a decision that directly opposes Catholic ethics. In such a case, the human and spiritual accompaniment of all those involved becomes even more crucial, respecting each person while always seeking to maintain an attitude of listening, and human and spiritual accompaniment, so that there is always space for hope to spring.

[312] Ibid.

Conclusion

We must now recapitulate the information already presented and offer some conclusions. We have shown the growing global relevance of population aging. One of the consequences of this is the increase in age-related diseases, including dementia. This causes progressive physical and cognitive decline, frequently along with depression, which eventually leads patients to lose contact with their self-identity. For this reason, dementia is often considered a justification for the moral legitimacy and convenience of euthanasia. Appeals are made to the principle of autonomy, expressed in the right to decide about one's own death, and to the principle of beneficence, which would require ending extreme suffering by ending the patient's life if she so requests.

Given the arguments usually presented to support euthanasia, Catholic theology "can help forestall simplistic ethics. We can add caution where it is needed, saying that human persons are not that simple. There is a complexity in the human person that our fix-it society too often overlooks. There is a multidimensional beauty that we ignore at our peril. And, yes, there is sin and we ignore *it* at our peril, too. That, I think, is what Catholic theology does best in theological ethics. And it is an essential contribution."[313] We want to contribute to the debate by showing the complexity of human freedom, to reiterate our thesis. Once dementia has been diagnosed, the patient is no longer free to request euthanasia. The decision may appear to be an expression of autonomy, but actually, it is not. The principle of autonomy is not respected, nor is there any sense of beneficence.

To support this thesis, we presented Laín's understanding of the brain's functioning. We then presented his theory of the human project. This information enabled us to highlight two crucial points. First, the brain functions as a unity in its most complex operations. Any local damage

[313] Kelly, *Contemporary Catholic Health Care Ethics*, 47.

affects the whole structure. This unity of action is needed for higher thinking, which is required to set up a life project. Second, we defined freedom as a structural moment within the human project. To reach this point, people first need to have an appropriate idea of themselves and their world. These ideas will direct people's desires to their goal through their free decisions.

Here is where we see the constraint on the freedom of the dementia patient. As shown in chapter three, social injustice regarding healthcare access and other social resources leaves specific vulnerable people at a clear disadvantage. The limited idea that they can have of themselves and their world may incline them to request euthanasia when they develop dementia, which is not necessarily presented as an alternative to people from privileged communities. It is impossible to speak of beneficence without prior conditions of justice. In addition to this external conditioning factor, in the fourth chapter we considered the theology of Aquinas regarding the relationship between the intellect and the will. In the context of a teleological understanding of human life, we showed how this relationship is consistent with Laín's secular approach and supports the argument that the impairment of our intellect caused by dementia constrains human freedom. Therefore, it is impossible to appeal to the principle of autonomy because its intellectual conditions are not satisfied in such patients.

Throughout our work, we provided arguments more readily accepted for public debate in a strongly secularized society like Spain. For this reason, we deliberately avoided appealing to a metaphysical understanding of human dignity, even though we agree with it.

Catholic Social Teaching, emphasizing social justice, is widely valued for its defense of the most vulnerable population. We saw that healthcare access inequity predominantly affects the economically disadvantaged, immigrants, women, and LGBT people. Public opinion is increasingly aware and sensitive to the discrimination these people have historically suffered,

allowing the Church to assert its arguments against euthanasia in cases where dementia affects them.

Aquinas's understanding of the human will allowed us to understand that this will needs the intervention of the intellect to be oriented towards its ends. Thus, we showed that an intellect impaired by dementia necessarily implies a constraint on prudence, and therefore on our will and freedom.

Finally, we proposed some action guidance. We insisted on the need to avoid talking about such a complex issue based on abstract ideas but rather on the situation lived by the particular person in each case. Without ever consenting to the practice of euthanasia, it will therefore be essential to help promote a healthcare culture that seeks justice and in which people understand the importance of preparing advance directives while in the fullness of their faculties. Catholic institutions and professionals will be responsible for accompanying such people and helping them to discern, without violating their consciences, even if we disagree with the decisions eventually made.

Bibliography

Abdel-Rahman, Emaad M., ed. *Depression in the Elderly*. Psychology of emotions, motivations and actions. New York: Nova Science Publishers, 2012.

