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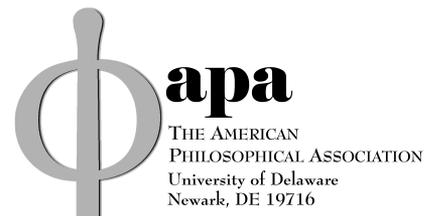
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FROM THE EDITORS

We are particularly pleased to be able to reproduce in this issue, by permission of Johns Hopkins Press, a classic from our past. Almost thirty years ago now, in 1982, Stephen Toulmin wrote a prescient article titled “How Medicine Saved the Life of Ethics.” Co-author with Al Jonsen of *The Abuse of Casuistry*, another classic contribution to the philosophy of medicine, Toulmin died in 2009. Tell me, dear readers—did medicine save the life of ethics?

As the doughty APA National Office continues to improve their already excellent support, our *Newsletter* is delighted to be able to offer our faithful readers an unusual treat—illustrated articles. Four presentations from the Committee-sponsored symposium on Health and Beauty, presented at Eastern Division as well as at the joint-sponsored session at October ASBH, are included in this issue. Leslie Francis’ comment on Lawrence Becker’s work on habilitation was inadvertently excluded from the last issue and is included here; and Ben Rich discusses important theoretical work on suffering and palliative care. A book review and a poem round out the issue.

We welcome your contributions and suggestions.
Mary Rorty and Mark Sheldon

ARTICLES

From the Crooked Timber of Humanity, Something Beautiful Should Be Made!

Anita Silvers

San Francisco State University

I. Introduction

Isaiah Berlin takes from a line in Kant’s *Idea for a Universal History with a Cosmopolitan Aim* (1784), “Out of the crooked timber of humanity no straight thing was ever made” (this is Berlin’s own translation) to characterize a major theme of his 1990 book of essays, *The Crooked Timber of Humanity*. In deploying the “crooked timber” locution, Berlin signals his anti-perfectionist approach to standards of political and practical value.

My thinking shares this same spirit. The approach to the standards of medical value I shall propose is anti-perfectionist, albeit perhaps in an unusual way, for I shall be pointing out how humans whose bodies literally are crooked are experienced

as beautiful. As well, I shall argue that medical professionals have at least a mild duty to cultivate such aesthetic judgment. By contributing a crucial experiential component that enables aesthetic appreciation of biologically anomalous individuals, medical professionals have both the opportunity and the obligation to advance inclusive justice for them.

II. Bioethics and Beauty

This essay is about the connection between medicine and beauty. The topic is not much explored in bioethics research, or in philosophical aesthetics, or for that matter anywhere else. So here I begin by accounting for why bioethicists have given so little thought to the role the value of beauty should play in the ethical exercise of medical knowledge and skills.

The absence of discussion about this topic is somewhat of a puzzle, for there was a time several decades ago—in the era when bioethics as a discipline was undergoing rapid growth but had not yet been subject to its current professionalization—when it was not unusual for scholars who previously wrote mainly about philosophical aesthetics to be drawn into the study of bioethics. I count myself as a comparatively latecomer from aesthetics to bioethics, having begun to think about moral and political issues in medicine beginning only in the 1990s. By the time I did so, bioethics scholarship already had been shaped by appallingly superficial and false presumptions about the lives of people with disabilities, embraced absent an evidentiary basis and lacking reflection by prominent influencers of the field. In sum, bioethicists typically gave no direct regard to people with disabilities, dismissing their lives as instances in which medical treatment had only partially succeeded or had completely failed.

Over the years, these biased misconceptions have changed, becoming somewhat camouflaged in some aspects but in others smoothed away. The publication in June 2011 of the *World Report on Disability*, a joint project of the World Health Organization and the World Bank, is designed to further the implementation of the 2006 U.N. Convention on the Rights of Persons with Disabilities. The *World Report* recommends both conceptual and organizational changes in the understanding of medicine and in the delivery of medical services needed to enable the one billion members of the world’s population who live with disabilities to flourish.² People with disabilities are more than three times more likely than nondisabled people to report being denied needed health care.³ The document recognizes disability bias that has infected the health care delivery system. Bioethics scholarship has been more likely to reflect than to remedy this problem.

Focusing on beauty initially may appear to be an odd strategy for reversing the devaluation of living with disability that characterized bioethics two decades ago and that, regardless of the direction global health policy now may be beginning to take, has yet to be extirpated from today.⁴ Seeking beauty may seem to be an aim with a strong affinity for perfectionism. Americans

sometimes are criticized for being so addicted to beauty that millions of dollars are wasted and millions of spirits are crushed as people strive in vain to look beautiful. Disability activists and scholars have been especially vigorous in condemning the valorizing of beauty. Seekers of beauty, they complain, distance whoever is not beautiful and people with disabilities are not beautiful. Except for segregated competitions such as the Ms. Wheelchair Contests, or for short-lived t.v. or magazine stunts, the disabled are not found among the images of beautiful people that appear on glossy magazine covers or appear on the many sizes of screens that command our attention every day.

Seeking beauty thus may appear unjustly exclusionary. Whoever falls too far short of achieving beauty will not merely be denied equal opportunity and social participation. Individuals whose beauty deficits are pronounced at best are relegated to social invisibility. In ordinary encounters with other people, seriously beauty-deficient individuals find it hard to make human connections because others turn their heads and look away. It is understandable that, from this perspective, beauty appears to be an enemy of justice.

To the contrary, I contend that the relationship between seeking beauty and engendering justice is quite a different one. The condemnations sketched above should instead be leveled at practices that hi-jack beauty and then transmogrify this value into something else. These familiar disability critiques of people's efforts to enhance their beauty do not have to do with why we value beauty. They miss the mark because the interventions they target for criticism are aimed at various kinds of external functionality, and not at experiences of beauty.

