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Welcome to the Fall issue of the Newsletter. This issue includes an article on health, by Kenneth Richman, from last year’s Eastern Division meeting; comments by Daniel Brudney and Joan McGregor from the Central Division panel on the ethics of organ transplantation; three papers from another panel from the same division on justice, habilitation, and healthcare, previewing a book by Larry Becker (Becker, Silvers, and Graver). The Pacific Division’s panel on neuroimaging and human nature has yielded a paper by Robert Rosenberg, and in addition to another contribution by Felicia Nimue Ackerman, the Newsletter’s poet, we have two book reviews—Mary Mahowald on Micah Hester’s recent book, End of Life Care and Pragmatic Decision Making, and Kevin Keith reviews the Moreno/Berger volume, Progress in Bioethics. We know you are all out there consuming the literature—consider reviewing your most recent favorite in our pages!

John Lizza will be missed, but it is a pleasure to welcome as incoming Chair of the Committee on Philosophy and Medicine the Newsletter’s long-time editor, Rosamond Rhodes. We’re looking forward to interesting panels on Division programs.

FROM THE CHAIR

Rosamond Rhodes

I am honored to take my place as the new chair of the APA Committee on Philosophy and Medicine and as the first woman to hold this position. Although this is a new role for me, I am familiar with the work of the Committee from my service as editor and co-editor of the Newsletter on Philosophy and Medicine from 1990-2007. Traditionally, this Committee’s activities have largely consisted in the production of the Newsletter and the presentation of Committee-sponsored sessions at the Divisional meetings. I intend to continue both and to perhaps make some additions.

The Newsletter allows us to exchange ideas about philosophic issues that bear on medicine. It also allows us to exchange ideas and announcements of activities. I am committed to making the Newsletter more visible, accessible, and useful to APA members. I would value any suggestions for furthering these goals. I would also like to take this opportunity to thank Mary Rorty and Mark Sheldon for their remarkable devotion to producing the Newsletter for us twice each year, and doing such a wonderful job in making the Newsletter both interesting and useful.

The Committee-sponsored sessions provide us with a place at the Divisional meetings for discussing issues related to medicine with a wide philosophic audience. These sessions invite philosophers who don’t regularly focus on issues in medicine to consider how general philosophical concepts apply to specific medical cases and broad conceptual issues in all domains of our field. Including Committee-sponsored sessions on the main Division programs helps to legitimize our area of interest. It also demonstrates how medicine raises intriguing issues for philosophers to consider and helps to overcome the tendency to marginalize philosophy and medicine as a tangential field. As I see it, bioethics and developments on the cutting edge of biomedical sciences present challenges for cutting-edge philosophical thinking with hard cases and hard science. I would like our sessions to continue to demonstrate that point.

The Committee-sponsored session for the upcoming APA Eastern Division meeting planned under the leadership of the immediate past chair, John Lizza, is an excellent illustration of that agenda. The session on “Beauty and Disability” will present views on how the concept of beauty should be factored into clinical and allocation decisions in medicine. The session will be chaired by Loretta Kopelman. It will include Anita Silvers, Sara Goering, and Peg Brand as speakers. Bonnie Steinbock will offer critical comments. This is an intriguing subject and it should make for a fascinating panel discussion. Several recent studies have found that people actually make decisions based on factors such as attractiveness and height, even when those considerations seem to be irrelevant. Although we value beauty in our lives, should it be a factor in moral deliberation? Are aesthetic reasons relevant considerations in medicine, and can they justify expenditures and risks? Should aesthetic factors or function take precedence in making treatment decisions for people with disabilities, or are they both legitimate concerns?

This topic will also be the focus of a shorter session with a smaller panel at the annual meetings of the American Society for Bioethics and Humanities (ASBH) this October in San Diego. The ASBH session is an invited Committee-sponsored event as a collaboration between ASBH and the APA. I would like to continue this collaboration as a way of promoting philosophers and the role of philosophy in bioethics and within ASBH.

John Lizza is working with Jason Eberl in organizing a Committee-sponsored session on “potentiality” for the Central Division meeting. Potentiality is an important metaphysical concept that has concerned philosophers since ancient times. In medical ethics, the concept of potentiality has been invoked in arguments about the acceptability of abortion, the moral status of the fetus, and the moral status of embryos that are discarded or used in stem cell research. Potentiality has also been a point of reference in discussions about the moral status of individuals who are in a vegetative state, a minimally conscious state, or brain dead. In the face of recent controversies over stem cell research and new imaging technologies, and renewed attention...
to issues related to the beginning and end of life, this promises to be an informative and engaging session.

The topic for the 2011 sessions at the Pacific and Eastern Division meetings have not yet been set. Feel free to forward your suggestions for future Committee-sponsored sessions or for other activities that the Committee should support and advance. In the meanwhile, I look forward to serving with the Committee for the next three years.

**ARTICLES**

The Embedded Instrumentalist Theory of Health and Its Ethical Implications

Kenneth A. Richman
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An embedded instrumentalist theory of health:

An individual A is in a state of health when A is able to reach or strive for a consistent set of goals actually aimed at by A. Where A’s goals are inconsistent in ways inaccessible to A, the relevant set of goals is that determined by the (idealized) objectified subjective interest of A. A will be unhealthy when false beliefs are central to A’s most dearly held goals. When we examine A as a biological organism, we find a set of goals that may be incompatible with the goals A adopts as a conscious agent with plans for his or her life. Rather than try to adjudicate between these two sets of goals, we embrace the conclusion that there may be two answers as to whether a given state is healthy for A. That is, we allow that there may be a conflict between the health of A qua organism and the health of A qua person. (Richman 2004, pp. 56-57)

Introduction

I will describe a theory of health that I first developed in collaboration with a physician, neurologist Andrew Budson. I later expanded and refined the theory in a book. The expansion and refinement taught me that my concept of health was too limited to stand on its own for assessing the needs of patients. A corollary concept of quality of life helps us to fill in where the health concept falls short, but has a different moral status. First, I will discuss some theoretical and methodological parameters that distinguish theories of health. Next, I will present my theory of health and the related concept of quality of life. I will then use these theories to discuss a specific patient.

My topic is The Embedded Instrumentalist Theory of Health and Its Ethical Implications. The ethical implications of a theory of health are the ways in which the theory directs us in pursuing a duty of medical beneficence. Under medical beneficence, healthcare professionals have a duty to support, maintain, or improve the health of their patients. With the possible exception of parenting, this is a duty that does not apply outside of the clinical relationship. A theory of health identifies what the duty of medical beneficence requires in more precise terms.

Theoretical dimensions

Approaches to the theory of health will fall into categories based on several parameters. For example, some approaches will be objectivist. Objectivists about health hold that claims about whether a patient is healthy are made true by facts about the natural world. Those who are not objectivist about health can hold that health is a construct that does not correspond to anything robustly real and objective. Constructivist theories will hold that a community cannot be wrong in judgments about health. Instead, community views and practices are precisely what determines what it is to be healthy in that community.

Theories of health also differ in the role of normativity. Normative concepts involve values. That is, a normative theory not only describes phenomena, but evaluates them—makes determinations that they are good or bad, better or worse. For now, I want to limit the discussion to normativity in claims about whether a condition or a person is healthy. The question of normativity in health concepts involves whether health claims are evaluative in themselves. A normative theory of health tells us that a state is good because it is healthy or that being unhealthy is bad simply because it is unhealthy. A non-normative theory can allow that healthy states are in general good and unhealthy states are in general bad, but will not attribute the values to the health status itself.

It is common to connect normativity with constructivism. People often assume that values could not be real, objective features of the world. This thinking is behind the famous theories of Thomas Szasz. Szasz argues that judgments of health or illness should be based only on biological facts. These facts will be free of values, as values could only come from contingent, social influences that, according to Szasz, are often used to abuse patients. A similar dislike for values arises in American classrooms. Students will sometimes claim that it is impolite to say that any action is morally wrong on the basis that values are not objective, observable aspects of the world. Usually (but not always) some examples from history (American slavery, the Khmer Rouge, World War II) serve to change the direction of the conversation.

Theories can also differ in whether they are merely biological or include some psycho-social aspect. Szasz’s approach is merely biological. So is Christopher Boorse’s well-known theory of health. Szasz and Boorse both connect the biological/scientific basis of their theories with the claim to be non-normative.

Summarizing the tendency to treat scientific approaches as non-normative, Mahesh Ananth (2008) writes that “the contemporary debate on the concept of health is basically between naturalists and normativists” (p. 3). (Psycho-social factors are non-natural.) Dominic Murphy emphasizes the distinction between objectivism and constructivism (Stanford Encyclopedia of Philosophy). These can both be good characterizations of the field because the parameters I’ve been discussing (objectivist and constructivist theories, normative and non-normative theories, biological and bio-psycho-social theories) tend to fall in line. Objectivist theories tend to be non-normative and biological; normative theories tend to be constructivist and bio-psycho-social. However, these are trends, not conceptual truths. My account of health is intended to be normative, to take account of individual psyches, and also to be objectivist. This means that claims about whether a patient is healthy are normative and have objective truth values (are either true or false).

The R-B theory

To describe my approach, I coined the term “embedded instrumentalism.” Preference satisfaction is another term for this type of theory. It could also be called an equilibrium view. Embedded instrumentalist theories describe an equilibrium between goals and states of affairs. Embedded instrumentalism is different from simple instrumentalism. A skill or object has instrumental value with respect to some particular goal. But
that value holds only if you embrace that goal. Embedded instrumentalism regards the match between states and goals as good in itself no matter what the goals are. In *Ethics and the Metaphysics of Medicine* (MIT Press, 2004), I defended the following embedded instrumentalist theory of health:

An individual A is healthy when A is able to reach or strive for a consistent set of goals actually aimed at by A.

I specify that health is the ability to reach or strive for our goals because we find value in working toward goals as well as reaching them. The “strive for” clause also leaves room for factors external to an individual that might interfere with goals being realized. For instance, we would not say that an athlete is unhealthy because he has the goal of winning a gold medal in the Olympics but cannot reach that goal because he happens to compete against Michael Phelps.

I hold that it makes sense to attribute goal-directed behavior to biological organisms. You can take this as an analogy or as literal. I think of biological goals as deriving from proper functions. When we think of person A as a biological organism, we find a set of goals that may be incompatible with the goals A adopts as a conscious agent with plans for his or her life. Here are two examples:

A man volunteers to participate in a clinical experiment which requires swallowing a toxin. The man qua organism wants to avoid the poison, to vomit it out. The man qua person wants to take in the poison in order to contribute to medical knowledge.

Tattoos are another example of personal choices that are contrary to biological goals. The body wants to maintain the integrity of the skin; the person wants the skin to be pierced and dyed to look fashionable, to celebrate a rock band, or to announce fidelity to a lover.

When we ask *Is this patient healthy?* my account can give different answers depending on whether we are interested in the goals of the body or the conscious, chosen goals of the person as a moral agent. That is, the health of A qua organism may be incompatible with the health of A qua person.

I will not have much to say about health qua organism, although I want to emphasize the idea that health qua organism and health qua person can diverge. Where conflicts arise, a Kantian framework justifies valuing the health of individuals qua persons over the health of individuals qua organisms. This is because the source (or the primary source) of value is choice by persons.

I hold that it is, *ceteris paribus*, better for people to be in a state that allows them to reach or strive for their goals than for them to be in a state in which this is not possible. An embedded instrumentalist theory of health will thus be a normative theory. From my perspective, it is the match between states and goals that is good, not anything about the states themselves. This account is intended to capture what is common among actual judgments about health while allowing for the rich diversity of human experiences and preferences. That is, it is meant to be reasonable and reasonably consistent with our intuitions.

Other embedded instrumentalist theories have been promoted by Ingmar Pörn, Caroline Whitbeck, David Seedhouse, and Lennart Nordenfelt.

According to this theory, what is healthy for an individual qua person can be very different from individual to individual. In addition, what is (or would be) healthy for an individual qua person changes as she adopts different goals. Significant goal changes can come with religious conversions, with becoming a parent, with education, or with changes in a person’s body, such as becoming disabled.

It is instructive to think about people with very limited goals. A person with very simple goals can be healthy with limited abilities. This may seem problematic. After all, a healthy person should be able to do many things. However, a limited set of goals can result from several possibilities. A person could have a small number of simple goals because of a profound worldview, as in the case of a monk. Another person has limited goals only because she is lazy; a third because she is depressed. A fourth person might have limited goals because that person has limited experience and imagination and simply does not know about the wonderful things life could offer.

We might be happy to say that the monk is healthy with limited goals and limited abilities. About the person who is lazy but not depressed, I would say that if that person has a problem it is a problem of ethics, not of medicine. (Kant writes in the *Grundlegung* (at 424) that it is impermissible to let one’s talents go undeveloped.) For the depressed person we may want to look for an underlying imbalance between what her body is trying to do and what it is able to do (presumably in the area of regulating serotonin levels). Once health qua organism has been restored, we can hope that the person will adopt a richer set of goals.

The individual with limited goals due to limited experience and imagination can be healthy. Her life could be better, and I believe that a caring physician who understands her life should care about making it better, but this would not be a specifically medical duty. Teachers, family members, friends, and librarians all share the duty to help enrich this person’s life. This is a duty of general beneficence regarding her *quality of life*, not a duty of medical beneficence to improve her health.

To explore this further, consider a patient who is unhappy because he cannot lift his arm to reach objects on a high shelf. He could be given physical therapy to improve his shoulder. Call this ability therapy. Or he could be advised to stop trying to reach so high and to move his things to a lower shelf. This would be goal therapy. Either approach would move the patient toward health (on my conception), but it is clear that successful ability therapy would improve his life more than goal therapy would.

It is precisely this type of case where social issues are likely to have an impact. It is easy to predict that patients with higher social standing would receive more support for their abilities and patients with lower social standing would be counseled to lower their expectations, or would simply expect that to be the solution. Social factors such as ability to leave work for medical appointments without losing pay will make a difference in the kind of care people ultimately receive.

It would be convenient if we could point to a *medical* difference—a difference in *health*—that resulted from these social factors. This would be convenient because we would then have an excuse to use the resources of the medical establishment to address the inequalities. Politically, injustice in the distribution of healthcare is more motivating than many other injustices.

However, my theory of health of persons does not, by itself, justify a claim of health disparity in this type of case. This emerges in part because my theory is grounded in the idea that what makes a goal important is that a person has chosen it. I hold that, within limits, human (or reasonable) choice creates value. A goal not embraced by a reasonable creature does not figure in the embedded instrumentalist equilibrium where health qua person is concerned. This idea is Kantian, although obviously not Kant’s. Note that creating more goals,
like creating more people, does not in itself necessarily make the world better.

What we find, then, is that health status is not the only relevant way to evaluate a patient's goals and abilities. Some people can be helped through goal therapy that encourages them to adopt a more substantial set of goals. My theory does not allow me to call this an improvement in health per se. Instead, I must say that when individuals take on a more robust set of goals, this can improve their quality of life.

I do not have a tidy theory of quality of life. I will say that quality of life is better when there are opportunities to use one's abilities to reach or strive for goals; it is worse when things get in the way of using these abilities. War, poverty, and thunderstorms can all get in the way of using certain abilities and hence can reduce quality of life.

In addition, quality of life is higher for those with “richer” sets of goals (an idea adapted from Nordenfelt’s discussions of health). Lack of education, lack of experience, low intelligence, or simple naiveté can lead to a relatively poor set of goals. But what makes one set richer than another? Richness may not be an objective characteristic. Certainly richness does not vary directly with the number of goals; sets containing few goals can be richer than sets containing many goals. The relative richness or poverty of a set of goals is probably best judged in the context of culturally determined values.

