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ANNOUNCEMENTS
Do you suppose the passage of 2,000 plus pages of a health care bill will remove some of our recent obsessions? Just in case you missed the Eastern Division symposium on that subject, this issue of the Newsletter includes some of the recent discussion. Also from that meeting, contributions from a symposium on Procreation, Abortion and Harm.

Three papers in this issue have been contributed by our faithful readers—and my threats and pleas have begun to bear fruit—we have two book reviews in this issue, and will have two more in the next issue! (And what would the Newsletter be like without a poem by Felicia Nimue Ackerman?)

The editors say a fond farewell to the outgoing chair of the Committee on Philosophy and Medicine, and welcome our incoming chair, ex-editor of the Newsletter, Rosamond Rhodes. John Lizza has been a pleasure for us to work with. Suggestions, announcements, and contributions are always welcome!

Mary Rorty and Mark Sheldon

“Change will also come to the APA Committee on Philosophy and Medicine. Here is what it will look like: Leonard Kahn (Air Force Academy), Rosamond Rhodes (Mt. Sinai Hospital), and Sandra Woien (Regis University) have been appointed to the Committee. Their three-year terms of service begin on July 1, 2010. As a past member of the Committee and an editor of the Newsletter on Philosophy and Medicine for many years, Rosamond Rhodes brings a lot of experience. She will succeed me as chair, as my three-year term ends on June 30, 2010. On behalf of the Committee, I would like to warmly welcome the new members. I would also like to thank Fritz Alhoff, Loretta Kopelman, and Kevin McDonald, whose service on the Committee will also end in June. They have contributed greatly to the work of the Committee.

At the last Eastern Division Meeting in New York, the Committee sponsored a session on “Health Care Reform” that featured talks by Lawrence Brown (Columbia University), Daniel Callahan (The Hastings Center), Norman Daniels (Tufts), and Leonard Fleck (Michigan State). Rosamond Rhodes chaired the session. Laurence Brown’s caution about the political uncertainty of whether reform would actually take place turned out to be right on the mark, as we watched the drama unfold in the subsequent months. There was some good discussion of the fragility of the political consensus, the amount of compromise in the current plans, and their feasibility. Norman Daniels was unable to attend the session, but his remarks are included in this issue, remarks which were read.

At the Central Division Meeting in Chicago, James Lindemann Nelson organized and chaired a session on “Rethinking the Ethics of Vital Organ Transplantation.” Franklin Miller (National Institutes of Health) presented his collaborative work with Robert Truog (Harvard University) on the question of whether to revise the “dead donor rule” to expand the pool of potential organ donors. Daniel Brudney (University of Chicago) and Joan McGregor (Arizona State University) provided commentary, which generated a lively and robust discussion of the issues.

At the Pacific Division Meeting in San Francisco, the Committee collaborated with the Society for Philosophy and Technology to sponsor a session on “Neuroimaging Techniques and Human Nature.” The session examined how advances in neuroimaging may affect or alter our understanding of human health care in this country. I agree with these observations and hope for movement on this front. Just as civil rights legislation has helped to create change in racist beliefs and attitudes in the country, perhaps the legislative reform in health care may precipitate a change in how we, as a people, look at health care. If the law requires us to provide for others in ways that we have not, we may gradually come to a realization that we “are in this together” and we can begin to address the difficult issues of cost savings and rationing in an ethically responsible way. There is a lot of work to be done, and a lot more change that needs to take place.

Mary Rorty and Mark Sheldon
nature. Inmaculada de Melo-Martin chaired the session, which featured talks by Fabrice Jotterand (UT Southwestern Medical Center) and Robert Rosenberger (Georgia Institute of Technology). Scheduled speakers Patricia Churchland (University of California–San Diego) and Mark Cohen (University of California–Los Angeles) were unable to attend.

Continuing its collaboration with the American Society for Bioethics and Humanities (ASBH), the Committee will sponsor a one-hour session on Beauty and the next annual ASBH meeting on October 21-24, 2010, in San Diego, California. Judgments of beauty sometimes are thought to discriminate against people, including those with physical or mental disability. At the same time, most people value beauty (however that may be understood) in their lives. How does such aesthetic valuation relate to moral valuation? Also, how ought one to balance these values in addressing disability? Loretta Kopelman will chair the session that will feature talks by Anita Silvers (San Francisco State) and Sara Goering (University of Washington) and commentary by Bonnie Steinbock (University of Albany, SUNY). The Committee plans to reprise this topic and invite additional speakers for a longer session at the next Eastern Division Meeting in Boston in December 2010.

It has been an honor and pleasure to serve for the last three years as chair of the Committee on Philosophy and Medicine. I would especially like to thank my colleagues on the Committee whose intelligence, kindness, and generosity of spirit have made my job easy and exciting. As is evident in the substantive content of this issue of the Newsletter, the editors, Mary Rorty and Mark Sheldon, have done great work in providing a forum for cutting edge work in the field. I would also like to thank the executive director of the APA, David Schrader, who was always responsive to the needs and concerns of the Committee. Over the last years, we have tried to encourage philosophers working on more theoretical issues in metaphysics, ethics, and social and political philosophy to turn their attention to some of the more practical concerns that occupy bioethicists and philosophers of medicine. At the same time, we have tried to encourage those on the front lines of bioethics and philosophy of medicine to reflect on how the more theoretical considerations might help clarify some of the difficult problems that arise in the practice of medicine. There is enough work for us all.

John P. Lizza
Kutztown University of Pennsylvania

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**U.S. Health Reform: Getting More Justice**

Norman Daniels
Harvard School of Public Health

My remarks fall into two parts. First, at the risk of covering what some of you may be familiar with, I explain why I think justice requires universal coverage (though this is not all justice requires to achieve an equitable distribution of health), why achieving efficiency in health systems is an ethical and not simply an economic issue, and why we need a fair process for resource allocation in health—none of which is fully realized in the current reform bills.

Second, since many of us believe a better reform—perhaps a more just one—has been whittled away in the political compromises that have been publicly displayed over the last few months, I want to discuss the somewhat confused notion of feasibility. Many of us appropriately want to build feasibility considerations into deliberation about what we ought to do and what we owe each other, since it is implausible to think we ought to do or owe each other what cannot be done.

Feasibility, I shall suggest, should not be understood as a straightforwardly empirical notion, though it sometimes is, but rather as it often is, a value-laden one. Many of our disagreements about what is feasible turn on value disagreements, including judgments about what ought to be done to change many other features of the world.

I: What justice ideally requires in the design (and thus reform) of health systems

In *Just Health Care* (1985) and in *Just Health* (2008) I have argued that health is of special moral importance because normal functioning makes a significant, if limited, contribution to the range of exercisable opportunities open to people. If we have social obligations to protect opportunity—either because we are egalitarians or some form of prioritarian about opportunity—then we have obligations to protect and promote health. These obligations involve both promoting and protecting aggregate population health and distributing that fairly. This means we must make efforts to reduce risks of ill health and to distribute those risks fairly. In addition, justice requires that we provide people with a reasonable array of services—preventive, curative, rehabilitative, and supportive in other ways (including palliative care), given technological feasibility and resource limits.

We know from many studies that health care is only one among many determinants of health in a population. In populations with no poverty, high basic levels of education, and access to universal coverage, we still find significant SES gradients of health (as the Whitehall studies of British civil servants and other studies robustly demonstrate). If we are concerned about equity in health, we owe people a just
distribution of the broader determinants of health. By “broader” I mean those determinants that go beyond medical care and traditional public health measures. In Just Health 1 illustrate what I mean by noting that Rawls’s principles of justice as fairness happen—quite serendipitously—to capture key social determinants of health, and if these principles were conformed to, we would have flatter SES gradients of health than we now see anywhere in the world. I note that our current U.S. health reform does not address this issue at all.

Suppose, as Sreenivasan1 does, that we can do more to protect equality of opportunity in a society through a better distribution of the social determinants of health than we can by investing heavily in universal coverage. Sreenivasan then argues that we cannot account for a commitment to universal coverage by appealing to an obligation to assure equality of opportunity. I disagree. We cannot prevent all illness, and those who fall ill have significant restrictions to their opportunity ranges. We may have to thin our health care benefit package in light of better ways to spend resources on health, but we still owe universal coverage for whatever benefit package it is then reasonable to provide. How do we determine what is reasonable to provide by way of a benefit package?

The answer Jim Sabin and I give to the last question is that we can arrive at legitimate and “defeasibly” fair decisions about what services to provide if the decision-making process about health priorities makes decision-makers accountable for their reasonableness (Daniels and Sabin 2002, 2008). Because we lack a priori consensus on principles that can resolve many resource allocation disagreements, we need a form of procedural justice to achieve legitimacy and fairness for decisions. Specifically, this means the decisions must rest on considerations all consider relevant to promoting population health and distributing it fairly, the decisions must be based on rationales that are public, and they must be revisable in light of new evidence and arguments. What this means, in my view, is that the opportunity-based account I offer provides foundations for a claim that we have a right to health (and health care), thought of generally as a right to a fair distribution of the socially controllable factors that determine population health, including universal coverage for a reasonable package of medical services. The specific entitlements that are the content of such a right are, however, specified by the fair, deliberative process I encourage (accountability for reasonableness).

Any account of reasonableness in health policy, especially in the design of a benefit package, must see efficiency as a handmaiden of equity. We want value for money in health because we can meet more health needs fairly for any level of expenditure on health if we have an efficient system. Moreover, we want the system to sustainably meet those needs over time, so we must control costs and get value for money. Efficiency is not an end in itself, or simply an economic goal, but a means of improving equity in meeting health needs.

II: Where does the current reform leave us?
Both House (promising 96 percent coverage) and Senate (94 percent coverage) bills fall well short of truly universal coverage. The Senate bill has a weaker mandate and fewer subsidies. The bulk of those not covered are, especially, undocumented immigrants. Perhaps if we devise legislation that provides a path to citizenship for many in this group, we can close the insurance gap further, but we still must address the substantive issue of principle—should undocumented immigrants be covered? I cannot now argue for the qualified “yes” I support.

Neither House nor Senate bills address other sources of health inequality beyond access to insurance. Neither bill adequately improves efficiency and contains costs in the reform. If our comparison is with a range of European or other Commonwealth systems, then we know we are passing over the much more efficient single payer systems as well as the strongly regulated private insurance systems of the Netherlands and Switzerland and the mixed ones of Germany and elsewhere.

Instead, the reform proposes “pilot” programs rather than a master plan, as Atul Gawande notes recently in the New Yorker. It is in this domain—where interests in reimbursement rates and profits are at stake—that the most important compromises about efficiency have been made (although the abortion restrictions are a different matter). Though Gawande suggests we need such pilots, and makes an analogy between the inefficiency of our system now and the inefficiency of our agricultural system a hundred years ago, other health systems now are much more efficient than ours, and our reform fails to adopt some of the key measures they use.

These systems rely on two main mechanisms to produce such efficiency and cost containment: a better balance of monopsony (buyer) and monopoly (seller) powers (e.g., large scale purchasing by public agencies), and a system of incentives that do not reward overtreatment, the diversion of funds into non-medical uses (including keeping people from services), and the unwise, unfettered dissemination of new technologies. Although our fragmented, private insurance industry is responsible for many of these problems, it is possible for a private insurance industry to have more efficiency in the service of equity if the private insurance is strongly regulated by a state with the right goals, as in the Netherlands and Switzerland. Our state, however, is arguably captured by that industry.

Neither bill proves adequate for ethically and empirically informed limit- or priority-setting. The public debate about reasonable limit-setting in health care has, in my view, been an abysmal display of scare tactics and lying (“death panels”). It has set back discussion of reasonable limit-setting significantly. For example, although the bills support comparative effectiveness research, it is at best only a partial solution to increasing efficiency through coverage decisions because it is limited to within-disease decisions, not decisions across conditions. Worse, the bills specify that comparative effectiveness research should be constrained from taking costs into account or from playing a direct role in decisions about coverage. The motivation for these restrictions is the fear politicians have of endorsing reasonable limit-setting.

Despite all these serious limitations, I believe it is wrong for supporters of universal coverage to turn their backs on the likely compromises we face. I explain that belief in what follows.

III: Justice and feasibility
Contrast the feasibility of the ideal just with the feasibility of steps to get more justice. When Rawls considers the feasibility (as measured by sustainability) of ideal justice (justice as fairness), he considers what strains of commitment arise for people raised within institutions that conform to his ideal conception. His claim (which I shall not assess) is that the principles of justice as fairness involve less strain of commitment than would result from conformance to a principle of average utility plus a principle of efficiency. Accordingly, justice as fairness is more feasible (sustainable) than a prominent competitor theory of justice. Testing feasibility in this way has nothing to do with how we can feasibly achieve institutions that conform with the principles—yet that is the notion of feasibility most of us consider relevant to efforts to reform existing institutions. Even if we do think justice ultimately requires certain arrangements (say an efficient, universal coverage system), “getting there from
here” poses problems of feasibility that are different from the sustainability of an ideal arrangement.

Moving toward institutions that significantly improve coverage, even if we do not achieve 100 percent coverage, is something that an ideal theory (such as my extension of Rawls) calls for; it is also called for by Sen’s (2009) approach toward “getting more justice” or reducing glaring injustice. One possible point of disagreement arises if a reform that partially closes the insurance gap makes it harder to achieve universal coverage in the long run. This might happen, for example, if a public option is excluded from the reform and a system that entrenches only private insurance has a harder time achieving efficiency and universal coverage. Then we might give more weight to securing the ideal outcome than to simply closing the gap, even closing it by a significant amount.

Yet disagreements about how hard further reform will be if we exclude a public option, like judgments about whether we can now include a public option, may themselves rest on other judgments of value. Some will say that if we close the gap “enough” then the improvement is worth it even if closing it completely later is made harder. Others will think that making 100 percent coverage harder to achieve—since this is a matter of principle—is a worse outcome than keeping the greater pressure on achieving the ideal that might result from perpetuating a bigger gap. Still others would insist that we should not hold those who will benefit now from partial reform hostage to an effort to achieve universal coverage once the conditions are right. I am suggesting that these differences in value judgments will influence judgments about feasibility. Thinking it is permissible to delay partial reform may lead to the judgment that more significant reform is politically feasible.

I am not claiming that we cannot distinguish (in theory) the empirical questions about likelihoods from the value judgments, but I am claiming that in practice we will find they interact and real disagreements may confute the two, so that we cannot resolve the disagreement simply by giving some evidence about probabilities. For example, people who think we should aim for 100 percent coverage and not settle for less are likely to judge the probability of success for that course of action higher than those who think we should not let the “perfect drive out the good.” The temptation is to think the world fits our values and so to shape judgments about feasibility accordingly. It would probably be wrong to think the real difference is a straightforward difference in the judgments about feasibility and that difference justifies the tactic—the direction of justification may go in the opposite direction.

Much of the controversy will surround claims about what is “politically feasible,” where political feasibility depends on the attitudes and beliefs, including the ethical views, of political actors. For example, will such actors think about the common good and not simply about party interests? Will the actors be aware of the difference and respond to claims about it? Will some value judgments they reasonably hold lead them to respond one way and not another, so that reasonable ethical disagreements may play a role in what they do? If so, disagreement about what is politically feasible may turn on the distribution of reasonable ethical views among political actors. I have in mind the following example: people who think it is wrong to delay benefits to some in order to achieve universal coverage may think it is less likely that political actors will change their minds and support more extensive reforms, whereas people who think it is acceptable to delay benefits for some in order to realize a requirement of truly universal coverage may believe political actors will see the light and change their minds in favor of such reforms.

In my own view, I think the current reform, imperfect as it is, does not make it significantly harder to improve the system further, and so is a justifiable reform. If I believed that there was a mass movement for a more ideal outcome, and that accepting the current reform would seriously hamper the chances of that movement achieving a better reform, then I would not settle for the current reform. I do not think that mass movement exists, however; nor do I see short-term prospects for building it. Instead, we must rely on existing political forces to arrive at the best compromise they can. My own feasibility judgment itself rests on deeper value judgments about the objectives of existing political forces and about what I can then expect of them in the absence of a mass movement for more ideal reforms.

IV: Summary: Six main points: five ethical, one ethical and political

a. Justice requires universal coverage and, if the reform passes, we will be closer to it, but not there yet.
b. Much needs to be done to distribute health more fairly in this country through broader forms of social justice, yet this reform improves the distribution of health care but little else.
c. Much more should be done to make the U.S. system more sustainable by giving better value for money in health care. We have a big agenda for reform in the future.
d. Priority setting in health care has arguably been set back by poor quality public discussion, but there is room for great improvement.
e. Judgments about feasibility are morally laden and are not simply an empirical constraint on what we ought to do and what we should view as just.
f. Better reform would require mass movement that could beat back vested interests. Critics on the right sense the lack of that movement and critics on the left are calling for improvements that are unlikely in its absence. The compromises—including cave-ins—we are getting is what happens politically when vested interests have a free hand buying political influence in the absence of a mass base with clear objectives.

Endnotes


2. I say “defeasible” because we may come to discover a persuasive argument for principles that can resolve our disagreement about a rationing issue, even if at the time of decision we have no a priori consensus on principles that can solve the rationing problem. At the time of decision we have an instance of pure procedural justice, but the later discovery makes the outcome only defeasibly fair. In this way, the case differs from Rawls’s example of gambling, where we cannot imagine discovering a principle of distribution other than the fair throw of the die.


Health Care Reform: Have We Made a Difference?

Daniel Callahan
The Hastings Center

When I was part of the panel on health reform at the APA meeting this past December in New York our focus was on the
uncertain prospect of reform and the likely ingredients of the various bills in the Senate and House under debate. But the reform did come about and, through the tactic of reconciliation, a bill was finally passed. What will it do, or fail to do, and what can those of us who are philosophers engaged with such matters learn from the public and congressional debate?

The main accomplishment of the bill is that some 33 million of the uninsured will be covered, some important restraints were imposed upon insurers in their coverage to stop a number of abuses, and exchanges will be established in the states to foster a more competitive insurance market. The main drawbacks of the legislation will be the delay of many of its provisions being put into effect (as a cost reducing strategy), its dependence upon insurer competition to bring down cost escalation (which it has always historically failed to do), the general weakness of its other cost control strategies, and its vulnerability to be weakened or partially repealed by future congressional action with a new party in power. I am one of many single-payer advocates—guaranteed losers from the opening round—who decided this bill was better than nothing. But not much better.

Along the way during the tumultuous debate, following its ups and downs, its almost daily cliffhangers, I wondered what role, if any, we might have in the political squabble and which of our ideas might at least get a nod. While I have carried out no systematic survey, my impression is that we philosophers were not much invited on the battle field, and even less so than during the 1994 Clinton reform effort. Ezekiel Emanuel (technically not a philosopher but often granted that honorary status) was an exception to that generalization, but it does not belittle his many talents to note that his relationship to Rahm Emanuel gave him a head start over the rest of us. When experts of one kind or another were asked to help out they were usually health care economists or policy gurus, a group notable for wrestling with the organization and management of health care systems, not with its ethical problems. Just how much difference even they made may not be known for some years, when some scholarly examinations of the reform struggle are written. Some years after the Clinton effort, the eminent economist Victor Fuchs surveyed his colleagues in the field, most of whom felt they had been ignored. The move from academic skills and research to political sway and usefulness is not easy.

I was particularly interested in determining whether some major health care issues that have preoccupied those philosophers like myself who had made a specialty of health care received attention. Two such issues are worth noting. One of them was access to care, the other rationing and the control of costs. There are at least four different ways one can get at the values pertinent to access: to use the language of justice, or rights, or the common good, or solidarity. Each has its philosophical and political science adherents, and a good deal of literature here and abroad behind them.

While I can hardly claim to have read everything that President Obama and members of Congress said during the debate, what I did hear or read was enough to convince me that none of those values was much evoked. The president, news stories had it, was at one point urged by his staff to talk about morality, to move away from his often cool, wonkish rhetoric. The best he seems to have done in response on any major occasion was to quote Senator Ted Kennedy on justice. Beyond that the main rationale for coverage of the uninsured was most often the economic cost of the uninsured, the chaos of the present system, and the misery of the uninsured and underinsured. But even that last-mentioned theme evoked an ethical concern without linking it to some specific concepts or principles. As with the Michael Moore documentary “Sicko,” Obama’s evocation of empathy was closer to the European idea of solidarity with our fellow citizens than to principles of justice or rights. I might mention that conservatives got much mileage out of their favorite values—none of the above—but of choice and competition. They made for better sound bites than anything the Democrats had.

My own interest in the debate was especially drawn to cost control and, at least among we philosophers, the perceived need to have a rationing discussion as a part of it. I even went so far, old-fashioned print man that I am, as to initiate and edit a blog devoted to the topic and featuring a number of postings that explored the need for rationing (www.healthcarecostmonitor.org). It soon enough became evident—and not just with Sarah Palin’s claim of a hidden “death panel” lurking in the early proposed House legislation—that politicians, left and right, do not want to get anywhere near the notion of rationing. It is a concept that appears abhorred by the general public, fought by the drug and device industries, and hated by a goodly number of physicians who believe that any and all decisions, economic or otherwise, should be left to doctors and their patients. Politicians do not like odds of that kind.

Evasion was thus in order. Yes, cuts will have to be made in Medicare benefits, in physician and hospital reimbursements, and in a variety of other services, but they will be made in the name of getting rid of waste and inefficiency, overutilization of technology, and some dubious insurer practices. But no, absolutely no recourse to rationing. No one will lose anything of importance. Many of us, it turns out, can talk about rationing in the classroom or the lecture hall or in like-minded circles and get away with it. But it is just unimaginable that any one of us will soon be invited by a congressional committee to present the case for rationing.

The two examples I have presented have not been encouraging about our potential influence in the corridors of power. Speaking truth to power has rarely been a successful effort, historically more likely to bring an execution or imprisonment than praise. Yet there is a younger generation coming along, reached in the undergraduate and professional school student bodies, that is open to taking seriously both justice and rationing. As with a flawed reform legislation, let us be thankful for what we can get. Philosophy, we should know, is a slow crawl, and patience a virtue. They killed Socrates; but we are still reading him.
an individual mandate. I will defend the moral and political legitimacy of that mandate.

1. Statement of the Problem
In a broad sense the idea of an individual mandate is politically troubling because we live in a liberal society. We affirm the political right of individuals to take all manner of risks with their health, including smoking, eating a high fat diet, refusing sound medical advice, engaging in risky sports, and so on. Why should we not also allow individuals who wish to gamble with their health and financial well-being to go without health insurance? Such a choice would seem to affect only them. Further, what is being mandated is not relatively inexpensive, such as having to wear a seatbelt. Instead, the costs of the mandate to an individual could be 10 percent of one’s gross income or several thousand dollars. In addition, what individuals are being forced to purchase is access to some range of health services, some of which might be deeply morally objectionable to some individuals, such as abortion services or prenatal genetic testing (which could result in a woman choosing to have an abortion). Of course, no one is mandated to take advantage of any of these services if they are deeply opposed to them, but their dollars are still making these services available to individuals who might otherwise not have access to these objectionable services. These points should be sufficient to get our discussion going.

