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APA NEWSLETTER ON

Philosophy and Medicine

MARY RORTY AND MARK SHELDON, EDITORS

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FROM THE EDITORS

Mary Rorty

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Mark Sheldon

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This issue continues the discussion, begun at the Pacific Division's Seattle meeting last spring, on health care for prisoners. However, the first paper, by Anita Silvers, "Beyond Prison Walls: Curtailed Liberty, Custodial Responsibility, and Institutional Health Care," moves that discussion into a larger sphere, and it is here that she recounts her own very painful and moving experience as an institutionalized child. Moving this discussion into a larger sphere, considering other institutionalized persons and health care, makes clear that an institutional setting poses very serious challenges independent of whether the institution is a prison. The issue is "depersonalizing treatment," where the issue is not the challenge of serving "two masters" but of maintaining "empathy and moral sensibility."

Andrea Pitts, in "Cruel and Unusual Care and Punishment: Epistemic Injustices in Correctional Health Care," continues the focus on prison health care, and puts forward the idea that "hermeneutical injustice occurs when a collective gap in knowledge unfairly deprives an individual of an ability to make sense of her/his own experiences." Her ultimate claim is that prisoners, given their lack of information and inability to access critical information pertaining to their treatment, and the way the Eighth Amendment of the U.S. Constitution is interpreted by the majority of Supreme Court justices, puts them in the position of being unable legally to deal with possible harms. Daniel Brunson, in his response to Pitts, makes two points. First, he is not convinced that the gap between ordinary citizens and incarcerated citizens is as great as it first appears. Second, though, the issue of the Eighth Amendment, as it impacts prisoners, may require special attention.

In "Making Fetal Persons: Fetal Homicide, Ultrasound, and the Normative Significance of Birth," Catherine Mills explores the role that fetal ultrasound has played in relation to the question of when, under law, personhood can be established. She reviews the way in which pro-life individuals have tried to use it, and she also reviews the feminist literature that suggests that an ultrasound does not "reveal" persons but, in some sense, "produces" them.

Two papers from ASBH come next. Barbara Stock, in "Relational Autonomy: From Critique to Action," explores the question of whether "relational autonomy" might be a way to provide greater power and autonomy to individuals not usually perceived as able to exercise autonomy. In "Vaccines: Parental Autonomy, Moral Choices, and Public Argument," Ana S. Iltis makes explicit what it means, on many levels, when parents refuse vaccines and seek exemptions for their children.

Finally, included in this issue are a poem by Felicia Nimue Ackerman and a brief piece by David Chambers on the question of tension between theory and experience.

FROM THE CHAIR

2014-2015: Forthcoming APA Panels on Philosophy and Medicine

Nir Eyal

HARVARD UNIVERSITY

This academic year, the APA Committee on Philosophy and Medicine is involved in four promising panels in the forthcoming divisional meetings.

Our panel at the Eastern APA meeting is on "Child Euthanasia," and was put together by Sarah Conly, from Bowdoin College (department of philosophy). In the wake of the recent Belgian law allowing euthanasia for minors, the panel will ask whether euthanasia should be practiced on minors, addressing both the moral permissibility and the practical aspects of child euthanasia. David Wendler, a philosopher from the National Institutes of Health (bioethics), will present "The Practice and Policy of Pediatric Euthanasia." Dominic Sisti from the University of Pennsylvania (medical ethics and health policy) will discuss "Nascent Values, Questionable Capacity, and Dying Well: Pediatric Euthanasia in Belgium and Beyond." Luc Bovens from the London School of Economics (philosophy) will talk on "Child Euthanasia: Should We Just Not Talk about It?"

One of our two Central Division meeting panels, "Long-Term Care for the Elderly," is co-sponsored both by the Committee on the Status of Women and by the International Network on Feminist Approaches to Bioethics. This panel addresses the challenge of aging populations around the world and the growing need for long-term caretakers. Who should take care of the old? The panel, put together by Rosie Tong, from the University of North Carolina-Charlotte, will feature

Lisa Eckenwiler, from George Mason University (health administration and policy), who will discuss “Long-Term Care, Global Markets, and the Ethics of Dis-placement”; Eva Kittay, from SUNY–Stony Brook (philosophy), who will talk on “Long-Term Care and the Problem of Patient Autonomy”; Jeremy Snyder, from Simon Fraser (health sciences), who will discuss “Can We Care for the Elderly without Worsening Global Inequity? The Case of Nurse Migration from the Caribbean”; and Hilde Lindemann, of the University of Michigan East Lansing (philosophy), who will present “Families and Professionals: Who Is Responsible?”

Another panel at the Central Division meeting is entitled “Moral Enhancement: A Critical Assessment,” and it was convened by Fabrice Jotterand from Regis University (health care ethics). This panel will first clarify what “moral enhancement” means and describe relevant developments in neuroscience. It will then tackle questions about the philosophical and ethical implications of moral enhancement. James Giordano, from Georgetown University (neuroethics and neurology) will present “Cognitive and Moral Enhancement: Realities, Risks, and Opportunities.” Walter Glannon, from the University of Calgary (philosophy), will speak on “Motivating People to Act Morally.” Nicole Vincent, from Georgia State University (philosophy), will discuss “Moral Enhancement: 60 Years On.” Finally, Veljko Dubljevic, from McGill University (neuroethics, and neurology and neurosurgery), will present “Implications of the ADC Model Judgment for the Theoretical Feasibility of Moral Enhancement.” (Prior knowledge of neuroscience is *not* required.)

Finally, at the Pacific Division meeting, Johann Frick from Princeton University (philosophy and Center for Human Values) is planning a panel on “Justice and Risk-Distribution.” Panelists may cover the conditions that make the imposition of risk permissible, the use of lotteries in the allocation of scarce health resources, risk-concentration in the choice between treatment and prevention in public health and social policy, the moral significance of epistemic versus objective chance in reasoning about risk, and hypothetical versus natural veils of ignorance. The panelists are Rahul Kumar from Queens University (philosophy), who will present “What We Owe to (Statistical) Others”; John Oberdiek from Rutgers University (law), who will discuss “Risk and the Distribution of Options”; Colleen Murphy from the University of Illinois at Urbana-Champaign (philosophy), and Paul Kelleher from the University of Wisconsin–Madison (bioethics), who will speak on “Risk and the Distribution of Options.” We hope that you will join us for some of these events.

The committee bids a fond farewell to Peter Schwartz, Miriam Solomon, and Rosie Tong, whose terms have ended. Thanks for your hard work, Peter, Miriam, and Rosie!

ARTICLES

Beyond Prison Walls: Curtailed Liberty, Custodial Responsibility, and Institutional Health Care

Anita Silvers

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INTRODUCTION

Reading Ken Kipnis’s “Social Justice and Correctional Health Services” drew me back into fear-filled recollection of a phase of my own early life.¹ So from personal memory I can confirm the accuracy of Kipnis’s portrayal of being punished by imprisonment. His characterization of the prevailing quality of that experience—namely, that it is a feeling of the palpable closing off of most familiar elements of social life—is astute and accurate.

Though no child convict, I nevertheless was an incarcerated child, subordinated in ways that left me indelibly untrusting of medicine practiced in an institutionalized setting. Despite never having been within the walls of a correctional institution, I can offer first-person testimony about experiencing incarceration because I too have been institutionalized. Of course, crippled children and criminals differ in important ways. In regard to their being wronged by health-care injustice when institutionalized, however, they are similarly situated, or at least were so back in the not so distant day when social policy preferred that disabled people be separated from the community.

In what follows I will explain what youngsters sent away to a crippled children’s hospital ward suffered in common with lawbreakers who are sent off to jail. This insight will warrant taking a second look at Kipnis’s diagnosis and prescription for righting conspicuous wrongs in correctional health services. His account, I shall contend, does not adequately identify the source accountable for the problematic maintenance of prisoners’ health.

KIPNIS ON CONVICTS

Prisoners excepted, most people in our society are permitted to eat when they are hungry and not expected to eat when they are not; for most of us, at any hour, access at least to snacks abounds. As for access to learning, has a desire for information ever arisen to plague you in the middle of the night? Reach for your laptop, activate a browser’s search function, and Google delivers the answer without your having to leave your bed. Feeling abandoned? Reach out through social media or, for the older generation who prefer their recreation to be less virtual, join the boys drinking at the local bar. Feeling crowded? You can distance yourself from teeming throngs or jam-packed places by proceeding to an isolated venue where you can be alone.

All these basic activities are readily at hand for, and can be executed at will by, people who are free. Prisoners are deprived of them except under narrowly restricted, strictly regimented, and what are likely to be uncomfortable

and unpropitious conditions. In sum, imprisonment is punishing because people's liberty to launch, at will, basic daily activities of body and mind such as those by which we nourish ourselves, construct our understanding of the world, and affiliate with others for companionship and collaborative enterprise is extinguished, at least to the extent that the correctional institution's managers can maintain control.

This is not to say that people at liberty to pursue these basic goals always succeed in achieving them. Or that individuals' freedom to pursue their goals offers equitable access to all means or to the best means or even to at least some minimally effective means of doing so. But those of us not experiencing imprisonment usually do not feel bereft of all freedom to try for them.

In contrast, a distinctive element of the imprisoned life is the stripping away of ordinary opportunity because the execution of familiar daily activities is stringently regulated, and familiar routes to achieve common personal and interpersonal comforts are barred. Thus, feelings of frustration and abandonment, fear, loss, and distress characteristically pervade the experience of being imprisoned. The effect, Kipnis observes, is a relationship between the system's managers and those they manage that presumes the latter's proclivity to defy the former's authority, and presumes as well the former's attentiveness to imposing authority nonetheless. These elements of social relations in prisons, he adds, "betoken an absence of trust."²

Kipnis finds this setting for the delivery of health services "remarkable."³ I do not believe, however, that normative aspects of this setting crucial for his argument are unique. Correctional institutions are not the only location where individuals needing health care experience such feelings of imprisonment. Nor are they the only setting in which lack of freedom extinguishes trust in the responsible provision of health care.

KIPNIS ON CUSTODIAL CARE

Two cases serve Kipnis to introduce the main issue, which is to lay responsibility for the provision to prisoners of health care of community standard quality.⁴ In one, the prison physician—a pathologist—stopped most of the long-time medication for a prisoner charged with stealing skis and a broom from his ex-wife's house needed to control his Parkinson's symptoms. The prisoner's stiffness became more and more profound; the institution's nurses dismissed his inability to move as malingering. Ten days later, finally hospitalized, he died, an outcome attributed by the acute care physician to the discontinuation of his medication. In the second case, a woman charged with smuggling drugs to her jailed husband and therefore jailed herself, complained of cardiac symptoms, which the prison nurse dismissed until the woman collapsed and died of a heart attack.⁵

Had these individuals not been incarcerated, the overwhelming evidence is that the first would have continued his Parkinson's medication and the second would have gone to an emergency room. They would have

been free to make the kinds of market arrangements by which most of the U.S. population secures health care, or to have made contact with emergency health-care facilities which are maintained for the general population's good. But they could not because the state had stripped them of their liberty.

By so doing, however, the state acquires responsibility to provide them with certain necessities, the deprivation of which would escalate harm to them far beyond what has been meted out as punishment. In other words, the source of prisoners' claims against the state for health care is the very circumstance that makes them unable to pursue it on their own, namely, the state's confiscation of their liberty. To delineate the circumstances in which medical professionals who are employed by correctional institutions must work, and to focus on a remedy responsive to his concerns about their role and concomitant responsibilities, Kipnis stipulates that each prospective recipient of the treatment is "properly convicted of serious wrongdoings or was being properly held pending definitive adjudication of charges thereof," which for purposes of his discussion legitimates curtailment of liberty and permits punishment by incarceration.⁶ The thrust of the subsequent argument will be to declare that the imposition of custodial authority on people properly placed in custody is provisional upon the correctional system's maintaining arrangements for at least minimally maintaining their health.

To strengthen the force of assigning custodial responsibility for health care, Kipnis equates the prisoner's position to that of a child. Initially, doing so seems to be a persuasive analogy for his purposes. Parents or their substitutes have authority over children, as correctional institution managers are authorized to exercise control over inmates. Parents are expected to curtail their children's liberty for the youngsters' own good, and defective parenting is signaled by, among other things, children whose conduct is out of control. Parental power is not unconstrained. Authority is provisional on the parents' compliance with legal and moral obligations to act for their children's ultimate good; systematic incapacity to do so on a parent's part may lead to transfer of the custody of younger minor children and emancipation of older minor children.

Proper filling of the custodial role demands more than good intentions. Effective implementation also must occur. To illustrate, having too many children to manage and support—an avoidable circumstance—may deplete parents' resources to the extent that they become unfit to be relied on in the parental role. Extrapolating from the parenting analogy, similarly imprisoning more convicts than the state's prisons can adequately hold and house leads to underfunded and thus harmfully deficient health care. Kipnis advises health-care professionals to withdraw their services from the correctional system if expected to practice in circumstances so impoverished as to cause serious shortcomings in the standard of care.⁷

To summarize, postulating that imprisoned people's situation relevantly resembles that of children is brought forward to support two conclusions. The analogy is advanced as an argument to justify offsetting the authority

imposed on prisoners with a duty to secure certain aspects of their welfare: specifically, satisfying their health-care needs. And the analogy extrapolates (with an assist from me) to trace deficiencies in the provision of health care to an excess of demand, or more precisely, to the creation of too large a population of needy recipients.