Case Application: David

So let me apply these ideas to the case of my father. He calls himself Dave. He gave permission for me to discuss his life. I also received approval from my university’s human subjects research ethics board.

Dave is now 78 years old. He is married and lives in what we call assisted living—a facility for older adults who can take care of most of their own daily tasks, but need a safe environment. Laundry, cleaning, meals, and transportation to healthcare and shopping are all provided. His wife (my mother) now needs much more assistance and recently moved to a facility with more nurses and aides.

Dave was educated as an electrical engineer, and earned a masters degree in business administration. For more than twenty years, he owned and ran a small retail business making picture frames. He enjoyed working with his hands. He enjoyed the relationships with his customers. These were more important than earning money, which was good because he didn’t make much money.

He believes in modern pharmacology, and prefers symptoms to be addressed through medication. He has changed his diet to control his blood sugar, but is generally suspicious when physicians suggest lifestyle changes to address medical problems. Until he stopped working, Dave disliked seeing physicians.

As the years progressed, Dave had increasing difficulty standing for long periods for his work in the store and in his workshop. Despite difficulties both physical and financial, he was able to continue doing what he wanted to do.

Since that time, Dave had two episodes that changed his health and his quality of life. The first episode began with a skin rash on his leg from poison oak. He scratched and it became infected, but he did not rush to see a doctor. The infection spread and became systemic (sepsis). He went to the hospital when he developed a very high fever. He soon became delirious and delusional. It took days to isolate the infection so that an appropriate antibiotic could be administered.

My father emerged from this episode very tired and unwell. He wanted to continue his business, and had difficulty accepting that this was not possible. His health was poor because he could not adjust his goals to match his lessened abilities.

He slowly regained some strength and his priorities began to shift. He focused on managing his many visits to physicians. Physicians replaced his customers as his primary social contact outside the home. Another focus was planning outings to museums or concerts with my mother.

In the second episode, my father fell at home one evening. He was having more difficulty with his legs, and lost his balance. He hit his head in two places. Overnight he developed a headache, then nausea. My mother called for an ambulance. When the ambulance arrived, he was confused and disoriented. He lost consciousness before arriving at the hospital. Imaging revealed two large subdural hematomas. His skull was opened to clean out one right away. The second was observed for a period, and a second operation was performed.

It was weeks before the medical team could bring Dave out of sedation safely. There followed several stages in which Dave’s abilities and goals went in and out of equilibrium. For a few months he was clearly very unhealthy both qua organism and qua person. His body was doing a poor job regulating blood pressure and blood sugar. Without help, he could not walk, speak well, remember simple facts, or perform basic activities of daily living (eating, dressing, bathing, etc.).

For several weeks after regaining consciousness, he could not remember that he was incapacitated, so he needed to be restrained for safety whenever he was not being directly supervised. He had terrible anxiety. One day he expressed regret that he had not been allowed to die. Referring to his living will, he said to me: “This is what we were trying to avoid.”

Eventually, Dave’s condition stabilized. While in a skilled nursing facility, his memory improved, his personality returned, and he became able to eat soft foods without assistance. Transferring (from bed to chair, chair to toilet, etc.) and walking remained dangerous without assistance. We were advised that he would need 24-hour supervision in order to be safe. This set a standard for assessing Dave’s health. Given a stable set of abilities, his goals of driving a car and living independently with his wife needed to be revised. He could have returned home with professional aides, but financial limitations meant that this was not practical. The financial limitations were a matter of quality of life, not of health. He had the abilities needed to live at home with aides, but there was no opportunity to do so. Goal therapy became the primary avenue to improving his health (qua person) at this point. In other words, a duty of medical beneficence mandated helping Dave understand his abilities and circumstances and to revise his goals in light of them.

This process was reasonably successful for a while. However, once financial arrangements had been made for him to remain at the skilled nursing facility, his abilities began to improve again. His brain continued to heal; his health qua organism improved. Dave was safe and reasonably well where he was, but his environment did not provide opportunities to exercise the broader range of abilities he was regaining. This was a challenge. In the local context, it had been necessary to invest nearly all of his money securing his place in the skilled nursing facility on the basis of the earlier prognosis.

Remaining in skilled nursing would not in itself have made Dave less healthy. However, a different environment would improve his quality of life by allowing him to adopt and then reach or strive for a richer set of goals. As I’ve indicated, I do not believe that this type of quality of life improvement is a special duty of medical personnel. Instead, it is a duty of the larger set of people who care or should care about the patient. It is a duty of beneficence, but not a duty of medical beneficence. Duties of efficiency (getting the most benefit out of available resources)
and justice (distribution of care) were also relevant, given that he was occupying a room where he no longer needed the level of care being offered.

My mother had a stroke while my father was recovering. Eventually, we were able to move them both to an assisted living facility.

What I find interesting about my father’s case is that, overall, his life is better than it was before the two episodes I described. He now has a wider variety of social contacts. He has returned to creating mosaics, cultivating orchids, and listening to music—activities he loves and does well but had abandoned for many years. He has accepted most of his limitations and contributes to the life of his community. His overall abilities are reduced, but because they are in better equilibrium with his goals, he is healthier. By most measures, his goal set is richer than it was when he was primarily focused on the daily tasks of his business, so his quality of life also seems better.

I may have said more here about what is not included among the ethical implications of the embedded instrumentalist theory of health than about what is included. A theory of health helps us to identify how to act on duties of medical beneficence. I believe it does not ground duties to improve quality of life for patients, which falls under a more general duty to improve lives that applies not only to medical staff, but also to others.

Comment on Miller and Truog

Daniel Brudney
University of Chicago

It is a pleasure to be asked to comment on Franklin Miller’s and Robert Truog’s papers on the dead donor rule. I am in substantial agreement with the thrust of their papers. That is, I am in substantial agreement with their starting point, that the brain death standard is implausible, as well as with their conclusion, that under specified circumstances it is morally justified to kill in order to extract organs for donation. Nevertheless, I want to raise two issues for further discussion. First, it seems to me that Miller and Truog can reach their conclusion only by putting very great weight on the concept of consent—and doing so has implications that Miller and Truog clearly want to resist. So consent, and whether one can bring its scope under principled control, will be my first topic. My second topic will be more speculative. It will concern the worry that public acceptance that organ donation involves killing will eventually degrade our moral character, that it will eventually lead us to regard as morally acceptable practices that we now regard as morally abhorrent.

I take Miller’s and Truog’s argument to be as follows:

1. Brain death is consistent with a wide array of continued bodily functionings, such as—now quoting from the Truog, Miller, and Brock paper, “circulation, hormonal balance, temperature control, digestion and metabolism of food, excretion of wastes, wound healing, fighting infections, and growth and sexual maturation in the case of children...most dramatically, pregnant brain dead women have gestated fetuses for up to three months.” This is such a wide array of crucial functionings that it is intuitively implausible to take brain death as the standard of death.

2. Killing is sometimes morally justifiable; in fact, morally justifiable killings occur every day in most American hospitals, namely, when life support is removed from a patient with the consent of that patient or of the patient’s surrogate.

3. In light of (1) and (2), we need to ask whether removing organs from a brain dead patient should be permitted, not as doing something to a no longer living being but, rather, as an instance of justified killing.

As noted, under current widespread practices, removing life support is thought morally permissible if the patient or the patient’s surrogate gives informed consent. The authors’ claim is that the removal of organs from a brain dead and adequately anesthetized—though still living—patient is similarly morally permissible if there is an appropriate advance directive or if the patient’s surrogate has consented.

The authors thus assert that we currently have and ought to continue to have a practice of justified killing in order to provide organs to save lives. They want us to face up to the actual content of our practices, to face the fact that the brain death rule does not track our intuitions about what death is like. They say that our current practices are morally defensible and have no need for a deceptive misdescription.

II

As I say, I am in basic agreement with Miller and Truog, yet I do have concerns. Let’s start with consent. The key to the authors’ defense of our current practices (not our current description of our practices) is consent. The authors claim that what is really happening when a patient (or her surrogate) asks for life-supporting machinery to be removed is that consent is being given for that patient to be killed. Similarly, when there is agreement to be an organ donor.

Now, this has the minor implication that countries in which the default on one’s driver’s license is that one is an organ donor ought to re-think that policy, at least so far as the motor vehicle accident victim is merely brain dead. It is one thing to have a default in which organs are taken from one’s dead body; it is something else to have a default in which one is killed so that organs may be taken from one’s body. Ex ante consent seems needed here. Still, this issue just goes to the need to educate people to understand and accept what organ donation already often involves.

The more substantial issue concerns the authors’ understanding of the scope of consent, that is, of the range of actions that consent can morally sanitize. If, for the purpose of organ donation, consent can make morally legitimate killing someone by removal of life-supporting machinery, can it make morally legitimate, for the purpose of organ donation, killing someone who will die soon but is not kept alive by machinery? Why should the presence of machinery make a moral difference? But if it is permissible, for the purpose of organ donation, to kill someone who is near death but not on life support, is it permissible to do so with someone who is not near death but consents to be killed, say, so that his daughter who is in need of a heart transplant may have one?

The authors are aware of both issues, seeming to regard the first as a possibly proper extension of their proposal but the second as beyond the pale, as altogether unacceptable. The question is how to forestall this second scenario, given the moral weight that consent already bears in the authors’ argument.

The authors’ claim is that consent to withdrawal of life support in ordinary cases and consent to withdrawal of life support as a prelude to organ donation are, in effect, instances of consenting to be killed, and that such consent can have sufficient moral force to make such killings morally permissible. The key here is that the patient (or her surrogate) makes the informed judgment that dying is more than compensated for by some benefit (the end of pain or of a very low-quality existence, or perhaps the saving of another’s life through organ transplant). Yet the authors do not want to permit killing in
every case in which a patient might make such an informed judgment—for instance, when, although I am healthy, I judge that it would be better for my daughter to have my heart so that she lives. But where is the principled drawing of the line?

The authors’ principle seems to be that, for the purpose of organ donation, no one ought to die who would not soon die anyway. However, that principle is not satisfied when a person who is machine-dependent but not terminally ill asks that life-supporting machinery be removed. Such a person might do so because she finds the current and future quality of her life worse than being dead. In such a case the authors must say that, by removing the machines, the doctors engage in a killing that is justified by the informed consent of the patient. It is then important to ask what the moral difference is between this case and the case of the father who wants to sacrifice himself for his daughter. He, too, is not in imminent danger of death, but he, too, judges that there is something more important than his continued life.

Of course, all sorts of practical worries arise here. To mention just one, if we allow people to sacrifice themselves for others this way, one might worry that people would be pressured into such sacrifices. No doubt there are other considerations that are external to the basic moral question. Still, we ought to ask the basic moral question. Independent of practical complexities, why permit the one consensual act of organ donation but not the other?

I am, in effect, raising the very difficult issue of what we may and may not consent to. However, by affirming the thesis that, in some cases, one may consent to being killed, the question of why in other cases one may not do so needs to be addressed at greater length. And while it may be true, as the authors say, that the father has no right against the doctors that they transplant his heart to his daughter, we still need to know why it would be wrong of the doctors to choose to do so—if, in fact, it would be wrong.

III

1. My second issue goes to the public response to the proposition that organ donation involves killing the donor. One could say that this ought not to be an issue. By hypothesis, such killing is (a) morally justified and (b) what we have been doing for years. Why should there be a problem with getting the public to accept that a practice that the public itself has believed to be morally justified is in fact morally justified—but merely under a different description? Nevertheless, the authors worry that correctly describing the practice of organ donation will lead to a fall in the number of donated organs, and in general to a reduction in public support for organ donation. That is surely a real issue. However, I’d like to touch on a different issue that the authors’ new description is likely to prompt. I will call it the conservative worry. It is an instance of a general worry often adduced about new medical technologies. The worry, cast in terms of the dead donor rule, goes like this:

i. Suppose organ donation involves justified killing.
ii. Making public the fact that organ donation involves justified killing will get people used to the idea that doctors engage in justified killing.
iii. If people get used to that idea, there will, over time, come to be more areas in which doctors will engage in what they and we, the public, consider to be justified killings.
iv. At least some of those areas will be areas in which right now we do not believe that killing is justified.

The worry here is a slippery slope in moral sensibility. Right now, at time T, we believe that practice X is morally acceptable but that practice Y is morally abhorrent. If we permit practice X to obtain, our moral sensibility will change so that later, at time T+1, we will find practice Y to be morally acceptable. But right now, at time T, we believe that that would be a very bad thing. Therefore, even if practice X is morally acceptable, we ought not to permit it.

This is an interesting argument and, as I say, versions of it pop up around bioethics. Let’s look at it more closely.

At time T we take there to be a set of reasons A-N that are jointly sufficient to show that, for example, non-consensual euthanasia is always wrong. Now imagine that our society lives twenty years with the authors’ proposal. Imagine that the practices of withdrawing life support and of harvesting organs for re-use go on as the authors propose, with a new, and more accurate, description of what we are doing, and there comes to be a public acceptance of such practices as instances of morally justified killings. Imagine now that, at this point, at T+1, a movement begins that recommends euthanasia for severely demented elderly people as well as for severely cognitively disabled people of any age. These are people who use large amounts of social resources and whose modest cognitive capacities make it seem that their quality of life is quite low. The recommendation is to euthanize such people even without their consent (such as it could be) or the consent of their surrogates.

Note that all the reasons, A-N, to find this recommendation morally unacceptable are available at T+1, just as they were at T. The worry is that the people at T+1 are ignorant, unintelligent, or not well-meaning. Indeed, we should assume that they are at least as informed, intelligent, and well-meaning as we are at time T. The worry is that at T+1 informed, intelligent, and well-meaning people will no longer believe that reasons A-N are jointly sufficient to show that non-consensual euthanasia is always morally wrong. The worry is that these people will weight reasons A-N less heavily than we do at time T, and that they will do so because they have become used to the idea of morally justified killings. They take as a matter of course that there are such things: it happens every day. Their moral sensibility has changed. The worry is that once the repugnance to kill is overcome, the consent/non-consent distinction will no longer seem to have such great moral force, not enough, anyway, to overbalance considerations of wasted resources versus lives of seemingly low quality.

The claims here are both empirical and moral. I’d like to abstract away from the empirical claim. That claim is that permitting justified killings—and accepting them as justified killings—will, over time, change our moral sensibility in what we now believe would be a pernicious manner. And moral sensibilities do evolve. Indeed, we often want them to do so. (The racists who said that integration would lead to wider acceptance of racially mixed marriages were not wrong; similarly, recognizing the rights of man eventually led to recognizing the rights of women; these are desirable changes in moral sensibility. There are slippery slopes that we should happily slide down.) Whether in the case at issue our moral sensibilities would actually evolve as the conservative predicts is uncertain, but the thought that changes in practices can lead to changes in moral sensibility is thoroughly plausible.

Still, the moral claim is what should interest us. Its structure is interesting. It says that we ought not to permit today what, today, we think is morally permissible because tomorrow our descendants will come to think something permissible which we, today, believe is not. In effect, we need to protect our descendants from themselves. We need to exercise a form of paternalism toward future generations.