Aquinas, Thomas. *De Veritate*. Green Bay, WI: Aquinas Institute, 2020. https://www.aquinas.cc/la/la/~QDeVer.

———. *Summa Theologiae*. Green Bay, WI: Aquinas Institute, 2020. https://aquinas.cc.

Aragão, Alexandra, Sander Jacobs, and An Cliquet. "What's Law Got to Do with It? Why Environmental Justice Is Essential to Ecosystem Service Valuation." *Ecosystem Services* 22 (December 2016): 221–227. Accessed February 24, 2023. https://linkinghub.elsevier.com/retrieve/pii/S2212041616303369.

Aristotle. *The Nicomachean Ethics*. Edited by H. Rackham. Second edition. Loeb Classical Library 73. Cambridge, Massachusetts: Harvard University Press, 1934.

Arrazola-Vacas, M., J. de Hevia-Payá, and L. Rodríguez-Esteban. "¿Qué Factores Ayudan a Explicar la Satisfacción con la Atención Primaria en España?" *Revista de Calidad Asistencial* 30, no. 5 (September 2015): 226–236. Accessed March 14, 2023. https://linkinghub.elsevier.com/retrieve/pii/S1134282X15000858.

Bauerschmidt, Frederick Christian. *The Essential Summa Theologiae: A Reader and Commentary*. Second ed. Grand Rapids: Baker Academic, 2021.

Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. 7th ed. New York: Oxford University Press, 2013.

Bedau, Mark, and Paul Humphreys. *Emergence: Contemporary Readings in Philosophy and Science*. Cambridge, Mass.: MIT Press, 2008.

Beltrán-Sánchez, Hiram, Samuel H. Preston, and Vladimir Canudas-Romo. "An Integrated Approach to Cause-of-Death Analysis: Cause-Deleted Life Tables and Decompositions of Life Expectancy." *Demographic Research* 19 (July 25, 2008): 1323–1350. Accessed January 23, 2023. http://www.demographic-research.org/volumes/vol19/35/.

Benedict XVI. Encyclical on Christian Love *Deus Caritas Est*. (25 December 2005), at The Holy See, https://www.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est.html.

———. Encyclical on Integral Human Development in Charity and Truth *Caritas in Veritate* (29 June 2009), at The Holy See, https://www.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html.

———. Lecture at the University of Rome "La Sapienza" (17 January 2008). At The Holy See, 2008. https://www.vatican.va/content/benedict-xvi/en/speeches/2008/january/documents/hf_ben-xvi_spe_20080117_la-sapienza.html.

Beorlegui, Carlos. “Los Emergentismos Sistémicos: Un Modelo Fructífero para el Problema Mente-Cuerpo.” *Pensamiento* 62, no. 234 (2006): 391–439.

Bloom, David E., David Canning, and Alyssa Lubet. “Global Population Aging: Facts, Challenges, Solutions & Perspectives.” *Daedalus* 144, no. 2 (Spring 2015): 80–92.

Brown, Juliette. “Self and Identity over Time: Dementia.” *Journal of Evaluation in Clinical Practice* 23, no. 5 (October 2017): 1006–1012. Accessed January 25, 2023. https://onlinelibrary.wiley.com/doi/10.1111/jep.12643.

Bunge, Mario. *Matter and Mind: A Philosophical Inquiry*. Boston Studies in the Philosophy of Science v. 287. Dordrecht: Springer Verlag, 2010.

Busquet-Duran, Xavier, Eduard Moreno-Gabriel, Eva Maria Jiménez-Zafra, Magda Tura-Poma, Olga Bosch-DelaRosa, Anna Moragas-Roca, Susana Martin-Moreno, et al. “Gender and Observed Complexity in Palliative Home Care: A Prospective Multicentre Study Using the HexCom Model.” *International Journal of Environmental Research and Public Health* 18, no. 23 (November 23, 2021): 12307. Accessed March 14, 2023. https://www.mdpi.com/1660-4601/18/23/12307.

Buzsáki, György. *Rhythms of the Brain*. New York: Oxford University Press, 2006.

Cheng, Xunjie, Yang Yang, David C. Schwebel, Zuyun Liu, Li Li, Peixia Cheng, Peishan Ning, and Guoqing Hu. “Population Ageing and Mortality during 1990–2017: A Global Decomposition Analysis.” Edited by Sanjay Basu. *PLOS Medicine* 17, no. 6 (June 8, 2020): e1003138. Accessed January 23, 2023. https://dx.plos.org/10.1371/journal.pmed.1003138.

