NEWSLETTER ON PHILOSOPHY AND MEDICINE

FROM THE EDITORS, ROSAMOND RHODES AND MARK SHELDON

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This is an eclectic edition of the Newsletter on Philosophy and Medicine. It includes news items, papers from a Committee-sponsored session, and a delightful short story.

Timothy F. Murphy has sent us the latest news from Florida. His report, “Gov. Jeb Bush Orders Terry Schiavo Back from the Dead,” is a must read for anyone who wants a chuckle and to keep up to date with the still-evolving strange case of Terry Schiavo. Kimberly Amoroso has sent us enlightening information on recent action in Washington, D.C., concerning embryo donation. In her piece on “Frozen Embryo Adoption and the United States Government,” she explains the Bush administration’s policies, fueled by a religious and political agenda, that provide direct support for embryo donation and also attempt to limit the destruction of human embryos by including embryo donation in a proposed FDA tissue donation policy. Amoroso shows just how those two policies conflict and why lobbying by assisted reproduction agencies ultimately succeeded in amending the tissue donation embryo donation regulations.

The third news item in this issue is “Medical Investigations of Homicides of Prisoners of War in Iraq and Afghanistan,” by physician Steven Miles. This important article was posted on 07/05/2005 <http://www.medscape.com/viewarticle/507284> in Medscape General Medicine ejournal. We thought that our readers were not likely to encounter this report and that it would be of interest because of the issues it raises about the role of physicians in war and torture. With the permission of the author and George Lundberg, the ejournal editor, we are pleased to include it in this issue of the Newsletter. In this article, Miles points out that the Armed Forces Institute of Pathology has the responsibility for determining the cause of death of prisoners who die in U.S. detention. Ten years ago, the Institute created the Armed Forces Office of the Medical Examiner (AFME) for this purpose. Miles argues that “the AFME was not prepared to investigate the deaths of prisoners who may have died of torture.” Miles succinctly and powerfully lays out the ways in which, in light of the Geneva Convention, the laws of the United States, and the United Nations and World Health Organization’s Manual on Investigation and Documentation of Torture, the AFME, and the Institute of Pathology have failed miserably. As Miles states, “Our national reputation and interests were harmed by these failures.”

Hilde Lindemann of Michigan State University organized this year’s Committee-sponsored session at the APA Central Division meeting. The topic was “Limits of and Challenges to Liberalism in Bioethics.” Given patient requests for such things as sex selection, amputation of healthy limbs, heart donation, selecting embryos for deafness, genetically altering embryos to make offspring white instead of black, the panelists were asked to discuss where and how physicians should draw the line. Margaret Battin, Howard Brody, Agnieszka Jaworska, and Rebecca Kukla all offered their views on these issues. The papers by Howard Brody, George Lundberg, Rebecca Kukla, and Agnieszka Jaworska are included in this issue, and, together, they provide a range of how this topic could be interpreted. In his paper, “Physician Integrity, Enhancement Technologies, and Consumer Autonomy,” philosopher-physician Howard Brody argues for drawing a line between interventions that should be determined by physician judgment and those that should properly be left up to patients. In “The Limits of Lines: Negotiating Hard Medical Choices,” Rebecca Kukla argues against drawing a firm line between medical decisions that must be governed by the patients and the place for physician discretion. Instead, she comes down for sorting cases into categories that would be more reflective of patient reasons. In “From Caring to Self-Governance: The Bare Bones of Autonomy and the Limits of Liberalism,” Agnieszka Jaworska identifies autonomy as the key issue. She explores the concept by defining a self-governing agent as someone who has a reason to pursue what she cares about. Employing this sense of autonomy expands the range of cases in which patients deserve protection from paternalistic interference.

We are happy to also include “We Gather Together” and “Rose and Blue,” a new short story and a new poem by Felicia Nimize Ackerman. Those Newsletter readers who have enjoyed her stories as they appeared in these pages will be happy to learn that a volume of Ackerman’s stories, Bioethics through Fiction, is being published by Rowman & Littlefield in their series Explorations in Bioethics and the Medical Humanities, edited by James L. Nelson. The book will consist of a series of essays she is writing about the relevance of her stories to bioethics, along with seven of her short stories, all of which originally appeared in magazines or anthologies and were reprinted in this Newsletter. “We Gather Together,” the story for this issue, raises interesting psychological questions about projection and the danger of leaping to presumptive conclusions about the lives of others. Both are hazards for clinical practice.

In order to continue offering our readers exciting issues jam-packed with timely and informative pieces and provocative philosophical discussions, please continue to send us your work. We also remind you to think of this Newsletter as a place for your announcements, letters, papers, case analyses, poetry, and stories. Please feel free to volunteer a book review. Your contributions and queries should be sent to Rosamond or Mark at the addresses below. Please include your phone and fax numbers and email address.

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FROM THE CHAIR

Of Unions and Unity
David DeGrazia
George Washington University

As spring approached this year, I was confident that our panels scheduled for the Pacific and Central Division meetings would run smoothly and that, soon afterward, I would hear glowing reports from committee members who had attended. That assumption proved only half correct.

Rosamond Rhodes, co-editor of this Newsletter, had organized for the late-March Pacific Division meeting in San Francisco a panel commemorating the twenty-fifth anniversary of the Belmont Report. With Rosamond chairing, the lineup of speakers and topics was as follows:

- Tom Beauchamp, “The Belmont Report: Some Second Thoughts”
- Alex John London, “The Belmont Report and the Social Division of Labor”
- Jodi Halpern, “How Emotions Influence the Ability to Consent to Research”
- Frank Miller, “The Ethical Significance of Distinguishing Clinical Research and Medical Care”

This promised to be one of our best panels in memory. But several weeks before the meeting was scheduled, discussion emerged about the possibility of a strike by union members who worked at the Westin St. Francis, where the meeting was to take place. It proved difficult, however, to attain a clear understanding of what exactly had happened and whether a strike was likely. In any event, one of the panelists, expressing understandable concerns about possibly crossing picket lines, pulled out. Should the panel run anyway? In addition to the difficulties of sorting out the factual picture, we continued to face challenging moral and pragmatic questions. If hotel management had not done right by its workers, how should we respond? We could, of course, pull the panel. Alternatively, we could hold the panel—with four of five speakers—at another venue in San Francisco, where some APA presenters were moving sessions. Or we could simply run the panel at the Westin—with or without a public statement about the situation involving the workers.

While all agreed on the importance of supporting unions, how best to do so was far from obvious. Moreover, other moral considerations were salient. For one thing, the Committee on Philosophy and Medicine and individual panelists had, after all, promised a panel. While it is unlikely that any such promise should be regarded as absolutely binding, it certainly carried significant weight. And what of all of the APA members who had scheduled flights and paid conference fees on the understanding that certain sessions, including ours, would run (as promised)? We were especially concerned about graduate students and many others who did not enjoy institutional support for travel.

As we continued to mull over these questions, I learned in discussion that another panelist wanted to pull out as well—partly due to union-related concerns and partly in the hope that the panel could be reconstituted fully, or nearly fully, elsewhere. At that point, it seemed best to me to cancel the panel and try to reschedule. I did so, and, after a few days that included communications with leadership of the American Society for Bioethics and Humanities (ASBH), we had a doubly felicitous result: an agreement to run the panel at both the ASBH conference in Washington, D.C., in October (although Ruth Macklin will be unable to speak there due to other obligations) and at the APA’s Eastern Division meeting in New York in December. Many thanks to the panelists and ASBH for making this solution possible.

Whew!

You will be happy to learn that our panel for the Central Division meeting at the Palmer House Hilton in Chicago ran as expected. Hilde Lindemann chaired the session, entitled “Limits of and Challenges to Liberalism in Bioethics.” Speaking were Howard Brody (Michigan State University), Agnieszka Jaworska (Stanford), Rebecca Kukla (Georgetown), and Margaret Battin (University of Utah). The session was, as expected, very well attended and stimulating.

As for upcoming panels, in addition to the one rescheduled for New York, there are two in the planning stages. Mary Rorty (Stanford) from our committee is organizing a panel entitled “What is Wrong with Medicalizing?” for the 2006 Pacific meeting in Portland, Oregon. Lee Brown (Howard), another committee member, is putting together a panel, “The Place of Compassion in Medical Education and Medical Care,” for the Central Division meeting in Chicago. Because another committee member, Ben Rich (University of California, Davis), was well acquainted with his own institution’s empirical work bearing on this topic, we decided to override our presumption that committee members will not serve as speakers (as opposed to chairs) on the panels we sponsor. I greatly look forward to the three upcoming panels.

I also look forward to working with Robert Baker (Union College), who joined our committee this month. He replaces Hilde Lindemann, whose term just ended. A heartfelt thanks to Hilde for her years of energetic, intelligent, and conscientious service to this committee.
Gov. Jeb Bush Orders Terry Schiavo Back from the Dead

Timothy F. Murphy
July 6, 2005, Tallahassee, Florida

Following the advice of Governor Jeb Bush, the Florida Attorney General issued a subpoena today, ordering Terry Schiavo to return from the grave and testify in a criminal investigation into the cause of her sudden collapse into an unconscious state some fifteen years ago. Ms. Schiavo was the subject of an extended legal battle about her medical treatment preferences, prior to her widely reported death earlier this year.

At a news conference in the capital rotunda, Mr. Bush joined the Attorney General and said he would ordinarily not want to call anyone back from the dead but that Ms. Schiavo’s testimony was essential to a criminal investigation. He said, “I call on Terry Schiavo to give up her eternal rest temporarily and appear before the courts. I would hate to see her death stand in the way of the sanctity of her life.”

Some critics immediately condemned Mr. Bush’s interest in Ms. Schiavo as politically opportunistic. The chairman of the National Democratic Committee, Howard Dean, accused Governor Bush of using criminal investigations to try to influence elections in the state. “I wouldn’t be surprised if the Republicans asked Terry Schiavo to fill out an absentee ballot for the next election while she’s around,” he said.

Some bioethicists criticized the action on moral grounds. Bioethicist Susan Strathmore of Buena Vista University said the legal order violated the privacy expected by the dead. “It is not reasonable that people should have to return from the dead to testify, merely to satisfy the random curiosity of politicians in power at the moment,” she said. “Besides, the state has not offered to pay for the costs of her resurrection,” she went on. “Who knows what she can afford at this point?”

By contrast, bioethicist Willie Camper of the University of the Gulf Coast said that while it would be unusual to recall someone from the beyond, it is not always wrong. He explained that “in bioethics, people should rise from the dead if—on balance—doing so produces more good than harm. We call this the ‘Lazarus Principle.’” He acknowledged that some people would still object because of “the yuk factor.” “They see these things through the lens of the Dawn of the Dead,” he said.

Leon Kass, chair of the President George W. Bush’s Presidential Council on Bioethics, said that he was sure that Ms. Schiavo’s family would happily welcome her return. But he also warned against far-reaching consequences of this action. For example, he worried that “criminals might use this precedent in order to extend their litigation indefinitely. For the average Joe, this is a pretty attractive form of life extension.”

“I imagine,” he said, “if not even executions put an end to death row appeals.” At the close of the news conference, the Florida Attorney General said that if Ms. Schiavo failed to comply with the subpoena, he would try to reconstruct her memories through stem cell technology and enter them into evidence. He said Ms. Schiavo’s parents have offered a lock of Terry’s hair for this use.

Testimony from biologically reconstructed memory has not, however, been allowed in any U.S. court to date, although legislation in favor of its use is pending in California. Speaking on the condition of anonymity, an aide to Governor Arnold Schwarzenegger said that the former actor’s experience in the 1990 movie, Total Recall, gave him considerable expertise in biological memory construction and that he will sign the legislation if it reaches his desk.

Frozen Embryo Adoption and the United States Government

Kimberly Amoroso
Mount Sinai School of Medicine

In 2003, the Rand Institute and the Society of Assisted Reproductive Technology (SART) concluded that there were approximately 400,000 frozen embryos stored in fertility centers throughout the United States (Hoffman et. al., 2003). According to this survey, a majority of the frozen embryos would be used for future pregnancy attempts by genetic parents. However, many will remain frozen, causing an ethical and financial dilemma for patients and fertility physicians. Many couples feel conflicted about the disposition of remaining embryos after they have completed their families. Embryos remain frozen at fertility centers accompanied by high emotional, ethical, and financial costs. Some couples will even abandon embryos in an attempt to avoid decision making about disposition.

One might think that this is particularly a problem for Christian couples. Many Christians believe embryos are human life and, therefore, oppose their destruction. Couples of other religious and nonreligious backgrounds may not believe that embryos are children, but, nonetheless, many do believe that embryos hold special value. This makes it difficult for couples to decide about disposition. Additionally, the experience of infertility treatment is psychologically challenging for many couples, and decisions about the disposition of excess embryos can recall that experience and cause the powerful related emotions to resurface.

Why Are There Remaining Embryos?

Although reproductive technology improves every day, young women who utilize in vitro fertilization (IVF) usually have less than a fifty percent chance of achieving a pregnancy from each attempt, and for older women the statistics are far worse (CDC/SART, 2002). To surmount poor statistics, fertility physicians use stimulation medications to encourage a woman’s ovaries to produce multiple eggs to be fertilized. The hope is that several embryos will be created, giving the couple an increased chance to achieve a pregnancy. Multiple pregnancies are a concern, so usually only two to three embryos are transferred back into the woman’s uterus. Remaining good-quality embryos may be frozen for future use. Additionally, it is difficult for physicians to predict how many eggs will be produced from a stimulation cycle. Each woman’s response to the medication is different, and there is also variability for the same woman from cycle to cycle.