Paternalism toward future generations is a bit of a puzzle. We are properly paternalistic in raising our own children, that is, in forming their values. If this is not only permitted...
but proper for individual parents and children, why isn’t it not only permitted but proper when it comes to one generation’s attempt to form the values of the next? Yet surely we should also be uneasy about not doing what is morally proper now (characterizing organ donation as morally justified killing) in order to avoid a decline in moral sensibility of beings who will, after all, be fully intelligent, informed, and well-meaning adults at the moment when they would have to decide, for example, whether compelled euthanasia is morally permissible.\(^7\)

In fact, I think paternalism toward future generations would be a mistake. Our best legacy to our descendants is intellectual honesty. On balance, therefore, I don’t see the impact on future generations as a sufficient reason to reject the authors’ proposal. However, I do see it as an issue. Admitting that institutionalized killing is sometimes morally justified is a big step—and whether the professionals who do it are called “doctors” or something else is much less important than admitting the fact of justified killing. Such an admission poses challenges not to our ability to find analytical distinctions—analytically, “consent” clearly separates the authors’ proposal from compelled euthanasia—but to our ability to ensure that, in the future, the relevant distinctions will be seen to have the moral weight needed to forestall practices that we now believe

### Endnotes

2. Miller and Truog don’t like to use the phrase “justified killings” because it may prompt emotional reactions that obscure the conceptual issues. However, I think that the phrase captures what they have in mind, and that we should tell it like it is.
4. “The key protection is consent, along with the requirement for a valid decision to withdraw life support.” Miller and Truog, “Rethinking the Ethics of Vital Organ Donations,” Hastings Center Report, p. 44. See also Miller, Truog, and Brock, “The Dead Donor Rule: Can It Withstand Critical Scrutiny?” p. 12.
5. See Miller, Truog, and Brock, “The Dead Donor Rule: Can It Withstand Critical Scrutiny?” p. 16.
6. Someone might bring up the idea that the internal morality of medicine prohibits doctors from killing, but this won’t work. For (a) by hypothesis, doctors already kill and are justified in doing so; and over time, they might come to see new forms of killing as justified, that is, as consistent with the internal morality of medicine—that morality might itself change. Anyway (b) which profession does the killing is less important than whether the killing will be seen to be morally justified.
7. And, of course, coercion is not at issue here but merely how we describe a particular phenomenon.
The concept of “brain death” too has come under serious criticism. Since its inception in 1968, so-called brain dead patients (Heart-Beating Donation) have been the major source of recoverable organs. Even though the neurological criteria for death determination have always generated some dispute (see, for example, Hans Jonas’ in “Against the Stream” in 1974), lately the chorus of dissent has grown louder and more wide-spread. Many of the current objections to brain death are raised by neurologists and other physicians. For example, Alan Swenson argues that it is empirically untrue that brain death marks the complete loss of integrative unity of all the biological functions of the body. Many functions continue in so-called brain dead patients, the most dramatic being accounts of gestation and birth of offspring. Even the President’s Council on Bioethics in its white paper, “Controversies in the Determination of Death,” in December 2008 concluded that there is “insufficient clinical and patho-physiological evidence to support the concept of brain death as ‘the irreversible cessation of all function of the entire brain.’” Professor Miller stated in an earlier article: “The practice of transplantation of vital organs from ‘brain dead’ donors is in a state of theoretical disarray. Although the law and prevailing medical ethics treat patients diagnosed as having irreversible total brain failure as dead, scholars have increasingly challenged the established rationale for regarding these patients as dead.”

According to Miller and Truog, under both determinations of death, it is not certain that patients are dead, according to UDDA criteria, before organ procurement begins. The upshot is that the determinations of death in the context of organ procurement are in serious trouble, they lack empirical justification, they have clinical guideline compliance problems, they are absent of philosophical rationale, and they have legal complications leading arguably to current practices that amount to criminal homicide. Hence, the violations of the dead donor rule in the current practice of organ procurement. What, then, is the way forward for the practice of organ procurement and transplantation?

**Challenge the DDR: Harm avoidance approach**

The way forward, according to Miller and Truog, is to challenge the conventional wisdom that killing patients to procure their organs is necessarily wrong. In response to the violation of the DDR in the practice of organ procurement, Miller and Truog search for a justification for organ procurement from still-living patients by asking whether the patient is harmed by killing him or her through the process of organ procurement. They argue that normally death is the gravest harm that a person can suffer, and since we have a duty to avoid harm, particularly physicians toward their patients, we have a duty not to cause death. But since in some circumstances death is not harmful to the patient, physicians don’t have a duty to avoid death. Consequently, they argue that “vital organ donation is not harmful when linked to prior valid decision to stop LST [life sustaining treatment].”

What should we make of this argument? From the fact that death is not necessarily the gravest harm to a particular person, it does not follow that physicians or anyone else are permitted to hasten death. On most accounts of our moral duties, outside of some versions of Utilitarianism, they are not a function of what will bring about the best consequences or maximize welfare. Because a patient has decided to discontinue treatment because she doesn’t see death as the worst harm or the patient might even see death as welcome, doesn’t, alone, change others’ duties not to kill her. Even though the patient doesn’t see death as the gravest harm, killing her, on most accounts of duties, violates a duty to her.

A slightly but importantly different argument claims that if the patient consents to the physician removing her organs prior to death—in other words, if the patient has full knowledge that the organ removal will cause her death and agrees to it—then the patient is not wronged by the organ removal prior to death. This claim presupposes that individuals have a right to decide what happens to their own bodies up to and including deciding their own death (Millian liberal principle). They are not wronged (even though possibly harmed) when they voluntary consent to the actions of others. Under this model, our duty is not to wrongfully harm others. But whether this principle is correct is contentious and certainly is not one accepted in current criminal laws in the United States and most countries in the world.

A second argument that Miller and Truog advance is that “When linked with a valid prior decision to withdraw LST, no one is made dead by vital organ donation who would not otherwise be dead by virtue of withdrawing LST.” No extra harm is being perpetrated against the patient by retrieving organs by killing the patient than would happen otherwise. Miller and Truog are not clear here about the patient’s consent to withdraw of LST and organ donation. Taking the organs from a patient who hasn’t consented to donation but has consented to having LST withdrawn is a harm to him even though he doesn’t see death as the gravest evil. Preserving patients’ right to decide whether their organs are removed—at any point—is of fundamental importance when individual autonomy is taken seriously. Some proponents of implied consent, that is, those arguing that explicit consent from the patient or family for organ removal is not required (they are assuming that everyone is consenting unless they explicitly opt out), argue for that position on the grounds that there is no harm to the donor after death to having one’s organs removed since the person has no interest in his or her organs after death. This account does not acknowledge post-mortem harm to the patient or family where the organs have been removed without consent. There are, however, many groups and individuals, who for a variety of reasons, including religious, do not want their organs taken after death and would see it as a harm to have it done to them.

But even if the patient has consented to both withdrawal of LST and organ donation, the patient has an interest in the way she dies, and without proper understanding of the organ procurement procedures—particularly if it is going to be done prior to death—she can be harmed by the procedure. Consequently, there is no extra harm only if the patient consents to having his or her organs taken before death.

Following the “no extra harm” argument, Miller and Truog introduce the trajectory argument; that argument is that the patient is on her way to death anyway and removing her organs before death doesn’t change that fact. But it does change the way that death is brought about. The patient will die as a result of her organs being taken out by the surgeon as opposed to her vital functions ceasing. Consider this analogy: an ex-husband bursts into the ICU a minute after the ventilator has been shut off and fatally shoots his ex-wife. He certainly could not circumvent murder charges by claiming that his ex-wife was (even though possibly harmed) when they voluntary consent to the actions of others. Under this model, our duty is not to wrongfully harm others. But whether this principle is correct is contentious and certainly is not one accepted in current criminal laws in the United States and most countries in the world.

Challenge the DDR: Causation

The standard objection to a view such as Miller and Truog’s is that there is a difference between withdrawing LST and allowing the patient to die, and causing death. What they are proposing is to cause death. Their response to the objection that they are proposing to cause the death of the patient is not to dodge the bullet and reject that they are causing the death of the patient, but to bite the bullet and challenge the claim that causing death is always wrong. Miller and Truog challenge the justification for the dead donor rule which is based on the principle that physicians shouldn’t cause the death of their patients. They
denied that it is always wrong for physicians to kill patients since physicians cause the death of patients outside the organ procurement protocols all the time, and those occurrences are widely seen as justified. Consequently, the assumption that it is always wrong for physicians to kill their patients is in error. Miller and Truog assert that when a patient asks that life-saving technologies be withdrawn and the physician complies with the request, and subsequently the patient dies, the physician causes the patient’s death.

To support their claim that physicians cause the death of patients when they withdraw treatment at the request of patients, Miller and Truog present two cases where the patients on life sustaining treatment have the same medical condition. In one case, a person enters the patient’s room intent on killing the patient and “pulls the plug” on him, and, in the other case, the patient requests to have LST stopped. They think that it is not coherent to say of the one case that the person pulling the plug caused the death of the patient and in the other case, where the physician pulled the plug, he did not.6

To support their “common sense” judgment about the notion of cause in these cases, Miller and Truog appeal to the jurisprudence classic Causation and the Law by H.L.H. Hart and Tony Honore.6 Hart and Honore, however, in their treatise are intent to demonstrate the complexities and the differences in our uses and meanings of “cause” in different areas of law and in common views about causation. (Even though they say that they want to vindicate “common sense,” this was meant in contrast to the then in vogue metaphysical and policy consideration accounts.) There are many ways the term “cause” gets used and for different purposes. There are also distinctions made, in not altogether consistent ways, between “conditions” and “causes.” And there are many factors that can be cited as causes of effects, for example, the presence of oxygen is necessary for fire and so are combustible materials, yet in most instances where an arsonist lights a match, the natural claim would be that she is the cause of the resulting fire. (Who would be the cause of the fire if a bystander spills a ten gallon drum of gasoline under the lit match?) Saying that something is the or a cause has different senses, consequently, as pointed out by Hart and Honore, “the concept of causation as we use it in ordinary life, is not a unitary one.”10 Often “cause” is used in the explanatory sense to account for why something happened. In the above cases, the physicians’ actions are part of the explanatory story of the patients’ deaths. Even so, the physician’s action of removing LST is not a full explanation since the patient had a terminal illness and in one case the patient asked for the withdrawal of care and in the other he did not. The full causal explanation of what happened would have to include these other causal factors.

Calling something “the cause,” Hart and Honore remind us, “calls for judgment and is something over which judgments often differ.”11 They go on:

Even the type of case which is most familiar, and most nearly approximates to Mill’s model of “cause and effect,” where causal connection between a physical event and some earlier initiating event or human action is traced through a series of physical events, involves an implicit judgment on such imprecise issues as the normal condition of the thing concerned and the abnormality of what is identified as the cause. Very often, in particular where an omission to take common precautions is asserted to be the cause of some disaster, a speculation as to what would have happened had the precaution been taken is involved. Though arguments one way or another over such hypothetical issues may certainly be rational and have more or less “weight” there is a sense in which they cannot be conclusive. When such areas of dispute are reached, the decision whether to describe the facts of a case in the term of some form of causal connection will be influenced very much by factors connected with the context and purpose of making the causal connection.12

Critical to deciding whether a causal factor is morally or legally relevant, that is, whether it is blameworthy, is determining what are the background factors or what would or should be the normal course of events. In Miller and Truog’s case of the patient dying after the physician withdraws LST, the patient did consent to withdrawal, and since patients have a right to decide what happens to their bodies—they have a right to refuse treatment—that forms the “course of events which would normally take place” and influences our judgment about “cause” for the moral and legal dimensions of the case. In the other case, where the person withdraws LST without the patient’s consent, then our assessment of the cause of death for moral and legal purposes would have been different.13

Though Miller and Truog’s cases might provide examples of “causes,” providing a description of what empirically happened in the cases, these cases show that the notion of “cause” is ambiguous and that for the moral and legal assessment of actions, we need to know much more than a description of the facts of the case. A physical cause, in this explanatory sense, is neither necessary nor sufficient for moral responsibility or legal liability. It is not necessary, as is illustrated by cases of omissions where there is no physical causal nexus and yet we assess the omissions as blameworthy. Cause in this physical sense is not sufficient since there are many physical factors that can be cited in cases, for example, the nurse turned off the ventilator, which might not be assessed as blameworthy.

Just the mention of a physical cause is insufficient to determine the moral status of the act. The reasons and justifications for actions or omissions are important in the assessment. These reasons are framed and assessed by the context in which they are done. Those determine what is the “normal course of events,” what is expected to have happened, both empirically and normatively. For example, are there good reasons for withholding treatment or withdrawing treatment from a terminally ill patient? One such reason is the fact that the patient refused further treatment. That fact, in the context of the U.S. medical system which respects patients’ autonomy and legally protects the rights of patients to refuse treatment, provides a justification for withholding treatment. The causal role of the physician withholding treatment plays a smaller role in our assessment of responsibility for the patient’s death in cases where the patient refuses treatment, since the patient has the authority to refuse treatment even if it will result in him dying. In the two cases, there are multiple causal factors at work: withdrawing the LST, the patient’s consent or lack of it, the underlying disease, the cardiac arrest, discontinuation of nutrition and hydration, etc., all of which are relevant to the blameworthiness or not of the actors. The fact that in one case the patient consents and in the other he does not is salient for the moral and legal judgments, as is the background assumption that a patient has the right to refuse treatment. Consent can change events in the world. Consent’s effect on the world is most graphically illustrated in the case of rape, where consent changes sexual assault into lovemaking. Nevertheless, because of our legal prohibition against physician assisted suicide in most jurisdictions, consent does not change murder (intentionally killing another) into physician facilitated death.

Miller and Truog have shown that withdrawing treatment from a patient who requests it is a causal factor in the death of
the patient, but saying that doesn’t tell us whether the person is responsible for the ensuing harm or whether the action was justified or not, blameworthy or not, criminally liable or not. Nor does it follow that it is appropriate to say that the physician “kills” the patient. We normally reserve the term “killing” for instances that are done intentionally with malice or at least recklessly. To say that a person killed another person normally implies that the agent was morally or legally responsible for the death.

In the law, physicians’ withdrawing or withholding treatment is classified as failure to intervene, instead of affirmative action. The courts have tended to analyze the physician’s omission not as the cause of the patient’s death. From Barber: “There is no criminal liability for failure to act unless there is a legal duty to act. Thus the critical issue becomes one of determining the duties owed by a physician to a patient....” Another widely cited decision (In re Conroy) claims: “Refusing medical intervention merely allows the disease to take its natural course; if death was eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.” This analysis also excludes as the cause of death the acts of clinicians carrying out the patient’s or surrogate’s non-treatment requests. Does the act-omission distinction and causation analysis of the court’s hold up to close scrutiny? It most likely does not. The court’s insistence that the physicians in the cases of withholding or withdrawing LST at the request of patients are not the cause of death seems to be supposing that more hinges on putative causation than the courts should infer from that determination.

Nevertheless, does showing that physicians are a causal factor in the death of their patients when they withhold treatment at the request of their patient change our judgments about the moral and legal permissibility of physicians’ causing the death of their patients during the organ procurement process? In other words, does establishing a causal connection in the one instance and its justification lead to the justification in another case where the physician causes the death by removing organs? In and of itself, it probably does not. In the two examples of Miller and Truog, we would give different assessments of the blameworthiness of the actors. In the case of withdrawing care where the patient consents, it is part of the causal explanation of the death of the patient, but so is the disease or condition of the patient. Without the LST the disease would and does explain the person’s death. Since the patient has authority to decide whether to start or continue LST—that is part of the context in which we deliberate about what are morally and legally relevant causal factors—the presence or absence of consent is very important to the moral and legal assessment. Second, removing organs from a patient is the direct cause (or proximate cause in legal parlance) of the patient’s death, since it is a sufficient condition for death. It is irrelevant whether or not the patient has an underlying condition which would eventually lead to his death; the removal of organs is sufficient to kill the patient. Since patients currently do not possess the right to consent to their own death (outside of very circumscribed physician-assisted suicide cases), the physician’s actions and intentions might well amount to criminal homicide.