Committee on the Decadal Survey of Behavioral and Social Science Research on Alzheimer’s Disease and Alzheimer’s Disease-Related Dementias, Board on Behavioral, Cognitive, and Sensory Sciences, Division of Behavioral and Social Sciences and Education, and National Academies of Sciences, Engineering, and Medicine. *Reducing the Impact of Dementia in America: A Decadal Survey of the Behavioral and Social Sciences*. Washington, D.C.: National Academies Press, 2021. Accessed February 20, 2023. https://www.nap.edu/catalog/26175.

Conferencia Episcopal Española. “Sembradores de Esperanza. Acoger, Proteger y Acompañar en la Etapa Final de esta Vida.” CEE, November 1, 2019. https://www.conferenciaepiscopal.es/wp-content/uploads/2020/02/2019-Familia-Vida-Sembradores-esperanza.pdf.

Congregation for the Doctrine of the Faith. *Letter on the Care of Persons in the Critical and Terminal Phases of Life Samaritanus Bonus*. Rome, 2020. https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2020/09/22/200922a.html.

Cylus, Jonathan, Gemma Williams, Charles Normand, and Josep Figueras. “Economic, Fiscal, and Societal Consequences of Population Aging – Looming Catastrophe or Fake News?”

Croatian Medical Journal 61, no. 2 (April 2020): 189–192. Accessed January 23, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7230429/.

Daly, Daniel J. *The Structures of Virtue and Vice*. Moral Traditions. Washington: Georgetown University Press, 2021.

Danesi, Marcel. *Forever Young: The "Teen-Aging" of Modern Culture*. Toronto: University of Toronto Press, 2003.

Draper, Brian. *Understanding Alzheimer's Disease and Other Dementias*. London: Jessica Kingsley Publishers, 2013.

Emery, V. Olga B., and Thomas E. Oxman, eds. *Dementia: Presentations, Differential Diagnosis, and Nosology*. 2nd ed. Baltimore: Johns Hopkins University Press, 2003.

Evenblij, Kirsten, H. Roeline W. Pasman, Agnes van der Heide, Trynke Hoekstra, and Bregje D. Onwuteaka-Philipsen. "Factors Associated with Requesting and Receiving Euthanasia: A Nationwide Mortality Follow-Back Study with a Focus on Patients with Psychiatric Disorders, Dementia, or an Accumulation of Health Problems Related to Old Age." *BMC Medicine* 17, no. 1 (December 2019): 39. Accessed January 25, 2023. https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1276-y.

Fellows, Lesley K. "Deciding How to Decide: Ventromedial Frontal Lobe Damage Affects Information Acquisition in Multi-Attribute Decision Making." *Brain* 129, no. 4 (April 1, 2006): 944–952. Accessed February 16, 2023. http://academic.oup.com/brain/article/129/4/944/371178/Deciding-how-to-decide-ventromedial-frontal-lobe.

Flatt, Michael A., Richard A. Settersten, Roselle Ponsaran, and Jennifer R. Fishman. "Are 'Anti-Aging Medicine' and 'Successful Aging' Two Sides of the Same Coin? Views of Anti-Aging Practitioners." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 68, no. 6 (November 1, 2013): 944–955. Accessed January 23, 2023. https://academic.oup.com/psychsocgerontology/article-lookup/doi/10.1093/geronb/gbt086.

Francis. Encyclical Letter on Fraternity and Social Friendship *Fratelli Tutti* (3 October 2020), at The Holy See, https://www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20201003_enciclica-fratelli-tutti.html.

———. Message to the Participants in the 32nd International Conference on the Theme: "Addressing Global Health Inequalities" (18 November 2017). At The Holy See, https://www.vatican.va/content/francesco/en/messages/pont-messages/2017/documents/papa-francesco_20171118_conferenza-disparita-salute.html.

Fredriksen-Goldsen, Karen I., Sarah Jen, Amanda E. B. Bryan, and Jayn Goldsen. "Cognitive Impairment, Alzheimer's Disease, and Other Dementias in the Lives of Lesbian, Gay, Bisexual and Transgender (LGBT) Older Adults and Their Caregivers: Needs and Competencies." *Journal of Applied Gerontology* 37, no. 5 (May 2018): 545–569. Accessed March 14, 2023. http://journals.sagepub.com/doi/10.1177/0733464816672047.