THE CUSTODY OF CHILDREN

Nevertheless, aspects of the analogy on which these conclusions are made to rest appear to render it inapt. One crucial point of dissimilitude between source and target should suffice to start the doubt. The source—the parental custodial circumstance—encompasses families generally and therefore the prevailing custodial subject will be a normally healthy child who is provided with supervision as well as support during a developmental process aimed at achieving capabilities for self-governance. This outcome is presumed to be achieved when the child reaches the age of majority, although individuals who demonstrably cannot sustain themselves may continue as dependents of their parents or other relatives, of social services or charitable organizations, or of the state.

In contrast, the target—the jail’s custodial circumstance—encompasses not all the ways, and not even a common way, that community members may relate to the state. Like that of child to parental authority, the relationship of prisoner to correctional institution managers involves an imbalance of power. But convicts who complete their terms, as well as detainees who are not charged or are acquitted at trial, are discharged from custody without further consideration of their readiness for self-governance. Unlike families, where youthful shortcomings are expected to be temporary, replaced by the responsible citizenship expected of adults, the preponderance of residents of jails are treated as if the deficits that propelled them into custody are likely to be permanent.

This is not to say that rehabilitation of the incarcerated is never tried. Nor is it to assent pessimistically to the proposition that, for correctional institutions’ residents, reentry to the ranks of normal citizenry never succeeds. Nevertheless, if analogical argument is to carry us through to better understanding of why incarceration courts inferior health care, more narrowly delineating the source group to match a broader band of the target group’s key characteristics will help. We therefore now turn to consider health care as experienced by a subset of children who resided not in the community directly under parental custodial care but in a much more regimented setting, in the direct custody of a health-care institution, captives in a crippled children’s ward.

Of all that Kipnis says about what punishment by incarceration means, the two illustrations he cites of death by medical negligence while imprisoned on charges (not on convictions) of minor infractions remind me of what it felt like to be a child in fear for her life because of incarceration in a chronic care institution. Disabled people fighting to reside independently in the community rather than in institutions often characterize life in the latter as being in jail. My story of being in such a place when I was a child indicates why the well-known Independent Living

Movement took shape. A key theme of this effort to enable disabled people to live in the community is fear of injury or death from medical negligence, or from other forms of dismissal that endanger their welfare by institutional practices that devalue their lives.

Such trepidation suffused the experience of institutionalized children like myself, transported far from home to rehabilitation hospitals, whose contact with family was rare due to distance, or prohibited by the institutional mantra that visits from parents made it more difficult for children to adjust to the rules imposed on them to facilitate ward management. The regime to which we were made to adjust was as strictly regulated, and as empty of opportunity, entertainment, comfort, and hope as a prison. It was barren as well of personal safety—we children witnessed some of our number being badly injured by negligent staff care. We were made voiceless and powerless. Watching a child die needlessly as our efforts to move the staff to save her were ignored was terrifying. Sometimes still that tragic death scene flashes before my mind’s eye.

I remember two nurses walking casually side by side, one complaining to the other about the problems her family and her job were visiting upon her. She pushed a gurney carrying a child forward, but did not see ahead because her eyes were fastened on her companion’s face. The child saw that she was being propelled toward the foot of a rocking bed, a device used to assist patients with compromised respiration to breathe. There had been previous warnings about the danger of gurneys passing too close to that bed, too easily caught by a rising corner and upended. And in the next moment the gurney was thrown over, its mattress sliding to the floor still carrying its passenger. The bed ceased rocking. An ominous silence replaced the rhythmic whoosh of the chest respirator that helped the child in the bed breathe. From her position flat on the floor the other child could see that the overturned gurney had yanked an electrical cord out of the wall.

The child in the bed, and the child on the floor, and the other children in the ward all called out, begging that the breathing apparatus be returned to the wall socket. The nurses were focused on righting the gurney, however, and returning the mattress and apparently uninjured passenger to it before a supervisor could enter the ward. They conversed at length about the risk to which they would be exposed by not reporting the accident, and the added danger to their jobs in case the seemingly unhurt child on the gurney might have broken any bones. Meanwhile, the children’s chorus of pleadings remained unheard.

Then the child on the bed stopped speaking. We still heard her faintly gasping or groaning (we didn’t know which) as she struggled to catch a breath. Perhaps to mask the absence of her voice, we raised our own louder, chanting with elevating anxiety but no observable effect, “plug it back in, plug it back in.” The child on the bed never spoke to us again. When staff’s attention finally turned to her, they rolled her out of the ward. The next morning we heard she had died.

The thorough dismissal of our entreaties left little room to doubt that much about our futures had been changed. In just a few weeks a virus had turned us from normally cherished children to socially devalued defective ones, at the mercy of a system that discounted our voices even when life or death was at stake. Cut off from families, friends, and teachers—that is, from our usual sources of social support—we no longer seemed to command even that level of recognition of ourselves as persons that as normal children we had taken for granted not many weeks previously, before we were taken ill. Like the two prisoners in the cases Kipnis advances as examples, from now on, even if we struggled, it was likely that we would not be heard.

Separated from our homes, and with activities of daily life regimented and comfort ruled out on grounds of institutional expediency, we institutionalized children felt we were being punished for having gotten sick. That even propitiously socially situated adults with disabilities have similar experiences in encounters with the medical system is well documented in disability studies literature. To illustrate, the anthropologist William Peace recently published an essay in the *Hastings Center Report* describing what happened when he was hospitalized for a virulent infection arising from paraplegic pressure sores. Peace recounts how the hospitalist on duty pressed upon him a prognosis dismissing him as being so defective that his putting up even a steadfast struggle to live would be unreasonable.

The physician's aim was to get Peace's consent to forego an aggressive approach to the infection and to accept comfort care instead. This patient refused to do so, was treated aggressively, experienced the lengthy and difficult recovery period of which the physician warned (and of which he always had been aware), and nevertheless recovered and is back writing articles to reform bioethics again. But he remains bereft of confidence about whether we generally can trust medical professionals' judgments, as they may be influenced by gratuitous underestimation of the value of our lives.

As am I, for I was the child on the gurney. I lay uninjured but frightened on the floor, staring at the unplugged cord so easy for the nurses to replace in the wall socket, but failing to penetrate their concern about loss of their employment and draw their attention to it. And so I also failed to save my friend's life. Could I have crawled across the floor to that wall socket and restarted the machine? For years I have obsessed about not attempting to do so, wondering whether I could have broken free of the staff—who were intent on lifting me back to the righted gurney to preserve the pretense that nothing harmful had occurred—to do so, always feeling diminished because I had not been able to do so.

DEPERSONALIZATION

Independent living advocates indict the practice of caring for disabled people in institutions that remove us from the community and thereby deprive us of both small and great opportunities that arise from being free, including the liberty to seek reliable health care. A chillingly similar

account of inconstant conduct and indifference by health-care professionals is described in the *New York Times* article from which Kipnis's examples of health-care injustice in correctional institutions were drawn. Further on in the article are reports of health-care professionals standing by while prison inmates and guards joined forces to try to help an inmate dying from the effects of heroin withdrawal, as well as an incident in which guards administered CPR to a prison-born neonate while a nurse stood by declining to participate because, she said, no equipment for a fetus or a newborn was to be found in that jail. As I reviewed Kipnis's sources, it was descriptions of health-care injustices like these that engaged me most.⁸ Importantly, there is no suggestion in any of the descriptions of cases that the *Times* article contains that withholding of required health care by the institution's medical professionals occurred because prison authorities directed or expected them to hold back.

The resemblance in the situations of prisoners and certain kinds of patients suggests that custodial care provided in institutions—whether hospitals or prisons—can be much less benign than the paradigm of parental care for children would make it seem. Moreover, while prisons are supposed to exist, according to Kipnis, for the explicit purpose of constraining the freedom of the individuals who are confined in them, hospitals—even those for chronic cases—are not supposed to have the same purpose. Yet, that two groups with such dissimilar members, placed in at least superficially very different types of custody, are both common targets of depersonalizing treatment suggests that the causes of their similar suffering also are likely to be the same.

If this is so, the impetus for correctional institution inhabitants being subjected to medical neglect cannot stem from features unique to this type of institution alone and not found in other facilities. It follows that the authority of the warden and the custodial administrative organization will not be the source of the medical neglect Kipnis describes, even if their over-riding concern is in maintaining security rather than in safeguarding inmates' health. So we should not suppose, as both Kipnis and Kleinig appear to do, that the source of negligence of prisoners' health is mainly to be found in "the conflict that health care professionals may experience within a prison setting," in that "institutional demands for security and order . . . clash with health care best practice."⁹

Why did the medical professionals in Kipnis's example dismiss the Parkinson's sufferer's and the heart attack victim's symptoms as malingering? These scenarios are reminiscent of the way women's symptoms used to be treated, as described by Susan Sherwin in her groundbreaking book *No Longer Patient*.¹⁰ For much of the history of medicine, female complaints regularly have been dismissed as imaginary products of women's unreliable emotional nature and inferior moral stamina. Feminist bioethics is wise, I think, not to overlook the culpability of individual clinicians despite the contribution the paternalistic system made to male physicians' dismissal of women's pain.

Similarly, the dying inmates' calls for help were attributed to their defective characters or to their biological conditions. Yet their medical conditions were comparatively easy to diagnose. Further, it is the responsibility of medical professionals to do so, regardless of whether their employer is a prison warden rather than the CEO of a medical teaching and research facility.

CONCLUSION

The conclusion the analogy with my own experience leads me to draw is that portraying medical personnel who work in prisons as serving two masters, the patient and the employer, is misleading. These days few clinicians anywhere are in fully private practice. It is common for them to anguish, at least occasionally, about conflicting directives arising from their obligations to serve individual patients' best interests and at the same time serve the organization that employs them. This is not a deflection of responsibility with which medical ethics can rest satisfied.

The prison setting stands as a paradigm of institutionalization's impact, which strips patients of their personhood, but correctional institutions are by no means unique in doing so. Institutionalization thus creates a challenge first of all to each employee's ability to sustain broadly inclusive moral perceptions and to resist the temptation to identify inmates, whether of prisons or asylums or nursing homes, not as fully human persons, but rather as things. The dilemma of the health-care professional who is a prison employee thus is not properly understood on the "two masters" model, on which the moral issue lies in difficult decision-making to weigh the incompatible priorities of patient and organizational interests, but instead as a demand to maintain their own empathy and moral sensibility against the influence of a workplace culture for which conscience does not count. Although my conclusion is similar to Kipnis's, I have arrived by a different route.

NOTES

1. All references to Kipnis's view are to his chapter called "Social Justice and Correctional Health Services" in Rosamond Rhodes, Margaret Battin, and Anita Silvers, *Medicine and Social Justice: Essays on the Distribution of Health Care*, 2nd ed. (New York: Oxford University Press, 2012), 373-84. My essay is based on my contribution to a symposium on Kipnis's view that was organized by the APA committee on philosophy and medicine at the 2013 APA Pacific Division meeting in San Francisco.
2. Kipnis, "Social Justice and Correctional Health Services," 377.
3. Ibid.
4. The cases are taken from a *New York Times* exposé of a for-profit corporation, Prison Health Services, with which public officials contracted to provide on-site medical care for prisoners. The article references many cases in which physicians and nurses employed by Prison Health Services failed to meet standards of care, or (in most cases) to offer any care at all, leading to the patient's death. Parenthetically, in some of these cases the prison guards attempted to render care when the responsible medical professional did not. Paul Von Zielbauer, "As Health Care in Jails Goes Private, 10 Days Can Be A Death Sentence," *New York Times*, February 27, 2005. http://www.nytimes.com/2005/02/27/nyregion/27jail.html?_r=0. They are introduced on p. 374 of Kipnis's chapter.
5. Von Zielbauer, "As Health Care in Jails Goes Private, 10 Days Can Be A Death Sentence."
6. Kipnis, "Social Justice and Correctional Health Services," 375.

7. Ibid., 383.
8. Von Zielbauer, "As Health Care in Jails Goes Private, 10 Days Can Be A Death Sentence."
9. John Kleinig, "Correctional Health Care: Further Reflections," *APA Newsletter on Philosophy and Medicine* 13, no. 2 (2014): 6.
10. Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia: Temple University Press, 1992.

Cruel and Unusual Care and Punishment: Epistemic Injustices in Correctional Health Care

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ABSTRACT

Hermeneutical injustice occurs when a collective gap in knowledge unfairly deprives an individual of an ability to make sense of her/his own experiences. Cases of hermeneutical injustice often involve forms of implicit bias and meta-ignorance that support the shared gaps of a social group's interpretive resources. To elucidate the harms caused by such forms of bias and meta-ignorance, I suggest that we turn to a concrete example, in this case, the context of correctional health care. In this paper, I argue that prisoners may face hermeneutical injustices with respect to their medical care. One of the primary reasons for this is that the current legal evidentiary requirements needed to prove civil rights violations with respect to medical care in prisons set unobtainable standards for many prisoners. The inaccessibility of those standards, I propose, is due to a series of hermeneutical gaps among the epistemic resources available to prisoners.

INTRODUCTION

In recent decades, feminist and critical race scholars have been breaking ground by examining characteristically *epistemic* forms of injustice. This area of inquiry within social epistemology takes as its primary focus the idea that a wrong can be committed on an individual in terms of her/his capacity as a knower. One category of epistemic injustice is what Miranda Fricker calls *hermeneutical injustice*.¹ Hermeneutical injustice occurs when a collective gap in knowledge unfairly deprives an individual of an ability to make sense of her/his own experiences.² Cases of this form of injustice, I and others propose, often involve states of implicit bias and second-order forms of ignorance—i.e., meta-ignorances—that support the shared gaps of a social group's interpretive resources. To elucidate the harms caused by such forms of bias and meta-ignorance, I suggest that we turn to a concrete example, in this case, the context of correctional health care. In what follows, I argue that persons who are incarcerated may face hermeneutical injustices with respect to their medical care. One of the primary reasons for this is that the current legal evidentiary requirements needed to prove civil rights violations with respect to medical care in prisons set standards unobtainable for many prisoners. The inaccessibility of those standards,

I claim, is due to a series of hermeneutical gaps in the epistemic resources available to prisoners.