For the sake of another
Miller and Truog argue that since retrieving vital organs is tied to a prior decision to withdraw LST, no one’s death is being caused by organ retrieval who would not otherwise die as a result of treatment withdrawal. And from that they argue that no one is being “killed for the sake of” saving the life of another. Nevertheless, the reason for retrieving the organs before death is “for the sake of another.” And if the patient dies because his organs were removed, and his organs were removed to save the lives of others, then there is a pretty straightforward sense in which he is being killed for the sake of others. It is not for the patient’s benefit that her organs are removed prior to death. The physician intends the death of the patient for the sake of getting the organs sooner rather than later. How unassailable the principle is that “no one should die for the sake of another” might itself be questioned. Soldiers sacrifice themselves for others, and so do individuals faced with tragic life boat situations. Permitting the terminally ill to make such a decision to die sooner rather than later explicitly for the sake of others is one that might be considered.

Where do we go from here?
This brings us to the larger worry about the debate surrounding organ procurement and definition of death. When the definition and criteria for determining death are driven solely by our interest in retrieving organs rather than the interests of the patient, we should worry about losing sight of the dignity of the dying person and the importance that death plays in an individual’s life. Since the 1960s, our attempts to redefine death to facilitate organ donation have shifted away from attention to the dying patient and his or her family to a focus on “saving lives” through transplantation. Thinking of Hans Jonas’ worries about the first iteration of our redefinition of death to facilitate transplantation, we too should worry about rationales that shift too much attention away from dying patients and toward merely facilitating organ donation. So too when we are seeking solutions to the problem that our current practices violate DDR, our solutions should respect the interests of the dying patient.

Much of the definition of death and the organ transplantation literature, as noted by Miller and Truog, attempts to obfuscate and rationalize the process rather than honestly confronting the problems directly. Up until very recently most theorists were unwilling to acknowledge the problems with the criteria for determination of death in the context of transplantation. Now, with scholars like Miller and Truog, there is a growing acknowledgement of the problems with our definitions, protocols, and processes. We applaud them for their intellectual honesty and their attempt to arrive at deliberative solutions, even if we don’t agree with all their analyses. Where do we think we should go with these revelations about organ donation and transplantation medicine?

Our preference would be to have a very honest public discussion about the criteria for determinations of death and the processes of organ transplantation. We need to have a conceptually coherent definition of death—one that is empirical sound, clinically operational, philosophically coherent, and morally acceptable. As part of the public debate, we should discuss whether we should permit dying patients who desire to be organ donors to consent to something like physician assisted death and permit the retrieval of organs before death. Such a policy would have many advantages, but its development and implementation needs to be transparent and public. One virtue of the policy of permitting patients to consent to having their organs removed before death would be an end to the gerrymandering of the definition of death and the application of the criteria for death. As Miller and Truog argue, the patient could be anesthetized and prepared for surgery earlier in the process, thereby not having to wait until patient arrests and then is quickly readied for surgery. This approach, if widely accepted, would have the virtue of candor and would retain the trust that is essential in the medical profession for transplantation medicine to go forward.

Can we justify organ donation without the DDR? Maybe, but the minimal conditions would have to include explicit patient consent to organ procurement before death and a general societal agreement of the practice. A change in our criminal laws would have to be part of the paradigm shift.
Endnotes
1. This paper was part of a panel discussion at the 2010 APA Central Division meeting sponsored by the APA Committee on Philosophy and Medicine focused on Franklin Miller and Robert Truog’s Hastings Center Report article entitled “Rethinking the Ethics of Vital Organ Donations.” The title of their presentation at the meeting was “Organ Donation without the Dead Donor Rule.” We would like to thank Jim Nelson for organizing this panel discussion.
10. Ibid., xxxii.
11. Ibid., 62.
12. Ibid.

Habilitation, Health, and Agency

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Health makes every plausible list of basic goods, at least by implication. It is so obviously good, and so obviously basic that it is sometimes on the list only as a precondition for elements that need special discussion. And initially, that seems understandable. Some level of good health is a necessary condition for almost everything we care about, both with respect to individual well-being and a sustainably productive, well-ordered society.

Moreover, one apparent connection between health and justice is clear enough: If health is a necessary condition for almost everything we care about, that will also include fundamental matters of justice. So if social structures undermine the necessary level of good health, or unnecessarily and systematically exclude people from the opportunity to have it, they will be prima facie unjust. So it is obvious that health must be on the list of basic goods for any plausible theory of distributive justice.

But lists create serious priority problems for theories of justice, and serious political ones for public policy. In complex modern societies, the infrastructure of production and distribution segregates such goods from one another. Food, shelter, education, employment, health, physical security, transportation, and so on each have their own sectors of the economy, their own government bureaucracies, and their own specialized advocacy groups. They compete for resources.

One thing that happens in this perpetual competition is perpetual compromise—perpetual give-and-take between deeply entrenched interests. And within such competitions, a good strategy for gaining priority for one’s special interest is to emphasize the cases in which its priority is an especially stark necessity—an undeniable, urgent, immediate necessity.

In the case of health, matters of life and death are strategic winners. So are matters of functioning that are essential for sustaining people as “fully cooperating members of society.” There is thus a natural (political) tendency to focus on health in that sense. This political tendency gives priority to a narrow (negative) definition of health—that is, health defined as the absence of physical and psychological disease or damage. The basic good of health thus comes to be identified with what can be addressed by medical research and practice. And triage rules can be applied, as necessary, for resolving further priority problems.

There is something wrong with this picture (or so I think). It is a detail of a larger picture that misleads us, both in theorizing about distributive justice and in making public policy decisions about it. Health is not the only thing that gets distorted in that larger picture, but it turns out to be the central one. The book manuscript discussed in the following papers develops this point in the following way.

The first step is to focus on the basic goods agreed upon by all plausible theories of distributive justice. One interesting consequence of focusing on them is that their very necessity for human life, both individual and social, suggests that our attention should first be directed toward the things that are necessary for producing, using, and sustaining those goods rather than toward the principles for distributing them. If we can’t get them in the first place, or can’t use them if we have them, questions about divvying them up are idle.

The second step is to notice the way that getting and using these basic goods is always connected to human development and human health—specifically to developing and sustaining various capabilities. Human beings are born massively underdeveloped, and require a long period of close care during which, in favorable circumstances, the requisite capabilities begin to emerge, or begin to be acquired. And this is a lifelong process: we need to continue to develop and sustain the capabilities necessary for acquiring, using, and sustaining basic goods. We need to be equipped for this continuous process, else we (and our attempts at justice in our social arrangements) will fail.

The third step is to notice that the concept of habilitation nicely captures this continuous process of developing and sustaining various capabilities. Habilitation is a venerable word, surviving in common usage in the term rehabilitation. Like rehabilitation, it simply refers to the process of equipping ourselves or others with capabilities or abilities. In the context of basic justice (the part about the list of basic goods all theories of justice agree upon), it directs our attention to the capabilities necessary for coping with life in a given environment, from a given physical, psychological, and environmental starting point. Which capabilities do we need? How many of them will emerge naturally, given our physical and psychological endowments and the stability of the environment we have? How many of
the remainder will emerge only if we acquire them through our own efforts? How many will have to be provided through social institutions?

**The fourth step** is to see how far the concept of habilitation can take us in clarifying the task of normative theories of basic distributive justice—not in a specific theory, or specific type of theory, but in such normative theories generally.

This fourth step is the main burden of the book. After a few definitional preliminaries, it is where the book actually begins. In the argument of the book proper I make some proposals that are, in effect, precursors to working out normative theories. They are meta-theoretical proposals, meant to reframe existing theories in order to improve the picture of the landscape they explore.

There are three main proposals.

**The habilitation framework.** One is a developed conception of habilitation—a conception rich enough to serve as a framework for normative theoretical work on basic distributive justice. This gives considerable attention to a redescription of the circumstances of justice, much enlarged from the ones standardly found in normative theories.

**Eudaimonistic health, and healthy agency.** A second concerns the role of health in habilitation. The argument here is that healthy in a broad sense is central to the habilitation framework: not health in the negative sense only (as in the absence of disease), but in the positive sense also (as in the presence of those physical and psychological strengths necessary for effective habilitation over a complete life). Moreover, there is an environmental dimension as well, since physical and psychological capabilities and functionings that are adequate or excellent in one range of environments may be inadequate or even lethal in others.

I characterize this form of health as eudaimonistic, since it seems closely allied with the conception of health found in those ancient ethical theories. I follow such theories (and contemporary developmental psychology) in thinking that the development of this form of health closely tracks at least the initial development of the virtues. And I also follow them in thinking that the development of a healthy form of agency is a central habilitative concern. Most of our ability to cope with the environments in which we find ourselves depends on such agency, which includes not only practical intelligence but certain prosocial dispositions as well.

**The health scale; robust health as the target for basic justice; and health as the representative good.** The third proposal has three closely related elements. First, I show that it is possible to construct an operationalizable, multidimensional scale for measuring eudaimonistic health. Next, I define a certain region of the scale—robust health, with special reference to robustly healthy agency. This has a clear upper bound well short of perfect health, yet it has comprehensive connections to all the other basic goods. This makes it an important target for basic distributive justice generally. And finally, I argue that eudaimonistic health can be used as the representative good for normative theories of basic distributive justice—replacing wealth and income, for example, as a way of identifying the worst off members of society, the next worst off, and so forth.

Most of the panelists at the APA session addressed this book manuscript either directly or indirectly. But in the best tradition of the Committee on Public Philosophy, speakers were many and speeches were expected to be short. Space here is even more limited, so we have only a selection of responses. But I think this selection gives a good indication of both the possibilities and pitfalls of my arguments as they now exist. I am deeply grateful to all the panelists—not just those represented here—for their help in my efforts to move the manuscript along toward eventual publication.

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**The Healthless Heterodoxy**

**Anita Silvers**  
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The greatest wealth is health.  
—Virgil (and Becker)

When a man is ill his very goodness is sickly.  
—Friedrich Nietzsche

I reckon being ill as one of the great pleasures of life, provided one is not too ill and is not obliged to work till one is better.  
—Samuel Butler, *The Way of All Flesh*, 1903

When asked whether they are hoping for a baby girl or baby boy, prospective parents often say, “We don’t care, as long as it’s healthy…” When asked how long they hope to live, older people often reply, “As long as I have my health….” These expressions reflect a commonplace about the value of health: Health is an important good of the highest priority.

The importance of health’s goodness is magnified, moreover, by another commonplace belief, namely, that realizing the value of other basic goods requires whoever seeks access to them to be healthy first of all. One version of the foundational role for good that health is thought to play makes it a sufficient condition for other goods. To illustrate, here is a Middle Eastern proverb that attributes such a power to health: “He who has health has hope; and he who has hope has everything.”^4^ And a similar idea prompted the eighteenth-century essayist Joseph Addison to observe, “Health and cheerfulness naturally beget each other.”^5^

In a different version of the foundational claim, health is proposed to be necessary for other important goods. Having one’s health has been claimed to be necessary for instantiating, enjoying, or taking advantage of other basic goods, whether these be material (such as food) or intangible (such as beauty), personal (such as education or liberty) or social (such as employment or association). To illustrate, John Locke issued the following warning: “If by gaining knowledge we destroy our health, we labour for a thing that will be useless in our hands.”^6^ To the nineteenth-century essayist Leigh Hunt, “The groundwork of all happiness is health.”^7^ In the overview of his new book prepared specially for this newsletter, Becker sums up this version of the primacy of health as follows: “Some level of good health is a necessary condition for almost everything we care about, both with respect to individual well-being and a sustainably productive, well ordered society.”

Philosophers thinking about medicine often append another seemingly commonplace idea to the conventional celebration of health as a central good. They take health (or, more precisely, engendering, improving, and preserving health) to be the medical profession’s aim. Public policy, the ensuing argument goes, should value healthcare services because health is a basic good. From the reputedly indubitable goodness of health, plus the (dubitable) hypothesis that (more) healthcare will cause (more) health, it thus has seemed to follow that respectable theories of distributive justice should assign access to healthcare comparative, and perhaps even categorical,

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priority over other goods, ones that people (at least, some people) more readily could do without or would turn down.

We should not, of course, be lulled into thinking that the apparent lack of controversy about the goodness of health signifies uniform agreement as to what health is. Health is both a neutral and a normative notion. In its neutral sense, health refers to an individual’s overall organic condition, and, of course, the processes that constitute that condition may be narrowly or broadly construed. In its normative sense, health is the soundness of that condition, however it may be construed.

In regard to normativity, there are several different ways of understanding how the idea of and facts about health can be a source of standards, prescriptivity, or regulation. Some theorists take the normative dimension of health to emerge from the neutral one, hypothesizing that the vitality of the human organism is constituted by natural processes which maintain it at an (approximately) optimal state as long as they work well. Here, neutral assertions about human biology are presumed to be preeminent, with normative claims supposedly reducing to them or at least not extending much beyond them.

Others believe that the normative dimension pervades the neutral one, in that social values are among the drivers for distinguishing desirable from disagreeable organic processes. On this approach, the normative aspect of conceptualizing health is enlarged and the neutral aspect shrinks. Here, the lines between the different kinds of organic conditions deemed pathological, normal, and optimal are held to be a function, at least in part, of diverse personal and social interests and policies rather than of distinct natural kinds. On this view, the apparently bright line dividing who is considered healthy from who is not comes from the placement of societal spotlights rather than from a natural inner glow.

What is sometimes characterized as “folk theory,” what I have been calling “commonplaces” of thought, is a third way of understanding the normative dimension of health. Simple observation of people’s behavior—especially by attending to what people say—can establish what we humans value, and on this basis we do appear to value our health as the commonplaces presented toward the beginning of this little paper suggest. Of course, only some of us do so thoughtfully, while others do so as an afterthought.

As a matter of methodology, agreement about the degree to which folk theory about the good of health should comply with medical theory, or conversely, medical theory should be responsive to what ordinary people think is good and bad health, is not robust. Some urge the medical profession to take the lead in improving the sophistication of public judgment about (un)healthiness, especially in regard to silent symptoms such as elevation of blood pressure or prostate-specific antigens. Others, however, object to the medical profession’s inflating ordinary people’s anxiety about who is health-deprived by designating comparatively low-risk biological states as pathological.

Regardless of which of the above positions about the connection between neutral and normative claims about healthiness is adopted, to say that medicine aims at health is to delineate the condition of the human organism as medical practice’s domain and the organism’s soundness as the achievement of its practitioners. And, of course, one expects those who practice to value the aim of their practice. Yet to be effective to ground principles, and for policy purposes as well, such agreement about a practice’s instrumental value must extend far beyond the practitioners themselves.

To illustrate, that teachers, the kind of people whose profession values learning, aim at improving others’ knowledge and skill does not establish general agreement about education’s being a good. Even the fact that schooling is institutionalized and is a practice supported by the state shows only that at some past time some individuals who valued educating everyone had political power to try to make it so. Similarly, the value medical professionals place on health may be idealized.

So we should look from a nonmedical standpoint to what I have been characterizing as commonplace commitments to better understand the contextualized nuances of claims that health is a good. When we do so what becomes clear is that, whether or not necessary for the realization of other goods, health is not itself intrinsically good. Health is, in other words, as dependent for being valuable on the right conditions obtaining as are the other basic goods that depend on health.