Another significant factor is that many couples prefer to have embryos frozen because of the significant physical, emotional, and financial cost of IVF treatment. If the couple is unsuccessful at achieving a pregnancy during their first attempt, or if they want additional children after a successful cycle, they do not have to bear the costs and stress of another IVF attempt when they have frozen excess embryos. Instead, they can utilize the frozen embryos from their initial IVF cycle. In this way, frozen embryos are an important asset for people
who are using assisted reproduction technologies. It is only after their families have been completed that the remaining frozen embryos become a dilemma.

**Embryo Adoption Versus Embryo Donation**

Couples have several different options for the disposition of excess frozen embryo. Embryos can be allowed to thaw and degenerate, they can be donated to Institutional Review Board (IRB)-approved research, or they can be donated/released to other infertile couples for their use in reproduction. Most IVF centers will offer anonymous embryo donation for their patients. The genetic parents are screened, and the embryos are released to recipients who are also screened. The couples are never known to each other.

Very few couples in the United States choose the anonymous embryo donation option (Hoffman et al., 2003). It is unclear whether this is attributable to the additional time and testing that must be performed on the donating couple, or because couples are not comfortable with the idea of embryo donation. Some may be concerned about their children having full genetic siblings who will be unknown to them.

Nightlight Christian Adoptions (NCA) may have been the first to use the term “embryo adoption” when it created Snowflakes, a nonprofit center for embryo adoption (Meckler, 2002 & Arekapudi, n.d.). Snowflakes coordinates the screening and matching of couples who have embryos to give with infertile couples. NCA hopes to “set a precedent...embryos need to be handled like any other child” (Foubister, 2002).

Embryo adoption programs differ from embryo donation programs in that they adhere closely to the tenets of traditional adoption. They require home studies, and families often meet and approve of one another. Snowflakes has strict criteria that it expects its recipient couples to follow, including requiring that couples do not reduce multiple pregnancies and that follow-up home studies are done following the birth of any babies. It is questionable whether Snowflakes would have any legal recourse against couples who didn’t adhere to these policies since there is no legislation regulating or recognizing embryo adoption. Additionally, in many states, the woman who delivers is considered the birth mother and listed on the birth certificate regardless of the genetics involved.

In 2002, President George W. Bush passed legislation allowing programs like Snowflakes to receive government funding to promote their embryo adoption programs (Office of the Press Secretary, 2005). Currently, government grants of $1 million per year are allocated for programs like Snowflakes, Embryos Alive, and National Embryo Donation Centers. At the same time, the American Society for Reproductive Medicine (ASRM) has been reluctant to apply for this grant money because of concerns regarding promoting one embryo disposition option over another (Meckler, 2002).

On May 24, 2005, President Bush met with families that have “adopted children as embryos” to “reiterate his opposition to using taxpayer money to promote (stem cell) research that takes life” (Office of the Press Secretary, 2005). The president considers embryo adoption to be a “life-affirming alternative” (Office of the Press Secretary, 2005).

**Pro-Choicers Up in Arms**

Using the term “embryo adoption” has many pro-choicers concerned because it suggests equating an embryo with a child. Many of the websites of these adoption organizations outright say that embryos should be given the same rights as children, including placement into “safe and loving environments.” Obviously, if eight cells need rights and protection, so do fetuses. If embryos are recognized as children, then all fetuses must be recognized as children. Proponents of choice feel that this type of language and federal support may challenge abortion rights (Vergara, 2002). Reportedly, for this reason, organizations like Planned Parenthood have sought to have the language of the grant changed from “embryo adoption” to “embryo donation” (Vergara, 2002).

**Proposed Legislation**

On May 25, 2004, the Food and Drug Administration released its proposed mandate for the regulation of tissue donation. Embryo donation falls under this mandate. The primary purpose of the mandate was to decrease infectious disease risk associated with tissue donation. Part of this regulation included a requirement that all tissue for donation (including embryos) would be tested for infectious diseases within seven days of its retrieval. This means that, in order for embryos to be eligible for donation (or adoption), within seven days from the time that the eggs are harvested and combined with sperm to create embryos they would have to be tested for infectious diseases.

This requirement may seem important or harmless enough in the context of most donated tissue (e.g., for transplantation), but for embryo donation this proposed legislation posed serious problems. For example, it is impossible to accurately predict when eggs will be ready for retrieval. Each woman’s response to stimulation medication is different. The eggs are retrieved when they reach an appropriate size in the ovary. For some women, this could be after eight days of medication, or ten, twelve, or fourteen days. Toward the end of a woman’s IVF stimulation cycle, she is monitored every day by her physician to determine the day of egg retrieval. Targeting the seven-day window prior to egg retrieval is impossible. Applying the regulation to embryos would, therefore, require couples to have repeat testing at additional cost. Infectious disease testing post retrieval is also problematic because there is no room for laboratory error. If a specimen is lost or dropped, there is no time for repeat testing within the seven-day window. Many of the tests required may take longer than a week to yield results, so a specimen problem may not even be determined within the seven-day window. Falling outside of the window would make the embryos ineligible for subsequent donation.

The second obstacle under this proposed mandate was that couples would need to know that they were interested in donating their embryos prior to completing their own pregnancy attempt. In vitro fertilization treatment is very stressful and an emotional roller coaster for many patients. Asking couples to think about whether they would want to donate embryos that have not even been created, or before their families have been completed, may constitute an undue burden. Couples who decided they wanted to donate after they completed their families would be left with no options for embryo donation.

Thirdly, this additional testing, which, for many because of the timing uncertainties, would need to be repeated several times, would add costs to an already expensive procedure. In vitro fertilization centers would also bear additional costs by spending time and money tracking and monitoring to ensure that correct testing was performed within the appropriate timeframe.

These new policies would have forced the destruction of more embryos and may have forced couples to dispose of their embryos in a way that was not acceptable to them. Additionally, more couples would choose to abandon embryos at IVF centers rather than deal with the decision to dispose of the embryos in a manner that is not satisfactory to them. This would leave IVF centers with the cost of storage, trying to
locate and seek legal action against those who abandoned embryos, and force centers to make decisions about destroying embryos without authorization from patients.

The proposed seven-day window was an arbitrary condition imposed by the FDA. Additionally, many states already have infectious disease regulations regarding gamete donation, and the ASRM has guidelines for screening gamete donors that include similar testing requirements. The New York State Department of Health previously had the strictest infectious disease testing window at thirty days prior to egg retrieval (AFA, 2005). This window has been effective in preventing infectious disease transmission from gamete donation (AFA, 2005).

**Reprive**

Fortunately, after receiving pressure from the ASRM, the final rule published by the FDA on May 25, 2005, was amended, extending the testing window to thirty days. Additionally, there are special exemptions for embryos that can be donated even if the donor couple is not tested within this window as long as the recipients are properly informed. The ASRM was successful in highlighting that the government’s policies would significantly impact embryo donation (adoption) programs. But the proposed legislating was not without cost to the reproductive medicine industry, which has spent the past year rewriting policies and procedures to comply with the originally focused mandate. Additionally, patients and advocacy groups, like the American Fertility Association and Resolve, have worked tirelessly to promote the rights of patients who want to fully exercise their options regarding the disposition of their embryos.

**Conclusion**

The issue of frozen embryos has many religious, psychological, ethical, and financial problems associated with it. The government, in an effort to bolster its stem cell research stance and appease the right-to-life movement, has given federal funding to embryo adoption centers. This alarms pro-choice advocates who fear the term “adoption” for cells. The government then proposed legislation without a careful understanding the scientific impact or even the impact on their own ideology.

**References**


**Medical Investigations of Homicides of Prisoners of War in Iraq and Afghanistan**

**Steven H. Miles, M.D.**

Center for Bioethics, University of Minnesota

**Introduction**

The publication of the photographs of the abuse of prisoners at Abu Ghrail has resulted in a widening circle of disclosures and official investigations of similar abuses in Iraq, Afghanistan, and at Guantanamo Bay. There are reports that some medical personnel neglected detainees’ medical needs and collaborated with coercive interrogations.1 Some physicians, medics, nurses, and physician assistants failed to report abuses or injuries caused by the abuses that they witnessed. This article reviews another human rights issue—the medical evaluation of cases in which prisoners potentially died because of mistreatment or under suspicious circumstances.

**Method**

This article is mainly based on government documents, including reports of U.S. Army and U.S. Navy criminal investigations, death certificates, autopsy reports, sworn statements, official correspondence between military personnel, and U.S. Department of Defense policies.
degree, it cites reports by human rights organizations and well-sourced media reports. Most of the events discussed in this article occurred in Iraq where the United States government accepts the application of the Geneva Convention's "Geneva Convention Relative to the Protection of Civilian Persons in Time of War," of which relevant excerpts are given below.

Excerpts from the “Geneva Convention Relative to the Protection of Civilian Persons in Time of War” (1949)

Article 129: Deaths of internees shall be certified in every case by a doctor, and a death certificate shall be made out, showing the causes of death and the conditions under which it occurred. An official record of the death, duly registered, shall be drawn up in accordance with the procedure relating thereto in force in the territory where the place of internment is situated, and a duly certified copy of such record shall be transmitted without delay to the Protecting Power as well as to the Central Agency referred to in Article 140.

Article 130: The detaining authorities shall ensure that internees who die while interned are honourably buried, if possible according to the rites of the religion to which they belonged, and that their graves are respected, properly maintained, and marked in such a way that they can always be recognized. ...As soon as circumstances permit...the Detaining Power shall forward lists of graves of deceased internees to the Powers on whom the deceased internees depended, through the Information Bureaux provided for in Article 136. Such lists shall include all particulars necessary for the identification of the deceased internees, as well as the exact location of their graves.

Article 131: Every death or serious injury of an internee, caused or suspected to have been caused by a sentry, another internee or any other person, as well as any death the cause of which is unknown, shall be immediately followed by an official enquiry by the Detaining Power. A communication on this subject shall be sent immediately to the Protecting Power. The evidence of any witnesses shall be taken, and a report including such evidence shall be prepared and forwarded to the said Protecting Power. If the enquiry indicates the guilt of one or more persons, the Detaining Power shall take all necessary steps to ensure the prosecution of the person or persons responsible.

Article 136: Upon the outbreak of a conflict and in all cases of occupation, each of the Parties to the conflict shall establish an official Information Bureau responsible for receiving and transmitting information in respect of the protected persons who are in its power. Each of the Parties to the conflict shall, within the shortest possible period, give its Bureau information of any measure taken by it concerning any protected persons who are kept in custody for more than two weeks. ...It shall...provide the aforesaid Bureau promptly with information concerning all...deaths.

Article 138: The information received by the national Bureau and transmitted by it shall be of such a character as to make it possible to identify the protected person exactly and to advise his next of kin quickly. The information in respect of each person shall include at least his surname, first names, place and date of birth, nationality, last residence and distinguishing characteristics, the first name of the father and the maiden name of the mother, the date, place and nature of the action taken with regard to the individual, the address at which correspondence may be sent to him and the name and address of the person to be informed.

How Many Detainees Died of Homicide by Torture?

In March 2005, the U.S. Armed Forces said that it suspected that twenty-six deaths were due to criminal homicides. However, it did not clarify whether these deaths occurred on the battlefield or in its prisons. The U.S. Department of Defense enumeration of “Substantiated” criminal homicides of detainees is certainly too low. There are cases in which a homicidal cause of death was not medically recognized and other cases in which the investigation of the death was insufficient to establish whether trauma was inflicted or accidental. Prisoners died of torture at Asadadad, Bagram, and Gardez in Afghanistan, and at Abu Ghraib, Camp Whitehorse, Basra, Mosul, Tikrit, Bucca, and an unidentified facility in Iraq (see Table ). These cases do not include deaths due to medical neglect, mortar attacks on prisons, or the shootings of rioting prisoners. Such cases will be considered after reviewing U.S. Department of Defense forensic medical procedures.

Substantiated and Unsubstantiated Homicides of Detainees

“Substantiated” criminal homicide by Armed Forces Criminal Investigation

“Unsubstantiated” due to unrecognized homicidal cause of death (false natural deaths)

- Homicide by torture method (e.g., asphyxia that was not recognized as cause of death);
- Homicide by heart attack; and
- Homicide by medical neglect.

“Unsubstantiated” due to obstructed/incomplete investigation:

- Obstructed investigation by local commander;
- Formally/informally unregistered detainees who are invisible to investigation; and
- Detainees who die by torture after rendition to torturing authorities in other nations.

Medical Investigations of Prisoners’ Deaths

The Armed Forces Institute of Pathology, Washington, D.C., is responsible for determining the causes of deaths of prisoners who died in U.S. detention facilities in Iraq, Afghanistan, and Guantanamo Bay. Ten years ago, the Institute created the Armed Forces Office of the Medical Examiner (AFME) to conduct autopsies of soldiers or civilians (including prisoners) who died while in the Armed Forces or under their jurisdiction. In 2002, budget cutbacks left the AFME with only two forensic pathologists; in 2004, it had thirteen. The AFME was not prepared to investigate the deaths of prisoners who may have died of torture. Its pathologists have published little on forensic pathology and are not known to have specialized expertise in investigating or documenting the injuries of persons who died as a result of torture.