To defend these claims, I first turn to recent literature in social epistemology to frame my analysis of hermeneutical injustice. Then, in the second section of the paper, I examine two Supreme Court cases that set the current evidentiary requirements for proving violations of the Eighth Amendment, the U.S. constitutional amendment that prohibits the infliction of cruel and unusual punishment. Finally, I argue that, due to systemic hermeneutical gaps in the context of U.S. prisons, such current evidentiary requirements unjustly restrict prisoners' abilities to legally address harmful forms of under/over-treatment and misdiagnosis in correctional medicine.

I. CLARIFYING HERMENEUTICAL INJUSTICE

First, to specify what I mean by hermeneutical injustice, I refer here to recent work by José Medina. While Fricker's view of hermeneutical injustice claims that interpretive gaps must be shared across a given collective to result in the marginalization or oppression of certain sub-groups within a body of knowers, Medina argues that hermeneutical injustices need not refer to *collectively* shared forms of ignorance.³ Rather, he asserts that a collective is often comprised of multiple sub-groups, and that hermeneutical gaps and resources may be distributed differently depending on a knower's position within any of the various sub-groups of a collective. For example, Medina offers Charles Mills's conception of "white ignorance" as a relevant epistemic distinction among a given collective body of knowers that affects the type of hermeneutical resources that are available to that collective.⁴ That is, many privileged subjects have not developed the interpretive resources for understanding their own social experiences as racialized, nor how such processes of racialization have been constituted via specific social practices. Thus, those subjects who *have* developed hermeneutical resources for interpreting processes of racialization constitute a distinct sub-group within the larger collective that may have very different tools for understanding their own social experiences.⁵ Correctional health care focuses on a specific sub-group of the U.S. population, persons who are incarcerated. That disproportionately affects certain sub-groups in the United States—African Americans and Latinos. So Medina's account of hermeneutical injustice is apt for my analysis.

Also with respect to correctional health care, Medina's conception of meta-ignorance is particularly relevant. Meta-ignorance, he claims, is distinct from first-order forms of ignorance in that first-order forms of ignorance involve "mistaken beliefs or [a] lack of beliefs" about an area of knowledge, whereas meta-ignorance involves "meta-attitudes that limit our abilities to identify and correct our ignorance" about first-order forms of knowledge.⁶ To be meta-ignorant of specific phenomena means that a knower does not *know that* she/he does not know about a given area of knowledge. Two of the ways that Medina discusses meta-ignorance are in terms of meta-blindness, a set of attitudes about certain beliefs, and meta-insensitivity, an affective numbness or indifference to one's own ignorance in a given area of knowledge. Additionally, meta-ignorance

effectively "protects first-order forms of blindness" by hindering a knower's ability to recognize epistemic gaps or sets of distorted beliefs about first-order phenomena.⁷ Meta-ignorance serves to occlude the subject's epistemic limitations and to preserve forms of first-order ignorance. For this reason, it is important to mark the *non-intentional* nature of many forms of first-order ignorance. Distorted beliefs and hermeneutical gaps that occur about particular first-order phenomena may be the result of socially supported or systemic forms of meta-ignorance that, in Medina's words, "maintain the subject's inability to learn about others and his or her predisposition to accept distortions about them."⁸

II. MEDICAL CARE UNDER THE EIGHTH AMENDMENT

To demonstrate the institutional structures in place that create unjust obstacles for the recognition and redress of systemic forms of injustice in correctional health care, I now turn to Eighth Amendment jurisprudence. It has been over thirty-five years since the Supreme Court ruling in *Estelle v. Gamble* that declared the denial of necessary medical care to prisoners a violation of the Eighth Amendment. In that landmark case, the plaintiff, J. W. Gamble, filed a civil rights action against the director of the Texas Department of Corrections, as well as the warden, medical director, and chief medical officer of the prison in which he was housed. Gamble stated that he was subject to cruel and unusual punishment due to the neglect and "inadequate treatment" of a back injury that he sustained while working in the prison.⁹ Several important outcomes of that case were that the Supreme Court declared that U.S. prisoners "were entitled to: 1) access to care for diagnosis and treatment; 2) a professional medical judgment [about their health care]; and 3) administration of the treatment prescribed by the physician."¹⁰ However, in this decision, the court did not rule in favor of the petitioner, Gamble. Rather, a precedent was set for standards for conviction in Eighth Amendment civil rights suits, including the ways in which such violations had to be substantively different from other kinds of medical malpractice. The court declared that the plaintiff must prove that medical providers or correctional staff acted out of what they termed "deliberate indifference" to the medical needs of the patient. Deliberate indifference, as the court's majority decision stated, meant that the prisoner was subject to "unnecessary and wanton infliction of pain" by medical or correctional staff.¹¹ The court concluded that Gamble's case did not show such wanton cruelty, but rather that his case had proved "medical neglig[ence] in diagnosing or treating [his] medical condition."¹² Thus, the treatment of Gamble at the hands of prison officials and staff did not constitute a violation of the Eighth Amendment. The court concluded that "medical malpractice does not become a constitutional violation merely because the victim is a prisoner."¹³

In this landmark case, the court was divided among those Supreme Court justices who thought that an individual intentional motivation should be necessary for determining violations of the Eighth Amendment and those who believed that such a condition was unnecessarily restrictive. Justice Stevens declared in his dissenting opinion, "whether the

constitutional standard has been violated should turn on the character of the punishment, rather than the motivation of the individual who inflicted it. Whether the conditions in Andersonville were the product of design, negligence, or mere poverty, they were cruel and inhuman.¹⁴ Citing here the Confederate prisoner-of-war camp in Andersonville, Georgia, where 13,000 Union prisoners died during their detention, this split decision was the first in a series of court rulings in which the majority opinion continually gave preference to individual and intentional forms of agency with respect to health-care-related harms in prisons.

In 1991, the court further examined deliberate indifference in *Wilson v. Seiter*. The plaintiff in the case, Pearly L. Wilson, charged the director of the Ohio Department of Rehabilitation and Correction and the Warden of the Hocking Correctional Facility in Nelsonville, Ohio, with permitting prison conditions in the facility that violated the Eighth Amendment. Wilson claimed that the Hocking Correctional Facility was overcrowded, excessively noisy, inadequately heated and cooled, unsanitary, and inadequately managed.¹⁵ Although this case did not address the medical needs of the plaintiff directly, Wilson charged the correctional staff with cruel and unusual conditions in the prison, which included health and safety concerns. The petitioner requested that the Supreme Court draw a distinction between short-term or one-time forms of harm and “continuing” or “systemic” forms of harm that constituted violations of the Eighth Amendment. Short-term conditions would be relevantly considered “unnecessary and wanton infliction of pain,” consistent with the ruling in *Estelle v. Gamble*. Systemic conditions would require no official claim regarding the state of mind of prison officials or sentencing judges. According to this distinction, Wilson’s charges would be considered claims about systemic conditions of punishment that violated the Eighth Amendment.

The majority decision of the court, however, rejected Wilson’s suggested distinction, claiming that to prove a civil rights violation, the pain inflicted on a person who is incarcerated must be “meted out” as punishment by a sentencing judge or by an official acting on behalf of the prison.¹⁶ The court’s ruling then established two evidentiary criteria that must be met to prove violations of the Eighth Amendment. The first, what I call the “negligence condition,” is an “objective” requirement, where, in the court’s words, the “deprivations denying ‘the minimal civilized measure of life’s necessities’” must be “sufficiently serious.”¹⁷ The negligence condition requires that the plaintiff prove that proper standards of health and safety have been violated. The second requirement, what I call the “*mens rea* condition,” a subjective requirement, states that the plaintiff must prove that the respondent had a “sufficiently culpable state of mind” and that she/he deliberately and recklessly disregarded the health and/or safety needs of the plaintiff.¹⁸ When applied to concerns about medical health and safety, the two criteria require that the plaintiff must prove both medical negligence and “[obdurate and wanton] behavior marked by persistent malicious cruelty” on the part of some individual regarding access to appropriate health care.¹⁹

III. EPISTEMIC INJUSTICES IN CORRECTIONAL HEALTH CARE

With this case history in mind, if we consider the potential resources and hermeneutical gaps within prison populations in the United States, it becomes easier to see how persons who are incarcerated may face epistemic injustices with respect to their level of health care. First, with respect to a minor point about the negligence condition of *Wilson v. Seiter*, recent literature on the epistemic dimensions of the physician-patient relationship cite that access to health magazines, health-related television programming, and online health resources, including information sites like WebMD and MayoClinic.com, have largely transformed the once-passive patient role into the more “autonomous role” of the patient-inquirer, one who actively investigates and critically assesses her/his own health care needs.²⁰ With no access to online health information sites and limited television and print information, prison populations may be at a considerable disadvantage in assessing their own health-care needs and the quality of care that they receive. As such, the lack of hermeneutical resources needed for prisoners to challenge standards of care for a given medical treatment may lead to an inability to even recognize or articulate forms of medical negligence that may be occurring in their health care.

Secondly, and perhaps more importantly, the *mens rea* condition is especially problematic in light of systematic forms of meta-ignorance that may exist in the context of correctional medicine. That is, the provider-patient relationship can be strained for several reasons in the context of correctional health care. Physicians and other health-care providers, like many other individuals, may feel that people who are incarcerated are not deserving of the standard of health care due to non-incarcerated persons. A large and much-discussed aspect of correctional health care is the set of costs and benefits that providing health-care resources to prison populations entails. One physician phrased it as follows in a piece for the American Medical Association during the same era as *Estelle v. Gamble*:

The physician in our society, goal oriented, hardworking, motivated by intellectual, economic and ego needs, has little empathetic relationship with the prisoner who is a patient. In addition, it is not beyond reason to suspect that the physician believes the prisoner is an exploiter, a malingerer, and even a source of veiled and violent threat. With so much to be done in this world, is the valued time of the physician to be spent in this area?²¹

Additionally, some critics argue that funding correctional health care programs and allocating medical resources to prison populations does not benefit society. For example, such critics claim that scarce medical resources, such as transplantable organs, are being wasted on individuals who are not “socially worthy.”²²

Moreover, problems of meta-ignorance in correctional health care may also particularly affect persons of color who are incarcerated, and who make up a disproportionate majority of the prison population in the United States.

Empirical research on racial disparities in health care suggests that people of color, in general, often receive a lower quality of health care than do whites, and there are provider-level factors that may be linked to the high rates of health disparities among racial groupings.²³ In this vein, current research in clinical psychology suggests that implicit biases and stereotypes of “well-meaning whites who are not overtly biased and who do not believe that they are prejudiced demonstrate unconscious implicit negative racial attitudes and stereotypes.”²⁴ Empirical research suggests that such forms of implicit racial bias and stereotyping can be attributed to certain meta-level attitudes about a subject’s lack of certain beliefs or sets of distorted beliefs at the object level. Secondly, research in clinical medicine also suggests that health-care providers routinely offer different treatment regimens to patients exhibiting identical symptomatology but whose visible identities differ by race or gender. For example, one study found that “male physicians prescribed twice the level of [painkillers] for white ‘patients’ than for black ‘patients.’”²⁵ Other studies also indicate that physicians routinely rate black patients lower than white patients in factors like intelligence, educational level, level of compliance, likelihood to abuse drugs and alcohol, and likelihood of follow-up with occupational and rehabilitational therapy. Such findings turned up in studies even when physicians were provided with information about their patients’ income levels and educational backgrounds.²⁶

While the empirical research that I mention above may point to a form of injustice within the context of health care writ large, within the context of correctional health care, the often implicit and disavowed nature of stereotyping and bias is likely to make it more difficult or nearly impossible for persons who are incarcerated to prove the *mens rea* condition of deliberate indifference. While there may be hermeneutical gaps that affect the ability of prisoners to have adequate access to health-care information, there may also be hermeneutical gaps or forms of meta-blindness and meta-insensitivity that affect the ability of correctional health-care providers to understand the extent and severity of the biases that may be affecting their diagnostic and treatment decisions for incarcerated populations of color. At the very least, if such biases and stereotypes are operative outside prisons, more research is needed within the context of U.S. prisons to see how stigmas and stereotypes about incarceration, race, class, and so forth may be affecting the level of care offered in correctional health-care settings. Finally, if meta-ignorance and implicit biases are operative within correctional health care, the *mens rea* condition established in *Wilson v. Seiter* sets the bar far too high for prisoners to obtain the requisite evidence needed to prove cases of misdiagnosis and under/over-treatment due to stigmas of incarceration, racism, sexism, homophobia, or myriad other non-individual intentional biases. While these are just a few considerations that may be relevant for addressing epistemic injustices in the context of correctional health care, more work is certainly needed to transform and to challenge the health-care conditions faced by some of the most vulnerable and disenfranchised members of U.S. society today.