Freeman, John Mark, and Kevin McDonnell. *Tough Decisions: Cases in Medical Ethics*. 2nd ed. Oxford; New York: Oxford University Press, 2001.

Fuster, Valentin. "Changing Demographics." *Journal of the American College of Cardiology* 69, no. 24 (June 2017): 3002–3005. Accessed January 23, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0735109717373278.

García-Valiño Abós, Javier. "La Voluntad Humana En Tomás de Aquino. Un Estudio Desde Sus Fuentes Griegas, Patrísticas y Escolásticas." PhD Dissertation, Universidad de Málaga, 2010. http://hdl.handle.net/10630/4983.

Goic, Alejandro. "Pedro Laín Entralgo, Physician and Humanist." *Revista Médica de Chile* 130, no. 1 (January 2002): 101–106.

Gratsch, Edward J. *Aquinas' Summa: An Introduction and Interpretation*. New York: Alba House, 1985.

Groenewoud, Antonie Stef, Femke Atsma, Mina Arvin, Gert P Westert, and Theo A Boer. "Euthanasia in the Netherlands: A Claims Data Cross-Sectional Study of Geographical Variation." *BMJ Supportive & Palliative Care* 0 (January 14, 2021): 1–11. Accessed January 20, 2023. https://spcare.bmj.com/lookup/doi/10.1136/bmjspcare-2020-002573.

Groenewoud, Antonie Stef, Ellen Leijten, Sterre van den Oever, Julia van Sommeren, and Theodoor Adriaan Boer. "The Ethics of Euthanasia in Dementia: A Qualitative Content Analysis of Case Summaries (2012–2020)." *Journal of the American Geriatrics Society* 70, no. 6 (June 2022): 1704–1716. Accessed January 20, 2023. https://onlinelibrary.wiley.com/doi/10.1111/jgs.17707.

Hause, Jeffrey, ed. *Aquinas's: Summa Theologiae, A Critical Guide*. Cambridge Critical Guides. New York: Cambridge University Press, 2018.

Holmes, Clive, and Jay Amin. "Dementia." *Medicine* 48, no. 11 (November 2020): 742–745. Accessed January 26, 2023. https://linkinghub.elsevier.com/retrieve/pii/S1357303920302073.

Jakhar, Jitender, Saaniya Ambreen, and Shiv Prasad. "Right to Life or Right to Die in Advanced Dementia: Physician-Assisted Dying." *Frontiers in Psychiatry* 11 (January 21, 2021): 622446. Accessed November 6, 2022. https://www.frontiersin.org/articles/10.3389/fpsyt.2020.622446/full.

John Paul II. Encyclical on the Hundreth Anniversary of Rerum Novarum *Centesimus Annus* (1 May 1991), at The Holy See, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus.html.

———. Encyclical on the Value and Inviolability of Human Life *Evangelium Vitae* (25 March 1995), at The Holy See, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.

John XXIII. Encyclical on Christianity and Social Progress *Mater et Magistra* (15 May 1961), at The Holy See, https://www.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xxiii_enc_15051961_mater.html.

Johnson, Kimberly S. "Racial and Ethnic Disparities in Palliative Care." *Journal of Palliative Medicine* 16, no. 11 (November 2013): 1329–1334. Accessed March 14, 2023. http://www.liebertpub.com/doi/10.1089/jpm.2013.9468.

Jordan, Mark D. "The Good That Draws the Will." In *Teaching Bodies: Moral Formation in the Summa of Thomas Aquinas*, 105–120. New York: Fordham University Press, 2017. Accessed May 12, 2022. http://www.jstor.org/stable/j.ctt1g2kn06.14.

Kaczor, Christopher. *Disputes in Bioethics: Abortion, Euthanasia, and Other Controversies*. Notre Dame Studies in Medical Ethics. Notre Dame, IN: University of Notre Dame Press, 2020.

Keane, Philip S. *Catholicism and Health-Care Justice: Problems, Potential, and Solutions*. New York: Paulist Press, 2002.

Keenan, James. "Casuistry, Virtue, and the Slippery Slope: Major Problems with Producing Human Embryonic Life for Research Purposes." In *Cloning and the Future of Human Embryo Research*, edited by Paul Lauritzen, 67–81. Oxford; New York: Oxford University Press, 2001.