2. Primary Considerations Supporting Individual Mandates
Three major arguments would be the main pillars supporting the moral and political legitimacy of the individual mandate. First, major health reform will require that insurers get rid of pre-existing condition clauses used to exclude risky individuals (or the likely costly health needs of these individuals) from insurance coverage. These individuals generally have more serious and more urgent health needs with very adverse consequences for them (premature death or permanent disabilities) if these needs are not met in a timely way with assured access to the necessary care. If anyone has a strong presumptively just claim to needed health care, these patients could easily assert that claim. But insurers will be unwilling to take on the costs associated with these patients unless the insurance pool is broad enough to spread those costs out so that insurance is affordable to all. That requires that virtually everyone be mandated to purchase the health benefit package guaranteed to all so that the insurance pool includes billions of dollars from individuals who are essentially healthy now (who might otherwise be motivated to gamble that they will remain healthy for the next ten or twenty years, which would allow them to gamble with those dollars instead at a local casino in the hopes of getting rich). 3

Second, if there is no individual mandate, a free rider problem would threaten the stability and fairness of the system. It is a political and moral fact that hospitals will not turn away patients with true emergency health care needs, whether or not those patients are insured or have any ability to pay for the care they will need. We commonly think of these costs as “being absorbed” by the hospital, but hospitals cannot “just absorb” those costs. Those costs have to be passed along to everyone else who is insured, which translates into higher insurance premiums for insured individuals. Those individuals are then paying “more than their fair share” for their own health insurance and health care. No doubt some individuals are so near the poverty line that even with government subsidies they cannot pay for any insurance product on the market. They cannot be justly accused of free riding. But other individuals have the economic capacity to pay for that insurance to the same degree as others in their income class and choose not to pay. That is unjust. These individuals are justly mandated to purchase health insurance.

Our third argument for the individual mandate is a little more complex. In brief, it is that reasonable cost containment can be more easily and fairly achieved if virtually all are part of the health care system, which is what the individual mandate seeks to achieve. I assume the reader at this point appreciates the fact that health reform is not simply about expanding access to needed health care for the uninsured and underinsured. Health reform necessarily requires health care cost containment as well, especially if we wish to protect the long-term stability and fairness of our health care system. 2

Health care cost containment necessarily means health care rationing to a large extent, i.e., denying individuals what from some social perspective is judged to be marginally beneficial non-cost-worthy health care. As things are now, individuals who are reasonably well insured can demand everything the health care system has to offer, no matter what the cost, no matter how marginally effective those health services might be. A prominent example at present is represented by these extraordinarily costly cancer drugs that cost from $50,000 to $130,000 for a course of treatment that will yield only extra weeks to extra months of life. 3 As we know from the heated rhetoric of health reform in late 2009, anyone who would advocate excluding these drugs from health insurance packages would be accused of being part of a “death panel.” What happens in practice is that the well insured will be successful in demanding these drugs. Those costs are simply passed on by insurance companies to employers. Marginal employers increasingly cannot bear those costs, so they simply drop health care as a benefit, thereby increasing the number of uninsured and underinsured in the U.S. None of these individuals will have any access to these drugs (or most other costly health care interventions, no matter how effective they might be in curing or ameliorating a range of serious health conditions). This is how we currently control health care costs...unfairly.

Individuals who are uninsured have no say in coverage decisions in our health care system. But the virtue of an individual mandate is that virtually everyone (as a patient) has a stake in controlling health care costs. No one can be pushed out of the system as a mechanism for controlling costs. If individuals chafe under the cost of the mandate, either as direct payers of premiums or as indirect payers of taxes to underwrite the cost of government subsidies for the economically less well off, then all can be part of a broad public democratic deliberative conversation aimed at controlling costs by identifying health care services in specific clinical circumstances that yield too little benefit at too high a cost to justify inclusion in a health care benefit package that all must pay for. Such a conversation would articulate health care rationing protocols that would apply to all in specific clinical circumstances because all would be part of the health care financing system (fragmented but with a large overlapping core of health services constituting a national benefit package). Assuming a fair and reasonable deliberative process, not co-opted by special interests, the rationing protocols that emerged from that deliberative process would be fair, transparent, and self-imposed. 4 This is justice as reciprocity, and it would have been made possible as a result of the individual mandate.

3. Necessary Conditions for a Sustainable Individual Mandate
We should note that an individual mandate is not a “stand alone” feature of health reform. There are a number of necessary conditions for successful and sustainable implementation of an individual mandate. Let me briefly identify those conditions.
First, an individual mandate must be coupled with guaranteed issue by insurance companies, i.e., insurance companies would not have the right to refuse anyone health insurance because of a pre-existing condition. Of course, if individuals were charged absurdly high premiums, that would be the same as refusing them coverage. So the second condition would be “community rating.” A small number of circumstances would allow very moderate increases in premiums to some individuals, but for the most part community rating would assure affordability. Third, there must be a clearly defined mandated basic benefit package, which is what allows for meaningful price competition among insurers and meaningful comparative judgments by potential purchasers of that insurance.

Fourth, there must be fair income-related subsidies for individuals who are mandated to purchase insurance so that roughly “equal economic effort” can be expected of all. As a fraction of income this would need to be graded to achieve the sort of fairness that a graduated income tax aims to achieve.

Fifth, there should not be any lifetime limits for needed health care. Health needs will vary enormously from one individual to another, typically for reasons that are entirely beyond the control of an individual. Some individuals might need a million dollars worth of NICU care just to get through the first year of life. Obviously, important issues must be resolved around what will count as a health care need. It cannot be something left to subjective judgment. Daniels’ fair equality of opportunity account is helpful in this regard, though (to my mind) it must be qualified in a way that would diminish the moral weight accorded needs that could only be met by means of marginally beneficial non-costworthy medical interventions.

Sixth, the individual mandate must be coupled with an employer mandate, what is usually referred to as “play or pay.” This is necessary to create a roughly level playing field among employers and to minimize the risk of their free-riding on the individual mandate. Employers would be free to offer a more generous health benefit package than the core package guaranteed to all in our society as part of the health reform effort, but employers would not have the right to offer a less generous package.

Seventh, some degree of risk-rating of individuals would likely be necessary so that no insurance company ended up with a disproportionate share of costly unhealthy individuals. Presumably a public compensation mechanism would be put in place to assure fairness of risk among insurance companies.

Eighth, effective cost control throughout the system would be necessary so that neither the cost of the mandate to individuals nor the cost of the subsidies to government (taxpayers) needed to support the mandate undermines the long-term affordability of the mandate. The painful message that must be accepted in this regard is that some sacrifice will be required by all who are part of the system, i.e., income and profits for those who deliver health care services and products, marginally beneficial health care in the case of patients. It is not realistic to believe that adequate cost control can be achieved through painless gains in efficient delivery of services.

The bottom line is that the individual mandate must be fair, must be perceived to be fair, and must be cost-effective. Fairness must be system-wide, which is what I have tried to emphasize in laying out the broader conditions necessary to protect the moral legitimacy of the individual mandate. This would be especially true with regard to cost controls and rationing protocols introduced into the system. It would certainly not be fair if stringent cost controls or rationing protocols applied only to the formerly uninsured, who would now be legally obligated to purchase health insurance. Our health care system will remain fragmented, but the sustainability of reform will require “enough solidarity” that there is a real sense in which “all are in this together.” This will be especially necessary when we are talking about the sacrifice of marginally beneficial health care.

The reader will notice that the most we can realistically require is “enough” solidarity, as opposed to “perfect” solidarity. Wealthy individuals have to be allowed to purchase those extraordinarily expensive cancer drugs because we have collectively judged those drugs yield too little good at too high a cost to justify inclusion in a package of benefits that those under the individual mandate would be obligated to pay for. Further, no one is made less well off as a result of permitting such purchases, nor are any individual rights violated, nor is there an obvious injustice (unless we were prepared to defend a very strong egalitarian conception of health care justice).

4. Objections to Individual Mandates
We now consider some ethical and political objections that might be raised with regard to the individual mandate. First, a paternalistic objection might be raised: What gives someone else the right to decide that as a healthy young person it is in my best interest to have health insurance that I do not see as the best use of my limited resources? I realize that I am taking a risk. I have given that due consideration. The risk is remote. Why should I be forced to fatten the profit margins of some insurance company?

Second, an objection might be offered based on my liberty rights of free association: Why should I have to be part of a health plan with older or sicker or irresponsible individuals whose health care I will be forced to subsidize? If I have to be in a health plan, I want to be in a plan with younger, healthier, health-conscious individuals so that I can save money to spend on other things that I regard as more valuable for my life right now. Maybe I want to spend those mandated dollars on preventive health services, e.g., a health club membership, instead of expensive medical interventions for chronic degenerative conditions.

Third, an illiberality objection might be proffered: Why should I be forced to pay for health care services that I find deeply morally objectionable, such as pre-implantation genetic diagnosis with IVF for couples who know they are otherwise at risk of having a child with a serious genetic disorder that will very adversely affect the length of life or quality of life of that child from early on? The same would be true for whatever the future might hold with regard to therapeutic interventions that were part of regenerative medicine, i.e., come about as a result of work with embryonic stem cells. It is morally irrelevant that I would never take advantage of these services. What matters is that others would take advantage of these services and my dollars would help to make that possible.

Fourth, some potential injustices are built into the individual mandate, at least in the version of the bill approved by the Senate in late December. The objection is that if individuals are forced to purchase health insurance by this mandate, then they will be the victims of the injustices that are built into that version of the individual mandate. More specifically, the mandates include “incentives” for consumers to reduce the use of health services, thereby saving money for the system as a whole. The incentives are really negative incentives in the form of various co-payments and deductibles. The justice objection is that these incentives will have very differential effects on the working poor subject to mandates compared to the relatively secure middle class. Co-payments and deductibles for the working poor will represent a much larger fraction of their income and, therefore, more of a barrier to accessing needed health care in a timely way. Too often these individuals will
forsake seeking care (or obtaining advice regarding the medical importance of that care) because they want to avoid incurring the cost to themselves.

5. Responses to Objections

We start with the paternalism objection. Ordinarily we respect the right of patients to make autonomous choices for themselves, even very foolish choices (which is why paternalism is presumptively objectionable). But patient autonomy rights are justifiably constrained in many contexts by considerations of health care justice. I do not have the right to use my wealth to buy access to the last bed in the ICU when other patients would have a stronger just claim to that bed. Nor do I have the right to impose health care costs on others by being uninsured, and suddenly finding myself with serious, costly, life-threatening health care needs. We might be tempted to say that this individual has no just claim to that needed health care, which might well be true if this individual refuses to purchase health insurance despite having the financial ability to do so (especially through reasonable public subsidies). But we (health care providers) would still have social/moral obligations of compassion to provide that care (especially if it would make the difference between life and death, or permanent disability and prevention of that disability), and those costs would have to be covered by others who had already paid their fair share for health care.

We should also note that national health systems, as in Canada and the UK, involve a mandate in that all must pay their fair share of taxes to support the health care system. Again, we have no good reason to regard this as unjustifiably paternalistic because the health care system is in many respects a “public good.” Huge public investments in medical research, training health professionals, and building health facilities are things that all benefit from (and hence, all are obligated to support to some fair degree). We should add that the “paternalism” in the U.S. associated with an individual mandate is a limited “paternalism” because what individuals are obligated to buy is a basic though somewhat comprehensive package of health services (both for their own good as well as the good of family members economically attached to them). No one is imposing on them extraordinarily costly and rare health care interventions for rare health needs. And if the basic benefit package is properly constructed, then it would also exclude very costly health services that yield only very marginal benefits. Individual liberty would be protected because individuals would retain the right to “buy up” from the basic package if they were so inclined. A side benefit of a system that looked like this is that we would be forced to have a public explicit conversation about the rationing issue, i.e., the services/circumstances excluded from the basic benefit package because they yielded too little good at too high a price. That in turn would force into the limelight the question of why tax subsidies should continue to be provided for employer-sponsored health care above whatever the value was of that basic benefit package we wanted to guarantee to all (mandate that all purchase). This in turn would facilitate bending the health care cost curve in a downward direction so that increases in health costs more closely reflected economic growth. And that ultimately would help sustain the stability of the reform efforts. Note that this way of controlling health care costs would be much fairer than using co-payments and deductibles to achieve that goal (with the inequities that would be imposed on the working poor).

The second objection pertained to alleged rights of free association being violated. If we consider this objection carefully, we will see that this is another version of “cherry-picking,” which health reform would forbid insurance companies from doing. From a moral point of view it does not matter that “cherries” choose to freely associate with one another as opposed to being chosen by an insurance company. What do we imagine such a system of free association would look like in practice? I am perfectly healthy and very responsible about my health, so I pay less than half of what everyone else pays for health insurance as a member of the Great Health plan. Then I find myself (even at a young age) with some cancer or heart disease or some other costly chronic degenerative disease with annual health costs (HIV). Do I then get kicked out of my Great Health plan (since these are annually renewable)? This would not be the result of my free choice (I realize I am now a badly bruised cherry with no right to associate with hard-body healthy cherries); instead, I would be denied my right of free association. BUT, free association must be mutual; I have no right to demand continued association. Does this mean all other health plans also have the right to exclude me (because I now represent a cost of $30,000 per year in needed health care)? That would very adversely affect my self interest. But if some health plan MUST take me (at a cost below what I will impose on that plan) then I am free riding; then I am not reciprocally respecting the right of free association of the members of that plan. If some health plan MUST take me or my serious health needs MUST be met (societal obligations of compassion), then we are back to justice-based reasons that justify the individual mandate.

The third objection was the claim that the individual mandate was illiberal in important ways. In a world as complex as our own, everyone will end up paying for some health services to which they have some serious moral or non-moral objections (and many of these services would have to be part of a basic benefit package guaranteed to all). This is something that mutual respect/reciprocity requires of all of us in a liberal, pluralistic, tolerant democratic society.

EXAMPLE 1: You are deeply opposed to IVF and pre-implantation genetic diagnosis (PGD) used to avoid having a child with a serious life-threatening, quality-of-life diminishing genetic disorder. You are a committed Right to Life person who would never use this technology. But if you were to have a child with cystic fibrosis (knowing this could happen because you were aware of genetic risks), I will be morally obligated (and committed) to providing all the costly medical care your child requires, even though I might believe you made an irresponsible choice by failing to take advantage of the PGD option (though I do understand and appreciate your moral perspective). But if I make this commitment to you (as a committed liberal pluralist citizen), then it is reasonable to expect you will underwrite the costs of my using PGD (though you have your moral/religious reasons for being opposed to this intervention). Our society is respecting your right to refuse to take advantage of this intervention for yourself; in this regard we are acting in ways congruent with our liberal commitments. Hence, the claim of illiberality misses the mark.

EXAMPLE 2: Think about regenerative medicine which will likely involve the use of embryonic stem cells. You are absolutely opposed to the use of this technology, no matter what it might promise in the way of avoiding premature death. So we allow you (in this hypothetical example) to choose a segregated health plan that excludes access to all interventions using embryonic stem cells. But you suffer a severe heart attack and will be dead in six months at age 54 unless stem cell regeneration is used to repair your heart. You want to live; you want this intervention; you now attribute a value to your life far in excess of the value you used to attribute to a 100-cell embryo, but you do not have the $100,000 it would cost for this treatment. Are we morally obligated to provide it anyway? Again, this is where obligations of compassion kick in, certainly if this intervention is very likely to be successful and to yield many extra years of high-quality life. And, again, it would be unfair if those now abandoned...
religious commitments required others who did not share those commitments to absorb these compassionate costs. Likewise, what if the patient is this eight-year old child with a serious life-threatening cardiac condition curable through an embryonic stem cell transplant (parents are committed to a Right to Life position and belong to a segregated health plan)? Do we do the transplant anyway (as in Jehovah’s Witness cases), and who should be responsible for absorbing those costs? This is another reason for an individual mandate that will cover medically effective, cost-effective health interventions that some might find objectionable for a variety of (non-public) reasons.

In general, we ought to respect deep religious moral commitments of others. This is essential to what political liberalism is about. But that respect cannot be given if it requires imposing substantial injustices on others in order to satisfy religiously rooted health-related preferences of some patients.

Our final objection pertained to the injustices that are built into the individual mandate as proposed in the bill approved in the U.S. Senate. Our first response is that those injustices ought to be remedied. The health economics literature is virtually unanimous in calling attention to the differential effects (we, moderate egalitarians, would say “inequities”) that large deductibles and co-payments would have on those who were less well off compared to those more well off. We saw this same problem emerge in regard to the so-called “doughnut hole” that was built into Part D of Medicare (aimed at providing prescription drug coverage for the elderly). The “doughnut hole” represented about $2,700 in prescription drug costs that the elderly would have to absorb entirely on their own after they spent $2,400 on prescription drugs (25 percent of which they would have to pay for). It was intended to be a strong cost containment mechanism. It did achieve that result, but it was clearly the less well off elderly who bore most of the burden of that cost containment mechanism. That is supposed to be corrected in the current health reform legislation. But the morally sound reasons that warrant that correction warrant a comparable correction with regard to the individual mandate. As noted already, health care costs must be contained for both moral and economic reasons. But the mechanisms employed ought to apply fairly to all who benefit from the health care system, not primarily those who are less well off both in terms of health and income.

Would an individual mandate still be morally justified if those injustices were not corrected? Probably. We need to recall that compassion is a moral virtue and an individual’s compassion is a moral virtue. If you think you began to exist at conception, my argument will apply, on your view, only to fetuses after about the 22nd week of pregnancy.

Summary

My concern is with fetuses that would, if they survived, be identical with—or one and the same individual as—the person into whom they would later develop. These are fetuses for whose sake one could act now in affecting the conditions of later person’s life.

People have different views about when we begin to exist. If you think you began to exist at conception, my argument should apply, on your view, to all fetuses.

If you think we began to exist only when the fetal brain acquired the capacity for consciousness, my argument will apply, on your view, only to fetuses after about the 22nd week of pregnancy.

Common sense intuition: reason to enhance

Suppose that such a fetus—one that is potentially identical with an adult—is genetically destined to develop cognitive capacities no higher than those of a higher nonhuman animal. I will call such capacities, in a human being, “radically limited.”

But suppose further that there is a method of genetic therapy that would enable that fetus to develop normal cognitive capacities. Even though many people are skeptical of the permisibility of enhancing a human fetus’s cognitive capacities beyond the normal range, most people think that there would be a strong moral reason to enhance this fetus to bring its capacities up to the normal level.
Assume enhancement identity-preserving
Let’s assume that this process would be identity-preserving: that is, that the enhanced individual would be the same individual as the unenhanced individual.

Four possible moral reasons that support cognitive enhancement for a radically cognitively limited fetus:
(1) Interests of parents and others in society: I won’t consider this
(2) Present interest of the fetus
(3) Future interests of the individual the fetus will become
(1, 2, & 3 are individual-affecting reasons.)
(4) Impersonal reason: good, but not necessarily better for anyone

If there’s an individual-affecting reason to enhance a radically cognitively limited fetus, then there is an even stronger reason not to kill a normal fetus
Suppose the moral reason to enhance the cognitive capacities of a radically cognitively limited fetus to the normal level is that the fetus has a strong present interest in developing normal cognitive capacities.

In that case, a normal fetus must have the same interest—that is, an interest in developing normal adult cognitive capacities, which it can’t satisfy unless it continues to live.

So if the reason to enhance the radically cognitively limited fetus is grounded in the fetus’s present interest, there should be an even stronger reason not to have an abortion. The reason is stronger because the alternative to cognitive enhancement is life as a radically cognitively limited adult, which is better than the alternative to allowing a fetus to live—that is, death. In other words, life with radical cognitive limitation is better than no life at all.

Dilemma
This should be troubling for those who hold a liberal view of abortion.

If you think there is a strong reason to provide cognitive enhancement for a fetus at any point in pregnancy, no matter how early, then you should think that there is an equally strong objection to abortion at any point beyond the point at which you think the fetus will be identical with the later person.

How can liberals about abortion avoid this consistency problem?

 Fetuses have no interests, or have weak present interests
Singer, Tooley: Some people deny that even conscious fetuses have interests, usually on the ground that they have no desires or preferences. On that view, neither a radically cognitively limited fetus nor a normal fetus has a present interest in developing normal cognitive capacities.

My view
I myself hold a less radical view. It is that the present interests of a fetus in its own future life are diminished in strength because of the great psychological discontinuity between the fetus and its adult self. This view is based on an intuition that the death of a fetus is less bad, even though there is a great loss of good.

Both of these views support the permissibility of abortion.

They are incompatible with the view that radically cognitively limited fetuses have a strong present interest in receiving cognitive enhancement.

But they are compatible with the view that the interests that the fetus will have as an adult matter just as much as any other future interests.

Future interests: distinguish prenatal injury from abortion
Distinguishing between the fetus’s present interests and its future interests is in fact what allows us to claim both that abortion may be permissible because a fetus has no interests, or because abortion frustrates only the very weak present interests of the fetus, and that prenatal injury is seriously objectionable if it will adversely affect the much stronger interests that the fetus will have in the future.

Failure to enhance = prenatal injury by omission
The appeal to future interests can similarly allow us to distinguish between abortion and the failure to enhance a radically cognitively limited fetus.

For failing to enhance the fetus is relevantly like causing it to be radically cognitively limited, in that the outcome is the same. It’s just that it involves allowing rather than doing.

One might say it is a passive form of prenatal injury, or prenatal injury by omission.

Summary: abortion frustrates only present interests, failure to enhance frustrates future interests
So the failure to enhance, like causing radical cognitive limitation, affects future interests, while abortion doesn’t.

If a radically cognitively limited fetus would later have a strong interest in having normal rather than radically limited cognitive capacities, that would explain the importance of enhancement in a way that is compatible with recognizing that abortion is permissible because it frustrates no interests at all, or frustrates only the weak present interest of the fetus in continuing to live and becoming a person with normal cognitive capacities.

But the interest of a radically cognitively limited adult is weak for the same reason
But some radically cognitively limited adults have cognitive capacities that aren’t much higher than those of a fetus.

Singer implication
On the view that specific interests presuppose specific desires, radically cognitively limited adults can’t have an interest in cognitive enhancement to the normal level. Nor can they have an interest in continuing to live. On Tooley and Singer’s view, they wouldn’t be harmed by being painlessly killed.

Implication of my view
And on my view that the strength of an interest in some future state of affairs is discounted for psychological discontinuity, a radically cognitively limited adult’s interest in radical cognitive enhancement must be weak for the same reason that a fetus’s interest in the radical transformation of its psychological nature is weak. Nor can they have a strong interest in continuing to live.

This makes it hard to defend the common view that a radically cognitively limited adult has a strong interest in developing normal cognitive capacities through genetic enhancement, while a normal fetus doesn’t have a comparable interest in developing normal cognitive capacities via normal biological maturation.

Of course, most radically cognitively limited adults have cognitive capacities that are higher than those of a conscious fetus. On my view, that means that their interest in acquiring higher cognitive capacities is correspondingly stronger than
that of a fetus. But the basic form of the problem remains: the relevant future interests are still comparatively very weak.

A footnote: Can animals have a strong interest in cognitive enhancement?
I stipulated that a radically cognitively limited human being has cognitive capacities no higher than those of a higher nonhuman animal.

If that adult would have a strong interest in cognitive enhancement, it seems an animal would as well—if the value of higher psychological capacities is at least in part intrinsic.

Summary: appeal to future interests fails
So it doesn’t seem that we can achieve consistency between a liberal view of abortion and the common intuition about the value of cognitive enhancement for a radically cognitively limited fetus by appealing to future interests.

Dilemma
If a radically cognitively limited fetus has a strong present interest in having higher capacities, or if a radically cognitively limited adult has a strong interest in cognitive enhancement, then it seems that a normal fetus must have a comparable interest in developing comparable capacities through continuing to live and undergoing normal biological development. So the reason to enhance is also a reason, in the normal case, not to abort.

But if the interest of a normal fetus is weak because of psychological discontinuity, the same should be true of a radically cognitively limited fetus and even, though perhaps to a lesser degree, of a radically cognitively limited adult.

Argument for impersonal reason
Turn now to the third possibility: the appeal to impersonal reasons.