Death Certificates

On May 21, 2004, a U.S. Department of Defense press conference addressed concerns about the deaths of prisoners in Iraq and Afghanistan. The Department released twenty-three death certificates that were incomplete and fell far short of standard medical practice or the requirements of the Geneva
Convention (Figure 1). Thirteen of the death certificates do not note a date of birth, a vital statistic that would be helpful in evaluating the claim that many prisoners died of heart attacks. None record the next of kin or disposition of the remains. Many do not specify the location of death: four simply record "Iraq." The incompleteness of the death certificates and autopsy reports suggests that Armed Forces pathologists supervising prisoners' autopsies did not have access to medical records, information about events preceding the deaths, or the circumstances under which the bodies were found to correlate with autopsy findings. Medical records were rarely created for Iraqi prisoners.7,8 If available, field investigators inconsistently noted their contents. Field investigators rarely documented any inquiry into confinement or interrogation events preceding the death.

The death certificate sections entitled "Other Significant Conditions" and "Major Autopsy Findings" are blank. Given that half of the deaths were caused by physical abuse, it is notable that none of the persons dying of "natural causes" had any noteworthy signs of trauma. For example, Baha Mousa was arrested and died in August 2003. He was heard screaming. A person who saw the body saw lacerations, severe chest trauma, and a broken nose. The death certificate said that the cause of death was "cardio-respiratory arrest-asphyxia" of unknown cause and does not record any signs of trauma.9,10

The May 2004 death certificates appear to have been finalized for the press conference rather than completed during the routine work of the pathologists. Most bear preliminary signatures dated within a week of the death, but seventeen of twenty-two certificates for deaths occurring between 2002 and 2004 were finalized within nine days of the press conference. It appears that pathologists signed their batch of certificates at a single sitting at which the earlier and later signatures were affixed. Figure 2, for example, shows all

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**Figure 1.** Death certificate. Notice the lack of birth date, detainee number, next of kin, circumstances of death, autopsy findings, and that the location of death is "Iraq."
five death certificates signed by Major Michael E. Smith. It appears that he used one pen and signature mark to simultaneously put a preliminary signature on certificates dated August 22, 23, and 25, 2003, and on October 23 and December 2, 2003, and then finalized those same certificates on May 12, 2004, with the same pen and hand stroke. A similar pattern is seen on death certificates signed by Colonel Eric Berg, Lieutenant Colonel Elizabeth Rouse, and Major Louis Finelli. James Caruso used the same signatures on his three death certificates and signed one for Jerry Hodge on May 13, 2004.

Two prisoners inexplicably have two differing final death certificates. Dilawar was a prisoner who was murdered in Afghanistan. A retyped certificate adds his age, religion, and a comment on the circumstances of death. The date of death and the rank, title, and address of the name-censored pathologist and the final signature date are also all changed. Fahin Ali Gumaa, who died after being shot under unclear circumstances, has two death certificates—one finalized before the May 2004 press conference and another finalized in June.

“Natural” Deaths

It is probably inevitable that some prisoners who reportedly die of “natural causes” in truth died of homicide. However, the nature of Armed Forces’ medical investigations made this kind of error more likely. The AFME reported homicide as the cause of death in ten of the twenty-three death certificates released in May 2004. The death of Mohamed Taiq Zaid was initially attributed to “heat”; it is currently and belatedly being investigated as a possible homicide due to abusive exposure to the hot Iraqi climate and deprivation of water.

Eight prisoners suffered “natural” deaths from heart attacks or atherosclerotic cardiovascular disease. Threats, beatings, fear, police interrogation, and arrests are known to cause “homicide by heart attack” or life-threatening heart failure. People with pre-existing heart disease, dehydration, hyperthermia, or exhaustion are especially susceptible.11-15 No forensic investigation of lethal “heart attacks” explores the possibility that these men died of stress-induced heart attacks. There are a number of reports of “heart attack” following harsh procedures in rounding up noncombatants in Iraq and Afghanistan. A typically sketchy U.S. Army report says, “Detainee Death during weekend combat...Army led raid this past weekend of a house in Iraq...an Iraqi who was detained and zip-locked (flexi-cuffed with plastic bands tying his wrists together) died while in custody. Preliminary information is that the detainee died from an apparent heart attack.”16 Sher Mohammad Khan was picked up in Afghanistan in September 2004. Shortly thereafter, his bruised body was given to his family. Military officials told journalists that he had died of a heart attack within hours of being taken into custody. No investigation, autopsy, or death certificate is available.17 An account collected by the Christian Peacemaker Team also suggests a stress-induced heart attack. On December 21, 2003, soldiers burst into the home of Mehadi Al Jamal, a retired land surveyor who lost an election because he was not a member of Saddam Hussein’s Ba’ath Party. The seventy-year-old man had a hip replacement and walked with a cane. The Christian Peacemaker Team reports the son as saying:

They pushed him like a criminal; they didn’t let him use his cane because his hands were tied. They handcuffed and put plastic hoods on my father, my uncle and my brother. I heard my father say, “I can’t breathe...” They pushed him into the vehicle. My father was in very bad condition at that time. He couldn’t talk because of the bag. ...I could hear him gasping. ...After that, my father stopped moving. ...[An] officer told me my father died from a heart attack.18

Abed Al Razak was treated at the Abu Ghrabi hospital in mid-2004 for an unspecified cardiac condition several days before he suddenly died. Criminal investigators carefully documented the attempted resuscitation. They noted that the body had “no apparent signs of extraordinary trauma or injury,” but they didn’t record any inquiry into the nature of his interrogation or confinement. Thus, it is not known whether Mr. Razak was hooded with a sandbag that impaired his breathing or ability to exhale body heat. It is not known whether he was subject to prolonged stress positions, “fear up
harsh,” heat or cold exposure, sleep deprivation, shouted threats, continuous loud noise, sexual humiliation, or whether he saw a relative being beaten.19

Abdul Kareen Abdura Lafta (also known as Abu Malik Kenami) was admitted to Mosul prison on December 5, 2003, and died four days later.20,21 The short, stocky, forty-four-year-old man weighed 175 pounds. He was never given a medical examination, and there is no medical record. After interrogation, a sandbag was put over his head. When he tried to remove it, guards made him jump up and down for twenty minutes with his wrists tied in front of him and then twenty minutes more with his wrists bound behind his back with a plastic binder. The bound and head-bagged man was put to bed. He was restless and “jibbering in Arabic.” The guards told him to be quiet. The next morning, he was found dead. The body had “bloodshot” eyes, lacerations on his wrists from the plastic ties, unexplained bruises on his abdomen, and a fresh, bruised laceration on the back of his head. U.S. Army investigators noted that the body did not have defensive bruises on the arms, an odd notation given that a man cannot raise bound arms in defense. No autopsy was performed. The death certificate lists the cause of death as unknown. It seems likely that Mr. Kenami died of positional asphyxia because of how he was restrained, hooded, and positioned. Positional asphyxia looks just like death by a natural heart attack except for those telltale conjunctival hemorrhages in his eyes.

Mishandled Forensic Medical Evidence

The Office of Medical Examiners did not develop adequate procedures for preserving evidence for trial. The cooler contained the autopsy specimens of the murdered prisoner, Mr. Nagen Sadoon Hatab, exploded while sitting on a hot airport tarmac awaiting transport to trial. Pathologist Colonel Kathleen Ingwersen lost the broken neck hyoid (wishbone) bone showing that a soldier had strangled Mr. Hatab. The throat and rib cage were found on two different continents. As Dr. Ingwersen explained, “I should have paid closer attention…instead of relying on what turned out to be a miscommunication with my assistant.” She suggested that she mishandled evidence because she was taking a drug to treat an allergic reaction to sandfly bites. The Armed Forces Institute of Pathology then obstructed the trial by refusing to allow independent DNA testing on the decedent’s rib cage that they had temporarily lost so that the prosecution could prove that it came from the decedent. The judge rebuked the Institute for its lack of cooperation and the broken chain of evidence, but the homicide charges were dropped against several defendants.22,23 The effect of the existence of two differing death certificates on the trial of those who murdered Dilawar remains to be seen.

Obstructed Death Investigations

Several Defense Department practices facilitate obstructing the medical evaluation of a death so that investigators are less likely to substantiate that a homicide occurred. Local commanders aborted or delayed some death investigations. At Husaybah, an unnamed prisoner made more than twenty escape attempts in thirty-six hours before he reportedly threw himself out of a window and died of head trauma. It is difficult to understand—given the routine use of restraints on noncompliant prisoners—how such a prisoner could throw himself out of a window. The camp commander delayed reporting the death. A cursory and inconclusive investigation was conducted more than a month after the body had been buried.24 At Camp Cropper in 2003, an Iraq prison where many detainees were abused, two investigations were locally closed without autopsies.25 In one, a prisoner being treated for chest pain “fell out of bed and struck his head. A CAT scan showed intra cranial trauma and signs of prior head injuries.” Another detainee was found “unresponsive by guards”; the body did not exhibit any signs of abuse or foul play.

It is highly likely that investigators failed to substantiate homicides of ghost detainees. Mr. Hadi Abdul Hussain Hasson was a ghost detainee at Camp Bucca in Iraq. He was captured on an unknown date in the spring of 2003. U.S. Army investigators learned of his death on July 27, 2004. The investigator wryly notes, “Due to inadequate record keeping, this office could only estimate the Mr. Hasson possibly died between April-Sept 03.” Mr. Hasson’s name was not found on the camp roster, military intelligence notes, medical records, or autopsy reports. The U.S. Army death homicide investigation was “unsubstantiated,” but the investigation file contains a note, “Preliminary investigation has revealed the following detainees have alleged they were abused while in Coalition custody…Hussain Hasson.” 26 Nasrat Mohammad “Amer” Abed al-Latif disappeared after being taken into custody. The twenty-three-year-old Iraqi physics student was shot during a raid on his house by plain-clothed armed men who appeared to be U.S. nationals. His father and two brothers were detained for five days. Soldiers told the family that they had taken the injured Amer to a medical facility where he had died and that his body would be returned to them. His body and records of his care have disappeared.27 Jamal Naseer was picked up by U.S. Special Forces in Afghanistan in March 2003. He was held in a small, overcrowded detention cell at Gardez, a facility that did not register its prisoners and which was closed to Red Cross monitors. No medical personnel visited Naseer during the seventeen days that he was held and beaten. Men arrested with Mr. Naseer were beaten, kicked, whipped, slammed against the wall, and immersed in cold water. Their toenails either fell off or were torn off. Eyewitness reports that Mr. Naseer suddenly fell to the ground, seized, and died. He was bleeding from his ear. The clinical history suggests that he died of a basilar skull fracture, an injury caused by severe head trauma with a hard object. His death was not mentioned in the Pentagon’s updated list of thirty-nine detainee deaths in July 2004. The Pentagon claims that it did not know of this case until a human rights organization, the Crimes of War Project, informed them of the matter. Six months after he died, the U.S. Army announced that it was opening an inquiry.28

“Rendition” is the practice of transporting prisoners to countries that practice torture for interrogation and imprisonment. It is against U.S. law and the Geneva Convention. There is no account of the fates of the several hundreds of persons who have been tortured during this practice.29 The United States bears responsibility for homicides of these prisoners.

The U.S. Department of Defense Responds

In 2004, in response to challenges to the veracity of death certificates and cases in which the reported cause of death had changed from “natural causes” to “homicide,” Pentagon spokesperson Lieutenant Colonel Ellen Krenke asserted, “There is no evidence that final death certificates were falsified.” 30 Another official offered a similar view: “An initial reported cause of death is a field expedient process, often made by local medical personnel not fully qualified to certify cause of death. Autopsies corroborate or correct initial inaccuracies.” 31 In February 2005, Assistant Secretary of Defense for Health Affairs Dr. William Winkerwerder, M.D., reiterated that there is “no evidence” of falsification of detainee death reports. 32

In 2005, the Defense Department released the Executive Summary of Vice Admiral Albert Church’s investigation of interrogation operations. It claims to have reviewed sixty-
## Afghanistan Detainee Torture Deaths

<table>
<thead>
<tr>
<th>Name, Age</th>
<th>Location of Detainer/Date</th>
<th>Event History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mullah Habibullah (also known as Habib Ullah), ~30</td>
<td>Bagram, December 4, 2002; U.S. Army</td>
<td>Dr. Ingwerson did the autopsy on December 6-8, 2002, and promptly signed a death certificate finding homicide by “Pulmonary embolism due to blunt force injury to the legs.” Defense Department issued false report of natural death and, when pressed by media, issued the death certificate in May 2004. Admiral Church identified this case as one in which medical personnel may have attempted to misrepresent the circumstances of death, possibly in an effort to disguise detainee abuse. Prosecution under way.</td>
</tr>
<tr>
<td>2 Dilawar, 22,42</td>
<td>Bagram, December 10, 2002</td>
<td>Dr. Rouse did the autopsy on December 13, 2002; signed the preliminary copy on December 13, 2002; and did not finalize the death certificate until May 20, 2004, just before the Pentagon press conference. The autopsy attributed the death to a homicide by “Blunt force injuries to lower extremities complicating coronary artery disease.” Defense Department issued false report of natural death and, when pressed by media, issued the death certificate in May 2004. The Defense Department has issued two different death certificates on this person. Admiral Church identified this case as one in which medical personnel may have attempted to misrepresent the circumstances of death, possibly in an attempt to disguise detainee abuse.</td>
</tr>
<tr>
<td>3 Jamal Naser,28,43</td>
<td>Gardez, Special Forces, March 2003</td>
<td>Severely beaten unregistered detainee. On September 20, 2004, the U.S. Army confirmed that it was opening an inquiry into the death.</td>
</tr>
<tr>
<td>4 Abdul Wali,28,44</td>
<td>Asadadad Base, Kunar, June 21, 2003</td>
<td>No autopsy performed. Cursory exam in the dark by Afghan officials. Former CIA contractor and special operations soldier charged with assault by beating Mr. Wali with a flashlight.</td>
</tr>
<tr>
<td>5 Abdul Wahid,45</td>
<td>Bagram, November 6, 2003</td>
<td>Dr. Kathleen Ingwerson did the autopsy, signed, and finalized the death certificate on November 13, 2003. She concluded that he had died of a homicide from “Multiple blunt force injuries complicated by probably rhabdomyolysis [extensive crush injuries of the muscles].” The Pentagon released the death certificate in May 2004.</td>
</tr>
<tr>
<td>6 Sher Mohammad Khan17</td>
<td>September 24, 2004</td>
<td>Military officials told journalist that he had died of a heart attack within hours of being taken into custody. Autopsy not released. Family retrieved the bruised body.</td>
</tr>
</tbody>
</table>