———. *Goodness and Rightness in Thomas Aquinas's Summa Theologiae*. Washington, D.C: Georgetown University Press, 1992.

Kelly, David F. *Contemporary Catholic Health Care Ethics*. Washington, D.C: Georgetown University Press, 2004.

Kilner, John Frederic, C. Christopher Hook, and Diane B. Uustal, eds. *Cutting-Edge Bioethics: A Christian Exploration of Technologies And Trends*. A Horizon in Bioethics Series Book. Grand Rapids, MI: W.B. Eerdmans Pub. Co., 2002.

Kim, Andrew. "Progress in the Good: A Defense of the Thomistic Unity Thesis." *Journal of Moral Theology* 3, no. 1 (2014): 147–174. https://jmt.scholasticahq.com/api/v1/articles/11288-progress-in-the-good-a-defense-of-the-thomistic-unity-thesis.pdf.

Knell, Matthew. "Thomas Aquinas on Free Will." In *Sin, Grace and Free Will - Vol. 2: A Historical Survey of Christian Thought*, 2: From Anselm to the Reformation:158–79. 1st ed. Cambridge: James Clarke & Co, 2018. http://www.jstor.org/stable/10.2307/j.ctvhrd1q9.

Knopman, David S., Helene Amieva, Ronald C. Petersen, Gäel Chételat, David M. Holtzman, Bradley T. Hyman, Ralph A. Nixon, and David T. Jones. "Alzheimer Disease." *Nature Reviews Disease Primers* 7, no. 1 (May 13, 2021): 33. Accessed January 27, 2023. https://www.nature.com/articles/s41572-021-00269-y.

Laín Entralgo, Pedro. *Alma, Cuerpo, Persona*. 1st ed. Barcelona: Galaxia Gutenberg - Círculo de Lectores, 1995.

———. *Antropología Médica para Clínicos*. 1st ed. Barcelona: Salvat, 1984.

———. *Cuerpo y Alma: Estructura Dinámica del Cuerpo Humano*. Madrid: Espasa Calpe, 1991.

———. *El Cuerpo Humano: Teoría Actual*. Madrid: Espasa Calpe, 1989.

———. *Idea Del Hombre*. 1st ed. Barcelona: Galaxia Gutenberg - Círculo de Lectores, 1996.

———. *Qué Es el Hombre: Evolución y Sentido de la Vida*. Colección Jovellanos de Ensayo 17. Oviedo: Ediciones Nobel, 1999.

———. *Ser y Conducta del Hombre*. Madrid: Espasa Calpe, 1996.

Larson, Eric B., Kristine Yaffe, and Kenneth M. Langa. "New Insights into the Dementia Epidemic." *New England Journal of Medicine* 369, no. 24 (December 12, 2013): 2275–2277. Accessed January 21, 2023. http://www.nejm.org/doi/10.1056/NEJMp1311405.

Lawson, David W., Alexandra Alvergne, and Mhairi A. Gibson. "The Life-History Trade-Off between Fertility and Child Survival." *Proceedings of the Royal Society B: Biological Sciences* 279, no. 1748 (December 7, 2012): 4755–4764. Accessed February 14, 2023. https://royalsocietypublishing.org/doi/10.1098/rspb.2012.1635.

Lee, Ronald, and Andrew Mason. "Some Macroeconomic Aspects of Global Population Aging." *Demography* 47, no. Suppl 1 (March 1, 2010): 151–172. Accessed January 23, 2023. https://read.dukeupress.edu/demography/article/47/Suppl%201/S151/169922/Some-macroeconomic-aspects-of-global-population.

Ley Orgánica de Regulación de la Eutanasia. *Boletín Oficial Del Estado*. Vol. 72, 2021. https://www.boe.es/eli/es/lo/2021/03/24/3.

Lutz, Wolfgang. "The Demography of Future Global Population Aging: Indicators, Uncertainty, and Educational Composition." *Population and Development Review* 35, no. 2 (June 2009): 357–365. Accessed January 23, 2023. https://onlinelibrary.wiley.com/doi/10.1111/j.1728-4457.2009.00282.x.

Lutz, Wolfgang, Warren Sanderson, and Sergei Scherbov. "The Coming Acceleration of Global Population Ageing." *Nature* 451, no. 7179 (February 2008): 716–719. Accessed January 21, 2023. http://www.nature.com/articles/nature06516.