Choice between radically cognitively limited individual and normal individual
Consider choice between causing a radically cognitively limited individual to exist and causing a different cognitively normal individual to exist. Intuitively, there is a strong reason to choose the latter. But that reason can’t be individual-affecting. It must be impersonal. It’s not worse, or bad, for anyone if the radically cognitively limited individual is caused to exist.

Same reason to enhance fetus
Intuitively, the reason to provide cognitive enhancement for a radically cognitively limited fetus seems equally strong as the reason to cause a cognitively normal rather than a radically cognitively limited individual to exist.

“No-Difference” View
According to Parfit’s No-Difference View, it doesn’t matter in these cases whether the individual who later exists with normal or radically limited capacities is the same individual as the one who would have existed had we chosen differently.

That’s essentially to say that the reason in both cases is impersonal.

And that’s what I think we ought to conclude: that the reason to provide cognitive enhancement for a radically cognitively limited fetus is impersonal, just like the reason to cause a cognitively normal individual to exist rather than a radically cognitively limited individual. There is comparatively little reason to provide such enhancement for the fetus’s own sake, now, or even for the sake of the adult into whom it will develop.

Not additive with individual-affecting reason
This impersonal reason isn’t additive with the weak, individual-affecting reason. For there doesn’t seem to be a stronger reason to enhance an existing radically cognitively limited fetus than there is to cause a fetus with normal capacities to exist rather than a different, cognitively limited fetus.

Question: If there is an impersonal reason to enhance, is there an impersonal reason not to abort?
It may be that this appeal to an impersonal reason to enhance doesn’t solve the problem. For there might be an impersonal reason to allow a fetus to live rather than to have an abortion. These issues lead to the difficult question of whether there is a moral reason to cause people to exist if their lives would be worth living.

Possible defense of an individual-affecting solution: Thomson argument?
Thomson’s argument appeals to the woman’s right to expel an intruder who has no claim to the use of her body for life support. It does not appeal to claims about fetal status or fetal interests. So if her argument is right, one can grant that a radically cognitively limited fetus has an interest in cognitive enhancement and that a normal fetus has an interest in continuing to live that’s just as strong. If the pregnant woman is going to carry the fetus to term, she has to respect its interest in having normal cognitive capacities. But she doesn’t have to carry the fetus to term, even though it has an interest in continuing to live that is just as strong as its interest in having normal cognitive capacities.

But Thomson’s argument has unacceptable implications for prenatal injury
In any case in which it’s permissible for a woman to have an abortion, it is in principle permissible for her to cause her fetus a grievous prenatal injury that will afflict it for the rest of its life.

If she has the right to kill, but it would be better for the fetus to continue to live than to be killed, it may have to accept the injury as the cost of being allowed to continue to use her body for life support.

If it is permissible for the woman to protect her interests in a way that kills the fetus, it should also be permissible for her to protect those same interests in a way that is equally effective but less bad for the fetus, when there are no other relevant effects.

Abortion and prenatal injury
Having stated the objection to Thomson, I should concede that I'm uncertain about it. I want to spend the rest of the time on this issue of abortion and prenatal injury.

It may seem that any sensible view will have the same implication.

It may be that this is just a plausible way to think about a case in which a pregnant woman has an interest that will be frustrated unless she either has an abortion or does something else that will injure her fetus.

Suppose her interest is sufficient to justify an abortion, but there is an alternative that would satisfy her interest equally well but would injure the fetus. It seems that since her interest can be satisfied either way, it drops out of consideration and all that remains is to consider the interests of the fetus, present and future.

It is better for the fetus to live, even with some disability, than to die now.

If it is permissible to kill it, it seems that it should also be permissible to do what will be better for it and worse for no one else—namely, injure it.
Hence, whenever abortion is permissible to prevent some harm to the pregnant woman, the infliction of nonlethal prenatal injury should be permissible as well if it would also prevent the harm to the woman.

**This conclusion is supported by case in which injury is congenital**

If the problem that would be caused by the injury were present from conception, it doesn’t seem that there would be a reason to have an abortion. That would be better for no one and worse for the fetus.

**Yet counterintuitive**

Yet, it seems counterintuitive to say that if the threat that a fetus poses to the interests of a pregnant woman would justify her having an abortion, it would also be permissible for her to protect her interest by causing her fetus to suffer a significant prenatal injury—for example, being born without arms, even though life without arms would be worth living and thus better than death for the fetus.

Can we avoid this conclusion?

**A different way of thinking about prenatal injury**

Separately consider the permissibility of the two options: abortion and prenatal injury, in each case weighing the interests of the fetus against those of the pregnant woman.

1. **Is abortion permissible?** If the fetus doesn’t have an interest in continuing to live, or if its interest in continuing to live is weak, then the woman’s interest can outweigh the fetal interest and abortion can be permissible.

2. **Is prenatal injury permissible?** The fetus may not have a strong present interest in avoiding some disability later in life, but the person it will become will have strong interests that will have been frustrated by the prenatal injury. When we weigh those future interests against the present interest of the woman, the woman’s interest is outweighed.

Therefore, it is not permissible for her to protect her interest by the option that would cause prenatal injury.

**Conclusion**

Abortion is a permissible option, prenatal injury isn’t. So when she has the choice between them, she ought to abort.

**Why can’t Thomson say the same?**

On Thomson’s view, there is no weighing of interests. It is a matter of rights. The difference between killing and injuring is irrelevant. Abortion is justified no matter how strong the fetus’s opposing interest is. So her justification applies even if the interests that are at stake are strong—as they are, when the alternative to protecting the woman’s interest is prenatal injury that will frustrate strong future interests. If the woman’s right overrides the fetus’s interest in continuing to live, it also overrides the later person’s interest in not being injured.

**Conclusion**

Hence, Thomson’s argument justifies prenatal injury when it’s not justifiable. So one cannot evade the initial consistency problem by appealing to her argument.

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### Affecting Definite Future People

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#### A. The Embryo of a Future Person

Consider what I shall call “the View”:

1. We have as strong a duty not to do things to an embryo that will result in harm (or failure to prevent harm) to the person that the embryo will definitely develop into or (give rise to) as we have not to harm (or not to fail to prevent harm to) that person when he or she is already in existence.

   Here is one premise in an argument for the View that I have considered elsewhere. If we have duties to an embryo, it is because of the person it will develop into or give rise to. Some think that this premise implies the View; that is, that any duties we have while there is only an embryo should be as strong and of the same general type of duties that we have to the person once he has developed, at least if we are certain that the embryo will give rise to a person.

   In place of that premise, Elizabeth Harman offers what she calls the Actual Future Principle: “An early fetus that will become a person has some moral status. An early fetus that will die while it is still an early fetus has no moral status.” It is not clear why Harman should not hold the View, for she also says: “The Actual Future Principle recognizes the moral status of early fetuses that will become persons; it is precisely these early fetuses in which persons can be said to be already present.” If a person is already present, then the fetus’s moral status should be the same as the moral status of the person.

   I am concerned that the View is wrong. It seems to me that while the premise may be true, it does not imply the View. That is, we can agree that any duties we have to treat a fetus in a certain way exist only because of the person it will develop into, or give rise to, but this does not imply the View.

   Here is an example which, I believe, shows that it is permissible to affect a future person by doing something to the fetus (or embryo) from which he develops or arises, though it is not permissible to affect the person in the same way by doing something to him once he exists. Suppose a woman has been given (via the natural lottery) a fetus gene that will result in a person with an IQ of 160. She decides this is too smart, not for the good of the person who has the high IQ, but for the good of the family. As a result, she takes a drug during early pregnancy to reduce the future person’s IQ to 140. I shall assume that this is an identity preserving change and so is a case of causing a person to be worse off than he would otherwise have been. I believe this is permissible (for reasons to be given below). But it would not be permissible, I believe, for the woman to give her child, once it exists, a pill that reduces its IQ from 160 to 140 or alters its genes so that the child will have an IQ of 140 rather than 160 in the future.

   What is the difference between (1) affecting the person by affecting the fetus and (2) affecting the person himself? A fetus is not the sort of being that is entitled to keep a characteristic that it has, such as a genetic makeup that will generate a 160 IQ. This is because it is not the sort of being that can be the bearer of rights (to retain anything). In addition, the person who will develop or arise from the fetus will not fall below an acceptable level of intelligence if he has only a 140 IQ, so he (as a person) is not owed a 160 IQ by his parent. These two facts are crucial. I think, to the permissibility of taking back from the fetus IQ points that the parent gave it. But since a child is already a person (I assume), it is entitled to keep a beneficial characteristic it
has, even if doing so raises the child far beyond the standard it is owed. Hence, I believe it is impermissible to give the IQ-reducing pill to the child, even if doing so would not cause his IQ to fall below the minimum a creator should seek for its child. By contrast, suppose we owe a good chance of an IQ of at least 100 to people we create. In this case, doing something easily avoidable in early pregnancy to a fetus that results in a person with an IQ below 100 may well be as impermissible as doing to the later child something that lowers its IQ to below 100.

Because the fetus does not yet have properties that make it an entity that is entitled to keep what is given to it, the act of taking away characteristics the fetus has (which will impact on the person that will be) is no different from not giving it those characteristics to begin with. And one would have a right not to give a future person that one created genes sufficient for a 160 IQ. Analogously, suppose that a parent puts money he need not give into a bank account that will belong to his child when she exists as an adult. The fact that the child will definitely exist as an adult does not imply by itself that it is impermissible for the parent to take back the money before the person reaches the age at which he can claim his bank account. There is no retroactive claim had by the person who will definitely exist to the good that precedes his appearance.

Some believe that the early fetus does not merely give rise to the later person but is an early stage of the later person. (I believe Harman holds such a view.) They may want to distinguish the early fetus from the set of sperm and egg before these combine into a conceptus with respect to any retroactive claims of the later person. Those who support the View, however, should not, I think, distinguish our duties to an early embryo from those with respect to a sperm and egg. That is, they should hold that if duties we have with respect to a sperm and egg are on account of the person to which they will give rise, then our duties with respect to the sperm and egg should be as strong as duties to the person that will definitely arise from them. For example, they should hold that it is wrong to do certain things to an egg that will not change the identity of the person who will arise from it but will make that person worse off than he would otherwise have been.

I suggest that we can also show that the View is wrong by considering a variant on the 140 IQ case in which the woman takes a drug that alters her egg that would have given her child an IQ of 160 so that it instead gives the child an IQ of 140. I believe it is permissible for her to use this means of making a change to a definite future person even though it would be impermissible for her to give an IQ-reducing pill to her child.

But now consider an in-between case called Delayed Change. Suppose the parent is not physically able to remove the genetic material that will lead to a 160 IQ at the fetus stage or from her egg and (as I have argued) is not permitted to take an action that would remove IQ points from the child-person once it exists. May she give to the fetus or egg a drug that will have a delayed reaction in childhood (like a slow bomb), altering the child’s genetic material so that it will have a 140 IQ rather than a 160 IQ? I do not believe this is permissible, nor do I believe that anything I have said implies that it is permissible. For it involves doing something at time t1 that will remove something good at t2 when there is a person to whom that item belongs.

Now imagine again a woman who takes from the fetus some genetic material, making it develop into or give rise to a person with a 140 IQ instead of a 160 IQ. This time, however, the woman does this in order to then transfer the genetic material into two other fetuses, thereby raising their IQs from 130 to 140 each. What I have said above, I think, implies that doing this would be permissible. The woman would be morally free to equalize beneficial traits among future persons by affecting their embryos (or the eggs from which they arise), even though she thereby makes one person worse off than he would otherwise be for the sake of other persons. However, I do not think it would be permissible for her to (safely) take from a child (already a person) some genetic material that will or does give him a 160 IQ, leaving him with a 140 IQ, so that she can transfer the material into two other children, raising their IQs from 130 to 140 each.

It is often argued that it is wrong to take organs from one person who could still benefit from them, against his will, in order to save other people. It is said that we may not treat separate persons as substitutable in this way. I have described this way of treating people as “subordination” rather than merely substitution. However, if what I have just argued is true, it could sometimes be permissible to take from a fetus or embryo biological material that would otherwise form an organ in the person to which the fetus will definitely give rise in order to generate such organs in other persons who would otherwise lack them. An embryo, even of a person who will definitely come to exist, would be substitutable AND subordinate. This will be true when removing the biological material from the embryo does not make the person into which it will develop fall below the line that a parent should seek in creating a new person.

B. Future Generations and the Non-Identity Problem

These results may bear on our responsibilities to future generations. Take the imaginary case in which we know that certain particular people will definitely exist in a hundred years, though we do not create them, and the fetus from which they develop or arise does not yet exist. Suppose we engage in activities today that will affect the environment in such a way that the air quality will not be as good in one hundred years, though it will still be above the level that we owe to future generations. Suppose, further, that there is no person in existence yet whose environment that future environment is and there is no one now who has a proprietary relation to the environment that he wills to future generations. I believe we may permissibly engage in the activities that affect the air quality. But if we were (somehow) transported one hundred years hence, it could well be impermissible to engage in the same activities that reduce to the same degree the air quality that the persons then living are already enjoying. In fact, it is not necessary that these living people (or the children in my previous cases) actually already be in possession of the better environment (or the more advantageous trait, whether it is the higher IQ or the genetic trait that will lead to it). Given that they are already persons, if their prospects as persons are for acquiring such a superior environment (or advantageous trait), it is possible that they should not be deprived of these prospects by certain sorts of events that occur once they exist. If we wish to do right by future generations, therefore, it will be very important to know what level of environmental quality they are owed by us, independently of what level of environmental quality they will be entitled to keep once they have it, and when the alteration to the environment will occur relative to the existence of the person affected by such an alteration.

Finally, let me consider the possible bearing of what I have said on these issues on what is known as “The Non-Identity Problem.” Derek Parfit famously argued that sometimes, at least, it seems not to matter morally whether we are affecting the same (identical) person for the worse or just making someone worse off than some separate (nonidentical) person would have been. Moral principles that tell us not to make persons worse off than they would have been are called “person-affecting principles.” Moral principles that tell us not to make there be

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people who are worse off than other people would have been are called “non-person-affecting principles.”

Let us assume that the worse life we are thinking of is still a life worth living, and also that it is a life that is good enough to meet the standards that a responsible parent could be held to in creating new people. Then we cannot argue that people are entitled not to have the worse life because they are entitled not to be in certain states.

I think what I have said against the View may bear on the Non-Identity Problem because I have argued that sometimes the way in which we affect someone for the worse can make a moral difference, not just the fact that we affect him for the worse. If we affect him by doing something to him or to some trait or resource to which he is entitled because, for example, he has it and it is or will be beneficial to him, this can have greater moral significance than if we affect him similarly by doing something to a trait or resource to which he is not yet entitled because he does not yet exist as a being who can have entitlements.

If person-affecting cases that are used in discussing the Non-Identity Problem do not involve entitlement, based, for example, on personal possession, then they do not compare the strongest form of person-affecting principles with non-person-affecting principles. This means that an argument for the moral equivalence of non-person-affecting and person-affecting actions using the weaker form of person-affecting cases would be crucially incomplete. For example, suppose we compare (1) a case in which someone does something that affects her fetus in a way that results in her child having a 140 rather than a 160 IQ (e.g., she smokes during pregnancy) with (2) a case in which someone creates a 140 IQ child rather than a different 160 IQ child (e.g., because she smokes prior to pregnancy). If these cases were morally alike, this would not show that the second non-person-affecting case is morally like (3) a case in which someone affects her child once it exists so that it has a 140 IQ rather than a 160 IQ (e.g., because she smokes in its presence).

Endnotes


3. Such an argument is made in Allen Buchanan, Dan W. Brock, Norman Daniels, and Daniel Wikler, From Chance to Choice: Genetics and Justice (New York: Cambridge University Press, 2000). I discuss it in “Genes, Justice, and Obligations to Future People.”


5. Ibid., p. 312, n. 3.


7. I first presented this argument in Creation and Abortion.

8. I owe this case to Arthur Applbaum.


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Procreation, Harm, and the Constitution

Carter Dillard

Humane Society

Introduction

This paper seeks to briefly explore the following questions: (I) Is there valid moral reasoning to support the claim that there are constraints on the sorts of existences it is permissible to bring people into, such that one would be morally prohibited from procreating (from conceiving and birthing a child) in certain circumstances? (II) Can a state justify a legal prohibition on procreating in those circumstances, using that moral reasoning, so that the law would likely be constitutional?

This paper will only briefly address the issue of abortion. Instead, it focuses on the combined behavior of conceiving and birthing. It will also focus only on the moral constraints that arise in virtue of the personal interests of the child whose procreation we are considering. I will argue that, while there are many moral reasons that might justify the law in question, it can be shown that procreating in certain circumstances harms the children born, and that preventing that harm is sufficient justification for the law.

I. Moral reasoning: Threshold-harm, and the notion of lives worth not living

The claims above immediately give rise to the non-identity objection: Acts that create persons cannot simultaneously harm them, because harm requires that the person harmed be made worse off than they otherwise would be; and without being created they would not otherwise have been. As will be discussed below, one response to the non-identity objection that may be uniquely compatible with certain legal principles would be the “Threshold Conception of Harm” (threshold-harm).

According to the version of Lukas Meyer (and to some extent Frances Kamm), a particular approach which is distinct from the impersonal threshold approach recently taken by Bonnie Steinbock, threshold-harm is the claim that we harm people by causing them “to be worse off than they should be.” Stated roughly, threshold-harm, or what Meyer has called subjunctive-threshold harm, occurs when our act or omission causes the victim’s life to fall below some specified threshold. It is to be distinguished from both diachronic harm, which is an action or omission that causes the victim to be worse off than before the action or omission, and subjunctive-historical harm, which is an action or omission that causes the victim to be worse off than she would have been had we not interacted with her.

According to the notion of threshold-harm, we would claim that procreating so as to bring someone into an existence that falls beneath a given threshold harms that person. I doubt there is anything I can add as a lawyer to the notion of threshold-harm as a philosophical response to the non-identity objection. However, theorists often acknowledge a categorical exception of a “life worth not living”3 when invoking the non-identity objection. I argue that this exception may itself suggest that threshold-harm sufficiently answers the non-identity objection.

Though claiming that the non-identity problem means that existence-inducing (and/or identity-determining) acts cannot harm those created, many theorists (including Parfit) focus exclusively on cases that do not create a “life worth not living,” a typical example of which might be a child born with Tay-Sachs disease. These theorists seem to exempt such cases from the non-identity problem, implying that creating a life worth not living—even from a purely person-affecting perspective—
constitutes harm to the person created. Tim Mulgan accounts for the "life worth not living exception" by noting that such lives are either worse than nonexistence, non-comparatively bad, or a life that "falls below the zero level."5

At the same time, there is a claim—though disputed by some theorists like Nils Holtug—that there is no value or disvalue in nonexistence and that, as such, it cannot serve as a basis for comparison at all.7 If that is the case, there would be no way to reasonably say that nonexistence is preferable to Tay-Sachs because there would be no basis from which to make the comparison. While the "life worth not living" exception seems to refer to harm to the person created, it cannot do so by any reference to nonexistence. If there is no value or disvalue in nonexistence, the "life worth not living" exception either accounts for a non-comparative bad (as Mulgan suggests), is based on the mistake of assuming some value or disvalue in nonexistence, or is in fact comparatively bad—but by reference to something other than nonexistence.

I believe that this third possibility best accounts for the intuition that, even under person-affecting principles, we harm the child afflicted with Tay-Sachs in creating her. Rather than regarding that life as a non-comparative bad, I believe the intuitive force of the notion of a "life worth not living" comes from an implicit comparison we inevitably make—upon considering the life—to some standard that is derived from life experiences. I believe that this standard is the standard—the threshold—at work in the notion of threshold-harm. I would argue that the "life worth not living exception," even from a person-affecting perspective, seems to harm the person created because her life falls somewhere below this threshold standard. Rather than saying that nonexistence is preferable to Tay-Sachs or that Tay-Sachs is a non-comparative bad (a life filled with bads that on-balance outweigh the goods in that same life), it is possible that the theorist acknowledging this exception is implicitly referencing the threshold (whatever it may be) in threshold-harm.

It might help to contrast this point with some points recently made, in prefacing an argument about asymmetry, by Jeff McMahan.8 As I read his work, McMahan argues that a life worth not living (what he calls "miserable people") is so by virtue of the fact that, in the life, the intrinsically bad states outweigh the good.9 It is comparative, in that the states within the life are compared, but the life itself is not compared to nonexistence, which is something I take McMahan feels it is impossible to do. I would call this view of the life worth not living "internally comparative" (what McMahan calls "noncomparative individual-affecting") in that there is a comparison made within the life, but not to some standard outside of the life (whether diachronic—compared to the past, or subjunctive-historical—compared to the counterfactual). McMahan then finds that: "The fact that acting against the reason [not to cause an individual to exist] would be bad in noncomparative individual-affecting terms seems insufficient to ground an individual-affecting reason not to cause a miserable person to exist." McMahan would, instead, pursue an impersonal approach.

I agree that the internally comparative approach seems insufficient. I care about how my life is, but more so when I compare it to others' lives, and even imaginary lives. Still, rather than take the impersonal approach (or be stuck unable to use the past or any counterfactual), one could still be externally comparative by using threshold-harm. The Tay-Sachs life seems not worth living because it is so, relative to the threshold. Whatever the threshold is, it is well above such a life, and the absence of a past or a counterfactual life, coupled with an intuition that the life is worth not living, points to the existence of that threshold.

Without defining the threshold (or dealing with how it is related to the notion that creation into certain existences may violate the moral rights of those created), this account might explain the life worth not living exception better than the alternatives above. It might also mean that anytime the exception is recognized (and it is recognized, almost ubiquitously, in both philosophical and legal literature) the theorist is implicitly invoking the notion of threshold-harm.

Regardless of this argument in favor of the notion of threshold-harm, I want to say a few things about it in general before explaining its relation to legal constraints on procreating.

First, is threshold-harm tautological in that, rather than comparing to the past (diachronic) or some counterfactual (subjunctive-historical), threshold-harm simply presumes that Tay-Sachs, for example, is itself a harmful state? I do not believe it is because, just as diachronic harm uses the past and subjunctive-historical uses a counterfactual, subjunctive-harm also uses an external standard: the threshold. Tay-Sachs is bad because it falls below the threshold, not because it is itself sufficiently bad.

Is it then ad hoc to use a threshold, as opposed to the past or a counterfactual? I do not know why these states of affairs, as opposed to an intuitive threshold, are any less ad hoc. The threshold would presumably be derived from life experiences, and to the extent non-identity is premised on the absence of a past or a counterfactual life, it makes sense to search our experiences for some third explanatory form of harm. It also seems unfair that contingent future people should have no baseline such that they cannot be harmed, and to the extent the past and counterfactuals are not available, the threshold may be the best way to explain how we feel about them.

Second, threshold-harm would seem to be a sufficient but not a necessary condition of harm in general. That is, there are other forms of harm. The pregnant mother who smokes may harm the child, though not cause its life to fall below the threshold.

Third, as I have said, I will not try here to fill in the content of what the threshold for harm may be. The law provides many standards that seem to suggest a threshold, but it is hard to isolate those reasons underlying these legal standards which are exclusively aimed at preventing harm to the child that would otherwise be born.

But, as Elizabeth Harman has said, "there is a threshold somewhere."10 And while it appears that Harman here is referring to threshold in a different way than Meyer, in that she uses non-comparative states (pain, disease, deformity) as harms that must then be justified by benefits, her point that there is and will be implicit disagreement as to the content of the threshold11 is relevant. Determining the threshold may simply be a matter of consensus-building through democratic law-making, fleshing out and crystallizing what people alive today intuitively regard as a baseline from which to determine harm for contingent future persons.