NOTES

1. Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (New York: Oxford University Press, 2007), 1.
2. *Ibid.*
3. José Medina, *The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and Resistant Imaginations* (New York: Oxford University Press, 2012), 103-104.
4. *Ibid.*, 105.
5. Recall that Mills argues that both whites and nonwhites can be subject to “white ignorance.”
6. Medina, *The Epistemology of Resistance*, 149.
7. *Ibid.*, 149-50.
8. *Ibid.*, 149.
9. *Estelle v. Gamble*, 429 U.S. 97 (1976).
10. Robert B. Greifinger, “Thirty Years Since *Estelle v. Gamble*: Looking Forward, Not Wayward,” in *Public Health Behind Bars: From Prisons to Communities* (Dobbs Ferry: John Jay College of Criminal Justice, 2007).
11. *Estelle v. Gamble*, 429 U.S. 97 (1976).
12. *Ibid.*
13. *Ibid.*
14. *Ibid.*
15. *Wilson v. Seiter*, 501 U.S. 294 (1991).
16. *Ibid.*
17. *Ibid.*
18. *Ibid.*
19. *Ibid.*
20. See, for example, Rebecca Kukla, “How Do Patients Know?” *The Hastings Center Report* 37, no. 5 (2007): 27–35; Robert Veatch, *Patient, Heal Thyself: How the “New Medicine” Puts the Patient in Charge* (New York: Oxford University Press, 2008).
21. Quoted in B. Jaye Anno, *Correction Health Care: Guidelines for the Management of an Adequate Delivery System* (Chicago: National Commission on Correctional Health Care, 2001), 18.
22. Kate Douglas, “Prison Inmates Are Constitutionally Entitled to Organ Transplants—So Now What?” *Saint Louis University Law Journal* 49 (2005): 562.
23. See, for example, “Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Findings from the National Healthcare Quality and Disparities Report, 2008,” *Agency for Healthcare Research and Quality*.
24. *Ibid.*, 10.
25. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: The National Academies Press, 2003), 11. Citing Carol S. Weisse, Paul C. Sorum, Kafi N. Sanders, and Beth L. Syat, “Do Gender and Race Affect Decisions about Pain Management?” *Journal of General Internal Medicine* 16, no. 4 (2001): 211–17.
26. M. van Ryn and J. Burke, “The Effect of Patient Race and Socio-economic Status on Physician’s Perceptions of Patients,” *Social Science and Medicine* 50, no. 6 (2000): 813–28.

Cruel and Unusual Care and Punishment: Epistemic Injustices in Correctional Health Care: A Commentary

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First, thank you all for coming to this panel, and especially to Andrea for an important and interesting paper, "Cruel and Unusual Care and Punishment," which applies recent concepts in social epistemology to an abiding issue of social injustice. Second, before I begin my commentary proper, I want to say a little about my background. I teach at Morgan State University, a historically black university, and I also volunteer at Jessup Correctional Institution, teaching courses to inmates. So I have some direct experience with the consequences of judicial and racial hermeneutic injustices. I mention these features of my experience not as an assertion of privilege, but rather to be clear that my commentary in part involves the deliberate assumption of the role of "warden's advocate." In this way, I hope to provide some "epistemic friction," to use Professor Medina's term, so that in testing Andrea's work we may more fully appreciate it. Quoting Medina: "I want to define epistemic friction as follows: epistemic friction consists in the mutual contestation of differently normatively structured knowledges which interrogates epistemic exclusions, disqualifications, and hegemonies."¹ While wardens probably do not need an advocate, a *guerilla pluralism* seeks epistemic frictions for their own sake, to energize conflicts rather than resolve them.² Accordingly, I myself have reservations about the arguments to follow, and their tendency to sustain the status quo, but I do consider them opportunities to continue our inquiry this afternoon.

While Fricker's concepts of epistemic and hermeneutic injustice, and their extension by others, offer powerful tools for critique, they also require careful attention to what is particularly epistemic in a case of injustice. Andrea provides this attention in her argument that inmates are denied resources to properly interpret their medical status, and therefore the quality of the care provided. Quoting Andrea's gloss on Fricker: "Hermeneutical injustice occurs when a collective gap in knowledge unfairly deprives an individual of an ability to make sense of her/his own experiences."³ Andrea focuses not only on the facts of inadequate correctional health care but also the epistemic failures that prevent recipients of said care from being aware of its inadequacy. In addition, she follows Medina's specification that hermeneutical injustice does not require a collective gap in knowledge, but instead is established through a differential in hermeneutic resources across and in sub-groups. Furthermore, Andrea rightly focuses not on first-order ignorance, as in actual mistaken beliefs, but rather on the forms of meta-ignorance that prevent a knower from even knowing that a belief could be corrected.

While Andrea evaluates the problematic standard established for Eighth Amendment appeals, about which more in a few minutes, I want to turn to her final section. I

cannot dismiss her contention that more research is needed concerning the influence of stigmas and stereotypes in correctional health care. However, she refers to recent work on how the proliferation of access to medical information, especially through the Internet, has transformed patients into fellow inquirers, more on par with their health-care providers. In contrast, "[w]ith no access to online health information sites and limited television and print information, prison populations may be at a considerable disadvantage in assessing their own health-care needs and the quality of care they receive."⁴ I see at least two potential problems with invoking the ideal of patient-inquirers. The first is that some forms of it depend upon individualistic conceptions of autonomy, which expect an impossible ideal of "omnicompetence."⁵ Instead, most recent work in health-care ethics begins with a conception of *relational* autonomy, which "take seriously the idea that individuals are always located within interpersonal relationships and broader social environments, and that these are pervasively influential."⁶ I am not accusing Andrea, or the thinkers to whom she refers, of presupposing an outmoded conception of autonomy, but I do worry that the contrast established between average citizens and inmates exaggerates the capacities of average citizens. Furthermore, as stated it might underplay the true porousness of prisons.⁷ Between contraband, family visits, guard rotations, new inmates, and reincarceration, the actual lack of access to information is perhaps less than we might think. In other words, while constrained, inmates are far from isolated.

On the other hand, the development of patient-inquirers brings its own problems, for one element of rising health-care costs is patient demand for the latest drugs, as advertising is also a plentiful source of information. Thus, to argue that non-inmates are epistemically privileged in comparison to current inmates might require a distinction between being *misinformed* and *un(der)informed*. I would not yet deny that the average free citizen has access to *more* information than the average inmate. Nonetheless, I am less certain as to whether the quality of that information is adequate, let alone whether the average citizen truly possesses the epistemic resources to interpret this information.⁸ For example, it is clearly in the interests of the medical and pharmaceutical industries (as opposed to particular providers or even a professional organization such as the AMA) to have people interpret themselves as being sicker than they are. Obviously, here we can also think of the questionable influence of pharmaceutical representatives on providers' care decisions.

I do not think that Andrea's general argument requires that inmates be epistemically *worse off*, in some sense, than average citizens; but perhaps her argument against the standards affirmed to establish Eighth Amendment violations does.⁹ In particular, one consequence of Andrea's argument might be that Eighth Amendment violations should be held to the same evidentiary standard as medical malpractice suits; that is, the *mens rea* standard of *recklessness* should be eliminated or reduced to the "objective" standard of *negligence*. This would, however, require a rejection of the constitutional standard of "unusual" punishment, and I see no reason why this standard should be lowered because of hermeneutic injustices, without further argument as to why

these injustices make it *impossible*, rather than difficult, to meet.

This brings me to my final comment, which gestures towards the next paper on this panel. Given the systematic and self-concealing nature of meta-ignorance, as either meta-blindness or meta-insensitivity, efforts to overcome meta-ignorance might be seen as supererogatory. This can cut both ways—the *mens rea* standard is too high because it demands more than could reasonably be expected from systematically underinformed inmates, and the *mens rea* standard is appropriate because we should not hold care providers liable for failures to do more than their duty. However, as this comment opens onto broader metaethical questions, I will stop here and ask Andrea to respond as she sees fit.

NOTES

1. José Medina, "Toward a Foucaultian Epistemology of Resistance: Counter-Memory, Epistemic Friction, and Guerrilla Pluralism," *Foucault Studies* 12 (2011): 21.
2. *Ibid.*
3. Andrea Pitts, "Cruel and Unusual Care and Punishment: Epistemic Injustices in Correctional Health Care," *APA Newsletter on Philosophy and Medicine* 14, no. 1 (2014): 6.
4. *Ibid.*, 8.
5. Cp. Lippman's critique of Dewey's participatory democracy in *The Phantom Public* (1925), among many others.
6. Entwistle et al., "Supporting Patient Autonomy: The Importance of Clinician-Patient Relationships," *Journal of General Internal Medicine* 25, no. 7 (2010): 741.
7. Baer and Ravneberg, "The Outside and Inside in Norwegian and English Prisons," *Geografiska Annaler: Series B, Human Geography* 90, no. 2 (2008): 205–16.
8. See Julie Beck, "Should I Be Getting Health Information from Wikipedia?" October 1, 2013, <http://www.theatlantic.com/health/archive/2013/10/should-i-be-getting-health-information-from-wikipedia/280138/>, for some exploration of these issues.
9. In *Bivens v. Six Unknown Federal Narcotics Agents* (1971), SCOTUS ruled that individual federal employees may be sued for damages arising from constitutional violations, if there is no other avenue for redress. However, *Bivens* actions must overcome qualified immunity, and so are held to the *mens rea* standard Andrea rejects. However, in *Minnecci et al. v. Pollard et al.* (2012), the Supreme Court ruled that a federal inmate in a privately run prison could not sue in federal court, precisely because of the availability of remedy through state tort law. So, while federal suits require a perhaps too-high standard, state suits offer an alternative avenue of redress.

harm to an unborn child through an unlawful assault on its mother."¹ While well-established in the United States, fetal homicide laws are only beginning to take shape in Australia.² The proposed law would mean that if an offender assaulted a woman and thereby caused the death of the fetus she was gestating, the courts would be required to impose a sentence of life imprisonment in all but exceptional circumstances—equivalent to the penalty for murder. While the proposed fetal homicide law is said to give appropriate recognition to the grief and suffering of the woman involved—and while it may help to do that—this is certainly not all it would do.³ For it would also give existence to a new legal subject in Western Australia, that is, the "unborn child": currently, under Western Australian law a child is only legally capable of being murdered when already external to the mother's body. Thus, the woman's body constitutes a kind of "natural" basis for a legal boundary—one that the proposed law transgresses and perhaps obliterates, at the same time as it purports to recognize the trauma associated with the transgression and obliteration of that boundary by another.

Fetal homicide laws thus traverse difficult territory in the maternal-fetal relationship, in which actions against one person come to constitute a crime against another. Significantly, these laws are typically formulated to provide legal protection for pregnant women against the intrusions of a third party against their person. However, it may be that they can also be interpreted more generally to provide legal protection for the fetus against others. So construed, such laws open up a danger for pregnant women themselves, insofar as their actions threaten the life and well-being of the fetus they carry. One recent example of the exploitation of this ambiguity in fetal homicide laws is the case of Bei Bei Shuai, a young woman of Chinese descent who is currently facing felony charges of murder in Indiana, after a failed suicide attempt resulted in the death of the thirty-three-week-old fetus she was gestating.⁴ If a woman's actions against herself, leading to the death of her fetus, can be legally construed as murder, where does this leave the law on abortion? The Western Australian attorney general insisted that the proposed law would not affect laws on abortion in any way, since it would not encroach on a woman's right to make decisions about her pregnancy.⁵ But a woman's decisional rights in regards to her pregnancy are at best an unstable dividing line; at worst, it is precisely her decision to terminate a pregnancy—that is, to intentionally bring about the death of the fetus—that substantiates a murder charge. Indeed, at the crux of the Shuai case is her suicide note, in which she apparently states her intent to kill her fetus.

This ambiguity between abortion and fetal homicide has been the topic of much discussion in legal literature, and it raises significant questions that bear further investigation. For one, it raises in a particularly pointed way questions about the moral and legal significance of birth, and the bearing it has on the status of the fetus. Birth has historically been significant in establishing personhood, but this reliance on birth is challenged by the shift to treating the fetus as a person for the purposes of some areas of the law. The further question then arises of whether that status must remain consistent across domains of the law, such as those

Making Fetal Persons: Fetal Homicide, Ultrasound, and the Normative Significance of Birth

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In early 2012, the then attorney general of Western Australia, Christian Porter, announced plans to introduce fetal homicide laws in Western Australia, which would "create a new offence of causing death or grievous bodily

addressed to the death of a fetus at the hands of a third party, and those on abortion. While these questions have been well canvassed in legal discussions, we might also consider the impact that technologies such as obstetric ultrasound have on notions of fetal life and personhood. Advances in medical technologies appear to render birth irrelevant, or at least considerably less significant, to the determination of fetal life. Consequently, it may be argued, the frontiers of fetal personhood should be made congruent with the current state of knowledge made possible by technology. Interestingly, obstetric ultrasound appears more and more to have a particular influence within the formulation of laws relating to the fetus, and there appears to be a broad consensus that it contributes to the construal of the fetus as a person. The task of this paper is to examine this influence, particularly through the rubric of the constitution of fetal personhood. Throughout, I will argue that obstetric ultrasound increasingly operates as a technological mechanism through which fetal life and personhood can be separated or made to coincide.

TECHNOLOGY MAKING PERSONS: OBSTETRIC ULTRASOUND AND THE LAW

The central issue in the differentiation and intersection of laws on abortion and fetal homicide is that of personhood, since a fetus can only be the subject of a homicide—that is, it can only be murdered—if it has the legal status of a person. Two points should be noted of this. First, and most obviously, the attribution of the status of personhood affords a definitive right to life that was hitherto uncertain or absent. But second, this also indicates that the person and the biological body of the human being are not necessarily co-extensive. This break between the human (that is, a thing that belongs to the species *homo sapiens*) and the person is a decisional space in which personhood can be attributed or withheld. As Judith Butler notes, the conventional response to this decisional space is to ask, “who decides, and upon what principle?”⁶ but in fact, it may be more telling to ask, by what mechanisms is such a decision facilitated? Or, in other words, what are the material framing conditions for such a decision? The contention of this paper is that obstetric ultrasound is coming to play a crucial role in the “personhood-deciding machine [that] marks the final difference between what must live and what can be legitimately cast to death.”⁷

Historically, the determination of the personhood of the fetus in common law traditions has rested on the “born alive” rule, according to which live birth is necessary to establish the applicability of homicide laws—that is, a baby must first be born alive in order to be the victim of a homicide. Not surprisingly, the interpretation of this rule has been controversial. As Kristen Savell outlines in her discussion of the born alive rule in the context of Australian law, the notion of born alive has been explicated in various ways, with little consensus on what the standards of separateness (birth) or evidence of an independent existence (aliveness) actually require.⁸ For instance, whether indicia such as crying, breathing, a heartbeat, and independent circulation are necessary or sufficient to establish that a neonate is alive for the purposes of the law is a matter of ongoing debate. Further, Savell points out that there is controversy

over whether the rule itself should be treated simply as evidentiary, or as providing a more substantive definition of the human being.⁹ Taken as an evidentiary rule, live birth was necessary in times past because it was impossible to rule out natural stillbirth as a cause of fetal death, or to ascertain with any certainty other causes. Today, however, the state of medical knowledge and technology is such that it is possible to establish that a fetus is alive well before birth, just as it is to ascertain that a particular act caused fetal death—through obstetric ultrasound, fetal heart monitoring, and fetal autopsy, for instance.¹⁰ Thus, it would appear that technological advances have rendered the born alive rule redundant. However, understood as providing a substantive definition of legal personhood, the born alive rule is not so easily rendered irrelevant by technological advances.