Lysaught, M. Therese, ed. *On Moral Medicine: Theological Perspectives in Medical Ethics*. 3rd ed. Grand Rapids, MI: W.B. Eerdmans Pub. Co., 2012.

Machón, Mónica, Isabel Mosquera, Isabel Larrañaga, Unai Martín, and Itziar Vergara. "Desigualdades Socioeconómicas en la Salud de la Población Mayor en España." *Gaceta Sanitaria* 34, no. 3 (May 2020): 276–288. Accessed March 15, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0213911119301785.

Mangino, Dominic R., Marie E. Nicolini, Raymond G. De Vries, and Scott Y.H. Kim. "Euthanasia and Assisted Suicide of Persons With Dementia in the Netherlands." *The American Journal of Geriatric Psychiatry* 28, no. 4 (April 2020): 466–477. Accessed January 29, 2023. https://linkinghub.elsevier.com/retrieve/pii/S1064748119304889.

Marijnissen, Radboud M., Kenneth Chambaere, and Richard C. Oude Voshaar. "Euthanasia in Dementia: A Narrative Review of Legislation and Practices in the Netherlands and Belgium." *Frontiers in Psychiatry* 13 (June 2, 2022): 857131. Accessed April 10, 2023. https://www.frontiersin.org/articles/10.3389/fpsyt.2022.857131/full.

Mathers, Colin D, Gretchen A Stevens, Ties Boerma, Richard A White, and Martin I Tobias. "Causes of International Increases in Older Age Life Expectancy." *The Lancet* 385, no. 9967 (February 2015): 540–548. Accessed January 21, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0140673614605699.

Mathys, Christoph, Psyche Loui, Xin Zheng, and Gottfried Schlaug. "Non-Invasive Brain Stimulation Applied to Heschl's Gyrus Modulates Pitch Discrimination." *Frontiers in Psychology* 1 (2010): 1–7. Accessed February 27, 2023. http://journal.frontiersin.org/article/10.3389/fpsyg.2010.00193/abstract.

McKhann, Guy M., David S. Knopman, Howard Chertkow, Bradley T. Hyman, Clifford R. Jack, Claudia H. Kawas, William E. Klunk, et al. "The Diagnosis of Dementia Due to Alzheimer's Disease: Recommendations from the National Institute on Aging-Alzheimer's Association Workgroups on Diagnostic Guidelines for Alzheimer's Disease." *Alzheimer's & Dementia* 7, no. 3 (May 2011): 263–269. Accessed January 28, 2023. https://onlinelibrary.wiley.com/doi/10.1016/j.jalz.2011.03.005.

Mendez, Mario F., Jeffrey L. Cummings, and Jeffrey L. Cummings. *Dementia: A Clinical Approach*. 3rd ed. Philadelphia, PA: Butterworth-Heinemann, 2003.

Peña González, José, and Antonio Piñas Mesa, eds. *La Antropología Médica de Pedro Laín Entralgo*. Madrid: CEU Ediciones, 2014.

Pontifical Council for Justice and Peace. *Compendium of the Social Doctrine of the Church*. Vatican City, 2005. https://www.vatican.va/roman_curia/pontifical_councils/justpeace/documents/rc_pc_justpeace_doc_20060526_compendio-dott-soc_en.html#Social%20doctrine,%20evangelization%20and%20human%20promotion.

Pope, Stephen J., ed. *The Ethics of Aquinas*. Moral Traditions Series. Washington, D.C: Georgetown University Press, 2002.

Rabanaque Mallén, Gloria, Sandra Robles Pellitero, Adoración Borrell Gascón, and Nuria Orozco Mossi. "Actitud de los Médicos de Familia ante los Cuidados Paliativos en Zonas Rurales sin Cobertura de Unidad de Hospitalización a Domicilio." *Medicina Paliativa* 25, no. 2 (April 2018): 95–104. Accessed March 14, 2023. https://linkinghub.elsevier.com/retrieve/pii/S1134248X17300848.