Finally, I don't believe—based on the discussion of threshold-harm above—that leaving someone out of existence through non-conception or early abortion causes threshold-harm. The necessary condition seems to be a victim whose actual life would fall below some specified threshold. The merely possible person, in being aborted or never conceived, cannot then become the future victim whose life falls below the threshold.

Thus, the notion of threshold-harm provides person-affecting and harm-based moral constraints on the sorts of existences it is permissible to bring people into, and thus the
II. Legal reasoning: Threshold-harm and the Constitution

In essence, the constitutionality of a law limiting procreation to prevent threshold-harm to the children born depends on many factors that cannot be explored here, but primarily on whether courts will regard procreation (as defined above) as a fundamental right. As Kirsten Rabe Smolensky recently noted, “while questions concerning reproduction have frequently arisen in the Supreme Court, the scope, and even existence, of a constitutionally protected interest in procreative liberty is debatable.”11 Nonetheless, even laws prohibiting behavior that is protected as a fundamental right may be constitutional, assuming the law can be shown to be necessary to achieve some “compelling” government interest.12 Assuming for the sake of argument that the sort of procreation we have in mind here is protected as a fundamental right, a state could still justify its law as constitutional based on such a showing. Philip G. Peters (who argues, unlike me, that there is a clear fundamental right to procreate as well as a Millian constitutional obligation on the state to show harm in infringing upon that right) has recently proposed that, just as the prevention of incest serves a sufficient state interest to limit the fundamental constitutional right to marry, a state can regulate advanced reproductive technology by showing a compelling interest in preventing harm to future persons.13 However, Peters (like Steinbock) uses an impersonal form of harm, or harm to the class of future persons through failure to substitute prospective children in a way that avoids suffering, rather than threshold-harm per se.

Before discussing how a state might use the prevention of threshold-harm as a compelling interest to justify a legal prohibition on procreating, we should clarify a few background issues that the discussion below implicitly raises but does not address.

First, there is one particularly promising dimension that constitutional law might add to the discussion of non-identity in general, but that I will not expand upon here. Unlike tort law, it is most likely open to serious legal debate as to who—as between the state and the would-be parents—would have the burden of proving that procreating in certain circumstances harms the children born, as well as what the level of proof required would be. It may be—depending on how a court interprets the constitutional right or liberty at issue—that would-be parents would have to show, to a high level of certainty, that procreation does not harm the child born. This raises many interesting issues because, while the non-identity problem is usually seen as making it difficult to show harm, it is perhaps better understood as making it difficult to show harm or a lack thereof. The core of the problem arises—as discussed above—from the inability to use nonexistence as a basis for comparison. If this is the case, the non-identity problem could cut against the would-be parents, as they would not be able to show that in having the Tay Sachs child she was not made worse off than she otherwise would have been. But I will not discuss that further here. Below, I will simply assume that the state has the burden of proof.

Second, it is worth keeping in mind that a legal prohibition on procreating based on a threshold-notion of harm could take many forms, in terms of the means by which the state would seek to prevent procreation below the threshold. The state can do many things to influence behavior, and the degree to which it actually burdens the constitutional right or liberty—via the means it chooses—will in part determine the constitutionality of the law. As will be discussed, some have proposed creating a statutory tort regime to hold parents liable to the children they create. Other proposals have simply included changes in tax and education policies. Alternatively, in State v. Kline, the Oregon Court of Appeals upheld a criminal probation condition which prohibited the defendant (who had previously had his parental rights terminated after breaking his son’s arm and fracturing his infant daughter’s leg) from fathering further children until he completed drug and anger management counseling, finding that “[t]he condition provides potential victims with protection from future injury.”12 In this case the state threatened the defendant with incarceration as a means of preventing him from procreating.

Third, while this paper assumes only for the sake of argument that the state has the burden of showing harm to the children born, a legal prohibition on procreating in certain circumstances could theoretically be based on a variety of other moral reasons. We can imagine a particular state banning a new ART procedure that, to one degree or another, may result in lives worth not living, and a couple challenging the law as an unconstitutional infringement of their un-enumerated Fourteenth Amendment right to procreate. Assuming that right is deemed constitutionally fundamental, the state would then have to show that it has a compelling (as opposed to a merely legitimate) state interest at stake.

While non-identity arguments in the law have traditionally focused on harm because non-identity has most often arisen in “wrongful life” cases where compensation for harm is an issue, Mill’s “harm principle” is not part of the Constitution,16 and the state could in theory base its prohibition on impersonal, rights-based, non-comparative harm, contractualist, etc., moral reasoning. There is simply no precedent that clearly requires the law be based on the type of narrow person-affecting harm to which the non-identity problem poses a problem. In fact, in Buck v. Bell, which has never been overruled and is one of only two Supreme Court cases to deal directly with the constitutionality of a legal prohibition on procreating, the Court based its decision upholding the law in part on the constitutional permissibility of the state preventing procreation as a means of promoting general welfare.17 A state could, of course, also base its prohibition on allegations of harm to persons alive today, or to persons whose existence is not contingent on the particular state action or omission at issue.

However, assuming that the type of narrow, person-affecting harm for which non-identity seems to pose such difficulties is the proper standard, it is worth noting that Mill himself at least implied that threshold-harm might be a fitting standard by which to judge procreation:

It still remains unrecognized that to bring a child into existence without a fair prospect of being able, not only to provide food for its body, but instruction and training for its mind is a moral crime; both against the unfortunate offspring and against society. …It is not in the matter of education only that misplaced notions of liberty prevent moral obligations on the part of parents from being recognized, and legal obligations imposed, where there are the strongest grounds for the former always, and in many cases for the latter also. The fact itself, of causing the existence of a human being, is one of the most responsible actions in the range of human life. To undertake this responsibility—to bestow a life which may be either a curse or a blessing—unless the being on whom it is to be bestowed will have at least the ordinary chances of a desirable existence, is a crime against the being.18
Fourth, it may be that the Harm Principle seems to apply because of a background assumption at work: that procreation is a private and intimate, or autonomous, act. However, while that may be generally true of non-reproductive sex, the act of creating another person may be incompatible with notions of autonomy and self-determination, in that a necessary condition of the act is the determination of some other life. Arguably, procreation is more akin to immigration than non-reproductive sex (because it involves the entry of a person into the polity), and it would be odd to think of immigration as a matter of privacy or autonomy. Immigration law—which is based on the state’s compelling interests in sovereignty—is in many places concerned with providing benefit to the immigrants in question, or at the very least ensuring that they enter with some threshold level of well-being, rather than simply avoiding their being made worse off. Arguably, in this way, the state’s compelling interest in procreation need not be about preventing harm at all.

However, with all of this said, let us assume that procreation is a private act, that it is protected as a fundamental right under the Constitution, and that, as such, the state must show a “compelling interest” in preventing harm (and comparative person-affecting harm in particular) to the children born, in order for any law prohibiting procreation to be constitutional. How might a state use threshold-harm moral reasoning to do this?

First, as I understand the moral notion of threshold-harm, the claim is that it is the actual child that will be harmed by being brought into the sub-threshold existence. While at the time threshold-harm is being assessed the child is merely prospective, the notion is based on avoiding future harm to what would be an actual person.

Second, as a matter of constitutional law, the state does have a compelling interest in protecting the welfare of living children. And based upon this interest, the state can terminate the constitutionally protected rights abusive and/or neglectful parents otherwise have to the care, custody, and control of their children—rights which, unlike the right to procreate, are firmly established in constitutional precedent.

Moreover, while the state’s particular interest here might be characterized as requiring the promotion of child welfare by assuring children receive benefits (perhaps even in a way that must maximize their welfare), it seems that at the very least preventing threshold-harm is sufficient to ground the state’s compelling interest: The state can use its compelling interests in child welfare to suspend and even terminate the state’s compelling interest: The state can use its compelling interests in child welfare to suspend and even terminate the would-be children’s lives from falling below certain thresholds, serves as a constitutionally recognized compelling state interest that would justify a legal prohibition on procreating in certain circumstances, even in the face of a fundamental right to procreate.

Perhaps the best counter-argument to this claim would be based upon the apparent absence of any actual legal or social thresholds relative to procreation, as opposed to parenting. If the notion of threshold-harm is based on widely held intuitions that there is a threshold under which lives should not be created, one might expect that threshold to have manifested itself in law, as it had with regard to parenting. Because, unlike diachronic or subjunctive-historical harm, the notion of threshold-harm is more abstract and based largely on moral intuition, its almost total absence in law and social convention may refute its very existence.

Conclusion

The notion of threshold-harm provides a moral basis to support the claim that there are constraints on the sorts of existences it is permissible to bring people into. While many theorists would expressly reject threshold-harm as a response to non-identity, in light of the intuitive force of the “life worth not living” exception, and the lack of value or disvalue in nonexistence, these theorists may nonetheless be implicitly invoking threshold-harm.

Furthermore, a state can constitutionally justify a legal prohibition on procreating in certain circumstances using the notion of threshold-harm because it accounts for what has been recognized as a compelling state interest: the prevention of children living in certain existences that fall below a given threshold.

Endnotes

Rights, Interests, and the Permissibility of Abortion and Prenatal Injury

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McMahan claims that Thomson’s rights-based account of the permissibility of abortion can’t yield the same intuitively appealing result as his own comparative-interests analysis: that it’s permissible for a pregnant woman to protect her interests in not having a child by aborting, but not by causing significant prenatal injury to a fetus she intends to carry. “On Thomson’s view, there’s no weighing of interests. It’s a matter of rights…. Abortion is justified no matter how strong the fetus’ interest is. …If the woman’s right overrides the fetus’ interest in continuing to live, it also overrides the latter’s interest in not being injured.”

It is not clear, however, that the strength of the violator’s interest is irrelevant on a rights account. A can have, and often does have, a right against B Xing even when B’s interest in Xing is stronger than A’s interest in B’s not Xing. But this doesn’t mean that B’s interests impose no limits on what A may permissibly do to B to prevent or stop his violation of her right. I don’t think even Thomson would hold that it was permissible to kill or torture someone trespassing on your property, if that were the only way to get him off. A woman’s right against trespassers in her own body may be far stronger, and permit her to override far stronger interests. But there are still limits. It’s doubtful that Thomson would permit a woman to torture a late-term fetus to get it out of her body. So Thomson might argue that the fetus’ future interest in not being born impaired was strong enough to make its non-lethal injury impermissible, even if its present interest in surviving was not strong enough to make abortion impermissible.

It may also be that the limits on rights-enforcement cannot be set solely in terms of the strength of the holder’s and violator’s interests. The assumed “inviability” of the fetus might permit the woman to expel but not injure it (except perhaps as a means or side-effect of expelling it). To make the point in terms of Thomson’s familiar analogy, I’m not sure whether the music-lover may amputate the unconscious violinist to whom he was attached rather than detach him. It might even be wrong for the music-lover to offer the conscious violinist an amputation as the price for continued attachment, a wrong akin to Kavkaesque exploitation in demanding too high a price for a life-saving good. Bodily integrity may play a significant role in the notion of inviolability, limiting what others may ask, and perhaps what the individual can offer, to secure his survival. It may be that an inviolable individual cannot alienate his limbs any more than he can sell himself into slavery. Such constraints are suggested by Kamm’s claims about the moral vulnerability of fetuses to IQ-equalizing genetic redistributions—a vulnerability she bases precisely on their lack of the same inviolability as children and adults.

One implication of taking inviolability seriously is that your obligations to others aren’t determined solely by their interests; that there are things you shouldn’t do to an inviolable individual even if it would be much better for him that you do those things. This kind of constraint was suggested by the Ashley case, in which the parents of a cognitively impaired little girl neutered her and chemically or surgically stunted her growth, the better to be able to care for her in their old age. Many disability advocates were troubled by their procrustean approach to the challenge of caring for their “pillow angel,” as they called her, even though the procedures may well have been in Ashley’s best interest. If
Ashley can be regarded as inviolable despite her impairments, she had a claim to bodily integrity to which her parents and doctors gave insufficient weight.

An Alternative Explanation for the Impermissibility of Prenatal Injury

McMahan holds that the pregnant woman could not cause the fetus a significant lifelong disability in order to avoid some setback to her own interests, “as the cost it must bear for the sake of using her body,” even if the fetus would be better off impaired than aborted; even if, we can add, it would have a life above some specified minimum or threshold. He holds that constraints on what the woman can do to the fetus as the price of carrying it must be due to facts about moral status of the fetus, facts that are in tension with liberal views on abortion. He sees a similar, but even more acute tension between the assumed obligation of a pregnant woman to cognitively enhance a radically impaired fetus she intends to bear and the assumed permissibility of her aborting a cognitively normal fetus. In failing to enhance the former or aborting the latter, the woman denies the fetus a future as a cognitively normal person, a future to which the fetus in both cases has only a tenuous connection. But the latter is greater for the cognitively normal fetus, since it gets no future at all. McMahan finds it hard to reconcile the widespread beliefs that (1) the woman planning to bear the impaired child has a strong duty to enhance it, but (2) the woman carrying the cognitively normal child has no duty to bear it.

In making this comparison, McMahan considers only two grounds for assessing the morality of aborting and not enhancing—person-affecting and impersonal. He argues that the same considerations of psychological discontinuity which attenuate a fetus’s interests in being born also attenuate the interest of a radically cognitively impaired fetus in being enhanced. A parent’s moral reason to enhance a cognitively impaired fetus, he concludes, “is not as strong as common sense intuition supposes that it is, if it is assumed to derive from the interests of the fetus or the later, radically cognitively-limited adult.” The only way that McMahan can see to account for the moral urgency of cognitive enhancement without considering third-party interests is to recognize impersonal reasons. But that, as Roberts points out, is a costly recourse.

I think there is another option; for a parent or perspective parent, there may be moral reasons for enhancement that are not strictly based on the interest of the fetus, but are not impersonal either. The decision about aborting is, in most cases, a decision about whether to become, or perhaps to remain, a parent, while the decision about enhancing concerns the duties of someone who has chosen to become a parent to the child who develops from the fetus.

I do not want to claim that a woman accepts a parental role merely by declining to abort—there are certainly circumstances in which she may intend to carry a fetus without intending to become its parent. But a woman who does intend to become a parent can, by aborting, reject or relinquish the parental role she had assumed, or intended to assume, with greater moral latitude than she can reject or relinquish such a role once the child is born. And in many contrasting cases like those McMahan discusses, it is reasonable to assume the woman faced with a decision about whether to injure her fetus, or to fail to enhance it, has already decided to take on a parental role.

That role, I would argue, imposes constraints that the woman does not face as the unwitting or involuntary carrier of a fetus, whatever its moral status. It imposes a duty to care for the child she intends the fetus to become, a duty that precludes her injuring the fetus just to avoid a setback to her own interests. The same goes for her failure to correct or avoid radical cognitive impairment by fetal enhancement. Even if the fetus suffers a greater loss in being aborted than in being born unenhanced, the woman does not have the same duties with respect to preventing the two outcomes. She has a role-based duty to care for the fetus if she chooses to bear it, a duty that may require her to promote its welfare by enhancement. She can, however, prevent such duties of care from arising or relinquish them, by aborting. That act may set back the fetus’s interests more than a failure to enhance it, but it also functions as a rejection or renunciation of the parental role that imposes such duties of care. This does not deny the relevance of McMahan’s claims about psychological discontinuity and postnatal harm; it merely sees their relevance in terms of the duties, and role, of a present or future parent. It may well be that a parent does not have as strong a duty to cognitively enhance the fetus as she would have to prevent it from developing a painful, degenerative disease. But how much of a duty in the former case depends to some extent on how we, or she, understand the parental role she is assuming. A child as radically impaired as McMahan stipulates—as opposed to a child with moderate or even severe cognitive impairments—can be cared for and loved by a parent, but not raised or reared in a conventional sense. Even on the most expansive and flexible understanding of the parental role, radical cognitive impairment may preclude the meaningful exercise of that role. This gives the parent a role-based reason, neither a strictly selfish nor strictly child-centered one, to enhance the fetus.

Indeed, the parent might have a similar reason for limiting the enhancement of a fetus, even if that limitation would not be in the child’s best interest. Thus, it might be in the child’s interest (it might not; this is highly speculative) to be born not only with great intelligence, but with intellectual and moral maturity, so that the parent would not rear it so much as orient it to the circumstances of its life, more of an extended briefing than a conventional upbringing. If that more limited role could be accomplished without loss of bonding and attachment, it arguably might be in the child’s interest to have such prenatal enhancement. But I think its parents would have a good, and not entirely selfish, reason for declining.

In contrasting different- and same-person cases, McMahan deliberately removes such role or relational considerations by placing the existence of the fetus that can be enhanced in the indefinite future. To invert a phrase from Eva Kittay, the fetus in question is “no one’s child.” I agree that it is hard to see much of a difference between McMahan’s two cases unless we place them in a procreative context. Once we do, I think that all sorts of interesting differences may emerge. Thus, imagine that, in one case, the parents are choosing among an array of gamete pairs, known to yield fetuses with widely varying cognitive capacities; while, in a second case, a pregnant woman learns that the fetus she is gestating has radically limited cognitive capacities. I suspect that a parent who chose a gamete-pair likely to yield a radically impaired fetus would have a peculiar, and troublesome, understanding of her parental role; an understanding that need not be shared by a woman who chose not to enhance the radically impaired fetus she finds herself carrying. This assessment is highly susceptible to missing details; my point is only that with any such specification, I would expect many differences to emerge.

Parental Role-Morality and Prenatal Redistributions

Considerations of parental role-morality may also lend credibility to Kamm’s claim about the permissibility of IQ-reducing prenatal interventions. She argues that because the fetus is not a full person, with a right to keep what it has, it is entitled only to those capacities that ensure that it will have a life above a
their prenatal loss is morally equivalent to their absence. This implies that fetuses can be subject to many welfare-reducing interventions that infants cannot be; that, in Robert’s words, we needn’t handle fetuses with the kid gloves required for handling infants. I’m not sure whether the consequent is true, but I have strong doubts about the antecedent—the permissibility of any welfare-reducing intervention that leaves the fetus above the minimum. The examples Kamm uses to support this claim are of interventions that serve to ensure family harmony or reduce sibling inequality: they keep the fetus from becoming a child “too smart” for the rest of the family, or significantly smarter than its siblings. As such, these interventions are ways, however questionable, of satisfying recognized parental duties—extreme and intrusive means of achieving ends widely seen as falling within the ambit of parental responsibility.

Although parents are certainly not required to pursue strict equality of welfare or capacity among their children, or even to adhere to the difference principle, they are expected to prevent or mitigate significant inequalities among their children, or to give priority to the worse-off, e.g., to provide greater assistance to children with academic or social problems than to those flourishing in those domains. The interventions Kamm describes all serve these purposes. While equally intrusive postnatal interventions might not be acceptable, these examples don’t show that any welfare-reducing prenatal intervention is permissible as long as it leaves the child above the minimum.

This becomes apparent in considering prenatal interventions that reduce the child’s welfare or capacities to the same extent but are not similarly sanctioned by the parental role. Consider a mother who seeks to appropriate the fetus’s intellectual capacity for herself, taking away 20 IQ points as a “maternity bonus.” Even if this leaves the child with an IQ well above the minimum, this seems far less acceptable than an intervention to equalize sibling IQ. The mother’s appropriation would not be acceptable even if it was compensatory; if she sought to restore the 20 IQ points she was convinced she’d lose by having another child. It would still be exploitative in Greg Kavka’s sense, setting an unreasonable price for the benefit bestowed on the child. I think, then, that it is possible to reject “the View,” as Kamm does, without regarding all fetal capacities above her minimum as fair game for prenatal redistribution.

At the end of her paper, Kamm draws on her account of limited fetal inviolability to suggest that the moral differences between same- and different-person cases may be overstated in comparisons between welfare reductions that are imposed prenatally. Depriving a fetus of goods to which it will not be entitled until birth is not as bad as depriving a born child of those goods, so the wrong in the former case provides a weaker contrast to the wrong of choosing to have a fetus that lacks those goods in the first place. The use of such weaker comparisons may lend spurious support to Parfit’s “no-difference” claim.

But this suggestion runs into a complication. If the threshold for entitlement is above a life-worth-living, as Kamm and Dillard claim, then actions which make it the case that a future child will not reach that threshold constitute person-affecting wrongs regardless of whether they are ID-affecting, regardless of whether the child could have reached that threshold. So the no-difference view must be assessed by comparing ID- and non ID-affecting actions that leave the future person above the threshold. An appropriate contrast would thus be between 1) delaying the conception of a second child, resulting in a child with an IQ 20 points lower than a child conceived now, but allowing the mother to devote more attention to her older child and thereby raise its IQ 20 points; and 2) taking genetic material from a gestating fetus, lowering its IQ 20 points, but raising the IQ of an existing child by the same amount. Sibling IQ-equalization at an above-the-threshold level would be achieved in both cases, but the latter seems, to me at least, a lot more problematic.

This contrast doesn’t rule out Kamm’s suggestion, as the second intervention might be even more problematic if it involved an IQ-transfer between two existing children. But it raises a question about the explanatory value of her diagnosis of “no-difference” contrasts. The problem is that the threshold view she adopts already seems to explain away the no-difference claim on many cases, by treating both contrast cases as involving person-affecting wrongs.

Prenatal Harm Prevention by Public Officials and Parents

Concerning Carter’s position on state intervention, my own view is that the state does have a legitimate, if not a compelling, concern for impersonal “harms” or at least widely distributed personal harms like increased tax burdens. So I think it actually may be easier to justify the state’s taking unintrusive measures to prevent a congenital impairment, e.g., by putting drugs in the water supply, than to justify prospective parents in selecting against those impairments prenatally or preconceptionally. A harm-minimizing or mitigating consequentialism may be (part of) the role-morality of public officials. So perhaps something like Brock’s “principle N” should guide “reproductive health” policies, though not individual procreative choices. I’m less comfortable assigning the state any benefit-maximizing or even satisfying role; if it is desirable to increase the population, it is for instrumental reasons, like maintaining a large standing army or keeping social security solvent.

Endnotes

1. While social roles are not as clearly rule-governed as professional ones, they do have established ways of accepting and declining. I don’t think a woman in our society can, except under an adoption, surrogacy, or other well-defined arrangement, intentionally bear a child without assuming the role of parent, whether or not she is willing to fulfill it. Nor can a man impregnate a woman directly or indirectly and decline a paternal role, except under well-defined conditions. And those conditions are controversial, e.g., the broad rejection of commercial surrogacy; Vellman’s objection to anonymous sperm-donation. But social roles can change, and it’s surely possible to imagine a decent egalitarian society, especially one with extra-uterine gestation, in which the continuation of a pregnancy need not involve the assumption of a parental role.

2. A role-based approach implies that the woman’s alternatives should be assessed differently by third parties. Unlike the woman herself, third parties needn’t regard the failure to enhance as more problematic than abortion; but they may have some interest in seeing the woman fulfill the duties of the parental role if she has voluntarily assumed it.

APA/CPL Session on Procreation, Abortion, and Harm Comments

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Carter Dillard’s remarks draw attention to the connections that we would like to see between law and moral theory. The threshold account of harm that Dillard endorses for purposes of dealing with the nonidentity problem is an attempt to avoid the need to introduce impersonal considerations into either (1) moral theory or (2) indirectly, the law, by way of the moral
theory that we turn to, or want courts to turn to, when we find that the law itself is indeterminate.

This is a sensible project. As Jeff McMahan would be the first to note, bringing impersonal considerations to bear within the scope of a plausible moral theory is quite a challenge. The challenge is underlined when the proposal is that that moral theory is something that a competent judge should feel free to consult when struggling to understand the right of privacy and trying to figure out just when the state has the authority to regulate or prohibit the sorts of intimate choices that mostly deeply determine the kinds of lives that we will lead. A procedure that has judges take impersonal considerations into account along with considerations regarding what is better or worse for persons as individuals would not firm up or clarify the law. It would rather make the law more indeterminate than ever. The better procedure would be one that left the “plausible moral theory” out of the picture altogether.