Whether the rule is interpreted as evidentiary or substantive has broader political implications that I will return to later; for now, the important point to notice is the way that medical technologies contribute to the instability and contingency of the category of the person. Insofar as the matter of what counts as a person is dependent on knowledge of the characteristics of that thing, technologies that permit such knowledge come to hold sway over just what can in fact be identified as a person. Of these technologies, obstetric ultrasound has come to play an interesting and significant role in the determination of fetal personhood. It contributes to the transformation of the category of the person, and its attribution pre-birth, by making the fetus visible to us in a manner that was previously only possible post-birth. Of course, the manner in which the fetus is visible is, more strictly speaking, not the same as post-birth, since the technology itself shapes the manner in which we see the fetus. In this way, ultrasound has come to be characterized as a kind of moral speculum: it allows us—or, rather, is perceived to allow us—to “see” just what is and what is not a person.

Obstetric ultrasound was developed throughout the 1960s and became increasingly routine during the 1980s. Initially developed as a military technology, ultrasound was used therapeutically in medicine up until the 1940s, when its diagnostic capacities began to be explored. In 1959, Ian Donald, then at Glasgow University, found that ultrasound could be used to measure fetal heads. During the 1960s, Donald developed and used ultrasound to detect conditions such as multiple pregnancies, *placenta praevia*, and fetal abnormalities. Since then, the use of ultrasound in pregnancy has become largely routine in the developed world and increasingly available in developing countries. Most interestingly, the technology of obstetric ultrasound has always maintained an intimate relation with the ethics and law of abortion, a relationship that seems to be increasingly important in the contemporary context.

Donald himself saw and exploited the potential of the ultrasound image of the fetus to alter a woman’s thinking about terminating a pregnancy. Committed to an anti-abortion position, in the clinic he used ultrasound to convince Scottish women who fell pregnant during the 1960s to carry their pregnancies to term, and also used ultrasound images and video publicly in anti-abortion

campaigns.¹¹ More recently, in a manner not unlike Donald's moralization of ultrasound, in the United States, ultrasound has been central to legal efforts to restrict access to abortion. Some nine states have introduced legislation in recent years that requires women seeking terminations of pregnancy to undergo an ultrasound and either be given the option of viewing the images or be required to do so. For example, Wisconsin's recent law requires that the medical practitioner involved display the ultrasound image while identifying any visible organs and external features of the fetus. Further, ultrasound was the medium through which a fetus was enabled to "testify" in court, when video of a nine-week and fifteen-week-old fetus was used in an attempt to introduce a bill in Ohio that forbids abortion after the detection of a fetal heartbeat (the so-called "Heartbeat Bill").

Ultrasound has also been central to attempts to reduce the gestational limit for so-called "social" abortions from twenty-four to eighteen weeks in England. The obstetrician at the forefront of the use of 3D and 4D obstetric ultrasound in the United Kingdom, Stuart Campbell, weighed into this controversy, arguing that ultrasound images reveal new details about fetal life that necessitate a reconsideration of abortion law. In an opinion piece he writes,

No one seriously disputes that the earlier a termination is carried out the better and safer it is. My own conviction about this has been influenced by my technique for producing detailed 3D images of the developing fetus that show it smiling, yawning, rubbing its eyes and apparently "walking" in the womb. Though I perform these scans every day, I am still overcome by the excitement and the wonder of the fetus that is learning to be a baby. By twenty weeks it smiles, makes crying expressions and sucks its thumb. At twenty-three weeks, it begins to open its eyes and develops quite complex patterns of behaviour.¹²

He defied anyone who disagreed with his proposal to reduce the upper limit for "social" abortions to eighteen weeks, "to see these pictures and not pause to wonder if they [the critics] might be wrong."¹³ In response, Campbell's critics argued that the scans provided no new scientific evidence about the neurological and behavioral capacities of the fetus.¹⁴

Uses of ultrasound images such as those of Campbell attempt to establish a neurobiological and behavioral continuity between the fetus and the neonate. The presupposition of this approach is that this means that the late-term fetus is as equally deserving of legal protection as the neonate.¹⁵ The underlying view is that personhood is intimately related to the possession of a set of identifiable characteristics, and these characteristics are possessed as much by the late-term fetus as by the neonate. Significantly, this is congruent with the argumentative strategy discussed earlier in regards to the born alive rule, whereby new evidence of biological characteristics, garnered by improvements in medical technologies, urges a transformation of the frontiers of personhood to encompass the fetus. According to this view, ultrasound is portrayed

as a representative machine that reveals biological data that ought to reset our notions of personhood. It allows us to more correctly identify the frontiers of personhood. In this way, it is characterized as a kind of moral speculum, allowing us to peer into the maternal body in order to find the person within. However, this underestimates the ontological force of the ultrasound image, and thereby fails to recognize the way that ultrasound does not so much reveal persons as produce them.¹⁶ Moreover, there is more going on in the political and legal reliance on ultrasound than the "developmental continuity" thesis allows, for what is crucial to the success of the anti-abortion strategy is a sophisticated mobilization of the emotionally charged nature of the ultrasound image.

WHAT DOES ULTRASOUND DO?

Given the apparent imbrications of ultrasound images and morality and law relating to the life and death of a fetus, it is worth considering just what it is that ultrasound images do. Are these simply a matter of representing the fetus as it is, though otherwise undisclosed to us? Attempts to render ultrasound as a means of acquiring evidence about the personhood of the fetus try to limit ultrasound to this representational role. Ultrasound thereby appears as the speculum through which the fetus becomes visible as a person. As feminist theorists have long argued, however, the function of ultrasound far exceeds this representational fantasy. In different ways, Rosalind Petchesky (1987), Carol Stabile (1998), Valerie Hartouni (1998), Sarah Franklin (1991), and others make clear that ultrasound frames the fetus and its relationship with the woman gestating it in very specific ways. That is, it occludes the embodied being of the pregnant woman and constructs the fetus as a being separate from her, and at times in conflict with her. Building on these analyses, I have argued elsewhere that ultrasound does not simply represent an already existing body, but actually constitutes the fetus as an embodied, social being toward whom we bear a particular ethical relationship.¹⁷ In the remainder of this paper, I wish to take this analysis in a slightly different direction, to elucidate the position of ultrasound in the designation of some beings as persons and others as not. I will make the case that in regards to the constitution of the fetus as person, ultrasound increasingly operates as the means of mediation between the human body and the concept of the person. Ultrasound is a principle means for establishing either the coincidence or, in some cases, the non-coincidence of the fetal body and the person toward which it attains. Thus, it operates at the border of the person and the merely human, bringing these into articulation—which entails both separation and conjunction.

It is often noted that the concept of the person derives from the Latin term *persona*, meaning the mask used in a play or performance, or the part played by an individual in life—in essence, a *role* that an individual plays. This etymology highlights the specifically performative dimension of the concept of the person, a dimension that takes at least two forms. The first of these is the sense in which being a person demands a certain kind of *performance*, or can be understood as such a performance. This interpretation is developed by Friedrich Nietzsche, for instance, in his proclamation that "there is no 'being' behind doing,

effecting, becoming; 'the doer' is merely a fiction added to the deed—the deed is everything."¹⁸ The second refers more directly to the force of the concept of the person, and its imbrication within social convention. In *How to Do Things with Words*, J. L. Austin (1975) identified a subset of speech acts as *performative* (rather than constative), in that they do things in their very declaration or utterance. They do not simply describe states of affairs or things, but actually perform the act they ostensibly describe. Austin saw the utterances "I promise" or "I apologize" as paradigmatic of such performative statements.

While Austin attempted to limit performatives to a particular grammatical form, social theorists have subsequently extended his identification of the performative capacity of speech acts well beyond this. Judith Butler's account of performativity, for instance, combines aspects of both Nietzsche and Austin, to account for the social constitution of the subject through the operation of discursive norms. Butler's work in books such as *Gender Trouble*, *Bodies That Matter*, and *The Psychic Life of Power* is dedicated to developing a critical ontology of embodied subjectivity, in which "performativity" comes to name a social force that fundamentally conditions the subject's possibilities for existence. In tying Austin's notion of performativity to Althusser's account of interpellation, Butler makes performativity a deeply social phenomenon inextricably linked to matters of authority and power. Further, she also makes it clear that subjectivity cannot be extracted from the linguistic conditions in which it appears, though these conditions are not strictly determining for the subject. Because of this, she argues in *Excitable Speech*, the body of the subject is peculiarly vulnerable to language (and vice versa). She argues that

Language sustains the body not by bringing it into being or feeding it in a literal way; rather, it is by being interpellated within the terms of language that a certain social existence of the body first becomes possible. To understand this, one must imagine an impossible scene, that of a body that has not yet been given social definition, a body that is, strictly speaking, not accessible to us, that nevertheless becomes accessible on the occasion of an address, a call, an interpellation that does not "discover" this body, but constitutes it fundamentally. . . . [T]o be addressed is not merely to be recognized for what one already is, but to have the very term conferred by which the recognition of existence becomes possible.¹⁹

I will return to other aspects of this statement in a moment, but for now the point to be made relates to the constitutive force of the address, which constitutes a body in the very process of naming it.

My contention is that in regards to the fetus, the concept of personhood has something of this performative force. This means that in being called a person, the fetus is *made into* a person, such that the name "person," "retroactively constitutes its reference."²⁰ The person does not exist prior to this designation, waiting to be recognized as a person. Rather, its "recognition" is only possible through

the interpellation effected in being called a person. Thus, the designation of the fetus as person performatively engenders the fetal person; or, in other words, that subject is brought into being through the conferral of the terms of its recognition. Consequently, fetal personhood is not a matter of the accurate attribution of the concept "person" on the basis of objective properties of the fetus, with the change in moral status depending on these changing properties. Rather, the attribution of personhood immediately and in itself changes moral status, and this attribution may occur independently of the actual properties of the fetus.

Importantly, in Austin's view, performative speech acts cannot be judged according to their truth-value, but are instead considered "felicitous" or "infelicitous," depending on their success in doing what they state.²¹ Thus, the claim that a fetus is a person—or, is not a person—cannot simply be judged on the basis of whether it is true or not; what matters is whether the claim is felicitous or infelicitous. This undermines the claim discussed in the previous section that the continuity between the late-term fetus and the neonate, revealed by ultrasound, grounds fetal personhood. In fact, developmental continuity may or may not be significant in whether a fetus can be understood as a person, depending on other contextual factors. In other words, though in itself it does not establish personhood, it may be mobilized in the delimitation of "the appropriate circumstances" for the felicitous attribution of personhood.²² At other times, though, it will be disregarded or set aside in the withholding of that attribution. It may even be used against the attribution of personhood, such as in the way that utilitarian philosophers emphasize the continuity between the fetus and the neonate to the end of justifying infanticide. This raises the question of just what the conditions of felicity may be for establishing fetal personhood. There is no doubt that the felicity of attributions of personhood is context-dependent, in the manner that Austin argued was the case for speech acts generally.²³ Further, the elements of this context necessarily exceed any attempt to circumscribe them.²⁴ Nevertheless, two points about the felicity conditions for the attribution of personhood to the fetus should be mentioned.

First, the felicity of a claim will be heavily dependent on the relationship of the fetus to the woman who gestates it, or, in shorthand, whether it is a "wanted" or "unwanted" pregnancy. A central question in determining the personhood of a fetus is, to what extent does the woman who gestates it bestow personhood upon the fetus?²⁵ Relational conceptions of personhood developed by feminist philosophers attempt to capture the social and moral significance of the emotional attachment that a woman feels to her fetus.²⁶ This is consistent with an emphasis on women's self-determination in the moral justification of abortion, and the mother's primacy in establishing the social status of her fetus. Further, various studies have shown that obstetric ultrasound has a significant impact in this attachment, where, upon seeing their fetus on the screen, women feel compelled to attribute personhood to them.²⁷ It is this kind of incitement of attachment that campaigns discussed in the previous section work upon. However, the effects of ultrasound on women's attachment to the fetus they

carry are more ambivalent than this allows. For the use of ultrasound may be double-edged: while it may in most circumstances encourage fetal personification, it can also have the opposite effect, typically in cases where fetal abnormalities are detected through clinical scans.