Bioethicists often criticize using medical knowledge in the pursuit of beauty. I shall point out that bioethics community and disability community complaints about valuing beauty rest on the same mistake. As with disability critiques, in weighing the propriety of invoking beauty as a value in medicine, bioethics conversations have tended to conflate aesthetic with other values, and the benefits and costs of seeking beauty with other pursuits.

There is propriety in weighing these other concerns and pursuits—especially those that detract from inclusive justice—in bioethics. But while beauty may be good, the beautiful is not the good. Therefore, at least two distinct issues need to be addressed. One is, What is medicine's capacity to bringing about beauty? The second is, In regard to this power, is medicine's exercising it good?

As to the first question, familiar critiques of medical efforts to enhance beauty do not have to do with the intrinsic value of beauty, but instead with the instrumental value of functionality, which is something else. Beautiful things, as Kant understood, possess a character of being purposive, but things are not experienced as beautiful in virtue of their actual functionality. In his Third Critique (*Critique of Judgment*, 1790), Kant analyzed judgments of beauty as being about objects that are appreciated for appearing purposive but without identified purpose. Inspired by a Kantian analysis of beauty, I shall propose a heretofore underrated role for medicine in regard to the creation of experienced beauty, which involves medical professionals exercising a capability for promoting inclusive justice.

III. Confusion with Nonaesthetic Concerns

The two instrumental values with which beauty so often is confused by bioethicists are attractiveness and normality. I shall address each of these briefly to indicate the circumstances in which each can be a worthy objective of medical intervention and suggest as well the conditions under which they are not. Having addressed critiques that are not about beauty but regard these two other things, I then shall proceed to suggest, albeit

briefly, an appropriate but neglected way in which medical knowledge and skill should promote beauty.

III.a. Attractiveness Is Not Beauty

The English word "cosmetic" comes from the Greek word for "adorn," which accounts for why calling something "cosmetic" means rearranging it superficially so as to look more desirable or more impressive, whether or not it really is so. There is, consequently, a moral bias against deploying medical techniques for merely cosmetic outcomes. Given the root understanding of "cosmetic," improving appearance can be rejected as an unworthy distortion of reality, hiding what a person's nature really is. But this seems to me an otiose objection that disregards the function that attractiveness often plays.

Let me illustrate why I am reluctant to dismiss the worthiness of improving patients' appearances. As the sociologist Kathy Davis points out, the initial large patient pool for surgical facelifts consisted of women who found themselves having to provide for their families after they reached middle age.⁵ That the stamp of maturity marked their brows, so to speak, when they sought entry-level positions in the job market proved dysfunctional given their economic status. Hence a practice of post-divorce cosmetic surgery grew.

I am suspicious of attempts to impose moral or political prohibitions against applying medical skills that will enable patients to gain functionality, even if social rather than biological function is the goal (and, parenthetically, even if functioning is enhanced rather than merely restored). In cases like those in Davis's examples, the patient is not seeking to acquire privileged status through superior social functionality, but simply to attain equal social opportunity in a cultural context where unfair biases reign. Nevertheless, some might reject using medical knowledge and skills to acquiesce to age bias this way. Some might even condemn as complicit in age bias those surgical interventions that enable patients' social functionality by making their faces more attractive. I reject that view because it is egregious to require the potential victims of social injustice to bear the brunt of fighting it.

Adopting this perspective also can resolve qualms about face transplants, surgery for children with facial anomalies, and so on. Face transplants are very challenging procedures and as such are not a plausible route for achieving superficial attractiveness alone. Such interventions are justifiable if (but only if) the probability of meaningfully improving social and/or biological functionality generously exceeds the probability of leaving the patient more dysfunctional than before. Improving functionality will be meaningful more or less to the degree the individual's current appearance is socially dysfunctional.

The emphasis here should be on pursuing intervention only if the margin for success is reasonably wide. That is because the probability of harm in reducing already compromised functioning even further should be a much weightier consideration than equally probable benefit. To create such a harm is to deteriorate further the patient's currently adapted life, a devolution surely more damaging than merely foregoing the opportunity for positive change. This perspective on how to weigh benefit against risk for patients whose functionality already is compromised has not been given sufficiently prominent recognition in bioethics. The advised approach is not revolutionary. This recommendation simply ratchets up some current cautionary considerations.

The reality of biases that render individuals with anomalous physiognomies socially dysfunctional creates a political obligation to permit and even pay for services that enable them to realize equality of opportunity. That obligation might

be discharged by effectively banning any expression of the bias, but, absent the political will to alter the conduct of all citizens alike, deploying the means for those who suffer from bias to have themselves altered so as to escape or reduce being targeted by others' biased conduct is justifiable. Thus, face transplants are shown to be justifiable (within constraints regarding the potential for improving physical and social functionality) despite their expense and the usual burdens of maintaining transplanted tissues against rejection, by invoking the experiences reported by the procedure's pioneer patients. In addition to demonstrable improvement in breathing, eating, speaking, sensation, and other physiological functions, which usually are the main benefits of this kind of profound facial reconstruction, face transplant patients report a noticeable reduction of encounters in which the people they meet turn their eyes away.

III.b. Normality Is Not Beauty

This brings us to the second value bioethicists sometimes confuse with beauty, namely, normality. Normality is a preeminent value in medicine but it should not be. Normality, in its familiar manifestation or interpretation as species typicality, usually but mistakenly is identified with optimal functionality. But functionality is conditional on a variety of both physiological factors which differ from individual to individual and social factors which are historically and culturally relative.