## Iraq Detainee Torture Deaths

<table>
<thead>
<tr>
<th>Name</th>
<th>Location of Detainer/Date</th>
<th>Event History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Radi Nu’ma27,46</td>
<td>British forces, Basra, May 8, 2003</td>
<td>UK soldiers delivered a note to house, “Radi Nu’ma suffered a heart attack while we were asking him questions about his son. We took him to the hospital.” Family were told at the hospital that no person of that name existed. Body found in morgue. RMP had delivered unidentified corpse on May 8 and told staff that cause of death was a heart attack but did not give any other historical or identifying information.</td>
</tr>
<tr>
<td>2 Nagen Sadoon Hatab47-50</td>
<td>U.S. Marines Camp Whitehouse, June 6, 2003</td>
<td>The base commander testified that a medic said that Hatab was “faking” or had a “mild heart attack” when seen six hours before death. Autopsy showed that he had been strangled, and the hyoid bone (wishbone) in his neck had been crushed when a soldier dragged him by the throat. However, the case fell apart when the Armed Forces lost the pathology specimens (see text). The Defense Department says that the broken bones came from bouncing the body in a Humvee after death. Dr. Kathleen Ingwerson did the autopsy, signed, and finalized the death certificate on June 10, 2003.</td>
</tr>
<tr>
<td>3 Dilar Dababa25</td>
<td>Secret center, Baghdad, June 13, 2003</td>
<td>There are several accounts of his traumatic death. Dr. Elizabeth Rouse did an autopsy on June 17, 2003, and signed the death certificate as a homicide by “Closed head injury with a cortical brain contusion and subdural hematoma.” However, she did not finalize the death certificate until May 14, 2004.</td>
</tr>
<tr>
<td>4 Baha Mousa29,50</td>
<td>Al Hakima, Basra, September 13, 2003</td>
<td>A twenty-eight-year-old prisoner was heard screaming and calling for assistance. Death certificate said that cause of death was “cardio-respiratory arrest-atrophyxia”; cause unknown. Lacerations, broken ribs, and a broken nose were not noted on the death certificate (seen by ICRC, which remains classified), although such were noted by witnesses who saw the body.</td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Location</td>
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</tr>
<tr>
<td>5</td>
<td>Mohamed Taiq Zaid</td>
<td>United States, Iraq</td>
</tr>
<tr>
<td>6</td>
<td>Obeed Hethere Radad</td>
<td>U.S. Army, Tikrit</td>
</tr>
<tr>
<td>7</td>
<td>Baha Dawud Al-Maliki</td>
<td>British forces, Basra</td>
</tr>
<tr>
<td>8</td>
<td>Kefah [Kifah] Taha</td>
<td>British forces, Basra</td>
</tr>
<tr>
<td>9</td>
<td>Mon Adel Al-Jamadi</td>
<td>CIA/SEALS, Abu Ghraib</td>
</tr>
<tr>
<td>10</td>
<td>Abed Hamed Mowhoush</td>
<td>CIA/U.S. Army, Al Qaim</td>
</tr>
<tr>
<td>12</td>
<td>Fashad Mohamed</td>
<td>US SEALS, Mosul</td>
</tr>
</tbody>
</table>

CIA = Central Intelligence Agency; ICRC = International Committee of the Red Cross; ICU = intensive care unit; RMP = Royal Military Police
eight detainees’ deaths but neither lists these deaths nor states whether they included all the prisoners who died. Some of these deaths were by criminal and justified homicide; some were by natural causes. Without further comment, Admiral Church noted three cases (Mullah Habibullah, Dilawar, and Al-Jamadi) in which medical personnel may have attempted to misrepresent the circumstances of death, possibly in an effort to disguise detainee abuse.35

Discussion

The Armed Forces Institute of Pathology bears primary responsibility for the inadequate investigation of detainees’ deaths. There is no evidence that its staff properly and forcefully asserted the need for field commanders to follow Defense Department policies for reporting prisoners’ deaths for investigation. In June 2004, in the wake of public concern about unreported deaths of prisoners under torture, U.S. Secretary of Defense Donald Rumsfeld sent a memo to field commanders reiterating U.S. Department of Defense policies for reporting and investigating prisoner deaths.34 The Institute’s death certificates failed to comply with U.S. Army and Geneva Convention obligations. In civilian practice, when a physician does not know the cause of death, or where the death is under investigation, the proper procedure is to write “pending investigation” or similar phrasing on the death certificate rather than enter a misleading or exculpatory cause. U.S. Army regulations dictate a similar standard: “When the cause of death is undetermined, the medical officer will make a statement to that effect. When the cause of death is finally determined, a supplemental report will be made.”35

Delayed death certificates have harmful consequences. They hamper investigators who use their findings to question witnesses while their memories are fresh. The contorted construction of “final death certificates” does not comport with Defense Department policy and allowed Defense Department spokespeople to knowingly announce that deaths were due to natural causes, an impression that Armed Forces’ pathologists who knew better did not challenge. For example, Pentagon officials claimed that Iraqi General Abed Hamed Mowhoush died of natural causes. Reporters learned that he had been beaten, stuffed headfirst into a sleeping bag, and sat on until he died. A paramedic could not resuscitate him; a military surgeon declared death by natural causes. Six months after his death, the U.S. Army released a death certificate and reported that he had died of homicide. A similar sequence of an incorrect Defense Department report of “natural deaths” was followed by late-arriving death certificates finding that “homicide” occurred in the cases of Dilawar and Habibullah. Delayed death certificates make it difficult to create the Geneva-mandated registries of decedents so that families can be notified and bodies claimed for burial. For example, Mr. Al Jamal died November 4, 2003; his death certificate was finalized on May 13, 2004, as his body lay unclaimed in the Baghdad Morgue.36 For want of a death certificate, relatives can be unable to get death benefits, seek redress, or have the closure of learning how and when a loved one died.

The AFME failed to fulfill its own policy and its Geneva obligation to ensure that death investigations could be used for sentinel public health research to identify torture as a pattern of preventable death.37 This failure was of critical importance between 2002, when human rights organizations began complaining of prisoner abuse, and 2004, when the Abu Ghraib photographs became public. By failing to report statistics on deaths by torture or signs of abusive injuries, it failed to perform its duty to issue an authoritative early warning that something was seriously wrong in the prisons.

The failures of the Armed Forces Institute of Pathology were amplified by other administrative, investigatory, and prosecutorial failures by the U.S. Department of Defense and Central Intelligence Agency (CIA). The U.S. Department of Defense has not provided a public accounting of the names, locations, circumstances, and numbers of prisoners who died by abuse or natural causes during arrest, transport to prisons, or imprisonment. It has failed to allow an independent review of autopsy photographs, particularly of the exterior of the bodies, which may show trauma that went unnoted. Allowing base commanders to abort or delay the investigations of prisoners’ deaths made it less likely that investigators would be able to substantiate that a criminal homicide had occurred. The failure to create prisoners’ internment records containing demographic, medical, and family information, and the failure to investigate the interrogation procedures deprived pathologists of the information that they needed for assigning a cause of death. The unexamined deaths of ghost detainees and of those who were sent to other torturing nations for interrogation are not counted, and it is unlikely that those responsible will ever be held accountable.

Even when investigators found a criminal homicide, the U.S. Department of Defense was reluctant to prosecute those involved, or who were aware of the abuse. A soldier who shot a prisoner to death was not prosecuted because he was not informed about the rules for using force against prisoners.38 At Camp Bucca in September 2003, an International Committee of the Red Cross monitor saw a guard shoot a prisoner in the chest. The monitor said, “The shooting showed a clear disregard for human life and security of the persons deprived of their liberty.”9 The U.S. Army concluded that the shooting was justifiable. Escaping, nonthreatening detainees were shot on other occasions.39 The base commander at Tikrit prison used an administrative procedure to preempt the prosecution of the soldier who killed Obeed Hethere Radad (see Table ). Most of the soldiers prosecuted for criminal homicides of prisoners received nonjudicial punishments, such as a reduction in rank, and the record of charges, punishments, and even the name of the victim are sealed.3

War conspires against forensic medicine. Autopsy facilities are inadequate and often far removed from prisons. There is often a low priority for employing military resources for forensic investigations. However, a great deal of material was available to the Armed Forces Institute of Pathology to assist its work. The United Nations and World Medical Association endorse the Manual on Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. It says that physicians evaluating corpses that may have been tortured must be trained to detect and document signs of torture. It specifies that corpses should be examined for signs of beatings, thermal and chemical burns, visible and invisible fractures, and signs of tight ligaments around the penis or extremities, suffocation, brain damage, suspension tears to ligaments or muscles or nerves, and anal or vaginal penetration. Each of these kinds of abuses has been reported in Armed Forces detention centers. That Manual, called the “Istanbul Protocol,” further states, “Forensic doctors should not falsify their reports but should provide impartial evidence including making clear in their reports any evidence of maltreatment.”40,41

The failures of the Armed Forces Institute of Pathology have had diverse adverse consequences. A death monitoring system, which might have led to earlier awareness and prevention of homicides and abuse caused by torture, was never operational. Mishandled evidence and incomplete evaluations allowed alleged perpetrators of lethal torture to go unpunished. The failure to integrate the completion of...
death certificates into a Geneva-mandated system for notifying relatives of deaths compounded the grief, anger, and uncertainty of families. Bodies were administratively buried rather than being interred by relatives with proper ceremonies in the family’s chosen place of interment. Our national reputation and interests were harmed by these failures.

Endnotes
Citations to government documents have been facilitated by the anthology: The Torture Papers: The Road to Abu Ghraib, edited by Greenberg KJ and Dratel JL. New York: Cambridge University Press, 2005. Its pagination will be used whenever possible.

Citations to government documents that are not in The Torture Papers pose unique bibliographic challenges. Subject fields, authors, recipients, and dates have often been redacted. The documents are neither catalogued nor indexed. Many, but not all, have page stamps with several different prefixes (no prefix, DODDOACID, or DOD). Accordingly, the letterhead name of the agency, date, and pagination are the best available citations at this time. Media and Defense Department documents have been posted and taken down; therefore, documents are not cited by the original URLs from which they were downloaded. The ACLU and Center for Public Integrity maintain repositories of government documents at http://www.aclu.org/tortureFOIA and http://www.publicintegrity.org/report.aspx?aid=396&sid=100. For brevity, all dates are given as month/day/year.

References

35. U.S. Army Regulations. 190-8:6-14(5-6).
Physician Integrity, Enhancement Technologies, and Consumer Autonomy

Howard Brody
Michigan State University

Here, I review the concept of physician integrity (PI) based on the internal morality of medicine (IMM), as developed in a series of papers co-authored with Franklin G. Miller. I then apply the concept to several "peripheral" cases, especially where advertising is commonly employed, to analyze the relationship between protection of PI and patient autonomy.

Miller and I have argued that the principal elements of the IMM (for present purposes) are the goals of medicine and ethically acceptable means (internal duties that constrain practices). A proposed list of the goals of medicine (from a Hastings Center international consensus conference) includes: 1) prevention of disease, promotion and maintenance of health; 2) relief of pain and suffering caused by maladies; 3) care of those with maladies, with care where possible; and 4) avoidance of premature death and pursuit of a peaceful death.

Internal duties that constrain medical practice include: 1) competence; 2) avoidance of harms disproportionate to benefits; 3) avoidance of fraudulent portrayal of medical science and skills; and 4) fidelity to the therapeutic relationship with patient.

Applying this model of PI results in three categories: 1) Core medical practices clearly consistent with PI (such as surgery for acute appendicitis); 2) Peripheral practices—problematic but not necessarily ruled out by PI (such as surgical sterilization and, we have argued, cosmetic surgery); and 3) Violations of IMM/PI (such as physician-administered or -ordered lethal injection for capital punishment).

I will now consider three practices that might be consigned to the "peripheral" category—direct-to-consumer advertising (DTCA) of drugs; cosmetic surgery; and whole-body high-speed CT scans for screening. My focus will be on the extent to which all depend on advertising to consumers.

One can articulate, first, a fairly standard defense of each of these practices based on an appeal to "patient autonomy" (which I do not here define further).