There are revealing contexts in which preferring not to have one’s health is understandable and rational, even if not necessarily agreeable. Here are some conditions under which not having one’s health, rather than the reverse, is a plausible desideratum. First, in cultures in which health is equated with being able-bodied, the apparent absence of signs of healthiness and presence of the reverse is a well-known strategy for individuals to gain support and obtain care from others. In some times and places people have mutilated themselves, disfiguring faces with acid or amputating limbs, to assist themselves in earning a livelihood begging. (Child beggars are starved so their health condition will appear precarious.) Second, cutting off a finger or shooting off a toe is a traditional way of making oneself ineligible for military draft. And third, as is well-known about Victorian times, women who feared the imposition of reproductive or other family duties could and did welcome various maladies and even invalidism to avoid them.

All the above heterodoxical cases are instances of individuals seeking freedom through injury or ill health: freedom from want, freedom from conscription, freedom from oppression of one’s body or soul. In these cases, health appears not as an asset but as a liability due to conditions of grave injustice. It is not the doers in these cases whose choices are pathological but instead the circumstances in which they have been placed. So despite being desirable usually or on the whole, health is not a categorical good. Health may be so as an ideal, but, as there are injustices that lead to health disparities in the neutral sense of the expression, there also are injustices that create disparities in the notion’s normative sense. The same level of health is not equally beneficial for everyone, and may even be harmful to some while privileging others.

This point about the defeasibility of health’s goodness under conditions of injustice contains an echo of why Kant is so stringent about how to establish a foundational good. Kant, we may recall, observed that while moderation usually is good, it is not so if its exercise permits injustice to reign. Noticing that other candidates for foundational goodness also are defeasible under some such conditions, Kant was drawn to the proposition that only the good will retains pure positive value regardless of circumstance.

Is it a happy accident, or more likely no accident at all, that for Becker healthy agency plays a not dissimilar role?

Healthy agency, as Becker describes this idea, enables us to respond to precisely the kinds of odd or difficult conditions that turn our values on their heads. Humans need healthy (in Becker’s usage of “health”) agency to cope with circumstances in which health (in folk or medical usage but not in Becker’s) is no longer a good, due to unfair distributions of liberty or of material support. As Becker puts it: “The necessity for recognizing and accommodating oneself to significant changes in one’s social or physical environment shows this in a pointed way, but there are many subtle, everyday ways in which impaired agency damages health generally.”
We may hold up Becker’s admirable strategy of building flexible responsiveness to changing conditions, and especially to altered personal and political contexts, into his picture of health as a foundational good against the brittle characterization of health some other philosophers have presented in arguing for health’s primacy for justice. Such theories recommend that policies for allocating public resources assign healthcare top priority. With this objective in view, health is defined narrowly by being equated with species-typical functioning. And, in turn, species-typical functioning is endowed with normativity by being identified as normal functioning.

Functioning as is typical for humans, as contrasted with anomalous functioning, then, is claimed to provide the greatest opportunity for selecting among the largest number of life plans. Next, democratic values are invoked to advance the premise of a public obligation to protect access to the full opportunity range equally for all, which requires all to be made to function normally. Not surprisingly given the argument’s motivation, healthcare, with its practices of repairing or remaking bodies and minds, is the obvious instrument for ensuring that people function normally. Thus, as this well-known argument goes, there is a democratic mandate for states to ensure that people equally are offered healthcare.

Cracks in this account quickly appear, however. For one thing, a fault line of relativity runs through the purported equation of functioning normally with having one’s health, because what is considered to fall within the range of normal functioning differs across times and places. Yet it seems counterproductive, on this view, to admit that whether individuals are healthy, or one is healthier than the other, is relative to the social contexts in which they are situated rather than to the state of the organism. That is because, if so, social services, rather than medical services, should have priority for public funds.

Second, and more important, the constraint placed on people by the circular arrangement of opportunity and normality is strangling. Whether opportunity is reserved for normal people, but denied those with physical or mental anomalies, often is traceable to society’s exclusionary arrangements rather than their unorthodox organic conditions. Of course, normality-catering social policies reject organically anomalous people, and such social policies in turn beget normality-catering understandings of health. Normality-catering standards for health in turn dictate medical intervention rather than broader societal change to resolve mismatches between individuals’ organic states and the opportunities they wish to access.

As Becker says, there is something wrong with this picture. And so, happily, his developmental account of healthy agency presents a very different picture from the craggy caricature of health as normal functioning. He discusses in detail what capacities humans need to develop in order to, if not be all we could be, at least to have a life. And he carefully shows how such development can be treated as a foundational good for various purposes without this valuation being exploited for institutional aggrandizement.

In this spirit, Becker’s picture enables health to be recognized as the aim of medicine without being reduced to a medical model. He also establishes that conceptualizing health as a developmental process will support scaling for purposes of distributive theory. And because health is a process rather than just an end state, it can manifest both as ideal and partial realization for the same life. All these achievements are to be found in Becker’s elegant and erudite discussion.

Most important, Becker’s conceptualization of health is compatible with the facts of our lives. The centrality of healthy agency in his account allows for health to be a foundational good, and yet for being healthless (or deficient in health) to be a reasonable choice under some conditions. This is the picture of health we need, I think, to build a theory of justice that integrates medicine with other relevant domains of practice, giving this institution its due without licensing it to dominate.

Endnotes
2. Ibid.
3. Ibid.
4. Ibid.
5. Ibid.
6. Ibid.
8. Cases of individuals who are gratified by being ill or being disfigured, such as the people called apotemnophiliacs, are not included among my examples here to avoid an extended discussion of whether conditions some label as pathologies can ever have positive value.

Lawrence Becker and Emotional Health in the Stoic Tradition

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I wish to address emotional health, a topic which surely cannot be left out of today’s project on the elements of healthy agency. The manuscript of Lawrence Becker’s forthcoming book, Habilitation, Health, and Agency, identifies some areas of concern:

• emotionality as part of the “standard equipment” of the human personality (in Chapter Two, p. 43);
• the role of emotions in agency (in Chapter Three, pp. 59-60);
• making the account of eudaimonistic health at least compatible with ordinary notions of happiness as a state rich in positive affect (later in Chapter Three, pp. 98-99).

It seems the habilitation model Becker uses ought to do as much as can be done in a neutral, cross-platform mode to provide a basic conceptual apparatus for addressing those aspects of emotional life that might come into theories of distributive justice. It ought to say at least what the word “emotion” refers to; how the emotions, whatever they are, play a role in agency; what emotional health might be; and how habilitation can promote that. It also needs to respect the widely shared intuition that the well being distributive justice seeks to promote ought to be a state rich in positive affect.

Now Becker and I share an interest in ancient Stoicism—although we come to it from different directions—and I was not surprised to see the Stoics invoked in this manuscript, along with Aristotle, as providing a precedent for its general approach. Of course, the appeal can only go so far: the Stoics are well known for holding very definite normative commitments grounded in theological and cosmological postulates hardly any philosopher would now accept. Becker’s intuition, though, and I think it is a good one, is that ancient eudaimonistic systems, even antecedent to their various normative positions, lay out a framework for philosophical inquiry that is quite similar to what he has in mind with habilitation. From this perspective Stoic thought can be quite helpful to him. For that school did a great deal to establish parameters for where to situate affectivity
within ethical systems. They do this both through definitional ventures, developing workable basic concepts of affective response, affective traits, and emotional health, and through descriptive ventures, recording observations of what human nature is, how agency works, and what means of habilitation are most effective. Becker has been over this terrain in his other work; but the task of sorting out what exactly is usable for this project is a complicated one, and not yet finished.

What I do here, then, is sketch a few features of the Stoics’ treatment of the emotions that seem to me especially relevant to Habilitation, Health, and Agency. I do this as a list of five key moves, with some brief indications as to how these interact with the norms of Stoic ethics. Three of these, the first three, are moves Becker also makes himself, and needs mainly to work out in more detail. The last two are perhaps more awkward for him, though I have no doubt he will be able to find satisfactory ways of dealing with them.

1. Identify the phenomena under consideration.

Contemporary discussions of affectivity have long acknowledged an initial problem of demarcation. While familiar terms like “anger,” “fear,” and “grief”—let’s call them E-terms—can be useful in picking out core instances of emotion, the list of readily agreed upon emotion types quickly runs out: should sexual arousal, or curiosity, or confusion, be considered an emotion? Are there emotions without names? And even with a perfect list of E-terms, one would find difficulties mapping the phenomena onto the list: Is this feeling an instance of fear?

The Stoics put considerable thought into devising definitions for the emotions that would accurately describe our subjective experience of them. Their point of entry is to establish a domain of affective phenomena within which the emotions are to be found. Without yet making any use of the E-terms in their language, they create a list of terms to refer to the subjective sensations that are most often reported by those who have been through some strong emotion. The Stoics’ list sounds odd in English (and hardly less so in Greek): they speak of “uplifting,” “contractions,” “extensions,” “outpourings,” “withdrawings,” “lowerings,” and “bitings.” All of these are assumed to have some sort of physiological basis: in the language of the Stoics’ armchair biology, they refer to some sort of change in the size and shape of the psychic material, which, being inherently sensitive, has the ability to register its own movements. For instance, the inner sensation of “contraction” refers to some sort of inward movement of the material psyche and also to the feeling one has when the psyche registers its own movement. The list of all such terms constitutes a domain of affectivity in that a response that involved none of them would not be an affective response.

But not everything that belongs to the affective domain is a full-scale affective response. Each of the Stoic definitions for what they call pathē (“emotions”) or eupatheiai (“good emotions”) stipulates that in order to count as such, the “contraction,” “shrinking,” “teaching,” etc. must have been produced through a particular cognitive process. A “contraction,” “extension,” or the like could occur in the absence of any judgment, but that low-level feeling is not an emotion by this definition. Cases like the panic attack in Aristotle, De Anima 1.2, that occurs without any thought of prospective evil, would be treated by Stoics as non-affective, like a heart rate elevated from running. By contrast, a full-scale affective response always depends on a judgment that something which the agent believes to be good or bad for herself has just occurred or is about to occur. For instance, the “contraction” that is distress represents a judgment that something one believes bad for oneself, say the loss of a wallet, has just occurred. It is an emotion because of the way it is generated, not because of the way it feels.

Still, the way it feels—the “contraction” itself—cannot be left out of the account altogether. For in fact we do experience some affective sensation every time we determine that objects we consider good or bad for ourselves are present or in prospect. If you could realize that the wallet was lost without having any feelings about the matter, then an observer would be justified in saying that you did not consider the loss a bad thing. That is, the concept of what it is to attach real value to something includes, in human beings anyway, a disposition to respond affectively to it. Affectivity tracks ascriptions of value. And this is not a normative claim; it is just a description of how human beings operate.

2. Identify the feature of affective responses that makes them relevant to agency.

The chief advantage of setting the boundaries on E-terms in this way is that it does a great deal to elucidate the role emotions play in agency. The connection between emotionality and moral action is a major concern of Becker’s. He mentions especially the violent and destructive emotions and the flat affect of the psychopath, but positive emotions are also a concern for distributive justice.

Emotions on the Stoic account are agency-relevant by definition: they are generated by a process of practical reasoning just as actions are. Indeed, on the full Stoic account affective responses are themselves actions: each of the affective predicates like “extending” or “contracting,” when it comes about through judgment, is something the psyche does, and striking someone in anger is just an instance of the psyche “extending” toward retaliation when it judges that to be a good. What arises through judgment arises through assent, and assent in the practical realm is the criterion for volitional action.

The obvious objection is that affective responses usually do not feel like volitional actions; they feel like something that comes over us beyond our control. Here is how the Stoics respond to it. They concede immediately that the low-level affective phenomena are not relevant to agency: action expresses cognitive commitment. But they maintain that those responses that involve a definite judgment are part of agency even though many people report feeling helpless before them. The miser enraged by an attempt on his wallet is more than a victim of circumstances. He may indeed feel himself carried away by his reaction, unable to put a halt to it, or, as we would say, “flooded”; for that, an explanation does need to be supplied. But one can supply such an explanation without compromising the main point about rational agency.

3. Identify a robustly healthy condition with respect to affective response.

When we speak of health, we shift our attention away from emotion events—physiological changes occurring at specific times in response to circumstances—and over to affective conditions: characteristics, dispositions, states, or traits that remain with a person through a variety of situations. For the moment we can just say that anything about a person that disposes her toward some discernible pattern of affective responses is an affective condition of that person.

I proceed with caution. The ancient Stoics’ account of what they call “health” is heavily freighted with their version of normativity—virtue is the only good for a human being—and is also starkly idealistic: it has to be perfect virtue. This is much more than Becker is looking for when speaking of robustly healthy agency. If, however, we come in on the ground floor of the Stoics’ treatment of emotional personalities we can see how their way of describing emotional response allows for a much more generally applicable standard of emotional health than the one to which they themselves are committed.
Because their definition of affective response gives a central role to judgments involving value terms, the first point of reference should be the truth or falsity of those judgments. It is at least initially plausible that the affective responses of a healthy agent would be ones that express true and justified notions of value. Health should be, at the very least, a disposition to respond emotionally to those objects that really are good or bad for oneself, and only to those. One can say this much without yet having taken a position as to which notions of value are correct.

For Stoics, the schema works out as follows. Judgments generally are regulated by prior beliefs that one holds; more specifically, the judgments involved in affective response are regulated primarily by the prior beliefs one holds concerning the goodness or badness of certain objects. Let’s talk about Euclio, the miser in Terence’s play. His belief that money is good for him is also a trait of character predisposing him toward positive affective responses when he finds he has gained money and negative ones when he finds he has lost it. The Stoics’ normative position, though, is that the only objects that can be truly good or bad for Euclio are features of his own character or conduct—objects integral to his own sphere of agency. His conviction that money is a good is false on their estimation and thus, using the truth of judgments as the point of reference, it is part of ill health, and the affective responses it generates are the inherently flawed pathē. Such a belief when deeply ingrained in the belief set is called by the Stoics a nosōma, a diseased affective condition. Conversely, the Stoics also envision a perfectly wise agent, one who attributes values correctly and infallibly and therefore believes only that things like courage and right behavior are goods. This conviction of the perfect agent will generate proper affective responses, called by them eupatheiai. For instance, the sage will feel a visceral revulsion at the idea of cheating an opponent and vigorous joy in dying for her country. The condition that disposes her to such responses is what Stoics regard as a perfectly healthy affective psychic condition.

But the story does not end there. Between the diseased agent and the perfect agent is a progressor agent, one who is well on the way to virtue but has not yet arrived. This third agent mainly agrees with the sage about where value lies, but his judgment remains fallible and his commitment to it is at best insecure: he believes that right action is good, but he does not know it. In the Stoics’ own terminology even the advanced progressor is still unhealthy—the term health is reserved for perfect health, and that depends on unshakeable knowledge. Yet even some Stoic authors admit that a person may be rid of all emotional “diseases” and safe from reversion to them. This does look like the robust health Becker has in mind.

4. Show that habilitation toward healthy condition is a possibility.

The main work has already been done. To the extent that the emotions essentially involve fully conceptualized ascriptions of value (and are not merely “modulated by” them), they will also be amenable to habilitation by any sort of teaching, training, or modeling that alters those dispositional beliefs. What is not subject to habilitation is only the lower tier of affective phenomena, i.e., the involuntary feelings that do not depend on judgments; these have already been excluded as not relevant to agency.