The array of biological capacities that make an individual typically, or even exceptionally, functional in some settings can compromise functionality in others. One of the standard illustrations of biological functionality conditional on context is sickle trait, which confers functionality on individuals in malarial swamps but not so much when an individual moves to a high altitude mountain site, and which seems benign (or more benign) for sedentary but not so much for energetic individuals.⁵ To give another example, extreme corpulence is socially functional for Tongans (corpulence is a mark of high social rank—the late King of Tonga was 444 pounds when he died at age 88 in 2006⁷) but is dysfunctional for non-Tongans who must buy two seats on a plane or otherwise need to find transportation outside of Tonga.

The history of children with congenital phocomelia is a prototype of this misplaced faith that functionality follows from the approximation of normality.⁸ From infancy, they used the hands and feet sprouting from shoulders and pelvis in unusual but functionally effective ways. But physicians and parents could not understand how the children could achieve manipulation or mobility except in the species typical way. Consequently prosthetic arms and legs of normal length were built for them, and their hands and feet were amputated to allow the prostheses to fit. The unfortunate result was a diminution of the children's functionality, for the dexterity and motion offered by the prosthetics fell far short of what they had been able to accomplish with their foreshortened fleshy hands and feet.

While the political issues arising from the often decried hegemony of the attractive and tyranny of the normal are serious, I believe them to be subject to rather straightforward resolutions about individual patients' opportunities for benefit measured against risk. Their main danger lies in the tendency to exaggerate the benefits of being normal and understating the risks of the proposed means to becoming so. Too often the prospect of reducing the individual's residual anomalous but effective functionality pales too rapidly against the dazzling but empty promise of normal functioning. Bioethical resolutions of such cases should be reasonably straightforward as long as what is at issue is posed accurately and clearly, not conflated with other questions, and not appropriated as stalking horses for much larger battles—such as those whether rationing schemes

should permit medicine to make cosmetic interventions—in which enhancing beauty is peripheral rather than central to the strife.

IV. What Beauty Is

Having said what beauty is not, we can now turn to consider what beauty is. As background, I begin by offering an enormously compressed discussion of a theoretical framework drawn from the philosophical field of aesthetics. Traditionally philosophical aesthetics has been concerned with such issues as where the property of beauty lies—and consequently what its nature, objective or subjective, is. Accounts of why people make judgments of beauty take aesthetic experience either (a) to serve some other value, usually by enhancing individuals' moral sensibilities or cognitive skills, or (b) to be intrinsically or categorically valuable, that is, valuable in itself.

Recently evolutionary psychologists have brought these two notions about aesthetic value together in the following way. They propose that the affective dimensions of experiences of beauty are vestiges of adaptive processing of environmental stimuli. Aesthetic preferences are responses to experienced objects that stimulate the adaptive exercise of our perceptual and cognitive capacities. Philosophers of art will recognize the affinity of this biological account with Kant's analysis of the judgment of beauty as expressing pleasure attendant on the free play of the decider's imagination with her understanding.

Both eighteenth and twenty-first century thinkers suppose that aesthetic experience facilitates our human ability to construct a sophisticated and fecund fit between the world and our abilities to know what may be in the world.⁹ To experience aesthetically is to apprehend structure in apparent discord, unruliness, or disarray. Symmetry thus is loosely associated with beauty, but aesthetic valuation demands that, to be beautiful, perceived orderliness must be somewhat hard won and therefore must be something more than bland or banal regularity. For aesthetic experience, it is the achievement of coherence—the perception of the fitting or working together despite complexity or other challenges of the regarded object's parts—that commands admiration.

We seek out innovative works of art for the pleasure of such experiences of discerning complex orderliness, but I contend that we can enjoy such aesthetic experience in our encounters with biologically anomalous people as well. This insight initially arose in an encounter I had more than a quarter century ago, and about which I have written intermittently since. It originated from my first close encounters with individuals with Osteogenesis Imperfecta Type III.¹⁰ For a week after I met them, I kept thinking they had a familiar look. And then I realized how I had seen them. Here's how I described that revelation at the beginning of my 2000 essay¹¹:

My friend sits before me. On the wall behind her the reproduction of a Picasso painting hangs. Although seen daily, the painting remains riveting to me. My gaze returns repeatedly to follow the contours of the pictured face, a flesh-colored triangle dominated by one tremendous egg-like eye, an unceasingly fascinating visual site.

My friend was born with a type of dwarfism: in addition to lower limbs too short for walking, she has the physiognomy characteristic of this condition. In appearance startlingly similar to the one in the painting, my friend's face is a fleshily broad-foreheaded triangle, flattened so that it seems much like a picture plane, dominated by enormous doe-eyes. When her face is in profile, one eye appears to occupy almost

the whole upper half of her head, very much like the immense eye in the profiled painted face.

Knowing how to look at cubist paintings apprised me about how to appreciate the look of my friend. But simply knowing how to appreciate her look did not suffice to engender



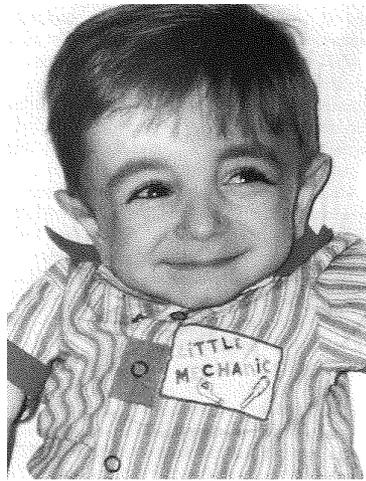
Picasso, *Maya with a Doll*, 1938.

the special pleasure that is the experience of beauty. One other part of the experiential formula was to learn about OI, and especially OI Type III. The interplay between entertaining conceptualizations that apply to ordinary (what I sometimes call “plain vanilla”) human biology and envisaging the riffs that human biology plays in the atypical but effective functioning of people with OI III

stimulated a gratifying interplay of understanding and imagination, very much along the lines of the Kantian account of aesthetic appreciation. Discovering that individuals with such prodigious biological differences can function so effectually is both compelling and pleasurable.