Second, then, this “prenatal paradox” indicates that ultrasound is invested in both the attribution of personhood and its withholding.²⁸ Consistent with both Austin’s emphasis on the degree of conventionality required for a performative speech act to be felicitous,²⁹ and Butler’s insistence on the repetition or citation of regulatory discourse, the felicitous performance of calling something a person is highly norm-bound. The clinical value of ultrasound is dependent on the elaboration of biophysical norms, against which any individual fetus can be assayed. In Foucaultian terms, ultrasound has thus been central to the “normalization” of the fetus, and to a lesser extent, of the maternal body understood as a “uterine environment.”³⁰ This integration of ultrasound within a complex of normalization is well evidenced in screening for Down Syndrome using nuchal translucency measurements typically taken at around twelve weeks gestation. In combination with blood tests and maternal age, these measurements are used to generate a risk calculation for the likelihood of the fetus having the chromosomal mutation responsible for Down Syndrome. On the basis of this risk calculation and further diagnostic tests, the large majority of women in developed countries terminate pregnancies when Down Syndrome is diagnosed.³¹ As this suggests, the clinical use of ultrasound can itself impact on the affectivity of a “wanted” or “unwanted” pregnancy, and the performative attribution or withholding of personhood.³² Interestingly, in cases where women wish to continue a pregnancy, or do not wish to undertake further diagnostic tests following a calculation of high risk, they often meet strong resistance.³³ They may find that their attribution of personhood is seen by others as misplaced, and insofar as it is, the felicity of the performative is tenuous and contested.

As this suggests, obstetric ultrasound is deeply implicated in the attribution or withholding of personhood in regards to the fetus. Or, in other words, ultrasound mediates between the human body and the person, insofar as it provides the mechanism by which they are allowed to coincide or fall apart. Given this role, it is illuminating to return to Butler’s statement from *Excitable Speech*, in which she invites us to imagine an “impossible scene, that of a body that has not yet been given social definition, a body that is, strictly speaking, not accessible to us, that nevertheless becomes accessible on the occasion of an address . . . that does not ‘discover’ this body but constitutes it.”³⁴ In the context of thinking about obstetric ultrasound, this scene is not impossible—rather, it is precisely the situation of the fetus. This invites some adjustment of theories of subject-formation, pushing the starting point for subjectivation well into the gestational period. For instance, in regards to the performative constitution of gender identity, Butler’s scene in which “the doctor who receives the child and pronounces—‘it’s a girl,’—begins that long string of interpellations by which the girl is transitively girled” would need to be revised.³⁵ The frequent use of ultrasound for sex determination at around eighteen weeks gestation

means that such gendering begins *in utero*. Moreover, the process of personification of the fetus might plausibly be said to begin with the address effected in the ultrasound image produced almost routinely at around twelve weeks gestation. Thus, ultrasound appears not only to undermine the normative significance of birth, but also its significance in processes of subjectivation and personification. It can either instigate or thwart those processes with the fetus *in utero*.

The matter of subjectivation also raises vexed questions about whether, and in what sense, the fetus be seen as an active participant in its own personification or subjectification. Appropriating the account of the performative constitution of the subject to elucidate the process by which ultrasound images personify the fetus raises in a particularly sharp way the question of the extent to which performativity presupposes agency, and, more specifically, intentionality, on the part of the subject thereby constituted. As Butler points out, Austin tended to presuppose an agential subject as the source of illocutionary speech acts.³⁶ For her, though, the question of agency and intentionality is more vexed. This is not the place to explore this question in detail (especially since it has been the focus of an extensive literature already); suffice to say here that the paradox of subjectivity, whereby the subject comes into being through its own citational practice, ensures that agency and intentionality cannot be taken as evidence of subjectivity prior to its emergence in and through discourse. Nevertheless, a popular way of understanding the performativity of gender is to say that someone is performing gender, even if they are constituted in that performance, and even if that performance does not have the effects intended.

This interpretation reveals something significant about the personification of the fetus, whereby agency, and perhaps even a kind of intentionality, is attributed to the fetus. What is often at stake in the use of ultrasound images in order to render legal change is the question of how certain actions on the part of the fetus can be interpreted, and, particularly, whether they can be interpreted in the field of emotions. For instance, Campbell’s comments cited earlier cast the fetus as capable of certain facial expressions such as smiling and crying, and give the impression that these facial movements meaningfully correlate with stimuli, that is, that they can legitimately be read as at least rudimentary emotional expressions. However, in general, emotions are understood to require a kind of intentionality, insofar as they “involve a stance on the world, or a way of apprehending the world.”³⁷ Understanding the fetus to be expressing emotions, even if only as basic as pain and pleasure (the absence of pain), therefore attributes an agency—albeit a limited one—to the fetus.³⁸ Many expert commentators are clearly uncomfortable with this view; for them, such actions are more appropriately understood as “unconscious” facial configurations that say nothing about the psychological state of the fetus itself, let alone count as more or less intentional expressions of an emotion.³⁹ Nevertheless, that the fetus is popularly understood to engage in a certain performance of emotive states, and that this performance is seen as evidence of personhood, is significant for an understanding of what ultrasound does. For this highlights the way that fetal

personhood is established through the framing of actions on the part of the fetus as iterations—performative practices—of personhood. Insofar as a fetus enacts characteristics of the person—for instance, expressing emotions that betray a consciousness internal to the fetus—then it is itself a person. The point is Nietzschean via Butler: insofar as someone performs being a girl, she *is* a girl. Insofar as a fetus performs personhood, it *is* a person.

This brief discussion of fetal emotion and personhood brings to the fore a point that has been implicit in much of my discussion, which is that the attribution or withholding of personhood is intimately bound up with—perhaps inseparable from—circuits of affectivity and their mobilization. The film theorist Lisa Cartwright (2008) has recently developed an analysis of the way that representations interpellate viewers or spectators in particular ways, and specifically through the moral emotion of empathy. For Cartwright, empathy means “the reflexive experience of awareness of the thoughts, emotions . . . or concerns of an other or others,” and offers a plausible alternative to the film theory focus on identification.⁴⁰ The significance of empathy is that it places the practice of spectatorship in a particularly moral register, and may prompt a kind of responsibility for the other or others. Cartwright writes, “spectators may also ‘feel themselves into’ those they can imagine not as themselves but as *theirs*, or rather, as their responsibility. Moreover, they may imagine themselves as part of a ‘we’ that shares that responsibility. This kind of empathy is at the core of sociality.”⁴¹ Importantly, Cartwright insists that empathy is not a matter of “feeling like” the other, but rather, of “feeling for” him or her.⁴² In this, her account of empathy appears to be consistent with what I have elsewhere called sympathy, drawing on the work of Peter Goldie.⁴³ Regardless of whether this affective relation to the other or others is more appropriately understood as empathy or sympathy, though, the important point to be made here in regards to the ultrasound image is that “seeing the fetus” draws its viewers into affective circuits and, in so doing, establishes a relation between the fetus made apparent in the image and its viewer. Perhaps because of the “unquestioned moral value” of personhood,⁴⁴ this affective relationship is almost overwhelming channeled through the category of the person. However, the matrix of personhood may be particularly ill-suited to capturing the moral valence of this affective relation. Rather than bringing to light the particular affect involved in pregnancy and its subtle relations with responsibility, this reliance on personhood obscures those subtleties, and instead, mires us in an over-determined reliance on technology for clarifying the frontiers of our ethical categories.

CONCLUDING REMARKS

In this paper, I have argued that the ultrasound image can be understood to have a performative force, which means that the fetus revealed in the ultrasound scan may be brought into being as a person in its address in the ultrasound image. It has the terms of recognition conferred upon it in this address, but that conferral may also be withheld. This shows that ultrasound acts as a mediator between the human body of the fetus and the concept of the person, allowing them to coincide or fall apart. Further, I have sought

to elucidate some of these implications by examining the way that ultrasound is increasingly embedded within legal phenomena such as the emergence of fetal homicide laws.

It should be clear that the routine use of ultrasound throughout pregnancy, and the politico-cultural mobilization of ultrasound images, contribute to undermining the significance of birth as the threshold of the appearance of the subject or person. If this is so, then it appears to lend credence to the dismantling of the born alive rule within the common law tradition. As I mentioned early in the paper, this rule is interpreted either as evidentiary—in which case technologies such as ultrasound appear to instigate a revision of the legal concept of the person—or as offering a substantive conception of the person that is not undermined by technological advents. As specialized as this debate about how to interpret the rule may seem, it has significant implications for women’s reproductive rights. Rendering the rule redundant allows for the passage of fetal homicide laws, which rest on the condition that the attainment of personhood can be established before birth. But this is also arguably part of a broader attack on reproductive rights. As Bonnie Steinbock points out, “many of those who advocate this change [to allow fetuses to be homicide victims] have a larger agenda: the ultimate abolition of abortion and the coercion of pregnant women.”⁴⁵ Thus, a new “prenatal paradox” may well be emerging: ultrasound affords women reproductive choice insofar as it permits them to make informed decisions about the continuation or termination of a pregnancy in light of diagnoses of fetal abnormalities, but the images produced in ultrasound also are used to undermine that very choice through the establishment of more restrictive abortion laws and fetal homicide laws. These latter laws seem beset by a similar ambivalence, in that on the one hand, they may give recognition to the significant emotive and embodied relationship between a mother and her fetus and the social status that she may therefore bestow upon it, while on the other they may be mobilized against pregnant women themselves—precisely, perhaps, when that relationship breaks down.

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NOTES

1. Christian Porter, “New Foetal Homicide Laws Planned for WA.”
2. Some thirty-eight states have now adopted fetal homicide laws in the United States. In Australia, fetal homicide laws are effective in one state (Queensland) and have been mooted in at least two others (Western Australia and South Australia). The New South Wales Parliament is currently considering an amendment to assault laws to include harm to or destruction of an “unborn child.”
3. Note that this goal could be achieved through different legal means, such as the imposition of harsher penalties for aggravated assault. See Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses*, for further discussion.

4. Ed Pilkington, "Outcry in America As Pregnant Women Who Lose Babies Face Murder Charges"; Pilkington, "Indiana Prosecuting Chinese Woman for Suicide Attempt That Killed Her Foetus."
5. Porter, "New Foetal Homicide Laws Planned for WA."
6. Judith Butler, *Frames of War: When is Life Grievable?*, 20.
7. Roberto Esposito, *Third Person*, 13.
8. Kristin Savell, "Life and Death Before Birth: 4D Ultrasound and the Shifting Frontiers of the Abortion Debate," 627–29.
9. See also Steinbock, *Life Before Birth*.
10. Kristin Savell, "Is the 'Born Alive' Rule Outdated and Indefensible?," 630–31.
11. Malcolm Nicholson Centre for the History of Medicine University of Glasgow, "Ian Donald—Diagnostician and Moralist."
12. Stuart Campbell, "Is It Time to Rethink the Abortion Law?"
13. Ibid.
14. See Sarah Hall, "Foetus Scans Fuel Abortion Debates."
15. See Savell "Life and Death Before Birth."
16. See Sarah Franklin, "Fetal Fascinations: New Dimensions to the Medical-Scientific Construction of Fetal Personhood."
17. Catherine Mills, *Futures of Reproduction: Bioethics and Biopolitics*.
18. Friedrich Nietzsche, *On the Genealogy of Morals*, 1st essay, section 13.
19. Judith Butler, *Excitable Speech: A Politics of the Performative*, 5.
20. Slavoj Žižek, *The Sublime Object of Ideology*, 95.
21. J. L. Austin, *How To Do Things with Words*.
22. Ibid., 13.
23. Ibid.
24. See Butler, *Excitable Speech*, 3–4.
25. Note that this may be different in cases of surrogacy, where personhood is more dependent on the attribution by the commissioning parents, who may or may not include a mother, rather than the gestational mother.
26. See, for example, Catriona Mackenzie, "Abortion and Embodiment"; Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care*.
27. See Lisa Meryn Mitchell, *Baby's First Pictures: Ultrasound and the Politics of Fetal Subjects*; Lisa Mitchell and Eugenia Georges, "Cross-cultural Cyborgs: Greek and Canadian Women's Discourses on Fetal Ultrasound"; Gillian Harris et al., "'Seeing the Baby': Pleasures and Dilemmas of Ultrasound Technologies for Primiparous Australian Women"; and Williams et al., "Conflicting Perceptions of the Fetus: Person, Patient, 'Nobody', Commodity?"
28. Janelle S. Taylor, "Image of Contradiction: Obstetrical Ultrasound in American Culture," 15.
29. Austin, *How To Do Things with Words*, 14.
30. See especially Michel Foucault, *Security, Territory, Population: Lectures at the College de France 1977–78*, 57–63.
31. The actual statistical figure is disputed, though one influential international study puts it at 92 percent (Caroline Mansfield et al., "Termination Rates After Prenatal Diagnosis of Down Syndrome, Spina Bifida, Anencephaly, and Turner and Klinefelter Syndromes: A Systematic Literature Review"). A more recent review argues that termination rates in the United States are significantly lower than this (Jaime L. Natoli et al., "Prenatal Diagnosis of Down Syndrome: A Systematic Review of Termination Rates (1995–2011)").
32. I concede that the mapping of "wanted" and "unwanted" onto the attribution or withholding of personhood here is not entirely justified, since it is possible for a woman to want to continue a pregnancy without attributing personhood to the fetus she is gestating. The reverse may also be possible, though perhaps at a higher cost. Nevertheless, it is the case that maternal attachment to a fetus is often cast as deeply intertwined with personification.
33. Janice Gothard, *Greater Expectations: Living With Down Syndrome in the Twenty-First Century*.
34. Butler, *Excitable Speech: A Politics of the Performative*, 5.
35. Judith Butler, "Burning Acts: Injurious Speech", 204.
36. E.g., *ibid.*, 203.
37. Sara Ahmed, *The Cultural Politics of Emotions*, 7.
38. The claim by Republican Congressman Michael Burgess that fifteen-week-old male fetuses can be observed masturbating, made in debates on the Pain-Capable Unborn Child Protection Act in Texas, is a particularly striking example of the attribution of agency on the basis of ultrasound images. See Adel M. Stan, "Texas Congressman: Masturbating Fetuses Prove Need for Abortion Ban."
39. Nadja Reissland et al., "Can Healthy Fetuses Show Facial Expressions of 'Pain' or 'Distress'?"; Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommended Practice*, 10. This attribution of emotion to the fetus raises a host of questions about the nature of emotion and especially its relation to physiological or bodily modes of expression. It is not possible to properly engage these questions here, but note that there is a tradition of understanding emotion solely in terms of expression—that is, without reference to internal "feelings"—deriving from Charles Darwin's classic study of expression in humans and animals. In terms of fetal development, one of the central issues here is the degree of awareness that a fetus is capable of *in utero*—even if it has the neurophysiological structures in place for such awareness, with a consensus emerging that the fetus is largely if not wholly unconscious *in utero* (David J. Mellor et al., "The Importance of 'Awareness' for Understanding Fetal Pain"; RCOG, *Fetal Awareness*).
40. Lisa Cartwright, *Moral Spectatorship: Technologies of Voice and Affect in Postwar Representations of the Child*, 23.
41. Ibid., 235–36.
42. Ibid., 33–34.
43. Mills, *Futures of Reproduction*.
44. See Esposito, *Third Person*.
45. Steinbock, *Life Before Birth*, 133.