More needs to be said, though, about the prospects for effecting an alteration of the beliefs that play the largest role in disposing us toward emotional responses. Becker makes much of a process called oikeiōsis or “appropriation,” which is identified in some Stoic texts as the usual mechanism of human development toward rational agency and eventually toward the moral virtues. In a best case scenario “appropriation” supplies a gradually increasing sense of investment in one’s environment, in human relationships, and in correctness of action and judgment, leading eventually to an absolute commitment to rational conduct for its own sake. If that is how human development works, regularly and reliably, then the prospects for building a just society, one way or another, seem fairly good: people need only to be freed of such defectors as ill health or abuse and allowed to develop to their full potential. The ancient Stoics, though, were rather less optimistic than Becker’s account implies at this point. Interfering with the ideal course of development is a second process they call diastrophē or “corruption.” This is a combination of cultural influences and interpretive mistakes made by the immature mind as it works out its map of moral conceptions. The result of this second process is that even well brought up people’s conceptions of good and evil are invariably malformed, with the results that we see both in conduct and emotional response.

This is not to rule out the possibility of habilitation. The ancient Stoics did hold that moral progress is possible, and even perfectible; but it is likely to be a lengthy and agonizing process, as the maturing mind struggles to free itself of its early mistakes and then to swim upstream against all the pressures of the surrounding culture. A large investment of resources will be required, both the progressor’s own and of teachers and advisors.

5. Show that the account of health satisfies common intuitions as to what happiness is like.

Becker expresses a concern that a habilitation framework will give some very significant role to what he calls a “purely psychological” conception of happiness as a state laden with positive affect. He cares about this both for certain substantive reasons, such as the influence of positive affective states on decision-making, and because this is the conception non-philosophers are most likely to recognize and care about—an important consideration if they are to cooperate in their own habilitation. This is a point of concern for the ancient Stoics as well. They are careful to insist that their account of the ideal or normative life does give rise to either constant or at least very frequent positive affect. The life of the sage in this system is a life crowded with goods, goods of friendship and conviviality as well as of noble thought and action, and the sage’s awareness of all goods yields a rich affective life with many feelings of gladness and mutual appreciation. The condition of perfect health is thus a life full of joy.

Our question though was not about perfect health but about what we (not they) have called robust health. Does the imperfect but well-developed progressor have access to the same kinds of positive affect as the perfect sage? For the ancient Stoics, the answer is no. The progressor gets goodness right and thereby recognizes that she is without it; she is indeed a rather earnest character, not a happy person in the ordinary sense. Becker is not bound to agree with them in this, but he’ll need to offer some account of how a person can be morally serious and at the same time content with a sub-optimal stage of moral development.

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Becker makes it his goal to clarify a set of background conditions and basic concepts that might be adopted by any account of distributive justice and to do so in a way that is “as uncontroversial and philosophically innocent as possible.” I have tried to cooperate by drawing on the conceptual apparatus of ancient Stoicism to fill in some specifics regarding emotional response and emotional health. In particular, I have hoped to
nudge Becker toward a clearer definition of what does and does not count as emotional response, a definition that will perhaps leave some of what we usually call emotion out of consideration. I’m also reminding him that corruption, as well as oikeiōsis, needs to be part of his developmental account, and that robust emotional health as Stoics are able to describe it may have trouble generating much positive affect. I have tried to bring out the philosophical appeal of some of the ancient moves without thereby loading the dice in favor of the Stoics’ own account of distributive justice. But even these preliminary issues definitely test the applicability of Stoic modeling to the meta-theory of justice in a modern frame of reference.

Some final questions about the project his manuscript represents:
1. Does the Beckeran habilitation framework define “emotion” in the way the Stoics do, i.e., as a cognitively mediated response relevant to agency?
2. Does Becker’s description of ordinary habilitation make sufficient allowance for misconceived notions of what objects are to be regarded as good and desirable?
3. How does the Beckeran account respond to the objection that ordinary social “appropriation” predisposes us to favor those who are familiar to us without consideration of even distribution?
4. If Becker assumes a Stoic model in which the presence of many integral goods supplies the condition of perfect psychological health with abundant positive affect, can he also construct an account of robust health which will include sufficient positive affect to satisfy ordinary notions of happiness?

I hope that Becker and others interested in his project will be able to resolve them to their satisfaction.

Endnotes
2. Just for clarity: these changes are not quite analogous to the autonomic responses of our affective science, things like galvanic skin response, increased heart rate, or release of hormones from the pancreas. The Stoics’ affective predicates are posited explanantia, not empirical observations. They may also be invoked to explain somatic changes like trembling, paleness, or tears, but that is a further explanatory step.
3. The ancient Stoics do not, I think, agree with Becker that it is possible to hold the beliefs ordinarily implicated in a given emotion without experiencing that emotion (“Stoic Emotion,” 252). One could certainly hold some of them—but much depends on having a full specification of what beliefs are required. Given the Stoics’ unified psychology of action, it seems that anyone who believes, and gives salience to the beliefs (1) that losing a large sum is an evil for himself; (2) that when an evil has befallen him it is appropriate for him to be distressed [i.e., to “contract”]; and (3) that a large sum has just been lost; will invariably have the full affective response.
4. Think of nepotism, or of the inside candidate favored above his credentials in many an academic search. Unfortunately, it would seem to be the very process of social oikeiōsis (section 5 below) that gives the unfair advantage in these cases.
5. In brief, the explanation has to do with discordance among one’s action-guiding beliefs. Having judged at time T that the anger-response is appropriate because something has occurred to engage my deeply held views of what is good and bad for me, I am not free at time T+1 to back out of that judgment, even if I then judge that it is better not to be angry. The anger at T overrides the stopping impulse at T+1.
6. The best text is Seneca, Epistle 75.8-13. As the passage is of special relevance for Becker I will break my own rule and include it here, in unrevised translation: “The one who is progressing is indeed counted among the foolish, and yet is separated from them by a considerable interval. Even among progressors themselves there are important distinctions to be made. According to some they are divided into three types. First are those who do not yet possess wisdom but have set their feet in that vicinity (for being nearby is still being outside). Do you ask who these people are? They are those who have put aside their emotions and their faults, but whose loyalty is still untried. They do not yet possess their good in such a way as to use it; nonetheless, it is no longer possible for them to fall back into those things they have left behind. They are now in that place from which there is no backsliding, but they do not yet realize this about themselves. As I remember writing in one of my letters, ‘They do not know that they know.’ Already it is their lot to enjoy their good; to be confident of it, not yet. Some authors delimit the abovementioned category of progressors in such a way as to assert that they have now rid themselves of the ‘sicknesses of mind’ but not yet of the emotions, and that they are still in danger, since no one has got beyond peril of wickedness but one who has shed it altogether, and no one has shed it altogether but one who has put on wisdom in its place. The difference between ‘sicknesses of mind’ and emotions is something I have explained more than once. I will remind you now as well. The sicknesses are faults that have become ingrained and hard, like greed and ambition. These are conditions which bind the mind much more tightly and have begun to be permanent evils of it. To give a brief definition, a ‘sickness’ is a persistent judgment in the wicked to the effect that certain things are very much to be pursued which in fact are only slightly worth pursuing. Or, if you prefer, we can define it this way: it is being overly concerned with things which one ought to pursue either casually or not at all, or considering something to be of great value when in fact it is either of some lesser value or of no value at all. The emotions are perverse movements of the mind which are vigorous and hasty. These, when they occur frequently and do not receive any treatment, cause the sickness just as a single cold in the head, if it is not protracted, brings on a state of health which
7. Though perhaps not for the same reasons, or not directly so. The usual concern of the Stoic authors is to combat the intuitive appeal of philosophical hedonism.
Perceptual Habituation and Image Interpretation in Neuroscience

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For my contribution to this discussion on neuroimaging techniques and human nature, I consider how human nature factors into everyday neuroimaging practices. More specifically, I offer an account of how phenomenological insights into human perception can be useful to scientists engaged in debate over image interpretation. This account is articulated below through the analysis of a long-standing debate in neurobiology over images of nerve samples prepared through an elaborate freezing process. I begin with a review of some of phenomenology’s most basic claims about human experience, and relate them to on-the-ground anthropological and historical work on microscope use and scientific image interpretation.

Phenomenology and Image Interpretation in Science

Martin Heidegger’s influential account of tool use and breakdown is helpful for calling attention to some of the most basic patterns of experience at work in human relations to technology (1953, 65). As a guiding example, he describes the experience of using a hammer. For a person deeply accustomed to using this device, her or his experience is organized in a particular way; as she or he hammers, the device itself withdraws into the background of the user’s awareness. The user is occupied with the work being done with the technology, rather than on the technology that makes the work possible. At this general level of description, Maurice Merleau-Ponty makes a similar point not about work, but on the nature of perception. He says, “the perceptual ‘something’ is always in the middle, it always forms part of a ‘field’” (Merleau-Ponty 1962, 4). That is, perception occurs with a figure/background structure. The thing one is looking at is presented against a background of which one remains less aware.

Anette Forss’s ethnography of cytology lab work can be interpreted in terms of these general phenomenological points (2005). She studies the everyday work routines of Swedish microscopists who analyze pap smear samples, screening for cervical cancer. This involves moving slides under the microscope and visually scanning for anomalous cells. Forss describes the microscopists’ experiences, “They talked about detecting a change, or perceiving a contrast in a pattern. Abnormal cells were described in terms of those that ‘stick out’ (‘poppar upp’ in Swedish)” (Forss 2005, 112). In the experience of these microscopists—experience which is deeply contextualized by preconception, focused task, and bodily and perceptual habituation—the anomalous cells stand forward with special significance.

Heidegger, of course, continues in his account of tool use to describe the user’s experience in the case that the tool one is using suddenly breaks. He claims that in such an instance of technological breakdown, all of a sudden this device which had remained in the background of the user’s awareness now instead stands imposingly at the forefront. The user becomes explicitly aware of the device itself (e.g., a broken hammer in her or his hand), as that device now obstructs the very work it had just previously made possible. Historian of electron microscopy Nicholas Rasmussen describes this phenomenon in terms of laboratory instrumentation. He says, “when an instrument malfunctions in a way that the microscopist cannot easily fix or does not understand, vision through the microscope becomes clouded impairing the embodiment relation and thus highlighting the machine’s former transparency. The instrument’s identity as not-self becomes evident, its alien quality intrudes and demands that attention be focused on it, rather than on what one was doing with it” (Rasmussen 1997, 230). Anthropologist Michael Lynch makes similar observations about the everyday practices of neural scientists using electron microscopes and interpreting images. Lynch uses the term “trouble” to refer to artifacts within images which call attention to the imaging processes themselves, rather than allow those processes to remain in the background of awareness. He says, “In lab work, the essential artifactual possibilities exhibited in the constructive horizons of a photograph are incidental and uninteresting except insofar as they provide circumstantial “troubles” for any ongoing project” (Lynch 1985, 120).

In what follows, I want to take these observations in a different direction. I want to consider a context in which it can be useful to purposefully highlight the actions of imaging technologies, and to discourage their tendency to remain in the background of awareness. The context I propose is scientific debates over image interpretation. In this context, I claim that it can be useful at times to highlight the background assumptions regarding imaging technologies which inform the rival positions of the debate. I recognize that terms like “trouble” and “breakdown” have strongly negative connotations. Nevertheless, here I want to articulate a kind of productive trouble, a useful breakdown of user relations to laboratory technologies. The point here is methodological: to develop concepts which can be useful for everyday scientific practice in their potential to emphasize user relations to technology.

Two further phenomenological concepts are necessary for this project. The first is Don Ihde’s claim that perception, and also human relations to technology, are multistable (1993, 37 and 77). The notion of multistability draws out two phenomena at once. On the one hand, this notion points out that humans can relate to the world through the mediation of a technology in multiple ways through multiple contexts. A technology used to do one thing in one context may also be used to do something else in a different context; using a technology can mean different things to different people. On the other hand and at the same time, the material specificity of the technology limits how these relations can occur—only some relations between the user and the technology will be stable. Think again about the use of a hammer. Ihde says, “It could, and perhaps is dominantly used, for its designed purposes, to hammer. But it could be used as a paperweight, an objet d’art, a murder weapon, a pendulum weight, a door handle, etc. This ambiguity of uses is, however, not indefinitely extendable” (1993, 37).

Through a series of papers, I have argued that images in science are also examples of multistable technologies (e.g., Rosenberger 2008; Rosenberger 2009; Rosenberger forthcoming). This occurs in terms of an image’s capacity to support multiple perceptually stable relations with users. We see this in scientific debates over image interpretation. Each side of a debate interprets the image to be consistent with its own theoretical account. Each side offers a different perspective through which one can perceive a contested image. Note that my claim here is made only in terms of the rival interpretations of the technology itself—the image. This does not imply that conceptualizing scientific images as multistable leads one to hold that rival theoretical accounts are all correct about the world, but simply that they each potentially enable a different coherent perceptual apprehension of the image.

The second phenomenological concept important here is the notion of “hermeneutic strategies,” which I have
developed to refer to the interpretive approach one brings to an image that enables a particular stable perceptual relation (e.g., Rosenberger 2008; Rosenberger 2009; Rosenberger forthcoming). The hermeneutic strategy through which one relates to an image determines which aspects of the image are perceived with significance (or which aspects “poppar up” as the Sweedish microscopists would say), and which instead constitute the background of the perceptual field. A hermeneutic strategy is the perceptual habits, the preconceptions, and the context of understanding that enables much of the content of a multistable image to gestalt in terms of a particular stable perceptual relation.

In scientific debates over images, the hermeneutic strategies are constituted by the rival scientific theories which purport to explain the images under contention. These hermeneutic strategies contain many features, some explicit, others implicit. For example, each provides an account of the perceptual content of the contested images, including which parts of the image are important, and how they relate to other parts. Each is also often informed by positions on a variety of relevant non-imaged data. And each, I claim, explicitly or implicitly possesses an understanding of the imaging process—the instrumental procedure through which the otherwise imperceptible object of study has been transformed into a perceivable image.

Imagine a debate between two scientists over how to interpret an image of an object of study which has been enlarged by a microscope. Their debate could ultimately rest on many things, such as differences in each scientist’s theoretical account of the object of study captured in the image. Another thing it could rest on is implicit or explicit differences in each scientist’s understanding of the imaging process, that is, the procedure through which the imperceptibly small object of study has been transformed as it was enlarged and thus made possible to see. Relevant factors here include the preparation process to which the object of study was subjected as it was readied for the microscope—isolating it, moving it to a microscope slide, perhaps staining it. Of course, the understandings of the microscope and camera technologies are also relevant, as are understandings of the implications of transforming the three-dimensional object of study into a static, segmented, enframed, two-dimensional image.

This framework of phenomenological concepts can be applied to scientific debates over images for the purpose of highlighting these sorts of human perceptual relations to laboratory technologies. I claim that explicitly conceptualizing disputed images as multistable can bring about a kind of productive trouble, a useful breakdown, which calls attention to the various features of the rival hermeneutic strategies of the debate. Those features which typically remain in the background of perception, such as the relations to imaging instrumentation, are drawn forward for inspection. This facilitates the critical contrast of these otherwise typically backgrounded features.

**Debate over Images of Neurotransmission**

To demonstrate the potential of this phenomenological framework, I continue with a review of the central case study through which I have developed this perspective (Rosenberger 2009; Rosenberger forthcoming). In this example of an ongoing scientific debate over image interpretation, neurobiologists disagree about the nature of neurotransmission, specifically the process through which a neuron releases transmitter into the synapse.