V. Advancing Inclusive Justice

Medicine does not usually deal with biological anomaly aesthetically. But, I propose, those who have the requisite access to medical knowledge have at least a mild obligation as a duty to do so. Although not commonly deployed for this purpose, medical knowledge can promote positive appreciation of individuals with biological differences who otherwise might be perceived as defective—whether the anomalies picked out (or on) be attributed to race or sex or disability or something else—as beautiful.



Child with osteogenesis imperfecta.

Coming one's self to appreciate the functional virtuosities of biologically atypical people rather than assessing their differences as defective, and guiding others in doing so, is an important and satisfying occupation. Regarding humans who are different, the physician or medical researcher can play a role similar to that executed by art historians in regard to art works that are different. The art historian is not the art critic. The art historian accounts for why some crafted objects deviate from more common or familiar ones, but does not demean them because of their divergences. Nor should the expert in biological processes devalue people because of differences in biological functioning. Art historians enable audiences to understand uncommon art and, by appreciating their innovation, to regard as beautiful objects that otherwise would be rejected as too disturbing. So can the medical professional enable similar appreciation of biologically uncommon people.

Kant's observation that from the crooked timber of humanity no straight thing was ever made can be taken positively as pointing appreciatively to the enormous variation among members our successful species displays. My emendation is that from the crooked timber of humanity much more that is beautiful can and should be made. By enabling humans with different biologies to appreciate each other—even to see each other as beautiful—medical professionals can promote their positively interacting with one another and by doing so can advance inclusive justice. That medical professionals should do so is a case bioethicists have not—but should have—made.

Postscript: On the day after I submitted a revised version of this essay, the *New York Times* ran a story about high school students who were shown photos of young people with visible genetic disorders and told not to look away. The photographer said of the pictures he made, “The idea was to bring these gorgeous kids into a community that didn't know them and create a more inclusive society. It's our responsibility to steady our gaze to see beauty, and not to look away...” And in their high school philosophy class, students searched for insights in the aesthetic theories of Hume, Kant, and Nietzsche.¹²

Endnotes

1. This essay is based on a talk presented in one version at the October 2010 Meeting of the American Society for Bioethics and the Humanities in San Diego, in a different version at the December 2010 meeting of the Eastern Division of the American Philosophical Association in Boston., and in yet a third version at the California College of the Arts San Francisco campus in March, 2011. It expands upon and applies my essay “From the Crooked Timber of Humanity, Beautiful Things Can Be Made,” *Beauty Matters*, ed. Peg Zeglin Brand (Bloomington and Indianapolis: Indiana University Press, 2000), 197-221. Note a difference in emphasis between my titles, and thus the articles, of 2000 and 2010. In the former, I show how and why individuals seen as defective when the standard of “normality” is imposed on perception can appear beautiful to aesthetic judgment. In the latter I argue that medical professionals have an obligation to promulgate a crucial component of such aesthetic judgment.
2. http://www.who.int/mediacentre/news/releases/2011/disabilities_20110609/en/index.html. Last visited June 18, 2011.
3. *Ibid.*
4. A clarifying caveat usually is called for at this point in the conversation to block the interjection of a false dilemma. To object to devaluing life with a disability (which for public policy purposes too often morphs into devaluing the lives of people with disabilities) does not entail objecting to programs for preventing or curing impairments that occasion disability. We should not set up the ideal so as to make it the enemy of the good.
5. Kathy Davis, “Luxury or Welfare? The Rhetoric of Cosmetic Surgery,” in *Enhancing Human Capacities: Conceptual Complexities and Ethical Implications*, ed. Erik Parens (Washington, D.C., Georgetown University Press, 1998). Kathy Davis, “From Objectified Body to Embodied Subject: A Biographical Approach to Cosmetic Surgery,” in *Feminist Social Psychologies*, ed. Sue Wilkinson (Oxford: Open University Press, 1996).
6. Geoffrey Tsaras, Amma Owusu-Ansah, Freda Owusu Boateng, and Yaw Amoateng-Adiepong, “Complications Associated with Sickie Trait: A Brief Narrative Review,” *American Journal of Medicine* 122, no. 6 (2009): 507-12.
7. http://en.wikipedia.org/wiki/T%C4%81ufa%CA%BB%C4%81hau_Tupou_IV. Last visited June 18, 2011.
8. “How Thalidomide Children See Themselves,” *Nursing Times* (April 24, 1969): 519-22. Reprinted from *World Medicine*, October 29, 1968.

9. For an evolutionary psychology take on aesthetic experience, see Denis Dutton, *The Art Instinct: Beauty, Pleasure, and Human Evolution* (New York: Bloomsbury Press, 2009).
10. Osteogenesis Imperfecta Type III. The child may be born with fractures and the skull is well ossified. There is progressive deformity of the skull, long bones, spine, chest and pelvis during early years. Face appears triangular with large vault, prominent eyes and small jaw. Sclera is blue in infancy but normal colour in childhood. Patients rarely walk even after multiple surgical procedures, and have very short stature. Early death can occur from respiratory infections predisposed to by reduction in vital capacity associated with severe kyphoscoliosis. Cf. <http://www.patient.co.uk/doctor/Osteogenesis-Imperfecta.htm>. Last visited June 18, 2011.
11. Loc. cit.
12. Winnie Hu, "In New Jersey, Learning Empathy By Looking Beyond Disabilities," *New York Times*, June 22, 2011, A18.