So it is a plus that Dillard’s proposal develops moral theory in a way that does not make reference to impersonal considerations. But he does leave us with the question of how the threshold account of harm will work.

One very basic question is whether leaving a person out of existence altogether is not itself a way of making a person fall below the threshold. The thinking behind this question is that the threshold account of harm can address the nonidentity problem only if it sets the threshold somewhere above the zero well-being level that is implied by the life that has no net value to the one who lives. (For a part of why the nonidentity problem creates a problem is that the lives that we focus on are stipulated to be lives that are unambiguously worth living, yet lives that we think at the same time are wrong to have been brought into existence.) But it also seems that the person who never exists at all has a well-being level of exactly zero. As McMahan elsewhere has pointed out, if the non-lethal fetal injury is bad for the future person who must live with the effects of that injury, never existing at all is still worse. If states are permitted under the U.S. Constitution to regulate with the aim of keeping children from coming into existence below the threshold—with the aim of preventing, e.g., the non-lethal fetal injury—isn’t there a simple argument that they are also permitted to regulate with the aim of keeping children from coming into existence at all?

Dillard says no—the unconceived child is not to be understood as falling below the threshold. But it’s important to see just what Dillard is saying here. The facile answer to the very basic question is that the U.S. Constitution allows states to restrict fundamental constitutional privacy rights only for the purpose of protecting actual existing or future persons against harm. Protection of still others—those persons who are, relative to the actual world, merely possible—is beyond the scope of the state. Efforts that burden, e.g., the potentially pregnant, or the newly pregnant, woman with the aim of protecting the merely possible are void on constitutional grounds.

Dillard in effect steers clear of the facile answer—he steers clear, that is, of what has been called “strong moral actualism”—by his argument that the Constitution should be understood to allow states to regulate for the protection of children whose existence would fall beneath the threshold, even if the child that same regulation really protects is a child who will never come into existence at all. So: the regulation that has the effect of forcing procreators either to bring children into existence above the threshold or not at all may be a regulation that turns out to be good for no actual person and bad for some actual persons. But Dillard points out that there is every reason to think that such a regulation would be constitutional. By implication: in some sense, the states are permitted to act to protect the merely possible—as well as existing and future persons.

Again, Dillard takes a sensible position. But still it leaves an important question unanswered. Having said that states are permitted to act to protect merely possible persons, are we now committed to say as well that states are permitted to act to protect merely possible persons against the harm of never coming into existence at all? If the state may protect the merely possible person against the non-lethal fetal injury, may the state also protect the merely possible person against the lethal early abortion?

The views described by Elizabeth Harman, Frances Kamm, and Jeff McMahan give us three very distinct answers to this question. According to Harman’s Actual Future Principle, the early fetus has lesser—in fact, no—moral status at the world where the early abortion takes place and the fetus never develops into what Harman considers to be a person, and full moral status at the world where there is no early abortion and the same fetus does develop into a person. That principle seems to imply (as Harman suggests) that it is permissible for the woman to have the early abortion but that, if she doesn’t, then she must handle the fetus with kid gloves.

Kamm, in contrast, suggests that we needn’t handle the fetus (or embryo, or sperm and egg) with kid gloves even at the world where there is no early abortion and the fetus (or embryo, or sperm and egg) does develop into a person. Kamm doesn’t propose that the fetus may be treated badly, but she does propose that it would be permissible for the agent to endow the fetus with traits that would turn out to be worse for the later-developing person than still other traits that the agent might have endowed the fetus with. Thus, suppose that it would make things go better for a future person for things to be done in a way that gives that person an IQ of 160 rather than an IQ of 140, and that the former could be accomplished without making things too much worse for anyone else. Kamm’s position suggests that the agent is nonetheless permitted to do the latter.

McMahan provides still a third view. We must handle the fetus that is going to develop into a person with kid gloves, and we must handle the better-off, possible future person with kid gloves as well. For, according to McMahan, when we have the choice, we must bring the better-off person into existence in place of the less well-off distinct person we might have brought into existence instead. On this view, our obligation is, in effect, that of protecting the better-off person against the harm of that person’s never existing at all. McMahan himself would here cite impersonal considerations as the source of this obligation; functionally, however, it would do as well to talk in terms of the obligations we have “in respect of,” if not “to,” the merely possible. Once, however, we bring impersonal considerations (which might equally well be described as considerations relating to the merely possible and the moral reasons that we have to ensure that they have more well-being rather than less) into the picture, the specter is raised of a stringent procreation obligation. If, in other words, the impersonal principle McMahan would be relying on is meaty enough to support the result that we must produce the better-off child in place of the less well-off distinct child, then for all we know now that same principle will also support the result that the early abortion and even non-conception are wrong in many cases in which we intuitively think that those choices are perfectly permissible. We just don’t know, because we don’t know whether the impersonal principle brings, e.g., the value of maximizing well-being in the aggregate into play or is to be structured along some other lines altogether. If the impersonal principle does bring the value of maximizing aggregate well-being into play, then the
implication will be that all possible persons are to be treated with kid gloves: that we are to avoid both the non-lethal fetal injury on their behalf and the “harm” of never bringing them into existence to begin with.

So it’s possible that McMahan goes too far by bringing to bear impersonal considerations in protecting the early fetus, the possible person, and possibly Kamm doesn’t go quite far enough. Harman’s results, which fall somewhere between these two points, seem highly plausible. But her Actual Future Principle does raise a conceptual problem—a problem that Harman is aware of and has a reply to.

The problem arises when we think about a world w1 where the woman does not have the early abortion. According to the Actual Future Principle, the early fetus has moral status at w1. For at w1 that fetus will eventually develop into a person, and that person’s own moral status is itself firmly established by the fact that that person is “actual” at w1 in the sense that that person will, eventually, exist at w1. Because the fetus has moral status at w1, the woman has a moral reason at w1, according to Harman, to benefit the fetus. More specifically, she has a moral reason not to impose the non-lethal fetal injury, and she has a moral reason, at w1, not to have the early abortion. But it is also Harman’s view that, at an alternate world w2, where the woman does have the early abortion, what she has done is perfectly permissible. Yes, she harms the fetus at w2. But at w2 the fetus has no moral status since the person the fetus develops into at w1 never actually exists at w2. And the woman, accordingly, has no moral reason at w2 to benefit the fetus—and no moral reason not to harm the fetus.

The conceptual problem then is that it seems that the combination of moral reasons the woman has at w1 would combine to generate the obligation at w1 that the woman not have the early abortion. But if she’s obligated at w1 not to have the early abortion, then she can’t be permitted at w2 to have the early abortion. To say she’s obligated to do the one thing is to say she’s obligated not to do any of the alternatives. And that looks like an inconsistency.²

A way out is to say that the moral reasons the woman has at w1 do not combine to generate the obligation at w1 that the woman not have the early abortion. It is to say that, despite the fact that at w1 the woman has a moral reason not to have the early abortion, and even in a case where the woman has no moral reason to have the early abortion and no moral reason to anything other than continue the pregnancy, the woman has no obligation at w1 not to have the early abortion.

So, Harman can avoid the inconsistency. But to do so, she must rely on a view that doesn’t take into account the possible person whose existence is the basis of the obligation at w1. The young woman instructed that she has a moral reason but not a moral obligation not to have the early abortion might be left perplexed. I don’t think we could blame her.

* * *

Happily, we have an alternative way of avoiding the inconsistency while retaining what seems most plausible in Harman’s results. We can take the position that all persons—i.e., all conscious, thinking things, whether non-human animal, or late fetus, or you and me—matter morally, but we all matter variably: some of the losses we incur have full moral significance and some have no moral significance at all, with the difference being where those losses are incurred in relation to the person who incurs them. More specifically, what I call Variabilism asserts the following.

Variabilism:
A loss incurred at a world where the person who incurs that loss does or will exist has full moral significance

for purposes of evaluating an act that imposes that loss or any of its alternatives, while a loss incurred by that very same person at a world where that person never exists at all has no moral significance whatsoever.

On this view, we are free to take the kid gloves off when it comes to some of the losses that a given person may incur, but we must leave them on when it comes to other of the losses that that same person may incur. If the loss is incurred by virtue of a person’s having been left out of existence altogether, we are under no obligation to avoid that loss on behalf of that person. At the same time, however, the bare fact that a person exists and suffers in a case where agents could have created more well-being for that person than they have is enough to ensure that that person’s loss has full moral significance: it counts against the act that imposes that loss.

We quickly run into conceptual issues when we try to say who matters morally and who doesn’t. The strategy behind Variabilism is that we can avoid those issues, while still positioning ourselves to solve some of our procreative puzzles, if we focus instead on which losses matter morally and which do not.

Among other things, Variabilism helps avoid the near-paradox that we saw McMahan grappling with earlier on. Why must we avert the non-lethal fetal injury but not the non-existence of that same person, when the latter is far worse for the person whose interests we profess to care about than is the former? Because the loss incurred as a result of the non-lethal fetal injury is incurred at a world where that person does or will exist, while the still deeper loss incurred as a result of our leaving that person out of existence altogether is incurred at a world where that person never exists at all. The former—and this would include the loss of 20 IQ points in Kamm’s case—has full moral significance, according to Variabilism, while the latter has none at all.

Variabilism can also help us to obtain the very result that Harman wants on early abortion. Thus, Variabilism can be expected to imply that the choice of early abortion or non-conception is (ordinarily) morally permissible if it is what the woman wants.³ That result will hold both for the world w1 where the woman never has the early abortion and for the world w2 where she does not. Moreover, this way of looking at things is perfectly consistent with the view that, even at w1, the woman has no moral reason not to have the early abortion. We can thus avoid the concern that we are pressed to take one of two unpalatable positions: that that moral reason itself gives rise to a moral obligation not to have the early abortion (which position puts us in danger of inconsistency) or that there is a serious disconnect between moral reasons and moral obligations (which position perplexes at least me). According to Variabilism, in other words, the woman has no moral reason at w1 not to have the early abortion—and hence no moral reason that we must then explain away.

Endnotes
3. Variabilism itself is just a theory regarding when harms, or losses, are morally significant and when they aren’t. To generate specific permissibility results, Variabilism needs to be combined with a plausible theory that would generate, on the basis of information regarding which losses are morally significant and which are not, specific permissibility results. It has been my impression, that, surprisingly, the
basic elements of an uncontroversial plausible permissibility theory—permissibility principles that would address many of the cases of interest to us, for example, in the present context—can be easily formulated, once we separate out the issue of the moral significance of the losses themselves. It is, that is, the loss rules themselves—Variabilism would be one, Moral Actualism (weak and strong) suggests another, the Prior Existence View (formulated, and correctly rejected, by Peter Singer) still a third, the Neutrality Intuition (formulated, and correctly rejected, by John Broome), a fourth, would be implied by the classical utilitarian principle, that is, Totalism—not the permissibility principles that are controversial.

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**Strawberry Ice Cream for Breakfast**

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Outside my window, all is pink and green.

Pink is my favorite color, I told them.

They gave me a room overlooking the pink garden.

They have wallpaper with pretty, pink swirls.

They feed me whatever I like—Strawberry ice cream for breakfast.

Here in this hospice, they want you to die happy.

They think a happy life makes you content to die.

Do they think a happy marriage makes you content to divorce?

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**Paternalism as Non-domination: A Republican Argument**

Dana Howard

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Few philosophers have been more suspicious of paternalism than John Stuart Mill. In what has become known as his Harm Principle, Mill presents a decisive principle to govern mankind’s dealings in coercion and compulsion: the only occasion that warrants interference on another’s action is to prevent harm to others. “Others” for Mill is the operative word; harm to oneself is not sufficient grounds for intervention. The very moment the Harm Principle is introduced, it is immediately followed by an explicit rejection of paternalism as sufficient grounds for coercion.¹

There are, however, two exceptions for which Mill found paternalism to be warranted: when the subject of such paternalistic intervention is a child or when the subject aims to sell herself into slavery. My paper focuses on these two interrelated exceptions that have been entrenched in the liberal orthodoxy, but it pays particular attention to the first exception—paternalism over children. There is something so seemingly self-evident about treating children paternalistically. However, the dearth of philosophical examination into paternalistic action over children is both theoretically negligent and practically dangerous.

Philosophers often follow Mill’s lead in assuming that paternalism is legitimate if it is directed at children and that there is only philosophical interest in paternalism directed at adults.² The general argument for brushing off the expressed interests of the child is that children do not yet know what is in their best interest and so for the time being they need to be treated paternalistically in order to develop into independent and capable adults. But there are many coercive measures contrary to the child’s wishes that are purported to be in her best interest. It is too broad a stroke to argue that paternalism is justified in all cases that involve children; some moral boundaries must be established on the kinds of paternalistic action that can justifiably be carried out. Intuitively, coercing a child to attend school when she feels it in her best interest to stay at home and play video games seems justified; more questionable, however, is the legitimacy of coercing a young self-appointed vegetarian to eat meat for protein. How are we to evaluate which of these interventions are paternalistic in the first place and which of these paternalistic interventions are legitimate?

A few philosophers have taken up the challenge of producing a standard of paternalism towards children.³ These theories go a long way in developing a theory of legitimate paternalism but, ultimately, they fail because they base their justification on some form of consent. Consent-based justifications of paternalism are especially problematic given the fact that children may not yet be at a stage of development where consent is even possible; moreover, whatever paternalistic measures are taken may influence the possibility of consent in the future. Instead of justifying paternalism on a consent-based model, I introduce a new defense of paternalism into the mix: one that focuses on developing in the child the capability of contestation rather than the possibility of consent. Paternalism happens regularly in the daily lives of children; in some cases it is justified and in others, it is not. By discovering the limits to paternalism for children, we can begin to see how these limits can extend to cases of paternalism against adult subjects whose values and interests are more clearly defined.

**Paternalism and Consent**

Gerald Dworkin provides an entry point on the topic of paternalism, which he roughly characterizes as “the interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person coerced.”⁴ Along with this definition there is an important caveat—namely, that paternalism “will always involve limitations on the liberty of some individuals in their own interest, but it may also extend to interferences with the liberty of parties whose interests are not in question.”⁵ Dworkin calls such a case “impure paternalism.” Impure paternalism is extremely prevalent in the lives of children and there is often nothing problematic in such censures. The state uses its paternalistic power by enforcing an age limit to get a driver’s license; it does this regardless of the expressed interests of precocious fifteen-year-olds both for their own safety as well as for the safety of older (and younger) members of society. Also, parents use their paternalistic power on their children throughout the humdrum of daily family life. Sometimes parents make paternalistic decisions for the child’s own interest but often for the interests of a sibling or perhaps even an aging aunt.

In an attempt to determine the limit of paternalism, Dworkin argues that parents should orient themselves in a way that their children will one day see the “correctness of the parental intervention”; accordingly, he emphasizes a notion of “future oriented consent.”⁶ But Dworkin’s theory faces two problems. First, children up to some age of development do not yet have the faculties necessary to consent and it is questionable what values they will hold in the future; this is especially relevant in thinking about those children whose parents weigh their values differently than the norm and may
be seen as attaching unreasonable weight to some value. It is uncertain what values the child of a Jehovah’s Witness will hold; will that child one day grow up to attach more weight to her religious convictions than to her life if her life depended on a blood transfusion? Even if future consent was guaranteed—if it is certain that the child of a Jehovah’s Witness will take up the same values as her parent—the legitimacy of some paternalist actions ought to still be evaluated. Which leads to the second objection: the guarantee of future consent is not enough for the legitimacy of a paternalistic action. Rawls presents an example of an intervention that coerces people to undergo a psychological treatment forcing them to abandon a presently held religious or philosophical belief for a different belief in the future. If guarantee of future consent is a sufficient condition for a paternalistic action then such a procedure would be justified. But future consent is a dubious concept when dealing with children. The tricky part about parental paternalism is that parents not only act in ways that they think are in the best interest of the child, but their actions also shape what the child herself takes to be in her best interest in the long run. The paternalistic action, if it is manipulative enough, may guarantee future consent on the part of the child; this does not mean that it is justified. If consent is a product of illegitimate coercion, then it ought not be counted. We therefore need to come up with a conception of paternalism that is not justified by the child’s current or future consent.

**Non-domination in the Family**

Recently, Philip Pettit and Quentin Skinner have reinvigorated the classic republican notion of freedom as not living in servitude to any other person, namely, “freedom as non-domination.”

This conception of freedom serves as an alternative to Berlin’s dichotomy of positive and negative freedom. It is not “positive” since it is not contingent upon the subject’s own achievement of self-mastery. And it is not completely “negative” since it attends to the types of relationships that the subject holds with others; as Pettit puts it, it is vigilant against “the power of interference that others may wield, not just on the actual interference that they perpetrate.” Freedom as non-domination makes room to call a person unfree even in cases that there is no actual interference. With negative freedom, or freedom as non-interference, a citizen is considered free if she lives under a despot who happens to be benevolent and therefore never interferes in her life. Similarly, in the absence of any domestic abuse laws, the negative conception of freedom considers a woman free even if she is under the constant threat of abuse, just as long as it comes to pass that her husband never hits her. With the negative conception of freedom as non-interference, people’s freedom is contingent on the success of charm, wit, or favor in the eyes of the dominator. Pettit’s conception of freedom concentrates on the relationships that the agent finds herself part of rather than merely the circumstances she finds herself in.

An asset of the republican conception of freedom is that it is “anxious about the informal sort of power that is not subject to constitutional check.” The state is not the only locus of coercion in our society; our freedom is often being undermined in more familiar settings such as in the workplace and in our intimate relations. While our vulnerability in these more personal domains is integral to our forging meaningful and codependent relationships, the importance of these types of relationships need not overshadow the fact that they have the potential to be incredibly unjust. This point is especially germane when it comes to the family. One of the advantages of belonging to a family is the security and shared responsibility for the welfare of all members of the family. This shared responsibility can also be its greatest liability. Individual well-being is often wrapped up in the well-being of others in the family and so family members tend to make many sacrifices for each other. But what sorts of sacrifices can be reasonably asked for family members to make and what sorts of burdens should they justifiably endure? This is an especially weighty consideration when talking about impure paternalism in the lives of children who may not be in a position to understand or endorse the sacrifices that they are making or the burdens they are suffering. Under the guise of intimacy, family members, especially the young ones, may be exploited and coerced to do things that are not only not in their best interest but have long-term damaging effects. Because the republican ideal of freedom takes into consideration the kind of relationships people have with each other, it confronts such challenges more directly than the positive or negative conceptions of freedom that may redirect the legitimacy of familial relations through the language of rights handed out by the state.

So what would freedom as non-domination look like within a family? Using Pettit’s definition, it is in effect when no family member (or members) dominates any other member (or members). There are three conditions that make domination possible: a member dominates another family member iff the dominating member has the (1) capacity to interfere (2) with impunity and at will (3) in certain choices that the other is in a position to make.

This is a theoretically dense definition, so I will quickly try to unpack its significance. When one has the capacity to interfere, it is an actual capacity. It is not an inchoate capacity that needs further development; rather, to have a capacity is to be ready to exercise that capacity at will and under present circumstances. A young child may grow up to become bigger and stronger than his mother, but this does not mean that currently he has the capacity to overpower her physically while still very young. On the other hand, the mother has the capacity to overpower her small child and if the only thing that is standing in her way is her love for her child and her will not to harm him, then the child is being dominated. For obvious reasons, it would be misguided to think that in order to secure the child from his mother’s domination, we ought to physically weaken her. The republican model directs us to restrict the mother’s capacity through legal or social reprimands. The need for reprimands leads to the second condition of domination: the interference must be at will and with impunity. If there are either legal or informal sanctions set in place over parental action, the mother is not able to interfere in her son’s life as she pleases; she is instead held accountable and must justify her actions either to her son or to the community at large.

One final point about the capacity to interfere: an act of interference can be arbitrary in the procedural sense without being arbitrary in the substantive sense. Namely, it is arbitrary in virtue of the control the parent wields over the child rather than the outcomes to which the interference gives rise. The possession of the dominating power is enough for it to be illegitimate, as the dominating agent need not actually interfere with the dominated person. Even if the dominating agent interferes only with good intentions or motives, this interference is still illegitimate if it is not forced to track the interests of the child. This is important when it comes to the relations between parents and children and underlies an essential point about the family structure regardless of the family members. If parents have the capacity to wield unchecked power and arbitrary interference over their children’s development, then the relationship itself is illegitimate. It is at this point we move from the moral realm into the political. While freedom as non-domination is a useful concept when it comes to evaluating what it means to be a responsible parent, the theory is parasitic on there being just institutions and social norms in place that
makes the familial relationship legitimate. Even in the case where parents are doing their best to not dominate their children in their paternalistic actions, the relationship itself is still one of unjust domination without the proper social and political structures in place.

**Developing the Capacity to Contest**

Admittedly, Pettit is not very clear about what counts as tracking the interests of the person suffering the intervention. I think this is because in the case of adults, interests are too varied and coming up with any objective standard of best interest of adults is highly contentious. In fact, it is surprisingly easier to develop an account of what is fundamentally in the best interest of all children precisely because their future interests are at present so indeterminate. While we do not know what particular interests a child will hold in the future, we do know that in order for that child to have any interests of her own (and not those of her parents or of the state) she must at least be able to develop the ability to contest authoritative interventions. It is the very ability to contest on the part of the child that must be tracked and developed.

The capacity for contestation is made up of parts. It is the capacity to think critically, along with the self-confidence to act according to one’s reflections, and at the same time structural avenues must be in place both within the family and in society so that contestations are paid due attention. Parents need to track the interests of their children even when the children cannot yet speak for themselves. An important component of this is the responsibility to ensure that children develop a voice as they grow up. Parents must ensure that their children develop the capacity to reflect on their parent’s decisions and be critical of them so that in the future they will have the ability to decipher whether or not the decisions that their parents are making are truly in their best interest, or whether or not they share their parents’ opinion about the good of the family in general. This means that even if parents don’t know what the child will take to be her best interest in the long run, they have to intervene only in ways that will one day develop the child’s capacity to contest. Not all interventions must actively develop this capacity. It is a sufficient condition of their legitimacy that they be consistent with the development of the child’s capacity for contestation.\(^{16}\)

Under the conception of freedom as non-domination, all members of the family have the duty to respect the freedom of all other members of the family. As long as they are not dominating their children—and this is a hefty proviso—whatever paternalistic action the parent takes is legitimate. If one considers freedom to be non-domination rather than non-interference, then paternalism of children is not necessarily a restriction of freedom. Though the child’s actions may be restricted, they are restricted in a way that is non-dominating since it is forced to secure the child’s freedom in the future. Paternalism is legitimate for children in the same way that all interference is legitimate: it is interference that is not arbitrary. Most parents, no doubt, have some sort of plan about how they are to raise their child, according to specific religious or secular traditions and by reinforcing specific values they hope the child will also come to hold someday. As long as these ideals enable the child’s freedom as non-domination and develops in the child the capacity to contest paternal (and state) authority then it is legitimate.

One may argue that children happen to be born into these relationships and so there is still the problem that they are being obligated without their consent. However, one of the greatest virtues of the non-domination model is that consent is no longer relevant. According to Pettit, consent is not what is important in thinking about the legitimacy of a power; it is rather the ability for the affected party (either the children, the parent, or the citizens of a state) to contest the “assumption that the guiding interest and ideas really are shared and, if the challenge proves sustainable, to alter the pattern of state [or familial] activity.”\(^{17}\) When thinking about state power over citizens, this can be interpreted as a rather thin notion of freedom; since there need not be any notion of prior consent, the legitimacy of the state rests on the ability for any member of the state to contest being dominated. However, when thinking about the family, the child’s ability to contest is a much more robust demand.