DTCA: The practice informs patients of new medications and prompts medical screening for serious but asymptomatic diseases (hypertension, diabetes, etc.). It helps to destigmatize conditions such as erectile dysfunction, allowing patients to seek needed care. Since physicians still serve as gatekeepers with the power to prescribe or not, the dangers of overuse or inappropriate use of medications is obviated.
Cosmetic Surgery: One's appearance can be a source of serious, even psychiatrically meaningful dysphoria and dysfunction. Only the individual can decide whether the risks and costs of surgery are worth the possible benefits. The average patient may well be unaware of the latest, less-invasive surgical techniques, so advertising plays an important educational function.

CT Screening: In selected individual cases, screening may be lifesaving. Screening is typically paid for out of pocket, so no communal funds are spent. Individuals should be free to spend their own money as they wish after being informed of options.

To each of these arguments based on “patient autonomy,” a rebuttal is possible, in terms of PI.

DTCA: Advertising, by its nature, misinforms rather than educates (it appeals to emotion, not reason). The physician has to take valuable time to eliminate misconceptions even before engaging in useful counseling. DTCA prompts the patient to arrive in the office as a would-be consumer seeking a prescription, not as a true participant in the process of health care (which might well require that emphasis be placed on life-style changes, not on the purchase of medications).

Cosmetic Surgery: Society is already plagued with commercial messages preaching the inadequacy of the normal human body and insisting that we must consume expensive products to make our bodies socially acceptable. Typical ads for cosmetic surgery add to this negative message by depicting slender, bikini-clad models, suggesting that any woman who does not measure up to that “ideal” is in need of surgery. Such ads spread what is arguably a “disease” (distorted expectations of adequacy and “beauty”) merely so that the surgeon can make money. This is somewhat analogous to an infectious disease expert who puts typhoid bacillus in the local water supply so that he can have an epidemic on which to practice his skills.

CT Screening: All available evidence and professional organization guidelines oppose the use of CT for general screening, due to the high false-positive rate in low-risk populations. The (Bayesian) reasons why an intuitively good test might really be bad for the individual are not, however, easily explained in sound bytes. Ads for CT screening systematically miseducate the public under the guise of promoting “prevention.”

The potential conflict between PI and patient autonomy considerations suggests two questions: 1) Does physician adherence to this conception of PI threaten patient and public autonomy? 2) Does it “over-medicalize” society?

If the PI-based rebuttals to the “autonomy” arguments offered above prove plausible, then it would seem that PI could, at least some of the time, function in defense of a deeper level of patient autonomy. A key question is—If we see an ad on TV and then run out to buy the product, how autonomous is our behavior? If the answer is: fully autonomous, then any restriction on the “right” to advertise and sell products is unacceptable. But if, on reflection, the answer is: less than ideally autonomous, then we can support social mechanisms that rein in advertising in the name of public interest protection. PI is such a mechanism of public interest protection. It is still important, nevertheless, to see that the main goal of PI is not to protect public interests per se but, rather, to protect medicine as a certain sort of moral enterprise. Society at large must still decide if allowing medicine to maintain that moral status is an overall social good.

Physician-centric practices are sometimes accused of causing an “over-medicalization” of society by inappropriately increasing physicians’ power. It is therefore important to see that what “medicalizes” society in these three case studies is not runaway medical hegemony but, rather, the advertising campaigns designed to increase profits. It is the advertising that turns normal health and appearance into a “problem” requiring a medical “fix.” By opposing advertising in these sorts of instances, PI actually acts as a force to constrain the inappropriate medicalization of the culture.

References

The Limits of Lines: Negotiating Hard Medical Choices
Rebecca Kukla
Johns Hopkins University/Carleton University

In April 2005, the APA Committee on Philosophy and Medicine hosted a panel on “Limits of and Challenges to Liberalism in Bioethics.” Those of us who were invited to participate in the panel were asked to consider the limits of patients’ right to demand access to medical interventions. It is not surprising that this issue has come to the fore in bioethics, given two well-recognized recent cultural phenomena: the valuation of patient autonomy and denigration of old-fashioned physician paternalism, and the explosion of new medical procedures with high market values but substantial moral or medical risks (such as bariatric surgery, postmenopausal IVF, and silicon breast implants, to name just a few).

Typically, the language of the limits here goes hand in hand with a specific conceptual framework and set of metaphors, within which we cast the question of the proper place and functioning of patient autonomy in medical care. We imagine the limit of patient autonomy as a line dividing those interventions that are rightly left to patients to choose or reject, from those risky enough to be rightly left to physician prescription. This image produces a privileged ethical question: Where should we draw this line? For example, my invitation asked, “Given patient requests for such things as sex selection, amputation of healthy limbs, heart donation, selecting embryos for deafness, genetically altering embryos to make offspring white instead of black, etc., where and how should physicians draw the line?” This invitation makes explicit the “line” interpretation of the “limits” question. Its list of questionable interventions keeps our ethical attention focused on the task of deciding on which side of the line different interventions fall. This line imagery in effect divides interventions into two domains, one in which the patient is sovereign and one in which the physician is sovereign. With this division comes the idea that neither party has any business intruding into the other’s domain. Furthermore, the language of the invitation takes it as given that the line is the physician’s to draw, so that patient autonomy, despite the primacy we claim to give it in bioethics, is ultimately a favor to be granted or withdrawn by physicians. On this picture, the physician becomes a kind of technician who provides services on demand and refrains from intruding on the decision-making process within the patient’s

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domain, and a gatekeeper with respect to those procedures that lie on the other side of the line.

In this paper, I will challenge this line-drawing strategy. The problem is not that the line dividing the physician’s from the patient’s sovereign domain is fuzzy but, rather, that the imposition of—or even the search for—any such line, no matter what its resolution, already distorts the ethical terrain. Of course, there are medical interventions that fall cleanly within the proper domains of physician prescription or patient discretion, such as how to set a broken leg, or whether to have one’s teeth whitened, respectively. But the interesting cases are those that don’t obviously fall into either camp, such as infertility treatments, living organ donation, and bariatric surgery. We cannot assume that somewhere between the easy cases there exists a line to be discerned, for it may be instead that such “middle” cases require a whole different kind of ethical analysis. I want to argue that the proper limits of patient autonomy are not boundaries around a domain of interventions within which the patient’s choices and preferences are sovereign; they are, rather, limits imposed by human finitude and dependency, which give us each less than perfect access to right reason, less than complete capacities to maintain fidelity to our own principles and values, and the appropriate and humble need for expert guidance and assistance. This reframing will recast the role of the physician in promoting patient autonomy, from gatekeeper and technical service provider to assistant in the development of patients’ finite capacity for autonomous choice and action.

A 2004 case study in the Hastings Center Report entitled “Is the Patient Always Right?” was specifically designed to raise questions about the limits of patients’ right to demand medical procedures. The clear implication of the title was that, within whatever domain we grant that right, the patient counts as a sovereign decision-maker who is “always right,” and her preferences and choices likewise count as infallible measures of right practice. But sustaining this thesis requires a physician to adopt one of two attitudes toward patients’ decision-making practices, both of which strike me as manifestly unacceptable. The physician can be a relativist and think that the patient really is always right—that somehow, despite his human fallibility and finitude, the mere fact that he chooses something makes it the case that his choice is right “for him.” Or, the physician can be a cynic and think that the patient may make bad choices within his circumscribed domain but that this is none of the physician’s business—her job is to treat this choice as if it were right and to provide the services that the patient requests.

To avoid this forced choice between relativism and cynicism, we need to find a way of asking about the limits of patient autonomy that does not equate autonomy with infallible sovereignty. In order to get there, I’d like to look at the Hastings Center Report case study in some detail. The case concerns a twenty-six-year-old lawyer, H. A., who, according to the text, asks to schedule a cesarean section (c-section) at the end of her health pregnancy, for reasons of “convenience”—scheduling a c-section will “allow her to fit the event into her and her husband’s busy schedules.” The text asks whether H. A.’s physician should grant her request and, more generally, whether the scheduling of c-sections “should be left to the patient’s discretion,” or whether doctors should “prescribe the method of birth.” Thus, the framing of the case presupposes the ethical model that I have set up for critique: it assumes a division of interventions into two categories, those that should be administered on the basis of patient discretion and those that should be administered on the basis of physician prescription, and then it asks upon which side of the line c-sections fall. Furthermore, its language of leaving decisions to patients’ discretion suggests that the physician’s ethical task is to back away from the patient’s domain and the decisions she makes within it.

The case study was published along with responses from two obstetricians, Peter Schwartz and Annie Lyerly. Schwartz sticks closely to the terms of the question he was asked. Accordingly, he summarizes the various risks and benefits of c-sections in the context of healthy pregnancies in order to determine whether there is a clear medical indication for preferring attempted vaginal births over planned c-sections. He assumes that if there is, then physician prescription is appropriate when it comes to delivery decisions, while, if there is not, then discretionary choice should be granted to the patient. Lyerly, on the other hand, strays from the framework prescribed by the case study and instead turns to a diagnosis of our general cultural resistance to elective c-sections. She points out that the language of “convenience” and “fitting the event into a busy schedule”—as though H. A. might not bother to deliver her baby at all if she can’t fit it into her schedule!—already frames the case in a way that trivializes H. A.’s reasons and preferences. Thus trivialized, the only reason to grant her request would be if her whims were medically inconsequential. Lyerly asks: Is the language of “convenience” really the most appropriate for articulating why a patient might want to exercise a certain kind of control over a momentous, life-changing, intimate event such as birth? As she puts it, “Convenience is why we order pizza, it is not why we decide when and how to have a baby.” When I taught this case to my undergraduates, they complained that Lyerly didn’t answer the question. As feminists, they said, we might criticize the text’s belittling portrayal of this career woman and her budding maternal narrative, but this leaves us with the question of which side of the “line” c-sections lie on. But Lyerly, I suggest, is refusing the imagery of domains of sovereign discretion bounded by medical risk criteria and insisting on the relevance of a patient’s needs, vulnerabilities, situation, and reasons to any assessment of whether she is exercising her autonomy appropriately.

For many medical decisions, there is no univocal best path to choose but, rather, a range of reasonable options. It seems that how much difference in total medical risks and benefits we tolerate within this range depends very much on the kind of decision in question and, in particular, on how deeply this decision is bound up with intimate and integral features of a patient’s larger narrative, values, needs, and well being. The choice of a cholesterol drug or ear infection treatment seems to counterenance a pretty small range of reasonability; even small definite differences in total medical risks and benefits will be sufficient to warrant some pretty directive counseling on the part of physicians. On the other hand, when it comes to managing the course of palliative care, or addressing a severe facial disfigurement, we insist upon a wide range of reasonability; different patients might reasonably choose paths with very different risks and benefits.

The more intimately and extensively a decision penetrates our lives, the more the various options will come with agent-relative, extra-medical risks and benefits that play a big role in determining the overall most reasonable course of action. When we are deciding how to die, how to give birth, how to mother, or how to come to terms with a major disability; options that fail to minimize medical risks can be the most rational choices, given other potential harms such as indignity, abandonment, and alienation, or potential benefits such as security, fidelity to loved ones, or comfort with one’s own identity. H. A. is trying to manage the entry of a new person into the world and her own transformation into a mother.
However her delivery goes, the decision cannot be plausibly interpreted as merely impacting the integrity of her PDA. And, for this reason, small differences in clinical prognosis between attempted vaginal births and elected c-sections, even if there are any, do not determine that a prescriptive approach to delivery decisions is appropriate. We cannot determine, then, whether a patient request falls within the range of reasonability simply by looking at the comparative medical risks and benefits incurred by a particular procedure. At a minimum, we also have to look at the meaning and impact of that procedure in the context of a patient's needs, values, and situation in order to determine how broad the range of reasonability should be.

What I have said so far is consistent with the conclusion that in the case of decisions bearing important extra-medical implications, we just need to set the line far to the left, as it were, and allow patients a great deal of sovereign discretion—as though, in such cases, patient preferences can just override differences in medical risk. But I don't think that's the right way to think about this. For when the range of reasonability is large and the repercussions of a decision penetrating, it becomes especially important to make the right decision from among the options that could be reasonable. It doesn't make much difference how my physician treats my ear infection, as long as it clears up in the end, nor does much hang on my decision to have my teeth whitened. But it makes a big difference how my labor and birth go and how my death goes. Patient autonomy, in such domains, is not sovereign discretion but the capacity to make and act upon what I will call a conscientious choice.

Conscientious action, as I use the term, is action grounded in responsible fidelity to the practices, goals, values, or models that an individual takes as her own normative standards. Such standards constitute her "conscience," which is made up of a host of practical and mundane normative commitments and values, in addition to whatever lofty moral principles and fundamental governing values she might hold dear. To a great extent, the norms and values to which we are committed are found rather than chosen ex nihilo. By the time we are old enough to be responsibly committed to any norms, we have claimed these commitments from a position within a particular culture, life, and set of intimate relationships. Thus, conscientiousness does not require that we live according to a "self chosen plan," to borrow a phrase from Beauchamp and Childress. Furthermore, all of us live within an epistemic division of labor, and we look to experts to help us set goals, develop preferences, and make choices within their domain of expertise. This mutual dependency in the face of our finitude in no way compromises our conscientiousness. Indeed, if we couldn't draw on one another's expertise in this way, we would have a social and epistemic crisis on our hands. At the same time, particular conscientious decisions and actions cannot be ad hoc. A random choice cannot display conscientiousness, which essentially involves fidelity to some ongoing goals, standards, values, or principles. Conscientiousness, then, is inherently a virtue displayed over time. A single choice may be conscientious, but this conscientiousness cannot attach to it in isolation. We choose conscientiously when our choice sustains our fidelity to our ongoing commitments. Thus, the negative liberty to choose "at our discretion," on the basis of whatever preferences we happen to have, is neither necessary nor sufficient for conscientiousness.