Beauty as Pride: A Function of Agency

Peg Brand IUPUI

As clichés go, there's none better than "Beauty is in the eye of the beholder."

Often this phrase is invoked to reconcile differing value judgments between pet owners, fashion designers, or family members who simply cannot fathom what you see of aesthetic value in another person whose looks fail to impress. But among aestheticians and lovers of art, this phrase can provide a plausible reason, a convincing rationale, or a failsafe escape from artistic disagreement. Locating the source of one's judgment of beauty in the eye of the beholder allows the viewer to be the subjective decider. Never mind that the artist has intentionally crafted a visual spectacle that embodies or expresses objective properties of beauty; let the decision rest with the viewer.

When the representation open to judgment is the human body—naked or nude (the distinction made emphatically by Kenneth Clark in 1956 in his classic book *The Nude: A Study in Ideal Form*)—then interpretation and evaluation become more complicated. No longer are we merely following the five-part formula of eighteenth-century British empiricists like Edmund Burke, Francis Hutcheson, and David Hume who characterized the supposedly "disinterested" experience of beauty as consisting of:

1. Perception
2. Triggered faculty of taste
3. Object with particular properties (of beauty)
4. Resulting in pleasure
5. Yields a pronouncement of "this is beautiful."

Rather, we are in the realm of contextual analysis: looking at the simple fact that many of the most famous nude bodies depicted throughout the history of art are those of women, created by men, as objects of beauty for us to freely gaze upon: perhaps disinterestedly, and perhaps not.¹

This presentation will explore and engage the newest mode of defiant challenges to that ideal standard of beauty portrayed throughout the history of art—the female form—as expressed by artist Joel-Peter Witkin in a series of provocative photographs from the past ten years. I will narrow the scope considerably, to only a few artworks, because they are so complex: choosing to focus on three images (plus one of a male nude) that involve bodies with disabilities posing, i.e., performing for the

camera, the photographer, and the viewing audience. This is basically a paper about artistic evaluation and how multiple interpretations can give rise to inconsistent and conflicting meanings. Images like Witkin's *First Casting for Milo* (2004) challenge the viewer to look closely, understand the formal properties at work, and then extract a meaning that ultimately asks, Is the model exploited or empowered? Is Karen Duffy, pictured here, vulnerable and "enfreaked" or is she potentially subversive, transgressive, and perhaps self-empowered?



Joel-Peter Witkin, *First Casting for Milo* (2004). Catherine Edelman Gallery, Chicago.

I will offer an argument in agreement with artist/author/performer Ann Millett-Gallant that favors the latter interpretation, but will augment and complicate the issue by also introducing a pointed question or two taken from a recent analysis by Cynthia Freeland on objectification. I judge the works by photographer Joel-Peter Witkin to be representations of disabled persons who are empowered through agency and pride, but I also worry about the risk of multiple, conflicting interpretations on the part of viewers who do not, or cannot, entertain such enlightened readings. Like second wave feminist views about pornography that depicted women in demeaning ways, or feminist critiques of Judy Chicago's *The Dinner Party*, Witkin's photos can be judged as potentially offensive. But they are also objects of beauty—both in terms of aesthetic properties (they are magnificent studies in black and white, shadows, the human body, with many classical references) and because of the feeling of beauty and pride felt by the posers, who become performers of their own beauty and pride. I argue that beauty trumps offensiveness. Pride wins. But I'm not sure that everyone will agree.

I. Disarming Venus

"Disarming Venus" is not my term but rather the creative phrase offered by author Ann Millett-Gallant in her recent book, *The Disabled Body in Contemporary Art*.² It is the title of the first chapter in which she seeks to educate viewers in how to "visualize disability" in opposition to canonical erasure or more recent trends of casting such bodies in freak shows and displays of "otherness." She cites images by painter Frida Kahlo as historical precedents of a woman picturing her own body (starting in the 1930s in Mexico) as "broken, wounded, and degenerate due to her disabilities."³ She focuses on self-portraits that display Kahlo's "personal and medical body" in images of "her numerous miscarriages, surgeries, recoveries, and physical degeneration."

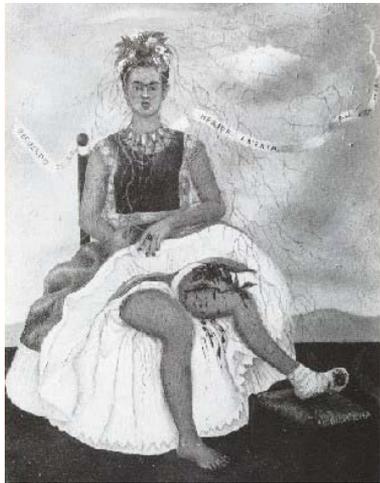
The "self" portrayed in Kahlo's work emerges as a body in pieces—graphically ripped apart, wounded, bleeding, and impaled. ...Kahlo was ahead of her time in her unashamed, graphic, and performative bodily displays of disability.⁴

She cites feminist admirers and the overall popularity of Kahlo—both as artist and Mexican role model—as she emphatically points to the transgressive nature of her performance:

This performance contradicts conventional narratives of pity, deficiency, and isolation that characteristically

surround disabled women...[she] is portrayed as passionate and sensual, rather than corporeally and sensorially “lacking” and helplessly dependent.⁵

Perhaps even more importantly for this session, being sponsored by the APA Committee on Philosophy and Medicine, her body—boldly on display as a “spectacle” (her preferred term—serves “as a site, target, and vehicle for ideology and creative



Frida Kahlo, *Remembrance of an Open Wound* (1938).

expression” within disability studies “to overturn predominant stereotypes about bodies and norms for social acceptability” based on medical models that view disability as “a set of medical and corporeal ‘problems’” to be cured, fixed, or eliminated.⁶ The posing of her self elevates Kahlo to a level of agency and activism; she becomes a proponent of visualizing the disabled that results in the subversive, transgressive overturning of traditional western ideals of

feminine beauty (such as those embodied in the classical *Venus de Milo*) and an example of a new and different sort of beauty, namely, one that exudes a concept promoted by the Disability Arts and Culture movement and involves what is known as disability pride.