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Relational Autonomy: From Critique to Action

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In this presentation, I examine the evolution of the concept of autonomy, discuss the application of current relational models of autonomy to clinical practice, and point to an intriguing direction for further development. To this end, I first describe classical conceptions of autonomy and review some critiques that have been leveled against them. Out of these critiques has grown a more nuanced, relational notion of autonomy, which has, in recent years, been applied to clinical decision-making. My goal is to set up a question for future inquiry: How far can the idea of relational autonomy go, in terms of expanding potential agency among those not typically considered to be autonomous?

To begin this discussion, we need at least a general sense of the word "autonomy." I take it to mean something like freedom or independence, but these terms alone are not sufficient. An autonomous being decides for *herself*—and, shifting emphasis, she *decides* for herself. This connotes more than just acting on random whims. The notion of self-governance comes into play here: the autonomous individual chooses courses of action that are consistent with her goals and plans. That doesn't mean that extensive soul-searching must precede every decision but does imply the ability to evaluate one's own choices. My cat freely and intentionally steals yogurt from my bowl, but it would be a stretch to call her action autonomous.

Arguably, autonomy as we understand it today was shaped by early modern philosophy, so I won't say much about the concept's ancient precursors, except to point to Plato's beautiful illustration of self-governance: reason as a charioteer, struggling to control the twin horses of spiritedness and appetite.¹ Immanuel Kant saw the human ability to self-legislate as the basis of our moral worth: "Morality lies in the relation of actions to the autonomy of the will—that is to a possible making of universal law by means of its maxims."² For him, autonomy did not mean simply doing what one wants to do, but rather it entailed acting upon those principles that one rationally concludes ought to be universal laws. From the Utilitarian standpoint, John Stuart Mill held that, unless one's actions harm others, one's individual liberty to speak and act as one chooses ought not be impeded.

And, of course, autonomy, along with beneficence, non-maleficence, and justice, form the pillars of the Principlist approach in bioethics. Beauchamp and Childress describe autonomy as “personal rule of the self.”³ When acting autonomously, individuals act (1) intentionally, (2) with understanding, and (3) in ways that are free from controlling interference by others. Beauchamp and Childress noted that, while intentionality is all-or-nothing, the latter two components are a matter of degree—a “substantial degree” is required, else autonomy will be diminished. This proviso is prudent, as requiring perfect understanding and complete absence of external influence would result in the conclusion that we rarely, if ever, act autonomously.

Not long after Principlism rose to prominence in the early 1980s, however, serious critiques of the concept of autonomy were posed, with feminist authors leading the charge. In their 2000 anthology, Mackenzie and Stoljar helpfully categorize five kinds of critiques. I’ll describe them briefly:

1. Symbolic

The character ideal of the “autonomous man”—one who is utterly self-sufficient, highly rational, and focused on maximizing his own interests—is pernicious. It oversimplifies human agency, prioritizes independence over other values, and encourages the denigration of competing values such as friendship and cooperation.

2. Metaphysical

Autonomy presupposes a view called individualism, which is false. “Individualism” can mean several different things, admitting of causal, psychological, and metaphysical interpretations. The easiest interpretation to defeat is the idea that human agents are causally isolated. As Annette Baier puts it, “Persons are essentially successors, heirs to other persons who formed and cared for them,” with earlier phases of life causally influencing later phases.⁴ Similarly, our sense of identity is constituted by the relationships in which we participate, so a radical individualism at the psychological level is also implausible. More controversially, it has been argued that social relations are essential components of personal identity itself (metaphysics, not psychology). Less common among feminist critics, and thus not examined by Mackenzie and Stoljar, one could attack autonomy at the metaphysical level by denying that people are metaphysically separate entities—perhaps because we are Spinozistic modes of a single substance, or because personal identity over time is illusory.

3. Care

Somewhat similar to symbolic critiques, care-based critiques see the valorization of autonomy as denigrating those values related to interdependency. Autonomy emphasizes separation from others, which some authors see as masculinist—in opposition to femininity. A better model, they hold, would be that of distinction from another, while yet interrelated, that is found in caring relationships between people.

4. Postmodern

These critiques posit that autonomy is a throwback to Enlightenment notions of the self as a fully rational, pure will (Kant) that is transparently self-aware (Descartes). These notions are complicit in narratives of domination and suppression of others, such as women, and in any case have been thoroughly debunked in the intervening centuries.

5. Diversity

The notion of an autonomous self seems to presume that one’s self is cohesive and unified—something like an indivisible Cartesian ego. Yet many, if not all, people have “multiple identities”—one is both female and African American, or one is both Caucasian and deaf, for example, resulting in an identity that is best characterized as intersectional.

Laid out in such broad strokes, some of the above critiques are vulnerable to the charge that they employ straw man and guilt-by-association reasoning. Pursuing this charge is not the purpose of my inquiry. Rather, I want to look at what the critiques get right, and what developments follow from these insights. In summary, these critiques include the observation that autonomy, as traditionally construed, is highly rationalistic and individualistic. But self-legislators don’t work in a vacuum; they live in societies that shape their identities and their capacities for reflection. Oppressive social forces exert influence in myriad ways. Individuals are often unaware of these forces, and even if made aware, can no more dismiss them than they can aspects of their personalities. So discerning what counts as a person’s “free” choice is deeply problematic.

Feminists and other philosophers have good reason to be suspicious of autonomy claims, yet doing away with the concept of autonomy altogether would eliminate an important tool for understanding oppression and agency.⁵ Thus, relational accounts of autonomy were developed, embracing the idea that socialization is central to decision-making capacity, and including interaction with key others as part of the exercise of autonomy. Autonomy, in the relational sense, is achieved by critical reflection on one’s beliefs and desires, prioritizing and integrating them, and attending to how they were formed. Relational autonomy theorists are particularly interested in tracing how social forces work to subvert autonomy through such things as destructive gender norms, ageism, and ableism.

In the evolution of the concept of autonomy, there is no clear line between relational *critiques* of autonomy and relational *accounts* of autonomy, but application to clinical questions seems to be evidence that we are operating in the latter stage. In recent years, this relational notion of autonomy has been brought to bear on questions of clinical import. The following are some examples from this literature.

Stoljar (2011) notes that informed consent is the accepted proxy for autonomy in medical ethics. Contravening this assumption, she argues that obtaining informed consent is not sufficient to ensure autonomous choice, when autonomy is understood relationally. The informed consent process may provide an opportunity for autonomous choice, but it does not ensure that this opportunity will be exercised. Moreover, informed consent does not require patients to engage in “strong evaluation”—the assessment of the normative worth of various competing desires. But if we assume that obtaining a signature on a consent form is not enough, what clinical practices might promote patient autonomy? Atkins (2006) discusses Diana Meyers’s relational account, in which autonomy consists in socially acquired competencies in self-discovery, self-definition, self-knowledge, and self-direction. Promoting these competencies, and in particular distinguishing genuine reflective choices from internalized oppression, requires time and expertise. Atkins’s focus is on the role of nurses in this process; she concludes that nurses would need specialized training that includes communication and counseling.

On the traditional conception of autonomy, strong familial involvement in competent patients’ treatment decisions is cause for concern, as it may constitute undue interference in the patient’s self-determination. Ho (2008) argues that contemporary medicine tends to make patients feel helpless and isolated, and making decisions as a family may actually increase the patient’s relational autonomy—particularly among ethnic groups for whom familial interdependency is a core value. Absent evidence of oppression or abuse, enforcing an individualistic model of decision-making can be paternalistic. Hunt and Ells (2011) consider rehabilitation patients’ choices to do things their health-care providers consider risky, such as choosing to live alone in a second-floor apartment after a stroke. They agree with Ho that it can be appropriate for family members to participate in such decisions but emphasize the role of health care providers, whom they see as not merely providing information and awaiting patient choices, but as engaged in dialogue. After all, one’s physical therapist, doctor, and visiting nurse are part of one’s relational network, and can assist in clarifying the patient’s reasoning and how the proposed course of action fits in with the patient’s values and goals.

As the first two examples (Stoljar and Atkins) illustrate, a relational approach to autonomy can be seen as setting the bar higher: patients must engage in critical reflection on goals and values, not merely sign off on a treatment plan. And autonomy is vulnerable to undermining: the relational approach “identifies a broader range of barriers to autonomous choice than is usually acknowledged in autonomy discussions.”⁶ But, as the second two examples illustrate, the patient doesn’t need to do it alone; there is the potential for partial, socially facilitated autonomy.

The above examples focus predominantly on competent patients, albeit those whose capacities may be compromised by illness. Yet they suggest an intriguing next step: Can relational autonomy be used to at least partially empower those who are *not* traditionally considered to be autonomous agents—such as individuals with severe

intellectual disabilities? Sherwin and Winsby suggest that this is possible in the case of nursing home residents, including those with dementia. If relational autonomy is a matter of degree, and patients are still capable of making some kinds of choices for themselves, then a commitment to the value of autonomy entails expanding residents’ roles in decision making, to the extent of their abilities.⁷ This, of course, is easier said than done, as it requires a nuanced understanding of residents’ fluctuating abilities and a rejection of the institutional model that prioritizes efficiency over customized care. One organization that seems to have more experience and success with this sort of thing than most is *L’Arche*, an international community of homes shared by people with and without intellectual disabilities. *L’Arche* embraces the belief that intellectually disabled people have something of value to contribute, and structures their homes so as to build relationships among residents and between residents and the wider community. “While this philosophy creates opportunity for connection and understanding, it also generates struggles, as both care giver and care receiver learn to negotiate the ambiguity of having power-related interactions while also trying to be friends.”⁸

NOTES

1. Plato, *Phaedrus*, 246a.
2. Immanuel Kant, *Groundwork of the Metaphysics of Morals*, 107.
3. Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 123.
4. Annette Baier, *Postures of the Mind: Essays on Mind and Morals*, 85.
5. Catriona Mackenzie and Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*, 3.
6. Susan Sherwin and Meghan Winsby, “A Relational Perspective on Autonomy for Older Adults Residing in Nursing Homes.”
7. *Ibid.*, 188.
8. Pamela Cushing and Tanya Lewis, “Negotiating Mutuality and Agency in Care-giving Relationships with Women with Intellectual Disabilities,” 177.

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Vaccines: Parental Autonomy, Moral Choices, and Public Argument

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Public discussion of mandatory vaccination, particularly of children attending school, is decades old.¹ Vaccination rates in some areas suggest that a growing group of parents are choosing not to vaccinate their children.² Outbreaks of vaccine-preventable diseases in populations with ready access to vaccination highlights the concern.³ Not only are unvaccinated children becoming ill, and in some cases dying, but because vaccines are not 100 percent effective, some vaccinated children also are harmed, as are children who for medical reasons cannot receive vaccines. The debate about mandatory vaccination largely has been framed around the role of the state in navigating the tension between the autonomy of parents to make choices for their children and families, and public health interests in protecting the health and safety of populations. Independent of this focus on law are important ethical considerations regarding what it is for parents to make autonomous decisions and exert parental authority responsibly; what it means to engage in responsible public debate; and how the voices of the privileged drown out the voices of the world's poor.

"JUSTIFYING" VACCINE REFUSALS

There are many different reasons parents give for not vaccinating their children. These include (1) the view that "My child is not at risk." This might be true, or at least it can be true that a child is at very low risk. But it remains true only as long as most other people continue to vaccinate their children. The limited risk is compliments of others who vaccinate their children and to the vaccines themselves, which have dramatically reduced the incidence of numerous diseases.⁴ This circumstance raises free-rider considerations.

Related to the claim that a child is not at risk for disease is (2) the view that the risks of vaccine are greater than the risks of the disease prevented, or the view that "I will not expose my child to anything that is not 100 percent safe" (a standard none of us meet). Some parents prefer to assume the slight risk of disease over the risk of doing something to a child that could cause an adverse reaction. This view reflects a common cognitive bias—omission bias. Omission bias leads us to think that it is less problematic to assume the risks of non-action than the risks of action.⁵ Alternatively, parents may (mistakenly) think that they can prevent exposure to a disease.