Freedom as non-domination confers on parents the responsibility to develop in their children the capability to one day contest the family decisions that the parents are making. As the child grows up and has objections to the decisions and practices of her parents, the parents are obligated to heed her contestations and “alter the pattern” of their paternalistic intervention. Pettit rightly argues that non-domination corresponds directly with the person’s “subjective self-image and intersubjective status.”\(^{18}\) As children are growing up, it is of ultimate importance that their contributions and contestations really count. Through having their own freedom guarded and developed and through being increasingly capable of respecting the freedom of their parents, children become people in their own right.

With this rough introduction of how freedom as non-domination would play out in the family, I would like to turn to two competing justifications for paternalistic intervention in children’s lives. These two justifications address the problems that arise out of future consent-based theories of justified paternalism such as Dworkin’s. The first model of legitimate paternalism is the primary goods model prominently defended by Amy Gutmann. The second model is a republican model that I will argue is a more attractive alternative.

**Paternalism and Primary Goods**

Theories that base the legitimacy of paternalism on future consent do so in order to avoid the task of delineating a class of objective goods that are independent of the explicit interests of the subject of the paternalistic intervention. We have already considered the shortcomings of such theories. So, leaving future consent-based models aside, we now turn to Amy Gutmann, who uses Rawls’s primary goods standard as a liberal justification for paternalism. The argument for the primary goods standard goes as follows: If there are certain primary goods that any rational adult would choose to have provided to them as children, then paternalistic interventions which provide these goods are justified. Gutmann asserts that there are in fact such goods and her list of “the most obvious” primary goods would contain: “adequate nutrition, health care, housing, familial affection, and an education adequate to choosing among available economic and social opportunities and to become informed, democratic citizens.”\(^{19}\) Since there are such goods, as long as parents or the state are providing these goods their paternalistic actions are not only justified; they are necessary. Because children have a right to these primary goods, it is the paternalistic duty of the caretaker to provide them. If the caretaker refuses or is unable to provide the child with one of the goods listed then the state should have authority to step in and act as a surrogate. On the other hand, by fulfilling their paternalistic duties, parents gain the right to “paternalistic agency”—a right against the state and other parties not to interfere with the family.\(^{20}\) Consequently, as long as parents are providing for their children the aforementioned primary goods, they have a right to govern their family in whichever way they see fit.

Yet, the above list of primary goods is not unassailable and it succumbs to the very pitfalls that future consent theories were
trying to avoid, namely, the presentation of a contentious list of objective goods that every person ought to hold regardless of his or her subjective interests. This is not a knockdown reason to reject Gutmann’s theory. However, it does highlight the possibility that Gutmann’s formulation is question-begging. While most people in our society would look at this list and see nothing contentious about its items, the sorts of adults who take issue with some of these primary goods are exactly the same adults whose paternalistic power the primary goods standard is aimed at limiting. When arguing about which paternalistic measures are unjustified, Gutmann cannot hedge her bets by including in her list of primary goods the very same items that are in dispute without presenting an argument to support the inclusion.

When it comes to education, for example, Gutmann vigorously defends children’s rights to primary goods against parents who claim rights to free exercise of religion. She grounds her argument on the notion that the aim of paternalistic action is justified if it respects in the child a right to autonomy. Gutmann makes the claim that children must be educated adequately and remain healthy in order for them to one day achieve autonomy. While this claim is true it is complicated by the question of whether autonomy is a realistic or even an ideal goal for the upbringing of children. This is the question that I wish to pursue in the rest of this section.

When pitted against each other, parental rights to paternalistic agency are secondary to the children’s rights to primary goods since parental rights are derived solely from upholding paternalistic duties. Gutmann examines the case of Amish parents who remove their children from compulsory school after completion of the 8th grade. Gutmann sides with the child’s right to an adequate education that will prepare her for “choosing unprejudicially among all conceivable conceptions of the good.” However, she concedes that, empirically, the state of the public educational system is currently so flawed that it is too deficient in developing this capacity: “The success of the Amish challenge to a primary goods standard of paternalism is therefore contingent upon the failure of a professedly liberal state to provide children with the resources and opportunities to choose among an adequate range of good lives.”

Gutmann concedes that given the low standards that our state currently sets in the public educational system, very few children are being prepared to become autonomous adults. Few children, regardless of their religious upbringing, end up choosing among an adequate range of good lives. Therefore, the state, in its negligence, has no clout to chastise the Amish parents for limiting their child’s freedom in similar ways. But Gutmann runs into trouble here because she conflates Berlin’s two concepts of liberty and pits them against each other. As she describes the states’ responsibilities, the liberty that the state owes to the Jehovah’s Witness or the Amish parents is the negative liberty of non-interference, while the liberty that the state owes to the children is the positive liberty of self-master or autonomy. If the state is negligent in providing the education or health care necessary for the child to develop freedom in the positive sense, it has little grounds to accuse the parents for being negligent in providing the same. With two different concepts of freedom in dispute, one is left to one’s intuitions to decide which is more important. Gutmann gives priority to self-mastery, even if it is unachievable with the current educational system. But self-mastery is a hefty achievement, whether a person is young or old, religious or secular, and has little to do with the current public school system in the United States. Furthermore, it is questionable whether it is an appropriate goal of education to develop in the child the ability to choose among all conceivable conceptions of the good life without prejudice.

Such an ability is a difficult if not impossible achievement. No matter what our upbringing or education entails, it develops in us prejudices and values that affect our life choices; and this is not necessarily a regrettable fact about our human condition. It is to some extent our prejudices and our particularities that make us who we are. Ideally, we should therefore not be detached from these particularities, but should be able to step back and reflect on them and decide if we are truly at home with them or whether we would prefer to shed some of them. Rather than focus on freedom as autonomy or self-mastery, Gutmann should focus on developing in the child the freedom of non-domination. Many of the same capabilities are shared between self-mastery and non-domination, but non-domination is more achievable. With non-domination the child is to develop the ability to contest the dominating power rather than choose without prejudice among all life options. Even if self-mastery were achievable, non-domination ought to be the ideal form of political freedom.

There are shortcomings to the primary goods model that do not simply rely on the dubious conception of autonomy or self-mastery. Even if the account was able to convincingly defend the child’s positive freedom against her parents’ negative freedom, it is mum when it comes to protecting the child in cases where the parents’ actions may still be seen as unreasonable even though her primary goods are being provided. A child may be receiving all the primary goods that she deserves and still suffer domination by her parents. A female child growing up in a patriarchal household may receive all the family affection, nourishment, education, and love that she deserves and still not be free because certain life and occupational choices become unavailable to her due to her gender. An argument that only takes into account whether or not the child is receiving primary goods cannot detect whether such inter-relational patterns of injustice emerge over time. On this point, I take Pettit’s condition of non-domination a step farther. One of Pettit’s conditions for domination is that the interference is more or less intentional; but I think that people should be protected from all domination whether it is intentional or not. Often the most nefarious forms of domination are when the dominator is unaware of his or her capacity to interfere or is unaware of the actual interference taking place. Freedom as non-domination is a better candidate to justify paternalism within the family since it deals with the informal ways in which freedom can be constrained unfairly. For this reason, and for the reason that it standardizes the conception of freedom across agents, I think freedom as non-domination is preferable to justify paternalism.

**Conclusion**

The notion of freedom as non-domination centers on the ability to contest rather than the ability to consent. Paternalism is therefore legitimate if it does not hinder the ability of the child to contest present and future paternalistic measures. Children may end up endorsing an identity they did not choose. But this need not be a bad thing. What is troublesome is when the parents who enjoy unchecked power can act in ways that never develop in the child the ability to reflect on whether or not the paternalistic actions were really in her best interest. With freedom as non-domination, children still have the opportunity to endorse retroactively their parent’s paternalistic actions, but they endorse it under the condition that they are capable of rejecting it.

This is indeed not a neutral position to hold; it privileges freedom above all other values. It actually remains loyal to the two exceptions that Mill thought justified paternalism. When thinking about freedom in this manner, the two exceptions collapse onto each other. Paternalistic action is justified when it develops the child’s capacity to never be dominated by another.
We are basically ensuring, through paternalism, that the child will never become a slave. With freedom as non-domination, paternalism is not the restriction of freedom, even if it may be a restriction of action. Paternalism, like any coercive act, is justified only when it respects the freedom of the interfered person. It does not matter whether the interfered person is a child or an adult, or whether the person is guided by religious or secular convictions.

Endnotes

2. For an example of a philosopher who holds this opinion explicitly, see Herbert Morris, “A Paternalistic Theory of Punishment,” in Paternalism, edited by Rolf Sartorius (University of Minnesota Press, 1983), 140.
3. Amy Gutmann asks, “If children are not the property of their parents, why—and to what extent—should parents have power over them?” in her article, “Children, Paternalism and Education,” in Philosophy and Public Affairs (1980): 338. Tamar Schapiro asks, “What is a child, such that it could be appropriate to treat a person like one?” in her article, “What is a Child?” in Ethics (July 1995): 715.
5. Recent laws banning the use of trans fats in restaurants are an example of the paternalism of this kind. Under such laws, the patrons are benefiting because their interest of health is being protected through the limitation of no longer being able to order delectably cholesterol-rich food; at the same time, there is another class of people whose freedom is being restricted—namely, the restaurant owners who can no longer use the inexpensive oil in cooking. See Dworkin, Paternalism, p. 22.
6. Dworkin’s use of the word “intervention” is problematic, since as I have already noted and will discuss later, children must have the support from guardians in order to thrive. The child would not persist without the appropriate “interventions” on the part of its guardians. So a better word might be “paternalistic action” or “paternalistic support.” I thank Asha Bhandari for pointing this out to me. See Gerald Dworkin, “Paternalism,” in Paternalism, p. 28.
8. This is a problem that received much attention in Bernard Williams’s later work in political philosophy; see especially Truth and Truthfulness (Princeton: Princeton University Press, 2002), Ch. 9.
12. Some people may be averse to thinking about familial relations as matters of justice. There is a long held tradition beginning with Aristotle that clearly distinguishes between the private and the public realm. The public realm is the subject of justice whereas the private realm is the subject of affection, care, and self-regulation. However, I follow the lead of political philosophers like Susan Okin who have attempted to incorporate the family into the political sphere and to be subject to public scrutiny. The family is political on both ends in that it contributes to shaping the political and is itself partly shaped by political processes. Philosophers rightly see the family as the first political institution with which the citizen of a state comes into contact. But the family and its structure is not only integral to the production of future citizens, it itself has been designed and reformed by political factors. As Susan Okin asserts, “There is a cyclical process at work, reinforcing the dominance of men over women, from home to work to what is conventionally referred to as the ‘political arena,’ and thence back home again.” See Justice, Gender and the Family (Basic Books, 1989), 113. Gender norms are not the only kinds created and reinforced in families; other norms include norms of respect, etiquette, and cooperation. It is therefore not only appropriate to talk about the family in political terms but necessary to do so. Also see Corey Brettschneider, “The Politics of the Personal: A Liberal Approach,” American Political Science Review 101 (February 2007): 19-31; and Michael Walzer, Spheres of Justice (Basic Books, 1983), Chap. 9.
13. Pettit, Republicanism, p. 52. This is a slight variation on what Pettit claims in Republicanism. I exchanged “acting arbitrarily” for “acting at-will and with impunity,” which is how the concept is developed in Pettit’s paper, “Freedom as Antipower.” While I believe that at-will and with impunity give a clearer understanding of what type of limits could be set on dominating interference, it would be clunky to continue using such a phrase. So I will use the concept “at-will and with impunity” interchangeably with “arbitrarily.”
14. While the child at a young age does not have the capacity to dominate his mother, he may turn out to have the capacity to dominate his mother when he grows older. There are many examples of children dominating their parents. In patriarchal societies, sons may quickly develop dominating relationships over all the female members of their family, including their mothers. The virtue of the republican model is that it can account for such power relations in a way which other theories of the family which deal primarily with children’s rights cannot.
16. For instance, parents may need to relocate the family for work-related reasons; such a decision would be a huge interference in the life of the child and the decision is not made to develop in the child the ability to contest parental decisions. Is such an interference justified? I would argue yes, if the move is consistent with the development of the child’s freedom as non-domination.
17. Pettit, Republicanism, p. 63.

Response to Dana Howard on Paternalism

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Given that I have limited space and that the primary purpose of commentary is to generate discussion, I will focus on those aspects of Dana Howard’s paper with which I either disagree or which require further clarification. My commentary will very briefly highlight four main issues: the presentation of future consent, the slide from general paternalism to parental paternalism within the family, endorsing contestation over consent, and why the way we think about primary goods matters.

Howard’s first target is Gerald Dworkin’s model of future-oriented consent in which parental paternalism is justified as long as children can reasonably be expected to one day appreciate the correctness of that intervention. Howard objects because children: (1) lack the capacity to truly consent and (2) have not yet formed their own values and voice. Several examples—parents of Jehovah’s Witness children denying a
blood transfusion and a forced psychological procedure that changes previously held beliefs—are supposed to get us to see that future-oriented consent doesn’t cut the mustard. For, Howard maintains, even if one could manipulatively guarantee that a child will adopt the same values as her parents, a theory that allows for this possibility is problematic.

Firstly, the way these examples place their emphasis on what actually comes about rather than what could be reasonably expected to come about does not accurately portray Dworkin’s position. Dworkin clarifies: “Parental paternalism may be thought of as a wager by the parent on the child’s subsequent recognition of the wisdom of the restrictions.” So, the guarantee of consent in any old which way is not what Dworkin is going for. Instead, there has to be an element of self-legislation on the part of the parent to see to it that, whatever interventions they undertake, these be of the kind which it is reasonable to expect the child to one day see as sensible. Dworkin would certainly be against the type of manufactured consent Howard is worried about. It seems to me that Dworkin would deal with “paternalism or death” type cases (similar to the Witness example) in a fundamentally different manner, as is made clear when he states: “[paternalistic interventions in cases like these are] a kind of insurance policy which we take out against decisions that are far-reaching, potentially dangerous and irreversible.” Given these clarifications, I’m not sure Dworkin’s future-oriented consent model is as problematic as Howard makes it out to be. Indeed, Dworkin’s “reasonable expectation” criterion seems plausible, or at least not easily dismissed.

My second main point relates to the paper’s mode of presentation insofar as it obscures what is possibly doing a great deal of behind the scenes argumentative work. The paper quietly transitions from the initial Mill-inspired question of “When is paternalism over children justified?” to “When is parental paternalism over children justified?” Of course, given that children typically grow up with parents and within a family structure, it seems entirely appropriate for “non-domination in the family” to be the locus of an argument on paternalism. And, given the paper’s implicit theme that “the personal is political,” it makes sense to ask: When is paternalism justified in relation to my children? However, this mode of presentation can make it look like a particular ethos of non-domination in the family is doing the political work of justifying paternalism over children all by itself. Instead, a careful reading of the piece and a deeper understanding of the civic republican tradition Howard relies on reveals that laws and social conventions are doing much of the work in securing non-domination.

As Howard admits in a few references, her theory of non-domination in the family is itself “parasitic on [there] being just institutions and social norms in place that [make] the familial relationship legitimate…the relationship itself is still one of unjust domination without the proper social and political structures in place.” She also notes that, “The republican model directs us [to] restrict [parental] capacity through legal or social reprimands.” If all this is true, if the theory of non-domination in the family is parasitic on legal reprimands formulated within just social and political structures, then we appear to be in danger of collapsing back into freedom as the space of non-interference (presumably carved out by legal rights) that Howard wanted to move beyond at the beginning of the paper. While it is true that theorists of freedom as non-interference often mistakenly develop a rather ham-fisted stance that sees law as uniformly constraining rather than enabling, I see no reason why this stance is theoretically necessary. And, if it is not a necessary consequence of accepting some version of freedom as non-interference, then I am also not so sure there’s much of a substantive difference between freedom as non-domination and a (slightly more sophisticated) version of freedom as non-interference.

If I understand the civic republican notion of freedom correctly, then freedom as non-domination cashes out to be something like freedom from the structural possibility that someone with a greater amount of power could—with complete impunity—arbitrarily interfere in spheres where one is competent to make decisions. The stipulation of a lack of impunity implicitly references either law or convention (that is, when we ask: Impunity from what?), and highlights why laws as enabling conditions of freedom are so important for civic republicans. But, I see no reason why someone who endorsed a more sophisticated version of freedom as non-interference couldn’t also hold a similar view of law as enabling or securing freedom. So, it seems further articulation is needed as to the relevant differences between these two conceptions.

Thirdly, I think Howard needs to say a lot more about precisely why the capacity to contest is necessarily always tracking the best interests of a child to a greater extent than other possible alternatives of consent (be they accounts of future, hypothetical, tacit, actual, or “possible actual” consent). She notes that contestation allows children to develop their “own voice” and “become people in their own right,” but nothing more than this. Similarly, I’m curious as to what constitutes desirable contestation versus merely contestation that is unreasonable or based on objectively bad reasoning (making generalizations based on small sample sets, improper inferences, ad hominem arguments, etc…). I know quite a few children (and even a few adults) who have mastered “contestation” in a sense, but in such a way that it actually seems to manifest a great deal of un-freedom. Presumably, Howard wants a certain kind of contestation to be fostered in children, and not merely contestation in general. However, once again, the positive account of what this would actually entail is under-specified and commentary regarding the institutions beyond the family that would cultivate this kind of contestation is missing as well.

Lastly, I don’t think that Howard’s portrayal of Rawlsian primary goods is entirely accurate. Roughly speaking, primary goods include rights and liberties, income and wealth, and opportunities and the social bases of self-respect. It is important to realize that Rawlsian primary goods matter not merely because they are, as Rawls puts it “what we want whatever else we want”—because they are goods that any rational adult wants. Instead, primary goods matter because of the way in which they came about cooperatively through what Rawls refers to as the basic structure.

Briefly put, for Rawls the basic structure is both the vehicle of social cooperation and the primary subject of justice. It is the way that major social and political institutions fit together as one system of cooperation. For Rawls, then, justice is not something that simply accrues between persons regardless of whether they are in cooperation with one another or not. Instead, justice only arises within the context of an overarching pattern of cooperation composed of smaller social and political institutions—including (but not limited to) the family. Howard was presumably referring to something like this when she spoke of her theory as being parasitic on just institutions and social norms. For Rawls, just institutions are what confers justice on the distributive outcomes.
which effect individuals. Seen in this light, the reason that primary goods matter is that they are the socially produced surplus constituting the needs and claims of citizens rather than the humanitarian needs of persons (which are supposedly already assured by the “social minimum” we get from Rawlsian justice as fairness).

The key point is this: we care about how primary goods are distributed not because we know what a just outcome of distribution looks like before any social cooperation takes place but because primary goods are cooperatively produced via the basic structure. Marginal inequalities in the distribution of these goods are then explicable by the fact that one’s access to primary goods indicates how the basic structure of a society “values” a given individual’s cooperation. Put differently, access to primary goods serves as a proxy for how one’s social participation is recognized by the basic structure.

Now, this account differs from the characterization Howard gives of primary goods as “a contentious list of objective goods that every person ought to hold regardless of his or her subjective interest.”

It matters that we get clear about why and in what way it is that primary goods matter because this then also lets us see why an exclusive focus on the family as the most basic or primary structural element of political life leaves one hamstrung when trying to pursue the initial question of the boundaries of legitimate paternalism. Indeed, Howard agrees that “Philosophers rightly see the family as the first political institution with which the citizen of a state comes into contact. But the family and its structure is not only integral to the production of future citizens, [the family and its structure have themselves] been designed and reformed by political factors.”

However, if this is the case, it seems like it would be better to pay attention to the ways in which social and legal institutions of non-domination (or perhaps non-interference) outside the family help shape those families themselves. Instead of asking, “When is paternalism over children justified?” we will perhaps access more wide ranging insights about justice if we hold fast to the initial question: “What justifies paternalism over children?”

Or, as I like to think about it in my role as a teacher and advisor: “When is paternalism over other people’s children justified?”

Endnotes

2. I nevertheless think Dworkin’s account is problematic, as it seems to take certain notions of consent and freedom for granted. My own views on how paternalistic interventions in the lives of children should be viewed (views which I don’t articulate here) are closely aligned with the account given by Onora O’Neill in chapter 10 of Constructions of Reason. Also see: Arthur Ripstein’s “Authority and Coercion” in Philosophy and Public Affairs 32 (Winter 2004): 2-35.
3. See note 12. Also see: G.A. Cohen’s Rescuing Justice and Equality, pp. 116-50 for an anti-Rawlian inspired critique of Susan Okin’s inclusion of the family in the basic structure. In short, Cohen thinks Okin’s call to include the family in the basic structure fails to see the problems with the fact that the basic structure itself is the subject of Rawlsian justice. Howard seems to want to follow Okin’s lead and at the same time also reject a particular (I think mistaken) interpretation of Rawlsian primary goods. This leaves me curious as to what her views are regarding the Rawlsian notion of the basic structure as subject and also who the primary subjects of Howard’s justice are.
4. See page 24 of this issue. My bracketed insertions for clarification.
5. See page 24 of this issue.
6. For a good discussion of how freedom as non-interference accounts typically view law as constraining, see: P. Pettit, Republicanism: A Theory of Freedom and Government, pp. 63-79.
7. I take this formulation to capture the three criteria Howard lists. Her note 13 explains where “impunity” comes from.
8. Apart from Dworkin’s future-oriented consent, the other forms of consent are simply those represented by Hobbes, Kant, Locke, and Rousseau. For the “possible consent of actual agents” see chapter 9 of Richard Bellamy’s Rethinking Liberalism and chapter 11 of O’Neill (ibid).
9. I thank Jon Garthoff for this formulation and several that follow. However, all mistakes are my own.
10. The problems with the social minimum as formulated in A Theory of Justice are taken up nicely by Jeremy Waldron in chapter 11 of Liberal Rights: Collected Papers 1981-1991. Rawls amended his views on this in Political Liberalism. It is not clear, however, that his response is sufficient.

Contraceptive Responsibility and Autonomy: The Dearth of and Need for Long-Acting, Reversible Male Contraception

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Key words: male contraception, research and development, gender norms, responsibility

Abstract: Not only is there a large discrepancy between the number of female contraceptives and male contraceptives, but there are no long-acting, reversible contraceptives (LARCs) for men. My main goal in this paper is to examine why this is the case. In particular, I analyze how the alignment of contraceptive responsibility with women has shaped the research and development of contraceptives and vice versa. I argue that male LARCs are necessary in order both to alleviate the burdens women face because typically being the ones responsible for contraception and to enhance men’s ability to control their reproduction. In order to strive toward a shared contraceptive arrangement between women and men, I propose concrete educational strategies for social change that will encourage the development of new male LARCs and increase the likelihood that men would utilize male LARCs that are developed.

Introduction

The invention of the female birth control pill was an important milestone for women’s rights. It was the first contraceptive not used during or after sex or related to the timing of sex. By severing the link between sexuality and reproduction, the pill allowed women to control their fertility outside of all sexual activity and without men’s participation or knowledge. Moreover, the pill was, and still is, significantly more effective than reversible barrier methods.1 While some women and feminists were critical of the Pill at first,2 especially because of the adverse side effects, American women generally welcomed the Pill, as seen by its immediate popularity. After the United States Federal Drug Administration approved the Pill as a contraceptive in 1960, the number of American women using it increased exponentially, from 1.2 million in 1962 to 6.5 million in 1965 to 10 million in 1973. By 1964, the Pill was the most popular form of reversible contraception, with 25 percent of all couples choosing it.3 Today, the Pill remains the most popular type of reversible contraception, and in fact is the most popular type of all contraceptives.4

Part of the reason the Pill was (and still is) so desirable is that it combined the strengths of the other two categories of
available contraceptives, barrier methods and sterilization. One of the most attractive features of barrier methods is that they are reversible; people regain their fertility when people stop using barrier methods. Sterilization has three main strengths: it is long acting (to the extreme, in fact, as it is permanent), it is extremely effective, and it does not involve any activity during the sexual act (whereas barrier methods must be used during sex). The Pill has all the strengths of sterilization, yet it is reversible—a very important characteristic for women who may consider having biological children in the future.