It is known that neurotransmission occurs through the action of tiny, clear, spherical organelles called synaptic vesicles. Synaptic vesicles reside within a neuron terminal and are filled with neurotransmitter. When the neuron releases its transmitter into the synapse, this occurs through a process in which the synaptic vesicles fuse to the terminal membrane, depositing their contents through to the other side and thus out of the cell. For more than thirty years, neurobiologists have disagreed about the process by which this fusion happens, and I refer to this disagreement as “the synaptic vesicle debate.”

The synaptic vesicle debate is composed of two major positions, the Heuser model and the Ceccarelli model. The Heuser model, advanced by John Heuser and his colleagues, holds that synaptic vesicle fusion occurs as a vesicle attaches then completely flattens out into the membrane (e.g., Heuser and Reese 1973; Miller and Heuser 1984; Takei et al. 1995). The fusion cycle is complete when an entirely new vesicle buds and separates from the membrane at a completely different location. The Ceccarelli model, advanced by Bruno Ceccarelli and his colleagues, instead holds that vesicle fusion involves the temporary attachment of a vesicle to the membrane (e.g., Ceccarelli et al. 1973; Torri-Tarelli et al. 1985; Fesce et al. 1996). According to this view, after the vesicle has released its cargo, it detaches there in the same location, and it remains intact.

A major component of this debate has been the disagreement over how to interpret images of synaptic vesicle fusions. Because the process of vesicle fusion occurs extremely quickly—in a matter of milliseconds—these researchers invented a procedure called “quick-freezing” to freeze samples almost instantaneously. This procedure includes the use of a device called the cryopress, or “slam freezer,” to freeze the sample at the desired millisecond. Then the membrane of the neuron is marked with metal (such as through staining or coating) so that it can be perceived through the electron microscope. Samples which are quick-frozen during neurotransmission yield images of vesicles fused to the terminal membrane. These images of fusions display vesicles which have been caught in the act—frozen while depositing their transmitter through to the other side of the membrane. If, for example, we take a neuron that has been quick-frozen during neurotransmission and we thinly coat the outside surface of the terminal membrane with metal, the image created will reveal crater-like structures. These craters are widely interpreted to be those spherical synaptic vesicles fused with the membrane.

While all involved agree that such images provide evidence that synaptic vesicle fusion is responsible for neurotransmission, debate continues over the exact process through which fusion occurs. There remains disagreement over exactly what each individual fused vesicle has been caught in the middle doing, and what each individual crater shape would look like it had only been frozen a moment later. This is to say that debate remains over whether to interpret these images in terms of the Heuser model or the Ceccarelli model. Where the Heuser model would predict that the fused vesicle would continue to collapse and flatten out into the membrane, the Ceccarelli model would predict that the fusion would close up as the vesicle detached from the membrane there at the same location as fusion. With this case of a set of images that can be coherently perceived in terms of rival theoretical models, I offer an example of multistable images in science. (For a more detailed history of this research, see Rosenberger 2009; Rosenberger forthcoming.)

The Heuser and Ceccarelli models comprise the rival hermeneutic strategies offered for these images. They each include features such as instructions on how to read the images’ contents, and positions on related non-imaged data, such as studies of the electro-chemical readings accompanying neurotransmission. They also each include, at times more or less explicitly, accounts of the implications of the neuroimaging techniques through which the imperceptible objects of study
are transformed into perceivable images. Such transformations include, for example, enlarging the otherwise too-small-to-see neurons through electron microscopy, and the shading and shadowing of samples to make their textures visible in the two-dimensional images. However, I suggest that the central transformation informing the synaptic vesicle debate is one of a temporal nature: the too-fast-to-see process of vesicle fusion is transformed into single moments of that process through the quick-freezing technique. The contours of the debate are deeply informed by the consequences of this transformation, and by researchers’ creative efforts to address the creation of images of samples frozen at different microsecond intervals.

Over the course of the 1980s, the Heuser model emerged as the more dominant view, in Lakatosian terms becoming the progressive research programme compared to a degenerating Ceccarelli programme. However, the 1990s saw a resurgence of the Ceccarelli model when the late Ceccarelli’s students unveiled a modified version of the account. This new version maintains the central claim that synaptic vesicle fusion occurs through the temporary attachment of a vesicle to the membrane, and adds further that this fusion occurs through a specific chemical structure called a “fusion pore.” They give the new model the name “kiss-and-run,” and this position continues to gather evidence and offer challenge to the also still advancing Heuser position (e.g., Fesce et al. 1996; Valtora et al. 2001). It is the kiss-and-run model which I have suggested is primarily presented with new questions when the images of this debate are reconceptualized as multistable.

If these images are considered in terms of their multistability, and each position of the debate is thus taken to possess a different hermeneutic strategy, it can be asked how the features of the implicit hermeneutic strategy offered by the kiss-and-run model appear when juxtaposed to those of the Heuser and Ceccarelli models. It becomes clear that while the kiss-and-run model is certainly generating new studies and evidence, work still needs to be done to determine the degree to which images generated through the quick-freezing technique support the kiss-and-run position. It is generally assumed that any evidence that supports the Ceccarelli model also supports the kiss-and-run account. But is it really the case that all the crater-shaped divots in the kinds of images described above should be considered to be instances of fusion pores? Also, with regard to the Ceccarelli model’s account of the temporality of vesicle fusion (i.e., at what milliseconds after stimulation vesicle fusion occurs in terms of this account), should the kiss-and-run model also be understood to operate on this same timetable?

These questions, I suggest, are important for the development of this scientific theory. And I offer these questions as a kind of evidence for the usefulness of the phenomenological perspective on imaging developed above.

References


So Lucky to Be Here

Felicia Nimue Ackerman
Brown University


My daughter keeps telling me
I am so lucky to be here.

She means instead of
in her five-bedroom home,
Which always has space
for another child
But not for a grandmother
in a wheelchair.

I am so lucky to be here.

My room is yellow as the sun,
Which warms my face
When I roll out onto the porch
And endure people
I have nothing in common with
Except age and abandonment.

For so long I dreaded
being shut away from the world.

But I am so lucky to be here,
The best nursing home
in Rhode Island,
Instead of where I would be
if people knew
That what killed
my unfaithful husband

Was not an accident.

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**BOOK REVIEWS**

**On Ending Life Pragmatically**


Reviewed by Mary B. Mahowald

University of Chicago

A century ago, Giovanni Papini claimed that pragmatism is indefinable, Arthur O. Lovejoy offered thirteen different versions of the term, and F.C.S. Schiller remarked that “there might be as many pragmatists as there were pragmatists.” Different accounts of pragmatism by classical American philosophers support all three views. It is this diversity that may have led Charlene Haddock Siegfried to define pragmatism historically rather than substantively as “positions developed in dialogue with the philosophical tradition of American pragmatism.” Obviously, this definition sheds little light on what the different positions developed within the tradition entail.

In _End-of-Life Care and Pragmatic Decision Making: A Bioethical Perspective_, D. Micah Hester provides a substantive version of pragmatism by drawing mainly on the writings of William James and John Dewey, supplementing this with references to the social psychology of George Herbert Mead. James’s account of radical empiricism is the philosophical core of Hester’s pragmatism. For James, he says, this approach involves three essential claims: “all experience matters, experience is wherein value arises, and the whole of moral experience is not available to any one person” (19). The communal aspect of experience (more fully developed in Dewey and Peirce than in James) emerges from the tie between the first and third claims: values arise within communities as individuals draw not only on their own experience but also on the experiences of others, thus reducing the inevitable limitations (cf. Jamesean “blindness”) of their individual perspectives. The narrative aspect draws on James’s description of experience as a “stream” that is continually flowing and fluctuating (9). Different and ongoing life stories figure pivotally and relevantly in everyone’s ethical decision making in all areas of their lives.

While addressing ethical issues at the end of life, Hester emphasizes “lived experience” as communal and narrative in nature. For him, as for Dewey, pragmatism is an extension of historical empiricism into practical, future-oriented decision making. This perspective is evident not only in Hester’s other writings (e.g., _Community as Healing: Pragmatist Ethics in Medical Encounters_, 2001), but also in his role as a clinical ethicist at Arkansas Children’s Hospital and in his innovative and successful effort to develop a Pediatric Ethics Affinity Group within the American Society for Bioethics and Humanites. Currently, Hester is Associate Director of the Division of Medical Humanities and Associate Professor of Medical Humanities and Pediatrics at the University of Arkansas.

Hester introduces his pragmatic positions with Plato’s description of how Socrates addressed his own impending death—in a manner that was integral to the narrative of his life. The fact that “living continues unto death” (9) makes dying a part of everyone’s life story. Accordingly, everyone should be allowed, and assisted if necessary, to write the last act of her own life. Hester refers to this process as “engaged dying (8-9).

From the standpoint of radical empiricism, Hester considers three distinct groups of dying people: those who are still conscious and capable of making their own informed and autonomous decisions, those who are no longer capable of such decisions, and those who have not yet or will never be capable of informed and autonomous decision making. In the last category, he focuses on seriously impaired newborns.

With regard to competent and conscious dying persons who are clearly capable of writing their own last act, Hester argues that they ought to be given access to the means by which to hasten their own deaths. When dying individuals are no longer capable of decision making, those who make decisions on their behalf ought to make them in accord with their previous life’s narrative. With regard to seriously impaired newborns, for whom the possibility of authorship of their own life story is obviously impossible, Hester believes that “aid in the dying process...should be focused on palliative practices” (150).

Unfortunately but understandably, Hester fails to consider dying patients whose capacity for decision making is indeterminable or limited, and those whose previous life stories are scarcely or wholly unknowable. Yet the majority of ethical dilemmas arise with this group of patients. Because questions about the patient’s own “authorship” cannot be neatly answered, ethical questions about their care are considerably more difficult than those raised with patients who fit into one of Hester’s three categories. His clearly defended positions are applicable to this fourth group only to the extent that the patient’s situation seems to put her closer to the first or second group.

That said, Hester has done a fine job of presenting his pragmatic perspective on bioethics, and applying it to ethical issues in end-of-life care. While I might quibble with a few of his interpretations and disagreements with colleagues in the field (including me), his book shows a wide and impressive grasp of current, relevant literature, both theoretical and empirical. Drawing on his previous writings, while adding new material and illustrative cases, he threads these smoothly into lucid and engaging prose. _End-of-Life Care and Pragmatic Decision Making: A Bioethical Perspective_ is an accessible, informative, provocative read not only for teachers, practitioners, and students of bioethics, but also for a broader audience.

Endnotes


Progress in Bioethics: Science, Policy, and Politics


Reviewed by Kevin T. Keith
Independent Scholar

Bioethics, more so even than most “applied ethics” fields, addresses issues shaped by abstruse empirical fact and the technical parameters of the technologized controversies of contemporary culture. The scientific/technological environment has become a defining feature of the lives and hopes of persons living in this unprecedentedly complex world.

It is tempting to imagine that our philosophy must be as technologically informed as our understanding of our lives has now become. The expectations that accompany such a perspective—that human flourishing must be in some ways dependent upon technological problem-solving, that a better and truer understanding of ourselves is a moral imperative, that the range of values and possibilities accommodated within the morally good life is wider than previously imagined, that the universality of these concerns embroils every person in a common moral quandary—define a particular stance, critical but welcoming, toward the prospect of aggressive engagement with the future through the tools and products of science.

Something like that is the position ascribed to “progressive bioethics” by the authors of the just-issued essay collection, Progress in Bioethics: Science, Policy, and Politics (MIT Press, 2010). What that position amounts to, in broad brush or regarding particular controversies, is by no means a settled matter, however, and it is that question this volume seeks to illuminate, if not resolve.

In their Introduction, the editors set themselves a particular task: “to address a seemingly simple question: What is progressive bioethics?” It quickly becomes apparent that neither “progressive” nor “progressive bioethics” is easily or uncontroversially defined. The different essays demonstrate varying perspectives on both those concepts, in some cases merely divergent, in some cases apparently in direct conflict. A number of the pieces offer particular positions, grounded in one or another vision of progressivism, on how current and future controversies involving biotechnology and public policy should be approached; none claims there is “a” progressive position on any issue. The impression they create, taken together, is of the universality of these concerns embroils every person in a common moral quandary—define a particular stance, critical but welcoming, toward the prospect of aggressive engagement with the future through the tools and products of science.

The opening articles—the Foreword, Introduction, and essays of both Section I: “Bioethics as Politics” and Section II: “The Sociology of Political Bioethics”—investigate the nature of progressivism, the issues that are or should be of interest to progressive bioethics, and the practicalities of politics and policy that bioethics is often involved in. A common feature of these pieces is a menu of particular principles or values the author believes progressivism must embrace (or, in some cases, reject). Many elements (an emphasis on science, the democratic process, autonomy, justice) are found in multiple articles, but the diversity here is great and hints at the possible scope of the otherwise vague label “progressive bioethics.” Each such list establishes an implicit definition of the field; each successive one challenges the foregoing and re-casts the issues in new terms and concepts.

Harold T. Shapiro’s “Foreword,” and the “Introduction” by editors Jonathan D. Moreno and Sam Berger, each comment on the scope or project of progressive bioethics; indirectly, they define the field in a way that sets the stage for much of the rest of the volume. Both also note the increasing politicization of biomedical issues; Shapiro calls for tolerance and mutual understanding across the political spectrum, while Moreno and Berger emphasize the rise of politically activist bioethics interest groups (particularly on the right) outside the academic and healthcare professions. Berger and Moreno also contribute the opening substantive essay, “Bioethics Progressing.” Here they tackle more directly the question of the nature of progressivism and its relationship to bioethics. They link progressivism to bioethics by way of “change,” “scientific knowledge,” and an emphasis on “pragmatism,” offer bioethics as “a model of progressive public policy,” and end by asserting “the four major values of progressive bioethics...critical optimism, human dignity, moral transparency, and ethical practicality” (emphasis original). The central themes of science, progress, and political process are laid down by these opening pieces.

The picture they build up, however, is challenged by Richard Lempert’s equally provocative chapter asking, “Can There Be a Progressive Bioethics?” He takes the content-neutral position: “bioethics should be neither progressive nor regressive, neither right wing nor left wing, neither liberal nor conservative.” The most diffident of the volume’s contributors, he cautions that “there is no guarantee that bioethical analysis will inevitably favor the conclusions associated with established political progressive positions.” Lempert offers his own enumerations of positions or principles progressives should either embrace (“placing science first,” “reasoning from principles,” autonomy, equality, and justice) or reject (“religious positions based on faith,” emotional (“yuck factor”) evaluations, “romanticism,” “symbolic statements...[of] moral supremacy of one’s group,” and libertarianism).

Taken in whole, they constitute a deep, lively communal meditation on what it means to live rightly in our technologically contextualized, fearful and hopeful, future-bound human lives.

Content

The volume is organized into five conceptual groupings, but the articles, particularly in the first few sections, work better as a seamless conversation flowing from and around, and repeatedly returning to, central themes that attract each of the authors in different ways. In many cases, sequential pieces touch upon similar issues from different or competing viewpoints, inviting the reader to sift and evaluate their disparate—though usually mutually sympathetic—contributions, and, often, re-evaluate in light of the still-broader perspective occasioned by each further reading.