This is the thesis of her entire book, as she works through numerous examples and argues that disability as socially constructed by our culture as abnormal, lacking, other, and freak, is wrong. She seeks to correct the readings of visual disability through her (admittedly) subjective interpretations of bodies on display by contextualizing them within an interpretive framework that sees and identifies with the poser/performer who chooses to exhibit her disability rather than hide or deny it. These posers choose to flaunt their bodily differences in resistance to mainstream culture

that teaches disabled people that our success is intrinsically tied to the denial of our disabilities and our bodies. If we are successful (“able”), we must “overcome” our disability—effectively defeat our impairments—and become as normal as possible, for, we are told, this is the goal.⁷

This form of self-exhibition is counterintuitive, alarming, and even shocking to some viewers. Photographer and disability studies theorist David Hevey has suggested that “photography ‘enfreaks’ disabled people, thus socially and visually constructing them as ostracized ‘others’.”⁸ This is the risk that all visual (and perhaps literary) representations run when interpreted by an audience who is unlearned in the interpretive framework advanced by Millett-Gallant. The question becomes, Is it worth the risk of misinterpretation to visually represent disability, particularly when the poser *feels* empowered, beautiful, and proud? The same question was once asked about women posing in porn designed for the male gaze, as if feminists knew better than porn-posers what was empowering and what was not. But more recent artworks by women have become more transgressive than ever, reproducing the conventions of porn

while simultaneously parodying them. The lesson of learning how to look is a valuable one, if not still controversial.

II. Performance as a Freakish Venus

When Irish artist Karen Duffy posed for the Witkin photograph in 2004, she was engaged in a silent performance of disarming Venus. Born without arms, Duffy has performed in live artworks since 1995 when she posed in the nude, in a self-objectifying act where she verbally explained that her body was already objectified in society and she was taking control/ taking back her dignity—from cultural stereotypes that cast her body as shameful, unacceptable, and better left unseen. She becomes the anti-idealized body: excessive and taboo. Staged by Witkin in seductive lingerie and partially shrouding drapery, she also openly performs “as a freakish Venus” who “means to intrude upon and liberate herself from histories of oppressive representations of women and disabled women specifically.”⁹ This is intended to be an exercise of agency by which one’s experience of disability becomes a tool toward artistic and feminist activism.

Moreover, she parades herself in defiance of a condemning medical gaze that has turned disabled bodies into “medical curiosities” within a purportedly sanitized, scientific, and objective realm. Citing early medical photography in the nineteenth to early twentieth century that became a widely popular form of entertainment, disabled bodies were displayed for paying customers to gawk over with voyeuristic pleasure. Millett-Gallant suggests that the photographer, Witkin (who studied such early photographs), appropriates the voyeuristic and theatrical medical gaze for the purpose of subverting its belittling power over such bodies that were forced to recoil under view. *Humor and Fear, New Mexico* is another work by Witkin that is cited as accomplishing similar goals. In this depiction, the author contends, the poser is “performing amputation”: a clear reference to medical vocabulary that focuses on the model’s impairments, her hands and particularly her right leg. Like

photographer and disability studies theorist David Hevey has suggested (that “photography ‘enfreaks’ disabled people, thus socially and visually constructing them as freakish, ostracized ‘others’”), critic Garland-Thomson maintains that fetishization of the body and particular body parts, derived from medical models, “serves to eclipse the multidimensional



Joel-Peter Witkin. *Humor and Fear, New Mexico* (1999).

nature of disabled subjects, constructing disability as social spectacle.”¹⁰ In other words, multiple readings of the body are lost in favor of one objectifying, “enfreaking” process by which the viewer gazes/stares to see and to know “what happened” to cause the abnormality. Upon learning that the model lost her limb, as a young woman, due to toxic shock syndrome incurred from the use of a tampon, and thus amputated by medical procedures, Garland-Thomson’s reading of the body-as-spectacle construes her in the “role of medical specimen, subjected to a diagnostic gaze/stare.”¹¹ Millett-Gallant argues

in response that the image “exceeds medical discourse in its blatant theatricality” and defies such a predictable, objectifying reading. But remember, beauty is in the eye of the beholder; with which reading are you more comfortable?

Perhaps, as we quibble over conflicting interpretations, it would be good to hear from the model who was reported to have said to Peter-Joel Witkin, upon viewing the finished photograph “with pride,” that it made her feel beautiful. This is Millett-Gallant’s strongest argument for her interpretation but it may not be decisive for some viewers who simply cannot read the image in that way. It is worth noting that one of my students, who weighs 83 pounds and is a force to be reckoned with when she enters the classroom in her wheelchair, giggled with glee when she saw this photograph and the previous one by Witkin. Having studied the works of Frida Kahlo, she felt vindicated by contemporary images of the disabled body in which she immediately saw (and felt, I presume) a similar sense of agency, pride, and beauty. She acted as if the artworld had finally caught up with the self-empowerment felt in the paintings by Kahlo that were seen as being ahead of their time, a harbinger of a more organized disability pride movement. She only read them in one way: positive. And she wanted to learn more about them.