Today, there is a variety of hormonal long-acting, reversible contraceptives (LARCs) for women: the Patch, the Nuva-Ring, injectables (e.g., Depo Provera), implants (e.g., Norplant), and hormonal IUD (e.g., Mirena). There is also a nonhormonal LARC, the ParaGard IUD (also known as the Copper T IUD). However, there are no LARCs for men, hormonal or nonhormonal. Since the 1950s, thirteen new female contraceptives (many of which are LARCs and/or hormonal methods) are now available for women, whereas men are basically using the same contraceptives they did four hundred years ago.

My main goal in this paper is to examine some of the contributing factors for why there are so few male contraceptives, especially in light of the development of a plethora of new contraceptives for women. Furthermore, I provide some concrete educational strategies for social change that would (hopefully) both encourage the development of new male LARCs and increase the likelihood that men would utilize male LARCs that are developed. Before turning to this, I first want to briefly point out why one should be concerned about the lack of male LARCs.

Why Should We Develop Male LARCs?

Women Currently Assume Contraceptive Burdens

One reason we should develop male LARCs is so that men can more feasibly and effectively share contraceptive responsibility with their partners. For many men, especially men in long-term, monogamous relationships, neither of the two currently available male contraceptives is well-suited for their contraceptive needs: they want a long-acting contraceptive, particularly one that does not need to be used during sex, that is not permanent in case they decide to have biological children. The lack of such options for men forces many men to rely on their partners to contracept. According to a 2008 report by the Alan Guttmacher Institute, female-only methods account for 67.3 percent of all contraceptive use, male-only methods (condom and vasectomy) make up 27.2 percent, and shared methods (withdrawal and abstinence) constitute 4.4 percent. Presumably, long-term heterosexual couples discuss what form of contraception to use, so in that way, it is a shared responsibility. However, as the above statistics show, over two-thirds of contraceptives target women’s bodies, which may lead couples to assume that the woman should take primary responsibility for the contraceptive. Yet taking primary responsibility for contraception typically entails financial and health-related burdens.

In the U.S., women themselves or their insurance companies are typically expected to pay for female-only contraceptives because they are seen as drugs or devices for just their bodies. There is a correlation between the cost and effectiveness of contraceptives. Although sterilization is the most expensive method, it is a one-time service, making it cost-effective in the long run. Female methods, especially hormonal ones, tend to be more expensive than male methods. Part of the reason for this is that women have to maintain these methods; for example, taking a pill daily or changing their patch monthly. Maintaining these methods is expensive, at least in part because it requires medical involvement. Only two of the eleven female contraceptives—the sponge and the female condom—do not require seeing a physician. This means that 82 percent of female methods require at least one physician visit in order to acquire the contraceptive. Moreover, 36 percent of female methods require a prescription, so women must continually renew their contraceptive by going to the pharmacy or doctor.

The one in five women of reproductive potential who are uninsured have to pay out of pocket for contraception, and, not surprisingly, they are 30 percent less likely to report using prescription contraceptives than women with health insurance. Even having insurance does not obviate financial concerns. Copayments can be high and often add up quickly. Additionally, many insurance companies do not cover contraception. As a result, women pay 68 percent more out of pocket toward their routine reproductive health care than men of the same age. Furthermore, only 25 states mandate insurance companies to cover contraception to the same extent as they do for other prescription medications and 13 of these states have provisions in place for providers, plans, or employers to deny contraceptive coverage for religious or moral reasons.

In addition to the financial burdens of contraception, there are also negative health-related side effects. Overall, the side effects for female methods are more serious than for male methods in part because there are various hormonal methods for women and no hormonal methods for men. But the two available male forms of contraception—condoms and vasectomy—also carry fewer risks than their corresponding female contraceptives, female barrier methods and tubal ligation, respectively. Some dismiss women’s side effects as “minor.” However, to the women who experience them, they are often far from minor. The most common reason women discontinue contraceptives is due to side effects, and most forms of contraception have discontinuation rates approaching 50 percent after one year of use. Moreover, women sometimes continue to use a particular contraceptive even if they are not happy with it because it is their least worst option. Side effects not only cause women to stop contracepting, they also prevent them from starting to contracept with a new method due to fear of potential side effects.

There are some other contraceptive burdens that sometimes apply, such as dedicating time and energy to contraceptive care (e.g., needing to see the doctor every three months for injectables) and enduring the bodily invasion of contraception (e.g., implants). While these burdens may seem insignificant, some women do not see them as such. Furthermore, these burdens span a woman’s reproductive life, a significant amount of time. Lastly, these burdens are problematic because they reinforce women’s already disadvantaged social positioning by limiting their freedoms within the reproductive realm and in other realms as well.

Men’s Reproductive Autonomy Is Limited

The fact that men are typically relieved of contraceptive responsibility and its corresponding burdens enhances their autonomy. However, it is important to acknowledge that men’s reproductive autonomy is also inhibited by the absence of male LARCs. Assuming men still want to maintain the possibility of having biological children, the only male-only method available to them is the male condom. Yet, given the condom’s high failure rate of 16 percent for typical use, men are not able to regulate their reproduction as effectively as women, for many female hormonal methods and IUDs have failure rates under 3 percent. To further decrease the probability of pregnancy, some couples use both the male condom and a female method. But even if men use the male condom, they are often dependent on women to also use contraception if they want
to use a method with a high success rate (and they are not yet ready for sterilization).

This dependence on women reduces men’s reproductive autonomy. Men have to trust that their partners are correctly and consistently using contraception. If a pregnancy does occur—either unintended by both partners or when the woman decides to stop contraception without telling her partner—men have no recourse. Men cannot mandate that women get an abortion. Regardless of the circumstances under which the pregnancy transpired, men are still held socially and financially responsible for any children they father. In some ways it seems unfair to hold men responsible for children they did not want when they are ill equipped to prevent pregnancy.

What men need in order to successfully control their reproduction is the one type of contraceptive they are missing (and that women currently have), LARCs. Indeed, the development of male LARCs would enhance men’s reproductive autonomy by enabling them to do what women have been doing since the advent of the female pill: effectively regulate their fertility outside of all sexual activity and without their partner’s participation or knowledge.

**Why Are There So Few Male LARCs?**

While there are many factors that help explain why there are so few male contraceptives and so many female contraceptives, I believe many of them stem from the association of women with reproduction, particularly the relatively recent alignment of femininity with contraceptive responsibility. In this section, I explore some of these factors as well as the relationship among them.

Before the “contraceptive revolution” of the 1950s and 1960s, which led to the development of hormonal and long-acting contraceptives, notably the pill, men and women shared contraceptive responsibility and some claim that men shouldered most of this responsibility. One reason for this is that contraceptive use was tied to the act of sex itself or to the timing of sex; therefore, men had to be involved. Dominant gender beliefs also played a significant role in men’s participation in contraception. Men’s presumed rationality and protective role were seen as reasons why men were better suited for contraceptive responsibility than women. Given that they were held responsible for contraception, men were usually held responsible for contraceptive mistakes. Prior to the 1960s, if a single man got a single woman pregnant, he was often expected to marry her.

Although many believe that the invention of the pill was the impetus for contraceptive responsibility shifting from a shared responsibility to women’s responsibility, historian Andrea Tone argues that this change emerged earlier, in the 1930s. Due to the United States Comstock Law of 1873, an anti-obscenity law that explicitly included contraceptives as obscene material and prohibits their distribution via mail or interstate commerce, people had trouble accessing contraceptives, as clinics and private doctors were often not very convenient, discrete, or affordable. Seeing an opportunity to make a lot of money, the success of contraceptive manufacturers’ campaign was twofold: not only did it encourage more women to use birth control, but it also ensured that the single largest proportion of those who did use female-controlled, commercially acquired contraceptives. The successful typecasting of women as contraceptive consumers reveals the centrality of industry to the history of birth control in America. The new alignments between women and contraceptive responsibility and between contraception and private companies paved the way for the success of the Pill. The overnight popularity of the Pill reinforced women’s role as contraceptive consumers, leading health care providers and researchers to focus almost exclusively on women’s reproductive health and to neglect men’s reproductive health.

The history of contraception shows how technology shapes ideology and vice versa. The current dominant contraceptive ideology is due, at least in part, to the available contraceptive technology: the plethora of female contraceptives and the paucity of male contraceptives. Nelly Oudshoorn, who devotes an entire book to the topic of the male Pill, asserts: “The predominance of modern contraceptive drugs for women has disciplined men and women to delegate responsibilities for contraception largely to women. Contraceptive technologies thus constituted strong alignments between femininity and taking responsibility for reproduction.” In other words, contraceptive use transformed from a new option for women to a duty: “contraceptive technology became contraceptive ideology.” This contraceptive arrangement and ideology has become so normalized and embedded in our culture that both women and men typically assume that women will take responsibility for contraception.

In turn, this ideology shapes the decisions of scientists, pharmaceutical company executives, government officials, and others about contraceptive research. The association of contraceptive responsibility with women played a role in the dearth of research on male contraceptives. It was not until the 1970s—50 years after scientists started researching “modern” female contraceptives—that scientists began researching new types of male contraceptives. Previously, scientists’ work on male contraceptives was limited to improving the condom. Because the female reproductive system has been studied for so much longer, more is known about it, which has facilitated the development of new female contraceptives. In contrast, scientists in the 1970s working on male contraceptives, especially hormonal ones, basically had to start from scratch because of the lack of available androgens. Increased attention to male contraceptives coincided with the establishment of the scientific and medical field of andrology, which is devoted to the study of the male reproductive system, in the late 1960s in the U.S. and Europe. However, compared to its sister field of gynecology, the field of andrology was, and still is, quite small. Before the 1970s, medical education typically overlooked or sidelined the male reproductive system, which contributed to the paucity of health care professionals trained in andrology. Furthermore, the field of andrology is fragmented. According to Oudshoorn, “practitioners with specific knowledge of the male reproductive system were distributed over a variety of medical specialties, particularly urology, endocrinology, gynecology, and andrology, rather than being concentrated in one specialty, as was the case for the female reproductive body.” In sum, the latter establishment, small size and fragmentation of the field of andrology make research and development of male contraceptives more difficult.

Another barrier to the development of male contraceptives is the scarcity of funding for such research. The distribution of research and development money in the 1990s was as follows: 60 percent to high-tech female methods; 3 percent to female barrier methods, spermicides, and natural fertility control methods; 30 percent to multiple methods (though mostly female ones); and only 7 percent to male methods. Some researchers who would like to study male contraception cannot due to a...
lack of funding. For example, Richard Anderson, a professor of clinical reproductive science at Edinburgh University says that “most of the work [on male contraception] has been initiated by university investigators and the World Health Organisation. There has so far not been a lot of money from corporate companies.” Despite positive findings on a male contraceptive pill, Anderson has not been able to conduct trials because no pharmaceutical company will financially support them.

The main reason pharmaceutical companies decline to fund male contraceptive research is that they do not think male contraceptives will be lucrative. “Contraceptive manufacturers…argue that tough U.S. drug-approval regulations, patent policies, and proconsumer product liability laws make it too expensive for the industry to develop new contraceptives.” Sheldon Segal, a population scientist, concurs with these contraceptive manufacturers, claiming, “It is not an overstatement to say that the liability issue is the biggest roadblock to contraceptive product development in the United States.” However, liability laws affect all areas of medical research, so, while it is definitely a factor in contraceptive research, there seems to be at least one other financial reason deterring pharmaceutical companies from pursuing male contraceptive research: they do not think there is a market for male contraceptives. From their perspective, devoting time, money, and personnel to this research is a bad investment because they will not generate a large profit like blockbuster drugs to treat diseases affecting the aging population in the West.

While nonprofit organizations also research contraception, they typically lack the resources to do so on a large scale. The World Health Organization had been one of the more visible and active nonprofit organizations working on male contraceptives, but today they focus entirely on female contraception because they see it as the key to helping women in developing countries. In order to develop male contraceptives, another actor—one that has both the resources and the interest—needs to step in. The U.S. government is one possibility. American politicians often lament what they see as the prevalence of abortions as well as the high rate of unintended pregnancy, especially among teenagers and unwed women. The government’s response to these “problems”—abstinence-only education—has not been successful. Instead of pouring more money into these failing programs, the government should divert money to research on male contraceptives. As private companies continue to pull out of contraceptive research, by default the government is going to play a larger role in this arena. For example, between 1970 and 1988, the percent of contraceptive research that received federal funding rose from 25 percent to 60 percent mainly because private companies were halting their research programs. The majority of contraceptive product launches in the U.S. in the 2000s have been initiated by publicly supported programs, not private companies. Although the government has emerged as a dominant actor in contraceptive development, this does not mean that its involvement is necessarily to the degree that it ought to be. Nor does this mean that the focus of such research is where it ought to be. The government needs to take a more active role in male contraceptive research if male contraceptives are to become available to the public.

While one may agree that the U.S. government is well-positioned to devote resources to male contraceptive research, one could still argue that, as with pharmaceutical companies, it too is a bad investment for the government because there is no market for male contraceptives. Because this claim is so prevalent, it is important to address and respond to two factors that contribute to this belief. First, there is the perception that men do not think they should be responsible for contraception and/or they are not interested in using contraception. Yet, empirical evidence often suggests otherwise. For example, a study by Glasier et al. revealed that more than 70 percent of men think men should take more responsibility for contraception. Furthermore, there is evidence that men are not only interested in using current male contraceptives, but also that they would use potential hormonal methods. This same study by Glasier et al. found that 55 percent of men would take a hormonal contraceptive pill, another study found that between 44 percent and 83 percent of men would use a hormonal contraceptive pill, another yet study found that 75 percent of men would consider using hormonal contraceptives more broadly.

Second, there is a perception that women will not trust men to use contraception. This perception was found in most of the 24 mainstream news articles written in English in 2006 on future male contraceptives I analyzed as part of my research. The titles of some of these articles (e.g., “Rely on a Man to Take the Pill? Surely They Have Got to Be Joking” and “Why Should We Women Surrender to the Tyranny of a Male Pill?”) make it clear that the authors not only think women will not trust men to use contraception, but furthermore the idea of male contraception is bad for women. Quotes that also convey these ideas were also common, such as, “I asked some friends if they would trust men, if male contraception became available, to bear the birth control responsibility. Not one of them said yes,” and “For a start, there are practical concerns. Never mind whether a man can actually be trusted to take a pill on a regular basis or not.” The concern that women will not trust men is also found in academic articles. For example, Jacqueline Darroch states, “the field of male contraceptive development has been plagued by…whether women will trust their contraceptive protection to a male method that they cannot verify is being used” (91).

What is interesting is that most mass media articles (and even some academic articles) failed to present empirical evidence that women will not trust men. In reading these articles, I got the impression that the view that women would not trust men with contraception was based mainly on social perceptions and ideologies, including the association of women with contraceptive responsibility (and reproductive matters more broadly), which was implicitly or explicitly stated in many articles. Interestingly, social science studies published in academic journals confirm that women in committed relationships would trust their male partner to use new contraceptives. Furthermore, while they may not be a representative sample, it seems safe to assume that most women who agreed to join clinical trials for male contraceptives, trusting their partner to use new contraceptives. Also, many couples already rely on male contraception, which presumably means that these women trust their male partners to use contraception. However, it may be easier to trust men with the available contraceptive methods since the use of both condoms and withdrawal take place in the presence of women and vasectomy is a permanent procedure.

There seems to be a disconnect between mass media stories and empirical studies regarding whether women will trust men to use contraception. I believe this disconnect can be explained by distinguishing between trust for individuals and trust for groups. On an interpersonal level, women generally trust their well-known male partners with contraception, whereas they typically do not trust men as a group (or some abstract man) to use contraception. Since trusting involves taking a risk, we are typically more reluctant to trust unidentifiable, amorphous groups than identifiable individuals because we perceive the risks associated with trusting a group, especially the possibility of broken trust, to be greater. In contrast, we tend to feel more secure when trusting an individual because he is a known entity. Few of the academic articles mentioned, let alone spent
time discussing, the difference between trusting an individual and trusting a group. However, Glasier et al. acknowledged it, remarking, “On the whole many women have rather cynical views of men in general which do not reflect their views of individual men—especially their partner.”

This perception that women will not trust men to use contraception is buttressed by (and buttresses) the cultural belief that men are not interested in taking responsibility for contraception. Some claim men are less motivated to use contraception because pregnancy entails fewer consequences for them than for women. As Segal quips, “If he doesn’t get it right, it is the woman who pays the price.” Besides the fact that women are the ones who experience pregnancy, one of the main reasons a pregnancy is thought to have more consequences for women is that women are assumed to be the primary caretakers of children. Yet, this assumption is based on socially constructed gender roles. If men were expected to be the primary caretakers of children, then pregnancy would also carry significant consequences for them. While it is true men cannot take on all of the responsibilities associated with pregnancy, men can share many of these responsibilities, such as paying for prenatal care and tending to the needs of the pregnant woman. In sum, the expectation that women assume all of the reproductive and childcare burdens plays a significant role in the perception that pregnancy has more consequences for women.

What Is Needed for Male LARCs To Be Successful?

Although developing more male contraceptives will make it easier for men to contracept, it is unlikely that men will start contracepting at the same rates women do without any changes in dominant ideas about contraceptive responsibility. The mere existence of a particular technology is not enough to change our current contraceptive arrangement. One only need look at the case of permanent contraception to see an example of this. Unlike the case of reversible contraceptives, the availability of permanent contraceptives is equal for women and men; both have one option available to them, tubal ligation for women and vasectomy for men. This equality of options might lead one might expect similar rates of tubal ligation and vasectomy. Yet, tubal ligation is practically three times more common in the U.S. Worldwide, tubal ligation is much more common than vasectomy, and in some areas, notably Asia, the difference in rates between these two types of sterilization is quite large. These differing rates cannot be attributed to availability of technology nor to the procedures themselves, as vasectomies are quicker, easier, safer, and cheaper than tubal ligations. It is the alignment of femininity with contraceptive responsibility that mostly explains why tubal ligation is much more popular.

In addition to technology, the normative social understanding of contraceptive responsibility must also change in order for male LARCs to be successful. Engendering social change is generally a multifaceted, amorphous endeavor. Here I will focus on just one, concrete strategy for change: education, specifically, teaching shared contraceptive responsibility between women and men. First, the federal government can encourage or even mandate that primary and secondary schools teach comprehensive sex education classes that include shared contraceptive responsibility. The suggestion that the federal government shape the sex education curriculum is not new. In the last eleven years, the federal government has spent well over one billion dollars on abstinence-only education. Although all fifty states except California originally signed on to receive this federal funding, seventeen states now decline it. The decision to reject federal funding reflects many state politicians’ dissatisfaction with abstinence-only education programs and preference for comprehensive sex education. Given the current movement against abstinence-only sex education, especially in light of the recent studies showing that it generally does not delay teenage sexual activity, it seems likely that many state governments would welcome federal funding for comprehensive sex education. Stressing the importance of shared contraceptive responsibility before or around the time children and teenagers become sexually active prepares them to make good and just decisions about sex and contraception throughout their lifetime. Currently, many children and teenagers learn about sexual activity through the media, which rarely includes contraception, or other sources, such as friends, unlikely to seriously and accurately discuss contraception. In contrast, comprehensive sex education programs send the clear message to children and teenagers that shared contraceptive responsibility is a normal, and expected, part of sexual activity. Normalizing contraception reduces its stigma and promotes its use.

Second, and similar to the previous suggestion, postsecondary schools for health care professionals, for example, medical schools and nursing schools, should include shared contraceptive responsibility in their curricula. Furthermore, curriculum should highlight empirical evidence for men’s interest in using contraception as a way to counter the common perception that men are not interested in it. The goal of changing the curricula is not only so that health care professionals recognize the importance of shared contraceptive responsibility (as well as see it as a feasible possibility since many men want to take responsibility for contraception), but also so that they pass along this message to their patients. Including shared responsibility is also beneficial because it highlights that men are typically excluded from reproductive matters. Most family planning programs are geared exclusively to women and family planning providers are sometimes hostile to men. Moreover, family planning providers often fail to discuss sex and contraception with men, even when the primary reason for the visit is treatment of a STD. Whereas women are supposed to see a gynecologist once they become sexually active, there is no equivalent for men. It is no wonder men generally do not think reproductive health includes them. Expanding the health care professional school curricula could also lead to structural changes that would foster shared contraceptive responsibility, such as more reproductive services directed at men and the potential burgeoning of the field of andrology.

A third suggestion does not entail direct instruction, but rather indirectly shaping people’s behavior through laws and policies. One way to indirectly promote shared contraceptive responsibility is to hold men legally responsible for their sexual and reproductive decisions. Examples of such laws already exist: forcing men to pay child support for children they fathered and classifying rape as a crime. Politicians and policymakers should work to strengthen existing laws and policies and strive to pass new ones, such as policies encouraging men to take a more active role in primary caretaking as discussed above. Since morality and legality often go hand-in-hand, laws that hold men responsible for their sexual and reproductive decisions send the message that men have a moral obligation to act in certain ways regarding sex and reproduction and to assume responsibility when they do not. Creating legal consequences for men’s sexual and reproductive choices teaches men to take responsibility for their actions, which hopefully pushes them to make better decisions and minimizes their ability to shirk from responsibility and blame.

I have provided a few practical educational strategies for achieving social change that will engender shared contraceptive responsibility. Clearly, these are not the only strategies, though they are a good starting point. In an ideal arrangement of shared contraceptive responsibility, neither partner faces limited
autonomy or unfair contraceptive burdens. Moreover, in such an arrangement, both partners are empowered to control their fertility, which typically leads them to make better decisions and have better outcomes. Improved decision-making not only benefits the agents of such decisions, but it also benefits other individuals and society at large. Given the advantages of shared contraceptive responsibility, individuals and governments should strive to achieve it.