Reis, Rogério Donizeti, Ana Maria Garcia Andrade, José Vitor da Silva, and Grupo de Estudo e Pesquisa em Cuidados Paliativos e Luto Gepecel. "Cuidados Paliativos a Pessoa Idosa Com Demência: Sentimentos Emergentes Com Reflexões Bioéticas." *Revista Iberoamericana de Bioética*, no. 12 (February 27, 2020): 01–11. Accessed March 14, 2023. https://revistas.comillas.edu/index.php/bioetica-revista-iberoamericana/article/view/12091.

Robine, Jean-Marie, and Sarah Cubaynes. "Worldwide Demography of Centenarians." *Mechanisms of Ageing and Development* 165 (July 2017): 59–67. Accessed January 23, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0047637416302548.

Rodríguez-Leyva, Ildefonso, José Eduardo Oliva-Barrios, Santiago Cueli-Barcena, Juan Carrizales-Rodríguez, Erika Chi-Ahumada, and María E. Jiménez-Capdeville. "Demencia Frontotemporal: Revisión y Nuestro Punto de Vista." *Revista Mexicana de Neurociencia* 19, no. 6 (October 22, 2019): 1637. Accessed February 16, 2023. http://www.revmexneurociencia.com/frame_esp.php?id=16.

Rojas C., Gonzalo, David Ladrón de Guevara, Rodrigo Jaimovich F., Enzo Brunetti, Evelyng Faure L., and Marcelo Gálvez M. "Neuroimágenes en Demencias." *Revista Médica Clínica Las Condes* 27, no. 3 (May 2016): 338–356. Accessed January 28, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0716864016300359.

Rubiera López, G., and J.R Riera Velasco. "Programa para Mejorar la Atención de las Enfermedades Crónicas. Aplicación del Modelo de Cuidados para Enfermedades Crónicas." *Atención Primaria* 34, no. 4 (2004): 206–209. Accessed March 15, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0212656704789106.

Sagbakken, Mette, Ragnhild Storstein Spilker, and T. Rune Nielsen. "Dementia and Immigrant Groups: A Qualitative Study of Challenges Related to Identifying, Assessing, and Diagnosing Dementia." *BMC Health Services Research* 18, no. 1 (December 2018): 910. Accessed March 14, 2023. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3720-7.

Sawyer, Douglas M., John R. Williams, and Frederick Lowy. "Canadian Physicians and Euthanasia: 2. Definitions and Distinctions." *Canadian Medical Association Journal (CMAJ)* 148, no. 9 (1993): 1463–66.

Steck, Nicole, Matthias Egger, Maud Maessen, Thomas Reisch, and Marcel Zwahlen. "Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review." *Medical Care* 51, no. 10 (October 2013): 938–944. Accessed January 25, 2023. https://journals.lww.com/00005650-201310000-00012.

Stump, Eleonore. "Aquinas's Account of Freedom: Intellect and Will." *The Monist* 80, no. 4 (1997): 576–597. http://www.jstor.org/stable/27903551.

Sudore, Rebecca L., Kala M. Mehta, Eleanor M. Simonsick, Tamara B. Harris, Anne B. Newman, Suzanne Satterfield, Caterina Rosano, et al. "Limited Literacy in Older People and Disparities in Health and Healthcare Access." *Journal of the American Geriatrics*

Society 54, no. 5 (May 2006): 770–776. Accessed March 15, 2023. https://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2006.00691.x.

Sulmasy, Daniel P. "The Varieties of Human Dignity: A Logical and Conceptual Analysis." *Medicine, Health Care and Philosophy* 16, no. 4 (November 2013): 937–944. Accessed April 11, 2023. http://link.springer.com/10.1007/s11019-012-9400-1.

Sun, Miao-Kun, ed. *Research Progress in Alzheimer's Disease and Dementia*. Vol. 4. New York: Nova Biomedical, Nova Science Publishers, 2007.

Taylor, Morag E., and Jacqueline C.T. Close. "Dementia." In *Handbook of Clinical Neurology*, 159:303–321. Elsevier, 2018. Accessed January 27, 2023. https://linkinghub.elsevier.com/retrieve/pii/B9780444639165000197.

Terry, Peter B. "Euthanasia and Assisted Suicide." *Mayo Clinic Proceedings* 70, no. 2 (February 1995): 189–192. Accessed January 24, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0025619611642894.

Tham, Joseph, Alberto Garcia, and Gonzalo Miranda, eds. *Religious Perspectives on Human Vulnerability in Bioethics*. Advancing Global Bioethics. New York: Springer, 2014.