III. Objectification or Subjectification of Performance/Posing?

It is worth noting that Millett-Gallant realizes that her interpretations are disputable. She always frames the question of interpreted meaning in terms of the *possibility* of the images being transgressive. She leaves open the charge of exploitation, “enfreakment,” and invites dialogue. Allow me to offer one way of extending the discussion, namely, by means of an interesting analysis of portraiture offered by Cynthia Freeland, by way of Martha Nussbaum. First, consider a third example by Witkin of a work that “performs amputation”: *Portrait of Greg Vaughn*.

Here the young, androgynous male body resembles the early Greek ideal kouros figure with idealized Classical features. But the overdone theatricality and humorous, playful props are absent. This young man poses in quite a vulnerable and expectant position. As Millett-Gallant observes,

this modern day *kouros*...is entirely nude (as the body is considered in art) and/or naked (as it is considered in medical imagery)...the photograph, like *Humor and Fear*, plays with visions of the body *with* and *as* ornamental objects...[it] not only represents but performs amputation, not as a surgical and disarming act of removing limbs, but rather as an embodied performance of identity...Witkin’s photographic performances of amputation dissect the inherent contradictions, supposed neutrality, and integrity of the medical gaze and medical imagery.¹²

But do they? Is this how you read this image, as opposed to the previous one? Or does the age of the poser and the vulnerability of his stance (with his arm leaning on the marble), jeopardize the preferred interpretation of an agentic, empowered, proud beauty?

A new book by Cynthia Freeland, entitled *Portraits and Persons: A Philosophical Inquiry*, offers an enlightening analysis of portraits in terms of personal identity as well as aesthetic qualities that focuses in one chapter on the topic of intimacy.¹³ Basically, Freeland’s thesis is that portraits are a genre of fine art that express (1) physical individuality and recognizability, (2) an inner life/character/psychological or mental states of the sitter (poser), and (3) an awareness on the part of both the artist and subject that they are self-consciously engaged in a process

of depication, thereby excluding most animal portraiture from the definition of the term. At one point Freeland suggests that the portrait subject must actually “look back” at the artist, allowing him/herself to be viewed, in order to be a full participant in the process of portraiture.¹⁴ I raise this condition from Freeland as a way of complicating the meaning of the performance of the poser in *Portrait of Greg Vaughn* because, unlike the previous two photos (but like the paintings of Frida Kahlo), he looks out at the artist and viewer. Freeland cites



Joel-Peter Witkin. *Portrait of Greg Vaughn* (2004). Catherine Edelman Gallery, Chicago.

Martha Nussbaum’s criteria for objectification as follows:

1. Person P uses person Q as an instrument (means);
2. P denies Q’s autonomy;
3. P treats Q as inert;
4. P treats Q as interchangeable or fungible;
5. P violates Q’s boundaries;
6. P treats Q as something that can be owned;
7. P denies Q’s subjectivity.¹⁵

She then constructs her own set of criteria, based in opposition to Nussbaum, that define what she calls “subjectification” that allows for the intimate depiction of a sitter in a non-objectified way:

1. Person P treats Q as an end and not a means;
2. P endorses Q’s autonomy;
3. P treats Q as active and alive;
4. P treats Q as unique and irreplaceable;
5. P respects Q’s boundaries;
6. P treats Q as something that cannot be owned;
7. P endorses Q’s subjectivity.¹⁶

It is easy to see how Freeland would interpret many so-called portraits of nude females in evidence throughout the canon of western European art history as objectified according to these criteria. But how do Witkin’s photos fare on her analysis?

Millett-Gallant’s informal criterion of agency seems to replicate conditions (2) - (3), and perhaps (6) - (7). But in looking at *Portrait of Greg Vaughn*, can we decisively say that Witkin treats Vaughn as an end and not a means (condition (1)) or as unique and irreplaceable (4)? (His uniqueness, indeed his humanity, seems threatened by his physical connection to the marble support, of which he appears to be a part.) In painting the model’s skin a pasty white to resemble the roughly hewn, unsculpted marble support, has Witkin respected Vaughn’s boundaries (5)? I believe these are difficult questions to answer and pose a challenge for Millett-Gallant who is willing to admit to competing interpretations of visual disability in art (and disability pride), but who repeatedly minimizes them. I do not have time to delve into it fully here, but Freeland is much more unsure about how to interpret problematic and controversial images; she cites, for example, the work of Robert Mapplethorpe and the examples that really push people over the edge, the



Sally Mann. *From the Night-Blooming Cereus series* (1988).



Popsicle Drips (1985).

photographs of nude children posed by their mother in rural Virginia: photographer Sally Mann.

Is it enough for Mann's daughter to report, later in life, that "we enjoyed being photographed. It gave us a sense of beauty?"¹⁷ The similarity, in some respects, of Witkin's *Portrait of Greg Vaughn* and Mann's *Popsicle Drips*, is instructive. It alerts us to the multiple meanings not only of visual representations of boyhood, young men's bodies, and the depiction of disability, but also to the professed voice of the poser/performer whose pronouncements might more reasonably be taken with a grain of salt. As mentioned earlier, I offer the comparison of these photos as a way to extend the dialogue begun by Ann Millett-Gallant, as it brings together two realms of inquiry—disability studies and feminist aesthetics—at the site of very complicated images. In re-reading Freeland's analysis, I sense her difficulty and frustration at arriving at clean, decisive readings of the photographs of Sally Mann. Aware that subjective responses can vary greatly, Freeland argues that some of Mann's photos fail the criteria of subjectification, and she relegates them to the realms of objectification instead. Her reaction to the comment made by Mann's daughter, Jesse, in which she conveyed a sense of enjoyment and beauty, is none too subtle:

My response to this comment is the same as the point made earlier about little girl beauty queens. It is difficult to defend the position that their choices to participate in competitions that objectify and hypersexualize them at a young age are autonomous. And so even if, like Jesse Mann, they comment later on that they enjoyed the process, their opinion does not cancel out the fact of their objectification. Sally Mann is like any other stage mom (or dad) using a child as means to an end.¹⁸