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Endnotes

1. Hatcher et al., foreword.
2. Notably, Margaret Mead said, “[The Pill] is entirely the invention of man. And why did they do it? ... Because they are extraordinarily unwilling to experiment with their own bodies...and they’re extremely willing to experiment with women’s bodies” (quoted in Djerassi 14).
3. PBS.
5. Oudshorn, 197.
6. One could claim that it is not always true that condoms are a male-only method since women sometimes provide them, negotiate their use, and help put them on.
7. Hatcher et al., 245.
8. The four methods that require prescriptions are oral contraceptives, the patch, the ring, and injectables.
11. Hatcher et al., 241.
12. Nass and Strauss, 119; Also see Glasier et al.
14. Indeed, Nass and Strauss assert, “Couples may use a particular method not because they like it especially but because it may be ‘the best of a bad lot’” (115-16).
15. Nass and Strauss, 125-26. Also see Grubb and Larsson.
16. According to Nass and Strauss, women commonly cite negative side effects as the reason they do not use contraceptives at all (or do not use a particular method, especially hormonal methods and IUDs) (119). That some women choose to avoid the burdens, especially the negative side effects, of contraception knowing that it means risking an unintended pregnancy shows the how unpalatable they find certain aspects of contraception.
17. This claim deserves more support; unfortunately, however, I do not have the space to adequately address it here. For more on this topic, see Beck-Gernsheim, Stubblefield, and Yanoshik and Norsigian.
18. Hatcher et al., foreword.
21. Parnell et al. For example, in the late 1950s, 50 percent of women who were single when they became pregnant with their first child married before the child’s birth, whereas by 1988, only 22 percent did so (Parnell et al.).
22. Oudshoorn is one such example. She states, “Prior to the introduction of new contraceptives for women in the 1960s, no stabilized conventions existed concerning the relationships between gender identities and contraceptive use” (13).
23. PBS; Tone, 313.
24. Tone, 309.
26. Ibid., 14.
27. Beck-Gernsheim, 32.
28. I am limiting my discussion to how cultural ideologies and factors have shaped the direction of contraceptive research and am not examining physiological differences between women and men that could also play a role. Some scientists and laypeople assert that there are more female contraceptives than male ones because it is easier to develop contraceptives that target women’s bodies (see Oudshoorn, 46; Duffy; Nuzzo, and Callaghan). Reasons such as the following are given to support this claim: women release one egg a month, while men produce millions of sperm a day and women’s fertility is limited to a handful of days each month, whereas men are consistently fertile (see Knight and Callahan 12 for more examples).
29. PBS.
30. Oudshoorn, 19.
31. Oudshoorn, 27.
34. Oudshoorn, 26.
35. Yanoshik and Norsigian, 70.
36. Quoted in Moss, 12.
37. Ibid.
38. Callaghan, Dow, Godson, Segal.
39. Yanoshik and Norsigian, 68.
40. Segal, 141.
41. Segal would probably respond by saying, “interventions involving the reproductive system are held to different standards or elicit different emotional responses than other pharmaceutical products or devices” (142). I agree with him that reproductive research is often perceived differently than other areas of research and think uncovering the source(s) of these different perceptions would shed light on why pharmaceutical companies are more concerned about liability for reproductive drugs than nonreproductive drugs.
42. Djerassi, 77.
43. Oudshoorn, 192-3; Dow, 6.
44. Knight and Callahan, 308.
45. Segal, 138.
46. Glasier, 649.
47. See, for example, Bourke and Bradbury.
48. Glasier et al.
49. Martin et al.
50. Weston et al.
51. There were probably more articles, but here are the ones I examined: Addison, Bourke, Callaghan, Christian, Glenda Daniels, Eyre, Godson, LaMotta, Levenson, Macrae, Mason, No author (Male pill has no lasting ill-effects, study reveals), No author (Male pill may put the men in control of conception), No author (Sperrm production recovers completely after stopping hormonal contraception), No author (Will birth control be his job?), No author (Would a male contraceptive pill work?), Nuzzo, Pirani, Randle, Richard & Judy, Ross, Sarler, Traister, and Wharton.
52. Christman.
53. Sarler, 12.
54. Glasier et al., Martin et al., and Weston et al.
55. Scott.
56. Distinguishing between trust for individuals and trust for groups is too big a topic to tackle in this paper. See author’s paper on this topic, which is currently under review.
Schechtman’s main contentions are:

(1) The quest to articulate human “identity” responds not to one question but two.
   (a) Re-identification: What makes a person at t1 the same person as she is at t2?
   (b) Characterization: Which beliefs, values, desires, and other psychological features make someone the person she is?

Failing to distinguish and separate these two leads to unsatisfactory and cumbersome views of identity.

(2) Pre-philosophically, people presume that facts about identity underlie four important features of our human existence: survival, self-interested concern (about our future, and retrospectively about our past), moral responsibility, and compensation. These four features of our practical and social life are linked much more to the characterization sense of identity, however, than to re-identification. A theory of characterization needs to speak directly and clearly to these four features, but a theory of re-identification does not.

(3) Psychological continuity fails as a re-identification theory of the self due largely to problems of logical form. Those include transitivity and determinacy/degree.

An instance of a transitivity difficulty occurs in fission cases: one personal train of memories and anticipations A branches into trains B and C, each of which is fully continuous in memory with A, but neither is psychologically connected with the other. If B is the same person as A because of psychological continuity, and similarly C is the same person as A, how can B and C not be the same person? Perhaps such problems can be solved, but only by the brute force of questionable ad hoc definition.

Neither the transitivity nor determinacy/degree problem, however, afflict theories of characterization, even when those theories heavily invoke psychological continuity. For the characterization dimension of identity, indeterminacy and the fact that identity comes in degrees pose no problem at all. Our beliefs, values, desires, etc., run the gamut from being passively received from the outside (“ours” in a minimal sense, but not “truly ours”) to being created and asserted by ourselves ("truly ours"). Moreover, all the four features of human life to which a theory of characterization can and must speak come in degrees. Consequently, the burden of explaining how identity enlightens the four features falls not to re-identification theory but to characterization.

(4) Our characterization identity (“personal identity”) is best captured by the notion of “narrative self-constitution”: “a person creates his identity by forming an autobiographical narrative—a story of his life” (p. 93). Individuals constitute themselves as persons, at a minimum, “by coming to think of themselves as persisting subjects” with memory and anticipation, but some individuals also “weave stories of their lives, and it is their doing so which makes them persons” [in a fuller sense]. A person’s identity “is constituted by the content of her self-narrative, and the traits, actions, and experiences included in it are, by virtue of that inclusion, [truly and fully] hers” (p. 94). (My suspicion that the additional bracketed language should be included is consistent with Schechtman’s previous point that the personal identity of characterization comes in degrees.)

That the individual constitutes itself as a self by a narrative is not the silly view that just any self-conceived narrative will do. Certain constraints govern the narrative for it to constitute the identity of a person. Developmentally, the narrative emerges socially, and others’ reactions to a person and her narrative help shape the narrative itself. In such a context the empirical, practical reality is that bodily continuity is important. I cannot simply claim in my subjective narrative to be Napoleon and thereby make my personal identity Napoleon, for example, and my personal identity does not contain the trait “witty and humorous” if others virtually never think I am. My legitimate
narrative identity may include, though, “attempts to be witty and humorous” or “loves to laugh at his own jokes.” Thus, there are both objective (external) and subjective (internal) elements in the narrative that forms to constitute my personal identity. If someone tries to exclude either the external or the internal components, we properly say that what they have produced is not a person-constituting narrative. Critics of Michael Jackson, for example, cannot leave out his own conception of himself as a non-abusing, loving parent, just as neither he nor his fans cannot leave out his most disturbing behaviors if they are accurately stating the narrative that constitutes Jackson’s self.

(5) It follows that bodily continuity can be defended as having a prominent role, albeit a limited one, in our complete notion of identity. Its role is not to be an exclusive theory of re-identification, where arguably it runs into compelling counter-examples (body transplants and body swaps, particularly). Bodily continuity typically functions socially as what we use for re-identification, and that social function is also a critical factor in one’s formation of a narrative self. In this way, re-identification and characterization ultimately connect. The connection is not, however, one of logical necessity.

Implications for Bioethics

DeGrazia has impressively pursued several problems in bioethics that are influenced by views of human identity, in the process refining and reinforcing the widespread impression that identity can significantly affect arguments about the definition of death, advance directives for later stages of one’s life in severe dementia, abortion, etc.

He articulates a division of labor within identity theory between “numerical” and “narrative” identity similar to Schechtman’s “re-identification” and “characterization,” and he relies significantly on Schechtman for his own view of narrative identity. DeGrazia, however, does not call his version of narrative identity “self-constituting.” Schechtman’s full view is provocative for our thinking on these problems above and beyond DeGrazia’s treatment.

Take survival. Of the four features of our existence to which identity speaks, this is arguably the one most integrally involved with identity: an individual’s survival seems to presuppose arguments about the definition of death, advance directives for later stages of one’s life in severe dementia, abortion, etc.

What happens, then, when we retain some memories and anticipations, but lose the capacity to weave them together in a narrative—as may happen, say, in moderately severe dementia? The “self-constituting” dimension that Schechtman attributes to a person’s narrative is marked by degrees, as the four features are, and that points to regarding ourselves are gradually going out of existence as we progress from significant dementia through severe dementia to being barely sentient. It is not just PVS that may mark a huge turn to personal non-existence; stages of dementia short of PVS also constitute kinds of non-survival. It is not merely that the later stages have less value for us than the earlier ones do; it’s that in them our very selves are gradually going out of existence. The later demented self is not a different person than the earlier one who made out the advance directive; she is much less of the same person. To be sure, self-constituting narrative is not the only valuable kind of existence, but it is the only kind of personhood, and when even memory and anticipation have dissipated, there would appear to be no narrative left at all, and no self.

This direction is hardly unexpected for a view of the self that emphasizes narrative. Yet, as hard as any view that makes narrative central may be on the existence of self in severe dementia and PVS, Schechtman’s particular view may also pull us (or at least creatively provoke us) in an opposite direction: it can extend, both backward and forward, the time over which the self endures. Narrative self-constitution is a social narrative, not a purely subjective anything-goes-inside-my-head one. That social element of narrative is what allows us to speak of times like infancy as included in a person’s story. “I was an awfully happy baby,” e.g., and in some cultures ancestral lineage becomes a major part of a person’s narrative (Schechtman herself cites this latter example, p. 104).

If such possibilities mark the front side of life, why can’t others extend my narrative past what we might think is literally the time of personal death? Loved ones will gather around a dying individual who is totally unconscious, e.g., and include that time in the story of a person’s life: “she was one tough bird at the end, too,” when she kept breathing peacefully 24 hours or more after removing the respirator and everyone expected her to die momentarily. Or even, perhaps, as a corpse or its remainder: “we scattered her ashes in the flower meadow on the flanks of Mt. Rainier, where she always loved to go. That wrapped up her life.” Moreover, if ancestors are an indispensable part of the personal identity constituting narrative in some cultures, descendants would seem to be capable of having that role also.

Thus, I would argue, a view like Schechtman’s is not only a provocative but rich and nuanced resource for our reflections on survival. In dementia we are literally lesser selves—i.e., less a self. It is not just that our survival becomes less valuable to us. But the narratives that constitute our “stories” and our selves also include time both before and after we are self-conscious. Here again, it is the fact that selfhood comes in degrees—it has an arc through life, from incipiently little to full self-constituting narrative to vanishing bits at the end—that gives narrative identity its capacity to stretch our philosophical views.

Take one further example of this revelatory potential of a self-constituting narrative view like Schechtman’s. As previously noted, if PVS and severe dementia are kinds of death, social expansion of one’s narrative may be a kind of “post-mortem” life. That’s why, I suspect, it seems far preferable to me—preferable even for my own sake—that my life be marked by the first rather than the second of the following two scenarios:

(1) I am allowed to die upon becoming severely demented but am not at all forgotten by others; they accompany me through my last years and months and afterward continue to tell stories of my life, including ones that incorporate some aspects of my dementia.

(2) I am kept alive longer, through the last, slightest sentence that might constitute positive well-being for me, but, perhaps in part because of the understandable ordeal of those years, my friends and family largely ignore me during my wind-down and subsequently seldom remember me at all.

There is much else of merit in this book on which I have not remotely touched, including acute criticisms and defenses of various twists and turns in both re-identification and characterization identity theory. Some large challenges, too, Schechtman may have slighted, such as what is the entity that constructs the narrative—does not the narrative presume a self, not constitute it?

Regardless of such observations, however, bioethics needs to wrestle with primary philosophical material such as The Constitution of Selves. It needs to do that not only if it is to achieve respect in philosophy itself, but if it is to reveal and
Human Identity and Bioethics


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In addition to their obvious and pressing practical significance, many bioethical problems display an added philosophical dimension that comes from their connection to questions about our fundamental nature. Developing biotechnologies threaten to trouble our understanding of what it means to be human, and potentially force choices that require reflection on what makes us the particular individuals that we are. It is not surprising, then, that many discussions in bioethics invoke the language of personal identity, and that many discussions in the metaphysics of personal identity describe real or imagined bio-technological manipulations that might be thought to alter our identities. There are, however, only a handful of studies that provide in-depth and focused investigation of both metaphysical identity questions and the bioethical debates in which they are implicated. David DeGrazia’s splendid Human Identity and Bioethics is one of these.

DeGrazia begins (after a short introduction) by laying out and defending the theory of identity that will serve as a theoretical framework for addressing four important debates in bioethics: the definition of death, the authority of advance directives, the use of enhancement technologies, and the moral legitimacy of various prenatal interventions. Key to his account of identity is the claim that there are actually two distinct notions of identity at work in bioethical problems (and elsewhere). Numerical identity is the identity involved in our literal persistence as single individuals. Most humans, however, also have a narrative identity that defines what is most important to them, what they value, and who they “really” are. This is the kind of identity at issue in an identity crisis, and is to be distinguished from literal, metaphysical questions of persistence. Since both kinds of identity show up in considering bioethical questions, he says, if we are to think clearly about these questions we will need a clear account of each, and of the relation between them.

Attention is turned first to the question of numerical identity. DeGrazia considers in great detail the strengths and weaknesses of the most important and influential approaches to this question including Lockeans and neo-Lockeans views (the latter represented primarily by Derek Parfit’s account), Jeff McMahan’s embodied mind account, and the constitution view (represented by Lynne Rudder Baker). In the end he concludes that a biological—or “animalist”—account (much like that defended by Eric Olson) provides by far the most plausible criterion of numerical identity. On this view each human person is identical to a human animal, and persists as long as the animal remains alive and no longer. In opposition to “personist” views, which see us as essentially persons (where personhood is an honorific, defined in terms of the possession of higher-order psychological capacities), the animalist view sees us as essentially human animals. Notably this means that questions of our persistence are totally independent of facts about our psychological lives. A human person who falls into a permanent non-conscious vegetative state, for instance, continues to exist (as a human non-person) on this view, because the human animal is still alive.

The animalist view does not insist, however, that all that matters to us is our animal nature. DeGrazia follows Parfit in distinguishing between numerical identity and “what matters” in survival. Our personhood may be of the utmost importance to us, even if it is completely unnecessary for our continuation. The significance of personhood and of psychological life is expressed in the second notion of identity—narrative identity. While DeGrazia’s animalism implies that someone who falls into a permanent state of unconsciousness continues to exist, he is keen to explain why it seems natural to feel that someone in such a state is “as good as dead,” or that they are gone, leaving only the shell they once inhabited. These feelings express the way in which we identify with our narrative identities—which are lost irrevocably with permanent loss of consciousness—and the immense importance this kind of identity has for us.

Both numerical identity and narrative identity are, each in its own way, crucial aspects of the identity of human persons for DeGrazia, but there is a clear hierarchical relationship between them. There can be non-narrating humans (infants, the demented, those in a vegetative state), but no narrative without a narrator. And when the narrator ends so must the individual story of his or her life. So, while the practical implications of identity may depend most immediately on narrative identity, they depend indirectly on numerical identity, which must be in place before development of a narrative identity is even possible. Summing up his position on the contributions of numerical and narrative identity to what matters, DeGrazia concludes, “it is only slightly inaccurate to generalize that numerical identity is necessary for these practical concerns, while narrative identity (which presupposes numerical identity) is sufficient” (89).

In the context of describing narrative identity DeGrazia also explores the related questions of autonomy, self-creation, and authenticity. He evaluates several standard views of autonomy, including skepticism about its possibility, and comes to rest on a definition according to which someone acts autonomously when she performs an intentional action if (1) she prefers that action to available alternatives, (2) she identifies with and endorses this preference, and (3) her identification with this preference does not result primarily from influences that she would, on careful reflection, find alienating. Self-creation involves living and directing one’s life autonomously; planning and undertaking the actions that constitute a life. Autonomy and self-creation are related to narrative identity because “self-creation projects flow from narrative identity and, as they do so, continue to write and often edit the narratives from which they flow” (106). Narrative identity, then, sets the groundwork for autonomous action by providing the motivations and projects that define when someone’s actions are truly her own. As we create ourselves through the autonomous living of our lives, we revise, expand, and fill in our narrative identities. It is worth being clear that for DeGrazia narrative identity does not collapse into autonomous self-creation because, while most humans self-narrate, projects of self-creation require additional resources that are not available to everyone. Those who are deeply oppressed, for instance, or who are completely consumed with finding subsistence, may not have the time, energy, or resources needed to engage in projects of autonomous self-creation.

The theoretical discussion closes with a consideration of the question of authenticity, asking whether moral limits might be placed on our projects of self-creation by the requirement that we be “true to ourselves.” DeGrazia acknowledges that self-deception and coercion are undesirable, but beyond that
sees no real sense to be given to the idea of a “true self” that we are morally obliged to express. He therefore suggests “that any self-creation project that is autonomous and honest is ipso facto authentic” (112). With this final piece in place DeGrazia is ready to sum up the picture of the identity of human persons that will serve as his theoretical framework in the remainder of the book. We are, he says, “(1) essentially human animals and (2) characteristically self-narrators and (where circumstances permit) self-creators who care about continuing as such” (114).

With the theoretical framework outlined, DeGrazia turns his attention to the bioethical debates within which this picture of the self will be deployed. Each of the next four chapters of *Human Identity* takes on one general area of bioethical concern. In each case we are given a summary of the relevant biological, philosophical, and policy background complete enough to make the discussion that follows accessible to a complete newcomer, yet sophisticated enough to make it worthwhile for the specialist. Major positions are thoroughly reviewed and critically evaluated, and new alternatives set forth. In each context questions of personal identity are some part of the discussion, but not the whole of it. What we have in these chapters is thus not simply the repeated application of a theoretical apparatus, but a revisiting of complex, ongoing debates informed by an illuminating new perspective that often transforms the discussion in fruitful ways.

The first of the specific problems DeGrazia discusses is the definition of death. He reviews the steps by which the traditional definition of death as the irreversible cessation of cardiopulmonary function came to be broadened to include whole brain death, and describes movements in favor of defining death in terms of loss of brain function as a conflation of numerical and narrative identity. Once we are clear on the distinction between these relations, he says, and on the fact that we are essentially human organisms, we will see that the most plausible definition of death is an updated version of the cardiopulmonary criterion, which he calls the “circulatory-respiratory” standard of death. It “asserts that human death is the *permanent cessation of circulatory-respiratory function*” (149). The arguments for this criterion are followed by a discussion of its implications for important policy issues associated with the definition of death, especially the dead-donor rule.

The next chapter looks at the authority of advance directives. The material here is particularly rich and dense, based on both biological and philosophical considerations, that we come into existence “some time between the sixteen-cell stage and the time at which differentiation characterizes all types and grades of narrative identity. He also has occasion to introduce and defend a slightly amended version of Jeff McMahan’s Time-Relative Interests Account of egoistic concern, which holds that at a given time egoistic interest in the future can rationally depend upon the degree of psychological unity in one’s life. The immediate implication here is that it is rationally permitted (but not required) for someone to discount sharply a future to which she has little narrative connection, even if it is, metaphysically speaking, her own future. In the end DeGrazia concludes that advance directives that are autonomously generated should have (defeasible) authority. En route to defending this conclusion, he provides a refinement of the theoretical account of personal identity, and of the relative roles of numerical and narrative identity in determining the limits of rational egoistic concern.

The next chapter, on enhancement technologies, is briefer and somewhat more straightforward. Here, questions about identity arise as one element in a broader discussion. DeGrazia considers a series of familiar moral objections to the use of enhancement technologies, and answers each. He does not deny that there are legitimate concerns about such technologies—we should worry about their safety, about considerations of justice in connection with their availability, and about their use in children—but argues that in each case these are concerns that can be met with proper attention and caution, and that they are not unique to enhancement. He then considers objections to the use of enhancement technologies based on identity, involving the claim that these technologies turn their users into “someone else” in a morally objectionable way. Predictably, he makes clear that this is not metaphysically true, and so that the sense of identity in question must be narrative. The objection based on narrative identity does not hold up on scrutiny either, he argues, because it is not clear that such technologies will alter narrative identity—usually they will not—and even if they did, it is not clear that such an alteration, autonomously undertaken, is morally problematic. The earlier discussion of authenticity plays a useful role here. Summing up the discussion DeGrazia concludes, “on a note of cautious openness to the use of enhancement technologies in projects of self-creation” (243).

The final chapter looks at a variety of concerns about prenatal interventions. This discussion begins with an argument, based on both biological and philosophical considerations, that we come into existence “some time between the sixteen-cell stage and the time at which differentiation characterizes all portions of the embryo and twinning becomes impossible” (253). Genetic interventions before this time, DeGrazia argues, have the potential to prevent someone’s existence by causing a numerically different human to come into existence than would have had there been no intervention. After this time, however, human identity is “robust,” and genetic interventions, though they may substantially change the character of a human person, do not replace her with a numerically distinct individual. This means that the ethical questions surrounding prenatal genetic interventions are different depending upon when these interventions occur. Carefully dividing these contexts and looking at the arguments specific to each ultimately shows, DeGrazia argues, that there is no identity-related ground for moral concern about prenatal genetic therapy at either stage, and reason to think that some forms of prenatal genetic enhancement might be morally permissible. There should be openness to the possibility of such enhancement, he suggests, but strong caution in its use. The chapter concludes with an interesting and illuminating discussion of Parfit’s non-identity problem, and a courageous discussion of abortion in which the modified version of McMahan’s theory of time-relative interests is used in an elegant justification of early-term abortion.
Human Identity is a valuable contribution to both bioethics and the metaphysics of identity at many different levels. One unique and important feature of the book is its scope and comprehensiveness. Each topic—numerical identity, narrative identity, and the individual bioethical problems—is treated with immense thoroughness, making every chapter of the book an invaluable resource for those finding their way into these problems. The more exciting contribution is, however, found in the original arguments and perspectives DeGrazia adds to the ongoing debates. Within each thread of the discussion he provides objections to existing positions and arguments for new ones that are innovative and compelling. Anyone focused on just one of the problems DeGrazia takes up will find a fresh approach and considerations that must be taken seriously. Not surprisingly, the arguments aimed at any single position are unlikely to entirely convince a specialist strongly committed to an opposing viewpoint. This is, of course, no real criticism. Rarely, if ever, is any single argument going to prove decisive for or against a particular position, and it is even less likely to occur in a book where the debate in question is just one of many being discussed.

While I do not want to downplay the important contributions DeGrazia makes on the ground in each and every one of the debates in which he engages, in my opinion the greatest value of this work lies in the broader perspective that comes out of the book as a whole. DeGrazia gives us a comprehensive and compelling theory of human identity. Not everyone will accept it, of course. I, for one, would argue for a much more integrated view of narrative and numerical identity—and between metaphysical and practical questions of identity—than DeGrazia does, and this would probably have implications for many of the problems he discusses. Still, few have managed to produce such a clear and panoramic view. This theory is then brought to bear on a range of loosely interrelated bioethical problems. Again, while some will disagree with the particular conclusions DeGrazia draws, they are all significant and well-argued. When all of these threads are taken together, however, a broad, substantial, and coherent picture emerges of who and what we are, and what this means for medical (and, more broadly, ethical) decision making. This model provides more insight into our condition than any particular argument for any specific position could. In fact, if I have one overall criticism of the book it is that DeGrazia ends it with discussion of abortion rather than with a concluding chapter that explicitly draws the larger lessons learned from the themes that emerge over and over again in each discussion.

The relation between biology and ethics is always a vexing and complicated one. David DeGrazia has given us a beautiful example of how it might be productively explored in his engaging and illuminating book, which promises to bear fruit for many years to come.

ANNOUNCEMENTS

Phi Sigma Tau National Honor Society
Are you a member of Phi Sigma Tau National Honor Society for Philosophy majors? If so, you may wish to join the unofficial Phi Sigma Tau Mailing List, pst@phisigmatau.org. To join, send an email to pst-subscribe@phisigmatau.org. If you have any questions, send me, Cindy Smith, the listowner, an email at cms@smith.org. We look forward to seeing you there!

Bioethics Conference