Thiede, Brian C., David L. Brown, Scott R. Sanders, Nina Glasgow, and Laszlo J. Kulcsar. "A Demographic Deficit? Local Population Aging and Access to Services in Rural America, 1990-2010: A Demographic Deficit? Local Population Aging." *Rural Sociology* 82, no. 1 (March 2017): 44–74. Accessed January 23, 2023. https://onlinelibrary.wiley.com/doi/10.1111/ruso.12117.

Thimm, Markus, Ralph Weidner, Gereon R. Fink, and Walter Sturm. "Neural Mechanisms Underlying Freedom to Choose an Object." *Human Brain Mapping* 33, no. 11 (November 2012): 2686–2693. Accessed February 15, 2023. https://onlinelibrary.wiley.com/doi/10.1002/hbm.21393.

Torre Díaz, Javier de la. "Eutanasia: Los Factores Sociales Del Deseo de Morir." *Revista Iberoamericana de Bioética*, no. 11 (October 28, 2019): 1–23. Accessed March 14, 2023. https://revistas.comillas.edu/index.php/bioetica-revista-iberoamericana/article/view/11599.

Torrell, Jean-Pierre. *Aquinas's Summa: Background, Structure, and Reception*. 1st ed. Washington, D.C: Catholic University of America Press, 2005. https://www.jstor.org/stable/10.2307/j.ctt284xr1.

Tulloch, Gail. *Euthanasia, Choice and Death*. Contemporary ethical debates. Edinburgh: Edinburgh University Press, 2005.

United States Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Care Services*. 6th ed. Washington, DC: United States Conference of Catholic Bishops, 2018. https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf.

Van Horn, John Darrell, Andrei Irimia, Carinna M. Torgerson, Micah C. Chambers, Ron Kikinis, and Arthur W. Toga. "Mapping Connectivity Damage in the Case of Phineas Gage." Edited by Olaf Sporns. *PLoS ONE* 7, no. 5 (May 16, 2012): e37454. Accessed February 16, 2023. https://dx.plos.org/10.1371/journal.pone.0037454.

Vatican Council II. Pastoral Constitution on the Church in the Modern World *Gaudium et Spes*. 7 December 1965. At The Holy See. https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.

Vaughn, Lewis. *Bioethics: Principles, Issues, and Cases*. 2nd ed. New York: Oxford University Press, 2013.

Velasco Bernal, Carmen, and Jose Maria Trejo-Gabriel-Galan. "Leyes de Eutanasia en España y en el Mundo: Aspectos Médicos." *Atención Primaria* 54, no. 1 (January 2022): 102170. Accessed January 29, 2023. https://linkinghub.elsevier.com/retrieve/pii/S0212656721002043.

de Wachter, Maurice A. M. "Euthanasia in the Netherlands." *The Hastings Center Report* 22, no. 2 (March 1992): 23. Accessed January 24, 2023. https://www.jstor.org/stable/3562561?origin=crossref.

Wagar, Brandon M., and Paul Thagard. "Spiking Phineas Gage: A Neurocomputational Theory of Cognitive-Affective Integration in Decision Making." *Psychological Review* 111, no. 1 (2004): 67–79. Accessed February 16, 2023. http://doi.apa.org/getdoi.cfm?doi=10.1037/0033-295X.111.1.67.

Wagstaff, Adam. "Poverty and Health Sector Inequalities." *Bulletin of the World Health Organization* 80, no. 2 (2002): 97–105.

Williams, Thomas, and Christina Van Dyke. *The Treatise on Happiness: The Treatise on Human Acts: Summa Theologiae I-II 1/21*. Indianapolis ; Cambridge: Hackett Publishing Company, Inc, 2016.

World Health Organization. "Ageing and Health." www.who.int, October 1, 2022. Accessed October 1, 2022. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.

———. "Dementia: Number of People Affected to Triple in Next 30 Years." *Www.Who.Int*, December 7, 2017. Accessed October 1, 2022. https://www.who.int/news/item/07-12-2017dementia-number-of-people-affected-to-triple-in-next-30-years.

Yashin, Anatoliy I., Kenneth C. Land, and Eric Stallard. *Biodemography of Aging: Determinants of Healthy Life Span and Longevity*. 1st ed. 2016. The Springer Series on Demographic Methods and Population Analysis 40. Dordrecht: Springer Netherlands : Imprint: Springer, 2016.