Making a conscientious decision about health care, especially when that decision is tightly bound up with the rest of our conscientious commitments, can be very difficult, and there is no reason to assume that patients' felt preferences are authoritative guides to conscientious choices. While conscientious principles can be found rather than chosen, some cultural tropes systematically undercut our ability to reflect well upon our own commitments and needs. We cannot assume, to return to our example, that all women will be able to make conscientious choices about how to deliver their babies when left to their own "discretion." Pregnant women are immersed in a culture that gives them specific and often conflicting messages that may well cloud their capacity for conscientious choice. On the one hand, even before they deliver, they are warned about the "grief" they may feel if they "fail" at vaginal birth and have a c-section. Indeed, the International Cesarean Awareness Network, or "ICAN," which claims to "provide support for cesarean recovery," denies outright that elective cesareans could ever be autonomously chosen. But, at the same time, women are also given the message that any choice that increases risk to their baby, no matter how negligibly, is irresponsible and un-maternal. Since elective c-sections seem to be marginally less risky for babies than other methods of delivery, this rhetoric pushes in the direction of c-sections. Furthermore, as Lyerly points out, "women often come to decisions about childbirth with unwarranted fear of pain, loss of control, [and] abandonment." Such contradictory and recriminatory messages and failures of security are ripe for undermining women's agency and their capacity for critical reflection.

I want to claim that the kind of autonomous decision-making we should be looking for when it comes to health-care decisions that intimately and integrally penetrate our extra-clinical lives is conscientious decision-making. Human autonomy is essentially finite and socially dependent autonomy. When we are given the liberty to choose at our discretion but not the tools for choosing conscientiously, then we may be stranded making an arbitrary, ungrounded choice that is not actually bound by the governing goals, values, and practices to which we are committed. Accordingly, I also want to claim that physicians have a responsibility to actively promote and protect patients' ability to make reasonable, conscientious choices. H. A.'s doctor, for instance, should not paternalistically prescribe a method of delivery. But he also should not simply grant her request for an elective c-section without further discussion beyond the communication of medical risks. He needs to probe beyond the easy language of convenience, trying to figure out why this request matters to her and whether it is grounded in reasonable and authentic concerns, or in intimidation by cultural pressures and myths or ungrounded fears. Fostering conscientious autonomy in the health care domain might include guiding and encouraging patients' attempts at medical self-education, displaying respect for their capacities for judgment and responsibility and holding them accountable for exercising them, and also using expertise to help them make a contextually appropriate rational decision. If, after her best efforts, a physician does not manage to get (what she perceives as) a conscientious, appropriate decision from her patient, the patient's choice, of whatever quality, still needs to be final tribunal when it comes to decisions within the range of reasonability. But this is quite different from saying that physicians have no business interfering with patients' choices. The practice of leaving health care decisions to patients' discretion, or treating their preferences as sovereign, can undercut rather than enhance conscientious autonomy.

Consider another kind of decision that has received a great deal of bioethical attention, namely, a couple's decision whether to have minimally invasive prenatal diagnostic tests such as ultrasounds and serum sampling. These tests carry very little by way of direct medical risks or benefits. Conscientious choice is particularly important here, since the
potential consequences for the extra-clinical lives of the prospective parents and child are serious, and the narrowly medical repercussions will not meaningfully help make the decision. Yet, our actual management of these decisions undermines rather than enhances the prospects for fully conscientious choice. First, we increasingly treat such prenatal tests as routine. Although they are always presented as optional, they are also presented as part of the normal course of care, so that a couple that chooses not to test must choose against the default. Second, the tests are positioned within a culture of prenatal care and pregnancy that strongly emphasizes self-surveillance, medical monitoring, and hyper-responsibility for the consumption of medical information. Against this background, taking the tests can appear to be the only responsible thing to do. Third, because we have officially classified these tests as falling under the domain of “patient autonomy,” and because we tend to equate patient autonomy with the uninfluenced liberty to make an informed choice, clinical counseling, to the extent there is any, focuses on the medical purposes of the tests rather than on their potential ethical and personal consequences. For instance, Nancy Press and Carole Browner found that California counselors responsible for offering the serum sampling test—a blood test that detects an elevated risk for certain major birth defects such as Down syndrome and spina bifida—never mentioned the words “abortion” or “termination” in counseling sessions, even though most of the women who received a positive diagnosis actually go on to terminate the pregnancy.9

We can expect that when these three trends are combined, prospective parents will generally decide to undergo testing—especially ultrasound testing, which is routinely prescribed without any formal informed consent process—and that they will do so without engaging in any detailed critical analysis of how this choice intersects with and impacts their governing values and commitments. In effect, although a formal moment of choice is available to patients, the choice is already all but made by the larger culture and routines of prenatal care. Indeed, Press and Browner found that overwhelming percentages of women agreed to take the serum sampling test,9 and that, when asked, they had strikingly little to say about the reasons for their decisions. Rather than casting the decision as a substantial ethical choice point requiring specific deliberation, they described the test as “simply another part of responsible prenatal care.”

A recent article in the Washington Post Magazine, “Hard Labor,”10 told the gut-wrenching story of a couple who had to decide whether to abort a fetus after finding out during a routine ultrasound that its cortical hemispheres had failed to divide.11 Despite what appear to be their best intentions, the husband and wife emotionally harass and abuse one another during the long deliberations that ensue. The article meticulously chronicles the pain they inflict upon one another, along with the pain inflicted by their common predicament. Much of this destructive behavior clearly issues not only from their disagreement over what is to be done—she is dead set against an abortion and he is determined that she get one—but, more poignantly, from their initial false assumptions that they would agree. For example, the husband throws out the ultrasound photos as they leave the office without asking his wife’s permission, and, once they have been rescued, she frames them and puts them by his bedside without his permission.

However, at no point does the article ask the questions that seemed most pressing to me: Why had this woman, who was deeply committed to seeing through her pregnancy no matter what, and who found abortion unthinkable, received the ultrasound in the first place? How could a loving couple not know that they would reach such radically different conclusions about something so important? And—most relevantly for my purposes—why had their doctor allowed them to have the test without checking whether they had talked to one another about why they were having it and what a positive result would mean to them? This particular test led to severe emotional trauma and almost to the dissolution of a marriage. These are risks of the test, and providers are responsible for conveying, containing, and managing this risk, even if it is not narrowly medical. Indeed, as cases such as this one show, making the test routine and designing the protocols for its administration introduce extra, iatrogenic risks in addition to the emotional and other risks inherent in the process.12

It is clear that the positive result and its implications caught this particular couple entirely off-guard. In advance of the event, they conceived of their ultrasound primarily as a social rather than a diagnostic event—an event during which they would “meet the baby.” Anthropological research has shown that this is how most people conceive of the test,13 and several cultural and medical devices support this perception. These include ultrasound booths that sell glossy photos in cute frames in shopping malls, the ritualistic use of ultrasound photos as baby announcements, and ultrasound technicians’ discursive focus on the sex and the “personality” of the “baby” during what is supposedly a diagnostic medical test. This context not only fails to encourage careful reflection on the import of the test but actively undermines and distorts such reflection.

Against such a background, it is especially crucial that providers ensure that tests are being chosen reasonably, responsibly, and conscientiously. At a minimum, this requires that the couple speak with one another about the implications of a positive result and about how taking the test coheres with their other conscientious commitments. The decision whether to undergo prenatal diagnostic testing surely falls within the domain of patient autonomy. But, against the cultural background within which this decision is situated, leaving patients to choose at their discretion will almost always lead to their choosing in a way that merely recreates and reinforces the cultural interpretation of testing as the normal, responsible choice. My point is not that patients’ values are governed by their culture as opposed to by some kind of purified individual will since I have insisted that our values and governing norms are largely found, rather than forged, out of whole cloth. Rather, the problem here is that some of the specific cultural norms and practices that govern prenatal care (and presumably some other kinds of care too) are, in virtue of their concrete shape and content, especially likely to distort moral perception and undermine conscientious agency. Providers are responsible for pushing against cultural presumptions with enough force to make the test stand out as an ethical crossroads that demands a reflective, responsible, owned choice. Neither a prescriptive strategy nor mere deference to patients’ sovereign preferences will accomplish this goal.

I have tried to reframe the question as to where physicians should “draw the line” in granting patient requests in at least two ways. First, when judging whether a patient request is reasonable, we can’t just look at what it is a request for but also at who’s making the request and for what reasons. Indeed, I am hard pressed to think of a medical procedure that couldn’t in some cases, be reasonably, conscientiously requested. (Of course, this is not to say that there are not perfectly sound reasons for banning various procedures as a matter of general policy.) The performance artist Orlan searched for quite a while to find a surgeon willing to build her the largest sustainable human nose in front of a crowd of spectators. In the context of Orlan’s highly self-reflective, artistic project, I think a physician could ethically fulfill her request. Second, I
have argued that, in those domains where patient autonomy is most important, physicians have a responsibility to foster conscientious decision-making and not merely to communicate narrowly medical risks and benefits and then provide services on demand. (The complexity and importance of this clinical responsibility will vary depending on the extent to which a medical specialty requires decisions that penetrate deeply into patients' extra-clinical lives and values: it is regularly a crucial responsibility for obstetricians, oncolologists, and fertility specialists, for example, and much less commonly an issue for orthopedic surgeons.) Hence, our recognition of a protected domain of patient autonomy in medical care does not require our commitment to a line dividing those situations in which physicians get to call the shots from those in which the patients' preferences are sovereign and the patient is "always right."

This second conclusion will make some bioethicists squirm because our current medical culture privileges negative liberty and respect for patient preferences, and it is suspicious of physicians' authority to participate in the formation of these preferences. Indeed, in fostering conscientious decision-making, physicians need to be scrupulously patient-centered. The moral and clinical task, here, is to make possible a decision that expresses fidelity to the patient's own conscience, but it is by no means easy to successfully separate this process from the imposition of the physician's own values upon the patient, especially given the perceived moral and social authority that still tends to attach to medical professionals. Intervening in patients' preference-formation and decision-making in the name of fostering conscientiousness is a risky process fraught with potential for paternalism, moral authoritarianism, and coercion. This is a large part of why bioethicists have swung so far in the direction of emphasizing negative liberty, nondirective counseling, and physician restraint. But we have seen that refraining from engaging with patient preferences isn't always a way of preserving autonomy—nor, given the complex cultural and personal fabric within these preferences are woven, is it a way of letting patients' "true" or "pure" preferences shine forth. It can instead be a form of abandonment, which strands patients with the burden of making an arbitrary, ungrounded, or culturally scripted choice that does not express fidelity to their conscientious commitments, and that may carry unacceptable personal and ethical risks.14

Endnotes

2. His conclusion is that the answer depends on H. A.'s future childbearing plans.
3. This point comes from "Pregnancy, Delivery and Risk Distortions," by the Obstetrics and Gynecology Risk Research Group, unpublished in-progress mss.
4. This is especially so given that both birth options are extremely safe for women with adequate prenatal care living in developed countries.
7. One of the principles in their mission statement reads, "patient-choice cesareans are unethical and immoral on the part of the physician. Women are not being fully informed of the risks of this option in childbirth, and therefore make decisions based on cultural myth and fear surrounding childbirth" (www.ican-online.org). Thanks to Karen Stohr for showing me this website.
9. Although there is some evidence that this acceptance rate is dropping.
10. April 10, 2005.
11. The condition is called holoprosencephaly.
12. Many thanks to Hilde Lindemann for pointing out the suitability of the notion of iatrogenic risk in this context.
14. Research for this paper was funded by the Greenwall Foundation. An earlier version of this paper was presented as part of the APA Committee on Philosophy and Medicine panel on “Limits of and Challenges to Liberalism in Bioethics,” Chicago, IL, April 2005. Many thanks to Hilde Lindemann, Agnieszka Jaworska, Jim L. Nelson, Karen Stohr, and the members of the Obstetrics and Gynecology Risk Research Group (Elizabeth M. Armstrong, Lisa Harris, Miriam Kupperman, Margaret O. Little, Annie Drapkin Lyerly, and Lisa Mitchell) for invaluable ideas and comments.

From Caring to Self-Governance: The Bare Bones of Autonomy and the Limits of Liberalism

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Well-informed patients occasionally ask physicians for assistance with choices and procedures that appear deeply misguided. Think of requests for cosmetic surgery designed to make the patient look more Caucasian; or requests for extra rounds of in vitro fertilization likely to jeopardize the patient’s overall health; or a Viagra prescription for someone like the Kinsey fan who takes pride in being able to masturbate to ejaculation in ten seconds flat.

Let me suggest a taxonomy of cases along the following lines. In some cases, although the choice is beneficial to the patient himself and perhaps even aligns genuine suffering, the choice is problematic because of its detrimental effects on third parties. Various subtypes may be distinguished in this category: for example, according to whether identifiable parties are likely to be directly affected. On one end of the spectrum lies the case of an AIDS patient asking the doctor not to inform his partner about his condition. On the other end of the spectrum are choices that, without directly raising the prospects of harm to identifiable individuals, merely contribute to more general socially pernicious effects. For instance, choosing to change one’s appearance to remove what are perceived to be undesirable racial features reinforces the climate of stigmatization based on race and invites the physician’s complicity in the propagation of suspect social norms; yet, it may not, by itself, cause well-circumscribed damage or injustice.1 In an altogether different category of
problematic cases—exemplified by the woman who requests further rounds of in vitro fertilization beyond safe limits—the patients’ choices seem detrimental to their own well being but do not adversely affect others in any way. These cases may be further subdivided along a scale that differentiates imprudent choices that compromise the patient's fairly immediate interests from choices whose detrimental effects are merely statistically predicted and projected for the patient's long term or future well being: refusal of prophylactic tests would be an example of the latter. Finally, in cases of a third type, such as the record-setting use of Viagra, the patient's choice appears to be motivated by very shallow values but does not undermine either the interests of others or even the patient's own interests as they are subjectively understood. In a subset of cases of the second or third type, a compounding problem may come to dominate the picture: in some instances in which the patient undermines his well being or pursues small-minded values, his choices may be so ill advised as to compromise his very dignity and constitute lack of self-respect.