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The picture they build up, however, is challenged by Richard Lempert’s equally provocative chapter asking, “Can There Be a Progressive Bioethics?” He takes the content-neutral position: “bioethics should be neither progressive nor regressive, neither right wing nor left wing, neither liberal nor conservative.” The most diffident of the volume’s contributors, he cautions that “there is no guarantee that bioethical analysis will inevitably favor the conclusions associated with established political progressive positions.” Lempert offers his own enumerations of positions or principles progressives should either embrace (“placing science first,” “reasoning from principles,” autonomy, equality, and justice) or reject (“religious positions based on faith,” emotional (“yuck factor”) evaluations, “romanticism,” “symbolic statements...[of] moral supremacy of one’s group,” and libertarianism).
Section II continues the development of progressivism and bioethics, with a focus on practical politics. R. Alta Charo’s “Politics, Progressivism, and Bioethics” is a lucid and helpful review of contemporary American bioethics policy debate and the roles, strengths, and weaknesses of interest groups and activist movements involved, as well as the rise of right-wing bioethics. Kathryn Hinsch’s fact-dense survey, “Bioethics: The New Conservative Crusade,” profiles many of the most-influential right-wing entities active on bioethical issues, their funding, and the links between them. Beyond mere factual reportage, both put these political topics in the context of bioethical theory and rhetorical praxis. Charo’s thoughtful essay sweeps from the Enlightenment roots of science-as-progress to the minutiae of First Amendment jurisprudence on—startlingly—the same issue. Hinsch notes the ways conservative groups have exploited public confusion over bioethical issues, and positioned themselves as resources for media needing an explanatory framework. (“Make no mistake, this is a race, and whoever succeeds in shaping public opinion first will profoundly affect society for decades to come.”) Both these articles should be pinned to the bulletin board of anyone involved in progressive bioethics activism or politics. One hopes the authors will update them regularly.

Laurie Zoloth, in “Justice That You Must Pursue,” calls for progressive bioethics to embrace “deep” issues regarding human nature, human need, and fundamental moral obligation—basic and ancient moral concerns she finds rooted in traditional Jewish teachings. Zoloth stands somewhat apart from most of the authors in this book: surely few progressives would call George W. Bush’s first nine months in office “a dreamy, sweet time in American public life,” or his stem-cell policy “a pretty good political compromise...that seemed to work.” But she details her disappointments with conservative bioethicists: their “rhetoric of eschatology,” “sentiment of ‘spirituality and souls,’” “commitment to ‘life in the aristocracy’ and obliviousness to others, especially children; and indifference to suffering and the ‘silencing of illness.’” Zoloth’s moral roll-calling, and review of the successes and failures of the Bush-era President’s Council on Bioethics (PCB), neatly caps off Charo’s and Hinsch’s organizational taxonomies of conservative bioethics. She ends by claiming “progressive politics is fundamentally rooted in optimism and a commitment to the power of democracy”—followed by a lengthy quote from the Port Huron Statement. (Ever the iconoclast: How many other Leon Kass fans would have done so?) This challenging and highly personal article adds a unique dimension to the work as a whole, and broadens the conception of what progressivism in bioethics should, or can, be.

Section III: “The Sociology of Political Bioethics,” addresses questions of the professional identity of bioethicists, and how progressive ideology meshes with other personal and professional values.

Paul Root Wolpe, in “Professionalism and Politics: Biomedicalization and the Rise of Bioethics,” offers an interesting overview of the ongoing professionalization of bioethics. He notes the confusions created by a lack of clear entry or membership criteria for the field and the simultaneous “biomedicalization” of existing social issues, and observes how right-wing commentators immersed themselves in bioethics debates while eschewing and demonizing the label “bioethics.” This implicitly interrogates issues raised by earlier authors: formal professionalization frames the role of progressivism within bioethics; “biomedicalization” bears on the relationship of progressivism to science; conservatives’ denial of their own bioethicness is a data point for the question whether “progressive bioethics” is a sub-category or a redundancy. Nominally narrow in focus, Wolpe’s article deepens debates that had appeared in different contexts and guises.

That progressivism may make an awkward fit with other commitments is explored in the following two essays, by John H. Evans and Eric M. Meslin. Evans writes on “The Tension Between Progressive Bioethics and Religion,” offering a useful capsule history of conservative religion (particularly Protestantism) in America, and the ways in which its various strains first ignored and then dove into bioethical debates; he emphasizes the “elite” nature of such debates on both right and left (“‘progressive bioethics’ is the liberal wing of the elite culture war”), and echoes Zoloth in claiming that “there is a tendency to de-emphasize [‘big questions’] among progressives. He traces much of this to the need for secular language and framing in public-policy debates, which he accepts as useful but limiting. Meslin pursues a somewhat similar course in “Can National Bioethics Commissions Be Progressive?” arguing that much of the work of the Clinton-era National Bioethics Advisory Commission was inherently progressive (“pragmatic policy recommendation based on sound science and sound ethics,” “not burdened by myopic ideological thinking”), but the history of policy advising and the various U.S. presidential commissions indicates that the political process does not guarantee progressivism within such groups. The article provides a wide-ranging history of process and politics which will be of interest to bioethicists planning or serving on future such commissions.

Section IV: “Conflicting Views of Biotechnology” contains one unabashedly pro-technology piece, and another warning against an uncritical stance on science. James J. Hughes argues, in “Technoprogressive Biopolitics and Human Enhancement,” for the transhumanist project as a culmination of progressivist ideology. The essay sketches “technoprogressive” positions on various bioethical issues, in every case seeking as much therapy, cure, or enhancement as is going, and offers yet another list of activist groups, organized by their positions on biopolitical and transhumanist questions. Hughes is both informative and exhortative, limning the cutting edge of techno-optimist futurism and arguing for a progressive bioethics expansive enough to endorse it. Less optimistic is Marcy Darnovsky: in “Biopolitics, Mythic Science, and Progressive Values,” she reminds us of the dangers of a naïve faith in scientific objectivity—and of the blunt characterization of the right wing as anti-science, thus valorizing the progressive embrace of science without critical reflection. She offers familiar but always-timely warnings that science can work for or against progressive values such as social justice and non-discrimination, and emphasizes the fail-safe functions of the precautionary principle and democratic decision-making.

The concluding Section V: “Progress Beyond Politics,” offers higher-level reflections on the field of bioethics in general. Art Caplan opens with a short piece, “Can Bioethics Transcend Ideology? (And Should It?),” in which, like other contributors to this volume, he notes the increasing entanglement of bioethics scholarship with practical—and partisan—politics; though acknowledging what can be lost, Caplan is more resigned than other commentators to the political nature of policymaking. Michael Rugnetta attempts to build a safe harbor for Catholic progressives in healthcare institutions. In “A Catholic Perspective on Care and Conscience,” he traces the history of “conscience clauses” in U.S. law and Catholic church policy, while pointing to aspects of Catholic doctrine that recognize a greater diversity of individual conscience and obligation to serve patients than church officials have acknowledged. Dan Callahan contributes a presciently timely essay on the need for universal healthcare coverage in the United States. As this review goes to press, Congress has just passed the much-delayed “Obama plan”
amid continuing controversy; whatever may develop in that regard, Callahan’s discussion of the moral underpinnings of healthcare access (“Upon what understanding of human nature and ends should health-care systems rest?”) will remain a relevant context-setting perspective. The final, thoughtful essay by William May, “Finding Common Ground in Bioethics?” recounts his experiences on both the Clinton Task Force on Health Care Reform and Bush’s PCB, and the arguments over religious perspectives in ethics that their work evoked. He offers one of the strongest voices affirming a “common ground” across religious traditions, but also warns of conservatives’ “religious dualism, a dualism, which, in varying ways afflicts each of the Abrahamic, monotheistic traditions of the West....They make the Devil coequal with God.”

In the “Afterword,” the editors remark upon the prospects for progressivism and healthcare reform in the advent of the Obama administration—a question that could not be more timely, though they could not have known that it would come to a head just after their book emerged from press.

**Limitations**

Necessarily, there are gaps in any single-volume work upon a theme as large and far-reaching as this one addresses. Some aspects of the potential definition of progressivism that the book hints at need further exploration, and at times the content or scope of the field seem taken for granted.

As has been noted, many of the authors stipulate the characteristics or qualities they expect progressive bioethics to adopt, offering collectively a smorgasbord of progressivisms the reader can choose among or pick at, as their appetite leads them. Though each of these conceptual schemata make sense in their own way, there is little argumentative support for most of them, leaving the reader wishing for a more cross-cutting analytical approach to tie down some of the definitional loose ends. It would have been interesting to see a round-table discussion among Moreno, Berger, Lempert, and Charo, and possibly Shapiro, Hinsch, and Zoloth, as to the necessary or sufficient characteristic features of progressivism, the exact nature of the relationships between progressivism, science, and bioethics, and in what way progressive bioethics is necessary, desirable, or optional.

As to specifics, though issues in other countries are touched on, there is heavy emphasis on recent controversies in American biopolitics. The Bush PCB is mentioned in ten of the fourteen essays, stem-cell research funding in eleven, and the Terri Schiavo case in almost half. (Perhaps more tellingly: George W. Bush receives no fewer than twenty-three Index entries; Leon Kass gets eighteen; Immanuel Kant, four.) Also, though there are attempts in some of these essays to tie modern progressivisms to the nineteenth-century political movement of that name, and to claim for progressivism the heritage of the Enlightenment, these amount to little more than historical nods. A broader sense of synchronic and diachronic context would be welcome.

In addition, it is striking that, except as regards religious commitment, there is little attention paid to diversity within the progressive perspective. Third-World issues and racial discrimination are mentioned in passing in a few of the entries, but the idea that dominant and non-dominant cultural groups might have entirely different relationships to technology and biomedical issues is not considered. And, though many of these authors evince an implicitly feminist perspective, it is surprising that the possibility of an explicitly feminist progressivism is not raised—particularly in the context of bioethics, in which so many of the wars are fought on the landscape of women’s bodies, and in which the progressive position, however defined, is understood to require a liberty of choices and goals, and legitimation of the technology employed in realizing them, like that often demanded by feminists. Similar comments can be made about disability and class—though issues affected by these distinctions are mentioned in the book (and several of the religiously motivated writers affirm a “preferential option for the poor” as a progressive value), the idea that they might inform particular and distinct, but no less thoroughly progressive, perspectives on moral issues is not addressed. In respect of these standpoints, progressivism is implicitly granted the kind of analytical neutrality that its proponents reject for science or politics.

However, these criticisms all amount to, not a denigration of any of the work presented in this volume, but a desire to see more of it, from more and broader perspectives of equal insight and sincerity. In that, the book’s greatest weakness may be that it is not longer than it is.

**Comments**

Though this volume is richly provocative and widely informative, it raises intriguing questions about the definition and content of progressive bioethics that require further examination.

Most significantly, it remains unclear why progressivism should have any of the content suggested for it, or why the themes many of these authors endorse are so self-evidently necessary to it. “Social justice” is extolled but undefined. Autonomy is often valorized, but the obligations of community almost equally often so; the conflict between them is rarely noted here, and not analyzed. Democracy is often nominated as a central commitment of progressives, but the tension between its utilitarian value (broadening debate, empowering individuals, preventing tyranny) and its too-frequent distortion by falsehood and demagoguery (a seemingly unavoidable observation in the American biopolitical context) is not critically considered. The danger—and seduction—of elitism is often acknowledged, but the assumption that democracy is both its opposite and its antidote seems much too hastily reached. Perhaps progressivism is in fact defined by a list of specific values and principles; perhaps it is a non-specific denominator applicable to incompatible points of view across a spectrum—but which of these is true presumably matters quite a bit, and the question remains open.

Even the role of science in progressive bioethics awaits further examination: though it plays an obvious and perhaps inevitable role in creating the “progress” that progressives look to, there may be other ways of conceiving progress and a progressive stance on technology. The current movement toward sustainable technology, environmental harm reduction, decreased reliance on irreplaceable resources, and small-scale agriculture enrolls progressive values toward progressive goals by way of an overtly technology-suspicious political program. An opportunity is lost in not considering whether progressivism’s pro-technology stance can accommodate the contemporary environmentalist and small-scale movements, and if not, what that says about progressivism.

The book also highlights, and leaves unresolved, the tension in progressivism regarding religion. Many of these writers endorse secular bioethics as necessary in a religiously pluralist society; some unapologetically acknowledge a science/religion divide and plump for science. Others argue that not only are religious motivations for bioethical principles respectable, they supply a source of value secular philosophy lacks. The inclusion of these disparate viewpoints may seem to manifest the progressive values of tolerance and pluralism. But in the end practical policies must be adopted, grounded on particular values or goals; religiously based policy-making inevitably imposes sectarian values and lifeways on non-professing religious traditions, but also warns of conservatives’ “religious dualism, a dualism, which, in varying ways afflicts each of the Abrahamic, monotheistic traditions of the West....They make the Devil coequal with God.”
citizens, while banning it renders certain values invisible to policy. Which path should be followed in a democracy is itself a value question, one that it seems implausible progressives can remain neutral on. This may be a fight that progressives do themselves no favors by avoiding.

Another possibly overripe conflict is the relationship between bioethical philosophy and public policy. Several authors decry the hostility and intellectual disingenuousness that often accompanies the practical aspects of biomedical policy. Perhaps, however, the answer is not to call yet again for more high-minded policy-making (what has that gotten us?), but to position ethical analysis separately from political sausage-grinding—to accept that identifying the right policy is only distantly related to implementing it, and that the tools for achieving both are not the same. This perspective might also clarify what practices we expect or perceive the various advisory and lobbying groups that surround the field to be engaged in.

Finally, the role of “big questions” in progressive bioethics is not obviously necessary or risk-free. Though it is gratifying to pontificate on human nature, telos, the good, and the righteous limits of lifespans and life plans, it is not accidental that those questions have generally been the province of conservatives who find in particular (reputedly self-evident) values and traditions convenient barriers to other people’s choices and projects they happen not to approve of for personal or religious reasons. It is all very well to speculate on the big questions, but, again, those musings must eventually instantiate as practical policy; since it does not require authorization on the “big” scale to justify a personal choice made under the principle of autonomy, the major significance of species-level axiology is to justify restraining, not empowering, autonomous choices. Before progressives undertake to determine what we all must be or want, it may be well to ask whether progressivism recognizes such questions as answerable.

In these and other ways, the book, and many of its authors individually, make a virtue of not engaging disputes whose solutions are pre-requisite to the broader project they endorse. The carefully polite and accommodating stances taken on contentious issues arising from incompatible values or viewpoints give the impression that progressivism is not anything particularly, or at least not anything progressives are willing to unambiguously defend.

In the end, it has not been said decisively what progressivism is, nor thus what it must do, or how—leaving the project of progressive bioethics frustratingly ungrounded and preliminary. This is not a fault in a collection of diverse viewpoints intended to provoke rather than settle that debate; the debate having been duly ignited, however, much remains to be discussed.

Conclusion

Progress in Bioethics offers an unusually rich and thoughtful set of readings on contemporary issues—both practical and theoretical—in bioethics, in the context of an extended and multi-valent reflection on the meaning and program of progressivism. It fails to come to any conclusion on those questions, which in fact is part of its message. Within the overlapping concerns and interests of its diverse group of authors, parallel and divergent themes can be identified, and the reader is ineluctably drawn into the emergent debate over the accuracy and propriety of each such individual vision.

Progress in Bioethics is must-reading for political progressives interested in biomedical issues, bioethicists who identify as political progressives, bioethicists in general who are interested in the conceptual landscape of contemporary biomedical policy and cultural controversy (particularly in the United States), and for those who seek to develop a humanitarian pro-science viewpoint, whether on biotechnology or other complexities of our technologized modernity. Anti-progressives who wish to know their enemy will find it instructive, and possibly more welcoming than they expect. It seems almost certain to energize debate both among progressives and regarding progressivism itself, in bioethics and more broadly, and it is strongly recommended to all who regard progressivism, contemporary bioethics, or both, as subjects of interest.