Other parents hold (3) that there is a history of bad behavior among pharmaceutical companies, that vaccine makers

and doctors are all subject to financial conflicts of interest, and that what they say, do, or provide should not be trusted. This view discounts the significant pharmaceutical advances that have transformed life as we know it, such as antibiotics and the polio vaccine. Related to this view of the pharmaceutical industry is (4) the view that there is a history of mistakes in medicine; there have been things in the past that people thought were safe but they were wrong. Consider thalidomide. The medical-industrial complex might be similarly wrong about vaccines. In particular, many parents cite concerns that vaccines are toxic, cause autism, are unnatural, and will weaken immune systems, discounting all evidence to the contrary.⁶

Additionally, (5) anecdotes and stories play an important role in some parents' opposition to vaccination.⁷ Parents might have heard a story about someone who believes their child was harmed by a vaccine, or they know a child who had an adverse reaction to vaccines, and that story guides their decisions about vaccination. Consider the use of anecdotal evidence in a different context. I had a childhood friend who was *not allowed* to wear a seatbelt in the car. In an era in which seatbelt use was not compulsory but efforts were underway to encourage seatbelt use, my friend's mother forbade her from wearing a seatbelt and told any parent driving her child that her daughter was never to wear a seatbelt. As a young girl, this mother had been in a car that caught fire. She and her family got out of the vehicle safely. She believed that had they been wearing seatbelts, they would not have been able to get out of the car safely and would have died in the burning car. We cannot assess her counterfactual claim, but many people would not hear that story and agree that children are better off never wearing seatbelts. We have sufficient data about seatbelt use to know that one's chances of surviving an accident and of surviving with fewer injuries increase dramatically with seatbelt use. Yet, especially if repeated often enough, an anecdote can seem far more significant and action-guiding than vast amounts of data. As Kahneman and Tversky have long observed, we are notoriously at risk for misjudging risk information. A variety of cognitive biases get in our way. In addition to the omission bias already mentioned, other biases include framing biases, whereby we are influenced greatly by the manner of presentation; anchoring biases, which refer to our tendency to rely on one piece of information, which itself might or might not be relevant, as the basis for all judgments; and availability heuristics, whereby we think that events with which we are more familiar or to which we have had more exposure involve higher risk or are more likely to happen.⁸ All of these can shape how we understand risk information and compare risks. If we see or hear substantial amounts of anti-vaccination information, we start to believe the risks are staggering.

REACTING TO ANTI-VACCINATION REASONING

When we respect anti-vaccination arguments based on alleged risk of harm, toxicity, and so on, we might be doing so because we respect people's concerns, experiences, fears, and the authority parents have over their children. But respecting the messenger is different from respecting the message. When we show respect for these arguments or claims and fail to distinguish between (1) respecting

people who tell stories, share fears, or are in authority, and (2) respecting messages lacking credibility, we have a problem.⁹ When people who are involved in health care and have a responsibility to promote health tacitly accept or actively promote these claims, when people who are trained to evaluate arguments, reasons, and justifications accept or even fuel anti-vaccination claims, or when people in positions of power such as television personalities celebrate these accounts and sensationalize vaccination refusals, we should evaluate carefully what they are doing. We must at the very least recognize the full range of implications of such judgments and the moral commitments they reflect. Foreseeable effects of such actions or decisions should be taken into account in assessing these choices.

First, the claims miss the very important point that vaccination decisions are moral decisions, and moral decisions are not just about “me and my children.” Morality concerns relationships between and among individuals and groups. I and many others have defended the view that parents have special obligations to their children and that the state generally is not the most informed or appropriate decision maker regarding our children.¹⁰ The claim here is not that all obligations are equal, nor is the claim here about making vaccination *mandatory*. The discussion here is about *moral* elements of parents’ vaccination decisions, including the obligations of parents to make well-informed decisions, and the observation that moral decisions are not solely self-regarding. Anti-vaccination claims tend to ignore or substantially de-value the interests of others and set aside the very real chance that non-vaccination decisions may hurt others. There is substantial evidence that low vaccination rates lead to harm. When immunization rates drop below a certain level—the level varies for different vaccines—we lose herd immunity and risk of exposure and infection goes up.¹¹ Communities with low vaccination rates have seen this in recent years, experiencing outbreaks of serious conditions such as pertussis and measles. Not only may children who are not vaccinated by parental choice be harmed, but others may be harmed as well. These include children who have medical contraindications to vaccinations, such as cancer or HIV, as well as children too young to be vaccinated. Thus, decisions not to vaccinate are decisions to dismiss the opportunity to use widely and easily available means that pose little risk to us individually to avoid harming others. The duty to avoid harm is widely recognized, though there is disagreement about what constitutes a harm and when one has fulfilled one’s duty to avoid harm.¹²

Persons who think vaccines pose very high risks to children might argue that this decision is justified because we do not have an obligation to put ourselves at great risk to avoid harming others. But the data overwhelmingly show that the risks of accepting vaccine are low.¹³ Thus, this decision is appropriately characterized as a decision not to use a low-risk, low-burden means readily available to us to reduce the chance that we will harm others, or that our own children will be harmed.

Not only does giving credibility to anti-vaccination narratives in the face of significant data that support vaccine safety

and efficacy imply that we may disregard the obligation to employ reasonable, low-risk measures to avoid harming others but it also implies that free-riding is permissible. Parents who do not vaccinate their children yet enjoy the security of knowing that their children are at low risk for serious illness have this luxury precisely because other people do vaccinate their children. This is a form of free-riding that we may well judge morally impermissible.¹⁴

Second, we need to recognize the global health implications of anti-vaccination campaigns. Numerous recent reports cite concerns that anti-vaccination campaigns in the developed West are putting the global poor at increased risk in at least two ways. First, anti-vaccination campaigns in the developed West are fueling anti-vaccination statements in countries where many of the world’s poorest people are at greatest risk from infectious diseases, resulting in numerous preventable childhood deaths.¹⁵ When poor children who have limited access to health care and poor nutritional status are exposed to serious infectious diseases, they are more likely than our own children to die. Their risk of non-vaccination is even greater than our own, yet we are helping to fuel the fire against vaccines. Second, the drive to eliminate preservatives in vaccines because they allegedly cause autism or other problems despite no evidence that these preservatives are unsafe could increase costs significantly, making them less accessible to the world’s poor.¹⁶ Without preservatives, single-dose vaccine vials must be used, and these cost significantly more—a circumstance that many physicians and public health experts have fought to avoid.

Third, we should understand stories—including stories aimed at discouraging vaccination—in context. The history of medicine is not a history that speaks only of failures, disasters, and discrimination. Surely there is a history of this, and not everything is safe enough. But we should not act as if no one ever has gotten anything right. Medicine and public health have gotten many things right, and data suggests vaccination is one of them. Numerous studies have looked at various aspects of vaccine safety.¹⁷ If we understand autonomous decisions as involving a requirement that agents be at least somewhat informed, then to ignore the reality of the history of medicine and data on vaccinations is wrong. Giving credence to claims that recast this history and the currently available data in ways that undermine the ability of others to make informed decisions is problematic.

A number of studies have shown that even just a few minutes of exposure to anti-vaccination websites full of narratives about vaccine dangers can have significant impact on how people think about vaccine risks.¹⁸ Treating unscientific claims about the dangers of vaccination as valid, all while ignoring the known risks associated with non-vaccination, is deeply problematic. This suggests that the media and others involved in public discussion of vaccine debates may have important responsibilities regarding how stories are portrayed and information is communicated.

Finally, anti-vaccination narratives that spread are generally offered and perpetuated by privileged people. Stories tend to be personal and from people with enough power to tell

them and to get others to listen—people who have access to various forms of communication and who are literate. Counter-narratives from poor mothers in resource-poor nations whose children cannot get vaccinated because of our first-world privilege are not widely heard. This imbalance can lead us to think certain kinds of risks of vaccination—even imagined, unscientifically supported risks—are unacceptable, particularly because there is just no compelling advantage. The anti-vaccination movement is a movement of the privileged. It is largely wealthy parents who choose to forego vaccination and who encourage others to do the same. But it is largely the global poor who suffer the consequences.

A powerful example of the disparate impact of non-vaccination involves rotavirus. In 1998, a vaccine for rotavirus was being used in the United States and elsewhere. Rotavirus is a virus that affects the bowels and can lead to diarrhea, and ultimately dehydration and death. About a year after the vaccine was licensed in the United States, the Centers for Disease Control and Prevention (CDC) identified an increased risk of intussusception subsequent to vaccination. (Intussusception is an obstruction of the bowel which happens when it closes in on itself by “telescoping.” This is a serious condition that can lead to tears in the bowel, infection, and tissue necrosis. If not treated, it can lead to death.) The vaccine was taken off the recommended list of vaccines produced by the CDC’s Advisory Committee on Immunization Practices and then withdrawn from the market. Subsequent studies raised doubts about the initial risk calculation and suggested that it was safe, but it was too late. For several years, until 2006, no rotavirus vaccine was available in the United States or in the poor nations where rotavirus often was fatal for children. This case raises interesting questions about what it means to judge that a vaccine is safe and effective and that the risks of the vaccine are justified and appropriate relative to the benefits. Is the risk-benefit calculus for a vaccine universal, or does it vary based on the relevant circumstances? While the vast majority of children in the United States who become symptomatic recover, sometimes following rehydration therapy, this is not true in resource-poor nations where it may be impossible to admit children to hospitals and rehydrate them. Even if the vaccine did pose an increased risk of intussusception as first suspected, it is plausible that the risk still was justified in places in which children who got rotavirus, a common virus, were at significantly increased risk of death. The first-world-risk-benefit calculus was imposed by default on the global poor.¹⁹ This is an instructive lesson regarding the impact of first-world decisions about what is good for us: such choices have the power to put others at significant risk.

In short, treating anti-vaccination narratives as if they were sound justifications for parents to exercise their parental autonomy and choose not to vaccinate their children, or even as grounds banning certain vaccines, does the following:

1. Ignores the important fact that my choice not to vaccinate may harm others, that many people recognize a responsibility to use low-burden measures to avoid harming others, and that parents who do not vaccinate their children enjoy

what relative security they have because the rest of us do. They are free-riding.

2. Privileges our own interests and needs while ignoring the global health consequences of our actions.
3. Distorts information about the history of medicine and vaccine safety data in ways that undermine informed, autonomous decision making.
4. Yields power to the already privileged who can speak loudly while further marginalizing the poor, particularly the world’s poorest.

The moral dimensions of vaccine decisions, of the anti-vaccination movement, and of how we choose to respond to anti-vaccination narratives are important, independent of political views about the authority of the state to mandate vaccines. Moreover, parents do not exercise their autonomy in a vacuum, and the extent to which decisions regarding vaccination put others at risk should be taken seriously, as should our obligation to avoid harming others.

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NOTES

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The Waist Is Larger Than the Belt

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First appeared in the Emily Dickinson International Society Bulletin, May-June 2012.

The waist is larger than the belt—
For put them side by side—
The one the other will exceed
With ease—it cannot hide—

The foot is wider than the shoe—
For try them inch by inch—
The one the other won't fit in—
Without a mighty pinch—

The mouth is greater than the will—
For show them something sweet—
The one the other will defy—
And in the end defeat.

Reframing, Bargaining, and a Ham Sandwich

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What does an old joke about a ham sandwich have to do with morality? It turns out that there is a critical insight here about why ethics has been such a poor guide to how we treat each other.

Years ago, my college roommate told a stale joke over dinner. He had just been tapped for Phi Beta Kappa, and I asked him what somebody majoring in topology did. Here is the story. You can see right away, this is about fairness. A slice of bread, regardless of shape, can always be cut so that the two halves are identical in surface area. Now a piece of ham can be added, and a cut can still be made that guarantees parity. A third ingredient, mayo, makes it very difficult, but justice can still be served.

The fourth plane, say mustard, is a deal breaker. There is no way a plane can be guaranteed to bisect four superimposed planes. Yeh, the punch line is, "Topologists have proven that you can't always cut the mustard."

This almost never comes up for discussion in ethics. Theorists hold that their knife can make clean, exact cuts that satisfy agreed standards in all cases. This is demonstrated by selecting unambiguous test examples with one or two dimensions to the issue at stake—what game theorist Ken Binmore calls "toy cases," that prove the sharpness of the instrument. Some theories are better at bread, and some are better at ham. If there is a disagreement, it is usually because one philosopher has piled on the conditions and then picks the analytical tool that cuts his or her way. (Frankfurt cases have elevated this to an art form.)

Politicians and real people do much the same thing. A handy way to win an argument or a card game is to say that the only suits that matter are the ones where you hold the aces. It is amazing how many single-issue voters have exactly one issue for each situation, but many situations. Generally the only philosophers who allow consideration of more than one ethical dimension at the same time are those building their theories on rights, like W. D. Ross or Martha Nussbaum. Beauchamp and Childress enumerate four principles, and the American Medical Association and the American Dental Association have expanded those to five.¹ Beauchamp and Childress are frank in admitting that their system inescapably leads to conflicts among principles that must be reconciled by finding a “balance.” But there is no principle that identifies when that balance has been achieved.

I am offering a simple rule: Individuals who find themselves in realistically complex moral engagements cannot be assured of finding a satisfactory ethical solution when there are at least four important considerations. This limitation holds even when moral agency is not expanded to others. Kenneth Arrow’s indeterminacy theorem for the social welfare function, or Dana Clyman’s impossibility theory for translating utility functions, both place the lower limit on a rationally consistent fair solution at a value of two because they allow at least two agents. Artificially limiting real moral engagements so they can be solved by ethical principles is playing false to save the theory at the expense of the interests of those involved. But by comparing preferred future actions rather than rational justifications, the number of alternatives can always be kept to two—an approach to resolving moral engagements not subject to this restriction.

(Excerpted from chapter nine of *Building the Moral Community*, a forthcoming book by David Chambers that expands upon the recommended approach to resolving moral engagements.)

NOTES

1. The AMA and ADA use Beauchamp and Childress’s four principles of respect for autonomy, nonmaleficence, beneficence, and justice, and add a fifth, veracity.

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