Of course, this is merely a theoretical taxonomy of various types of reasons why medical professionals may cringe at their patients’ requests and be tempted not to comply. In real life cases, these reasons will often be mixed. Consider, for example, why one might have regarded Michael Jackson's request for plastic surgery as deeply problematic. The choice propagated socially abhorrent norms of appearance and, in this sense, had pemenic third party effects. It was motivated by vanity—a less than admirable value. It was also not in Jackson's own interest to change his appearance in a way that won him more loathing than admiration. And the results compromised Jackson's dignity, as the details of his appearance and the flaws of the surgery became objects of public scrutiny and ridicule.

All these types of reasons that make us queasy about patients' requests deserve scrutiny from the point of view of the limits of liberalism. Note, however, that liberalism does not face inherent difficulties in justifying why choices that harm third parties or contribute to the weakening of social justice need not be straightforwardly respected. John Stuart Mill famously recognized this in his very formulation of the principle of liberty: “the only purpose for which power can be rightfully exercised over any member of a civilized community against his will, is to prevent him from hurting others”2 By contrast, given the liberal emphasis on respect for autonomy, choices that are problematic merely because they reflect shallow values, or harm only the chooser's own interests or dignity, need to be respected. According to the liberal approach, each individual's capacity for autonomy is the ground of value and the most fundamental locus of respect. It is up to the individual how she chooses to exercise her capacity for autonomy and whether she does so at all. We need to respect the capacity for autonomy in all its manifestations, however imperfect they may be on a given occasion. In other words, we need to respect the capacity for autonomy even if it is exercised in service of shallow values, or against the agent's own acknowledged or unacknowledged interests.3

Setting the issue of effect on third parties aside, ill-advised or imprudent choices may cease to be protected by liberalism only when it can be legitimately determined that the chooser lacks the capacity for autonomy, or that she faces specific impediments to adequate exercise of autonomy that are beyond her control—such as, for example, incorrigible lack of access to the relevant information. That is, self-regarding choices can be genuinely problematic, in the sense of lacking the claim to straightforward respect, only when a specific problem with the agent's capacity for autonomy, or the adequate conditions of its exercise, is identified.

In this presentation, I will work within these basic liberal assumptions. My analysis carries bad news for sympathizers of liberalism who nonetheless seek a justification for expanding the range of cases in which people can be legitimately prevented from making bad decisions, in the medical context or elsewhere: I will argue that the requirements of the capacity for autonomy are even less demanding than traditionally assumed and, consequently, that a liberal has even less room, within the confines of her own doctrine, for deeming a choice unworthy of respect. Moving a step further, my analysis will also imply that an individual may go against her own acknowledged values and against her own preferences as to which of her motivations to act on and still be autonomous in the full sense. This result is particularly relevant for those who advocate limiting the permissiveness of liberalism by attending to flaws in people's actual implementation of autonomy. It will turn out that some choices that initially may look problematic not only deserve basic respect as expressions of the chooser's capacity for autonomy but also deserve full deference as choices that are truly the agent's own.

1. The Alternative Minimal Case of Autonomy

Any account of autonomy includes a story about what makes an attitude fully one's own, and, thus, a suitable basis for self-governance. Thus, an account of the agent's ownership of her attitudes—of what I will call, following Harry Frankfurt, internality—is a suitable starting point of a theory of autonomy. Philosophical conceptions of internality have been dominated by two models. The first model emphasizes value judgments as paradigmatic internal attitudes. This is the model advanced by Gary Watson in his original critique of Frankfurt.4 The second model focuses on self-reflection, on the ability to step back from one's first-order motivations and assess them in some way.5 But on this model, this self-assessment is not necessarily evaluative. Rather, what is needed is an appropriate psychological structure: a hierarchy of psychological attitudes (desires about desires, or other higher-order motivations) thought to comprise autonomous endorsements. In this way, the capacity for autonomy has been understood to require either the ability to make evaluative judgments or the ability to reflect on one's own mental states, or sometimes both. However, I argued extensively elsewhere that neither evaluation nor motivational hierarchy is needed to account for the phenomenon of internality. The attitude of caring about someone or something, I argued, is a nonhierarchical, nonevaluative, internal attitude. Let me briefly recap the contours of this argument.6

On the account I favor, caring about P is a complex emotional attitude that comprises various less-complex emotions, emotional predispositions, and desires directed at P: joys at P's successes, frustrations at P's failures, fearful anticipations of possible dangers for P, relief when P escapes such dangers, disposition to grieve at the loss of P, and so on. Most of these constitutive components of caring are emotions, themselves composed of interrelated simpler components—emotional episodes—such as, in the case of grief at the loss of P, for instance: the tendency to dwell in one's thoughts on memories of P and of the circumstances in which P was lost, having one's attention directed at objects and details associated in some way with P and with the events leading up to the loss of P, tendency to ruminate in one's thoughts on how those circumstances could have gone differently, etc. In a nutshell, caring about P is largely a matter of emotional vulnerability to P, which requires a great deal of emotional integrity and sophistication.

As it turns out, children as young as two and three are capable of caring of this sort, usually about their parents or other family members. This helps establish that caring is both
nonhierarchical and nonevaluative. At this age, children are barely beginning to discover that they have attitudes toward the world, such as wanting, so they are unlikely to direct their wanting or other practical attitudes at the newly discovered wanting itself. That is, they are unlikely to form motivational hierarchies. At the same time, as has been amply documented in developmental psychology literature, these children don’t understand the concept of belief as an attitude that can be correct or incorrect, so they cannot have the idea that their evaluations are correct and that the lack of recognition of them would be a mistake—which is necessary for the proper grasp of any evaluative concept. Therefore, they cannot form evaluative judgments. Since these children are nonetheless capable of caring, we can conclude that caring presupposes neither motivational hierarchy nor evaluation.

Further, caring attitudes invariably appear to be internal to the agent. Unlike in the case of mere desires, or individual emotional responses such as anger or fear, it seems very hard and paradoxical to fully distance oneself from one’s caring attitudes, to view them as foreign, to feel oneself taken over by them. It is common enough to experience a strong desire that one has to fight off like a foreign intrusion, or to have an outburst of anger with respect to which one is a “mere passive bystander,” but being a passive bystander to one’s caring attitude is an oxymoron. This is not to say that it is so hard to eva

Putting all these pieces together yields the result that caring attitudes are internal but neither necessarily evaluative nor necessarily constituted by motivational hierarchies. And this means that internality requires neither motivational hierarchy nor evaluation.

Suppose I am right about this. We have now made room in our moral psychology for a class of attitudes cognitively simple enough so as not to require reflexive understanding of one’s own mental states and, yet, sufficiently complex emotionally to carve out a distinct self from among the chaos of mere psychological happenings. On my picture, caring is indeed such an attitude. Since caring attitudes do not presuppose understanding of one’s own mental states—be it one’s own motivations or the correctness of one’s own beliefs—they are less intellectually demanding than both second-order desires and evaluative judgments. Yet, since such attitudes are nonetheless internal, they are plausible building blocks of autonomous self-governance.

Internal attitudes are appropriate starting points of autonomy, but additional elements are needed for a complete instance of autonomy. Autonomy involves self-governance, so it is not enough for the self to causally bring about action; the self must truly govern. One may think that either motivational hierarchy or evaluative judgment would have to be introduced at this stage. However, on closer examination, this turns out to be unnecessary. True enough, self-governance is normally rightly interpreted to be normative self-governance, or governance mediated by reasons. The agent must normatively govern herself by way of her internal attitudes exercising normative guidance. One may think that this automatically introduces an element of evaluation. However, as David Velleman has insisted, there is a difference between perceiving a course of action under the guise of the good (under the guise of value) and acting for a reason. A teenager who sees creating mischief and havoc as a reason to engage in a prank does not necessarily judge mischief and havoc to be good. His aim may be to be bad for a change, and he may treat the badness of mischief and havoc as his reasons to act. Similarly, a young child may take his mother’s pain to be a reason to offer comfort, without the further understanding, or the further thought, that it is good to alleviate his mother’s pain. Self-governance must involve normative governance by attitudes that are truly one’s own, but this may well consist in internal attitudes being sources of reasons, which does not necessarily require judging the objects of internal attitudes to be good. The self-governing agent I have in mind would take herself to have a reason to pursue what she cares about. On this picture, the ability to act for reasons is sufficient for the governance aspect of autonomy, and evaluating or judging good need not be involved.

Evaluation is thus unnecessary to this sort of governance, but is motivational hierarchy also unnecessary? One may think that some sort of motivational hierarchy is introduced when we require a self-governing agent to take herself to have a reason to pursue what she cares about. Isn’t this agent—the objector would say—treating her own caring as a reason? And isn’t this a kind of second-order attitude that takes caring, a first-order attitude, as its object? However, the fact that a person treats (some aspect of) what she cares about as a reason does not imply that she must recognize her caring attitude itself as the source of the reason. In fact, she doesn’t even need to understand that she has this caring attitude. Her caring about P leads her to treat advancement or flourishing of P as a reason, or, better put, her caring about P partly consists in treating advancement or flourishing of P as a reason. No second-order attitude needs to be formed in this process. Moreover, the agent’s claim to self-government is not affected by this lack of self-awareness. The agent’s internal attitudes can exercise normative guidance through their content without the agent being consciously aware of having these attitudes.

According to the portrait of a minimally autonomous agent I have assembled so far, this agent cares about certain things and guides her actions in light of seeing reasons to pursue those things. However, acting on reasons of this sort can still sometimes come short of genuine self-governance. Our theory must stave off the possibility that seeing a reason would simply amount to being in the grip of the reason. This is a particularly pressing concern when an emotional attitude is a source of reasons because being in the grip of an emotion and an emotion-influenced picture of reasons is a common phenomenon. As Jodi Halpern has emphasized in a somewhat different context, emotions such as fear and jealousy can, in certain circumstances, “hijack” a person’s perception of pertinent facts and her expectations for the future so as to render her unable to shake off the emotionally charged view of her predicament. In this rigid or (as Halpern puts it) concretized emotional state, the emotional view dominates the person’s thought processes and is cut off from ordinary internal sources of possible, even momentary, correction: the person is no longer subject to the ordinary ebb and flow of diverse, potentially conflicting emotions, and her emotional view is also isolated from ordinary cognitive processes of gathering and assessing pertinent evidence. A similar rigid adherence to an emotional view is, I imagine, possible in the case of caring, and it could presumably extend beyond the perception of facts to also affect the agent’s perception of reasons. Just as a person in the grip of fear and the feared perception of facts—as Halpern rightly argues—would not be exercising autonomy, we should say the same of a person in the grip of caring and the caring-dictated perception of reasons. We thus need to specify what conditions our...
candidate autonomous agent must meet so as to escape being merely in the grip of reasons.

Again, one may think that appeal to motivational hierarchy or to evaluative judgment is necessary at this juncture. In order to avoid being in the grip of a perceived reason, doesn’t the agent need to be able to reflect on why he treats this particular consideration as a reason? Alternatively, doesn’t the agent need to treat his perception of reason as correct, thereby making an evaluative judgment? Yet, this time again, the minimum requirements turn out to be a bit less demanding. What really is required to avoid being in the grip of a perceived reason is some openness to the possibility of seeing things otherwise. One way to express this is to say that the agent must see a specific consideration as a reason against the background of the possibility of reflection—so long as we interpret what constitutes reflection very broadly and do not confuse reflection with assessment of one’s own motivational states. Gary Watson’s understanding of practical reflection can be a source of guidance on this last point. Watson has reminded us that reflection can be a first-order phenomenon—reflection need not take the agent’s own motivations as its object. On this conception, reflection is a process of considering the substance of the various courses of action and their consequences in one’s particular circumstances. Further, if reflection is to satisfy our desiderata, the agent must be so constituted as to be open to the possibility that a fresh perception of reasons will result from this process. Of course, in keeping with the account I have developed so far, what is needed is a possibility of treating something different as a reason instead, not a fresh evaluative judgment. Reflection would typically be an imaginative exercise, but even the engagement of the imagination is not necessary. What we are after here is the possibility of dislodging a rigid emotional view, but nothing near full reflection. For example, so long as spontaneous shifts of emotional frame are possible (by analogy to what is suggested by Halpern), the openness to a fresh perception of reasons may be already in place.

Note that, to avoid the charge of being in the grip of a reason, one’s perception of a reason need not even be a direct result of the process of reflection. Rather, as I have said, one needs to see something as a reason against the background of the possibility of reflection. This simply means that the agent must be capable of some reflection and must be satisfied with the reason in question in light of whatever reflection he happens to have thus far actually engaged in.

Altogether, then, what seems to be sufficient to avoid being in the grip of a reason is that one takes a consideration as a reason in the context of the possibility of first-order reflection and that one is satisfied with treating that consideration as a reason given the reflection one has already undergone.

In sum, the resulting minimal case of autonomous decision-making comprises the following foundational elements. First, the agent cares about a particular object P; this assures that the attitude that guides the decision-making is internal—and thereby an appropriate starting point of self-governance. Second, the agent acts in light of seeing reason to pursue what he cares about; this introduces the element of governance. And, third, this selection of a reason for action takes place against the backdrop of the possibility of first-order reflection, and the agent is satisfied with the reason in question in light of the reflection in which he has actually engaged. This assures that the agent is not merely in the grip of treating caring-based considerations as reasons. At no point in this picture does the need arise to appeal to evaluative judgments, or to a hierarchy of attitudes about attitudes.

2. Implications for the Limits of Liberalism

Now, what does this all have to do with the limits of liberalism? On the account I have given, it is a lot easier to achieve a complete exercise of one’s autonomy than has been traditionally understood. And this means that the capacity to fully exercise some form of autonomy is, in principle, easier to come by than we may have assumed. One normally would expect such an easing of the requirements for the fundamental underpinnings of autonomy to immediately affect when in practice people can be assumed to fully possess the capacity for autonomy so that their decisions merit noninterference under the tenets of liberalism. However, in this case, such effects may be masked. This is because the capacity for autonomy requires not only the fundamental underpinnings I have been discussing so far but also vital supplemental powers. These include the ability to engage in means-ends reasoning (so as to be able to advance what one cares about in the concrete circumstances of the world in which one is acting) and the psychological ability to convert one’s decisions into actions (that is, freedom from disorders of the will, such as addiction or extreme impulsiveness). If these supplemental powers require a higher degree of intellectual sophistication than the basic elements of minimal autonomy, the modified understanding of autonomy I have defended here may not lead, for example, to any changes in our estimates of when human beings acquire the full set of prerequisites for autonomy in their development, or when they may lose it due to mental illness or neurological impairment.

However, more importantly for practical purposes, the account I have given changes the requirements for what it takes to properly exercise one’s autonomy. And this means that a larger set of choices than we may have hitherto understood qualify as completely and properly autonomous. If a normal adult who is presumed to have all the prerequisites of autonomy makes a decision based on his caring attitude, so long as he is not in the grip of caring, his choice may not be defective in any way not only when it goes against his well being, his dignity, or reasonable ideals of conduct but even when it goes against his own higher-order desires and/or long-standing values.

It is well known in bioethics that the principle of respecting patient autonomy may come into conflict with promoting the best interests of the patient, whether understood in terms of well being, or dignity, or reasonable standards of conduct. What I have tried to establish here is the possibility of deeper and more troubling conflicts. A patient may implement all the proper elements of autonomous self-governance and yet come out choosing things that are deeply troubling even by her own lights. For example, a patient may request extra rounds of in vitro fertilization against her own better judgment because she cares so much about having a child. Or a patient may request Viagra against his better judgment because he happens to care a great deal about setting ejaculation records. These patients may not be exercising autonomy in ideal or perfect ways, but their choices cannot, according to what I have argued, be classified as not, in fact, autonomous. Refusal of their requests would be particularly injurious to respect for autonomy, much more so than a paternalistic refusal directed at a person capable of autonomy who happens to forgo its exercise on a particular occasion, due to weakness of the will, thoughtlessness, denial, or lack of attention. From the point of view of liberalism, the range of cases in which patients ought to be seen as adequately exercising their capacity of autonomy, and thus deserving the highest level of protection from paternalistic interference, has greatly expanded.
Endnotes

1. For a nuanced discussion of cases of this sort, see Margaret Little. “Cosmetic Surgery, Suspect Norms, and the Ethics of Complicity.” In Enhancing Human Traits: Ethical and Social Implications, edited by Erik Parens (Washington, D.C.: Georgetown University Press, 1998), 162-76.


3. Liberalism does not require an individual to aid others in activities the individual does not approve of, and this limitation may sometimes also apply to physicians. I note this complication but do not have space to explore it here.


7. Of course, it is not so unusual to feel oneself overcome, overwhelmed, or swept away by a caring in the sense of lacking control over it and feeling helpless vis-à-vis its power. But even such a powerful caring is not normally experienced as an external force.


10. Note that this is compatible with the possibility of giving up on one’s caring—with deciding to cease to care and following through. What is ruled out is caring and being dissociated from what one cares about at the same time. Thanks to Michael Bratman for prompting this clarification.


We Gather Together

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Glenda’s mother, who had grown bored with retirement and gone back to teaching social studies, was talking about a student who felt guilty over being sorry for herself when so many people were so much worse off. “I asked her why she felt guilty. Precisely how would it help those people if she stopped being sorry for herself?” She leaned forward, taking a mint from the white dish that matched her pearl bracelet but not her hair. White hair was practically the only misfortune that was really an opportunity, she had once told Glenda—you could dye it all sorts of nice shades. Currently she was trying out light auburn, just the color Glenda had in mind for her own hair eventually.

“Tell her to charge herself five dollars an hour.” Brian swung his feet up on the maroon leather ottoman he and Glenda had given themselves for their ninth anniversary. “For every hour she spends on self-pity, she should donate five dollars to charity. Don’t most of those prep school kids have plenty of money?”

“Oh, she would still consider it a virtue to get over her self-pity,” Glenda’s mother said. “I don’t know why it is so hard to make students these days realize that they get no moral brownie points for something that doesn’t help others.”

Glenda stood up. “I’ll be back in a few minutes.” She walked out onto the landing and down the stairs. Then she knocked on the door of the only other apartment in the converted old house and waited.

Five minutes later, she was still waiting. How long would a crippled old woman take to get to the door? Glenda knocked again, heard an uneven tread, then a “Yes?”

“It’s Glenda Fletcher from upstairs.”

Miss Pratt opened her door but kept the chain on, making Glenda feel vaguely dangerous. “I would like to invite you to have Thanksgiving dinner with us tomorrow,” Glenda said. “My mother’s here, too. She’s visiting,” she added after a moment.

Miss Pratt was silent so long that Glenda began to wonder whether to expect a reply at all. What did she know about Miss Pratt, anyway, except that she looked about eighty, used a four-pronged cane, and never seemed to go anywhere but to the porch for her mail? And Glenda, who often spent much of the day in her sunroom that overlooked the street—reading novels, daydreaming, and tending her many potted plants—had never seen anyone come to Miss Pratt’s but the grocery delivery service. “Invite a lonely elderly neighbor to your holiday dinner”—it sounded like something from the local paper’s Community Matters column. The columnist also wanted you to notify the Department of Elderly Affairs if your elderly neighbors showed deterioration in their personal habits. Surely, uncombed hair and a nightgown and egg-stained bathrobe in the afternoon would qualify, but Glenda was hardly about to turn Miss Pratt in for failing to be all dressed up when she had nowhere to go. Miss Pratt was leaning heavily on her cane now, and just as Glenda was coming to think it might be time to end this encounter, the old woman spoke.

“I already have plans. I will be spending Thanksgiving here with friends,” she said, looking away, her voice fading like an afterimage.

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“Feast your eyes upon fair and warmer with winds light and variable,” Glenda’s mother said the next morning. “If I were a meteorologist, I would be ashamed to show my face today.”

“Aren’t you glad social-studies teachers can make mistakes without the whole city’s finding out?” Glenda was mixing miniature marshmallows into a sweet-potato casserole. She gazed through the kitchen window, seeing trees swaying, twigs breaking off, rain falling like nails. Thrills from a safe distance. “I love to watch storms from indoors.”

“You always did,” said her mother, chopping pecans for her special stuffing. “You always loved pecans, too,” she added, handing Glenda several.
“There’s a weather advisory. Maybe Miss Pratt’s friends won’t be coming. Maybe I should try her again.” Glenda ate the pecans, then helped herself to three miniature marshmallows.

“Maybe Miss Pratt’s friends exist only as a dodge for her to avoid your invitation. You said you never see her go anywhere or get visitors.” Glenda’s mother retrieved a pecan that had fallen into her lap; she was wearing Glenda’s red apron with “THIS IS YOUR BRAIN ON DRUGS” printed beneath a picture of a brain atop a plate of pills.

“She gets mail. Although I guess it’s mainly catalogs.” Glenda had a sudden, unbearable image of Miss Pratt in a dingy, imperfectly buttoned housedress, snatching catalogs from her mailbox, as if looking through them would be the highlight of her day. “I’m going to—”

“Can’t you take no for an answer?”

“I’m just following the wise counsel of someone who told me that the only way to get moral brownie points is to help others.”

Glenda’s mother covered the dish of stuffing, put it in the refrigerator, and walked over to the sink. “But who could want what is obviously a charity invitation?” she asked over the running water.

Lots of people, Glenda thought. “Believe me, when I was in high school, I would have grabbed a charity invitation. To anything. If you’re lonely enough, you don’t look into people’s motives. Besides, you get pretty good at self-deception, you know.” But maybe her mother didn’t know, any more than motives. Besides, you get pretty good at self-deception, you anything. If you’re lonely enough, you don’t look into people’s motives.

Now her mother was preparing cranberry relish and suggesting that if Glenda tried approaching Miss Pratt sometime when charity was not officially being practiced, it would be far less patronizing, not to mention more convincing. “Not to mention more time-consuming. She is right downstairs, after all. Who knows how much attention she might turn out to want? Would you be prepared to offer charity friendship several times a week?”

“Well,” Glenda said, “it’s not as if I had a shortage of free time.”

“But you always say—”

“I know.” What Glenda always said was that free time was the second-best thing in the world, ranking right after love. She also liked to say she had the least respectable occupation for a professor’s wife nowadays: none. Glenda’s mother was not retired; Glenda was. Glenda had retired at twenty-six, upon realizing she loved her dissertation director rather than her dissertation topic, marrying him, and dropping out of graduate school. She had never had a job. She was not writing a novel, painting, or sculpting. Nor could she qualify as a traditional homemaker; she had, by choice, no children. She did no volunteer work. She just did whatever she wanted. Each day was an adventure, and there was no need to fill it with things that sounded adventurous to other people. Glenda read novels (lately, Agatha Christie and Sinclair Lewis), watched television (she was looking forward to next week’s Alfred Hitchcock marathon), took care of her plants, went to museums, libraries, and malls, met friends for lunch, studied whatever interested her as long as it interested her, and cooked elaborate dinners for herself and Brian. Glenda also defended her way of life when it came under attack, which was often.

“What do you do?” people would ask. Then there was the university’s eminent sociologist who had recently published an essay criticizing idleness, not so much in people like Glenda, but in offspring of the very rich. His reasoning applied to Glenda, though. He thought everyone needed the experience of holding a job in order to understand how most of the world lived. Most people got colds, Glenda pointed out to anyone who brought up the essay, and most married couples had fights. Most people in the world, if it came to that, were desperately poor. If you had the great good fortune to be free of those things, were you supposed to catch a cold, pick a fight with your spouse, or impoverish yourself? But the sociologist, like Glenda’s mother, also thought everyone should do something to help others. Maybe it was time for Glenda to start. “I’ve decided to follow your wise counsel,” she said. “I’ll invite her to lunch next week and take it from there.”

“I’m impressed,” said her mother, “and I hope you will be rewarded by having her turn out to be such fascinating company that charity is beside the point.”

“That’s a lot easier to imagine if you’ve never actually met her,” Glenda said.

* * *

The day after her mother drove back to Connecticut, Glenda left the apartment early and went to the Korean ceramics exhibit at the Rhode Island School of Design Museum. She spent the following day watching the Hitchcock marathon. On the third day, she decided to stop procrastinating. She began lurking around the mailboxes, but it was two more days before she saw Miss Pratt.

“Hello,” Glenda said, watching Miss Pratt’s hand curl around a cluster of catalogs. “How was your Thanksgiving?”

“Fine, thank you, and yours.” Miss Pratt recited the last two words without the customary intonation, making them sound like a statement instead of a question. She was wearing a housedress, not a nightgown, but it was dirty and missing a button, and her cardigan had holes in both sleeves.

“It was very nice.” Glenda hesitated. “Were your friends able to get here?”

“Pardon?” Miss Pratt’s voice had sharpened, making Glenda feel like a snoop.

“I mean,” she said, “with the storm…”

“They came,” said Miss Pratt. “They always come. They come every day.”

Glenda took a step backward.

“They come every day,” Miss Pratt repeated softly. A shaft of sunlight struck her, illuminating her sparse hair like a feathery halo, and what amazing teeth she has, Glenda thought, how strong and white, expensive dentures, maybe, maybe that’s why she can’t afford proper clothes, and of course I’m not going to call the Ministry of Elderly Adjustment so they can come and get her medicated out of these delightful delusions that have her suddenly looking so elated, why shouldn’t she have imaginary friends if she hasn’t got real ones, and—

“To them I am not old and crippled,” Miss Pratt was saying. “I—”

“They come to me in a better world, where there is neither young nor old, healthy nor crippled.” Miss Pratt smiled beatifically. “On the Internet,” she said, and turned and hobbed back into her apartment, closing the door behind her.
POETRY

Rose and Blue
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My hospice room is rose and blue.
The blue is like the sky.
They think that if you’re happy here,
You’ll be content to die.
They proffer comfort, warmth, and peace,
All shining like the sun.
They strive to meet your every need.
They meet all needs but one.
So now I have another scheme,
My object all sublime.
I’ve gotten on a transplant list,
And so I bide my time.

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