IV. Millett-Gallant's Performing Amputation

In this final photo by Joel-Peter Witkin, Ann Millett-Gallant herself, the author of the text I have used primarily throughout this paper, is performing amputation. Entitled *Retablo*, *New Mexico*, she is the figure on the right with her back to us in an elaborately staged retablo which references Latin American, Catholic folk art traditions (and for Millett-Gallant, she notes, the works of Kahlo). Witkin was inspired by a retablo image of two lesbians embracing, posed above a prayer to San Sebastian, thanking him for bringing them together. Witkin's photograph also contains this prayer (at the bottom) and is steeped in the European tradition of retablos such as the Italian painter Duccio's painting of Christ resisting Lucifer's temptations (although in Witkin's, this includes a future of the world after the tragedy of 9/11). The principle female nude is modeled after Veronica, who gazes down at her lover, Sylvia, staged on a pedestal covered in flowing drapery, and includes a

characteristic St. Sebastian and a skeleton reminiscent of death. Even Millett-Gallant summarily states, "I cannot logically explain the photograph, as it defies a central narrative. It is far more sensory than sensible," but she is quick to proffer that she felt no embarrassment disrobing, removing her prosthesis, being painted white, and being posed.¹⁹ She concludes her book with this image, sharing her thoughts with us:

I have my back to the camera and am seated on my two shorted legs (one congenitally amputated above the knee and one below), as I extend my "deformed," or here fabulist/fabulous arms. The female figures are opposing in the positions—one flaunting the front of her nude body, the other much smaller and flaunting her back. The two bodies complement one another and complete a disfigured, heavenly narrative. Witkin said he especially, aesthetically admired my back, which inspired the pose. This seated figure that is me is magical and all-powerful; as viewers stare at my back, I stare back. Like the other models in this book, I perform for my readers/viewers. Life becomes art.²⁰



Joel-Peter Witkin. *Retablo*, New Mexico (2007). Catherine Edelman Gallery, Chicago.

I leave the final analysis, interpretation, and evaluation up to you. Does performing amputation embody agency, pride, and beauty? Or is it an ill-conceived exploitation of one's vulnerability? I would suggest that there are multiple interpretations to ponder here and that perhaps the more we consider, the richer the discussion will be. I look forward to the discussion in the hopes that we can discern even more nuanced criteria for a concept of "disability pride" and the natural correlative of that

concept, one which has so far remained unnamed: the concept of disability beauty.

Endnotes

1. My favorite Burke quote always seemed to reveal more desire than disinterest: "observe that part of a beautiful woman where she is perhaps the most beautiful, about the neck and breasts: the smoothness; the softness; the easy and invisible swell; the variety of the surface, which is never for the smallest space the same; the deceitful maze, through which the unsteady eye slides giddily, without knowing where to

- fix, or whither it is carried.” Edmund Burke, *A Philosophical Enquiry into the Origin of Our Ideas of the Sublime and Beautiful*, trans. J.T. Boulton (Notre Dame: University of Notre Dame Press, 1968), 115; see also Peg Zeglin Brand, ed., *Beauty Matters* (Indiana University Press, 2000), 10.
2. Ann Millett-Gallant, *The Disabled Body in Contemporary Art* (New York: Palgrave Macmillan, 2010).
 3. *Ibid.*, 2.
 4. *Ibid.*, 2-3.
 5. *Ibid.*, 4-5.
 6. *Ibid.*, 7.
 7. *Ibid.*, 9.
 8. *Ibid.*, 13. The work referenced is David Hevey, *The Creatures that Time Forgot* (London and New York: Routledge, 1992).
 9. Millett-Gallant, 37.
 10. *Ibid.*, 84. The source is Rosemarie Garland-Thomson, “Seeing the Disabled: Visual Rhetorics of Disability in Popular Photography,” in *The New Disability History: American Perspectives*, ed. Paul K. Longmore and Laurie Umansky (New York: New York University Press, 2000), 335-74.
 11. Millett-Gallant, 84.
 12. Millett-Gallant, 95-96.
 13. Cynthia Freeland, *Portraits and Persons: A Philosophical Inquiry* (Oxford University Press, 2010).
 14. *Ibid.*, 21.
 15. *Ibid.*, 199.
 16. *Ibid.*, 200.
 17. *Ibid.*, 223.
 18. *Ibid.*
 19. Millett-Gallant, 143.
 20. *Ibid.*, 144.

Disability, Internalized Oppression, and Appearance Norms

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Whether disabled or not, people who do not meet appearance norms often feel intense pressure to use available medical interventions to “fix” their appearance. Feminists have critiqued the practice of cosmetic surgery given its complicity with sexist norms of appearance and standards of beauty.¹ In disability studies circles, the pressure to adhere to norms of species-typical functioning has also been widely criticized.² Should such criticisms extend to practices and medical interventions designed to help people achieve species-typical *appearance* norms? In this paper, I argue that they should, but with certain caveats. Namely, the criticism of species-typical functioning is not so much a problem with the attempt to help people achieve the norms as such, but rather the social, institutional, and contextual features that make that offer very difficult to resist, and that simultaneously denigrate the worth of the individual as she is without typical functioning. In a world in which disabled people were widely valued and respected for their abilities, some individuals might well prefer to use medical technologies or other interventions to attempt to achieve typical functioning. But not all would, and we could perhaps be more confident that what motivated individuals who did desire such change would not be a sense that they could not be complete or valued without it. Similarly, in the case of interventions to achieve normal appearance, what matters most, morally speaking, is not that an intervention aims at producing a particular look, but rather

the relative ease of acceptance of the individual regardless of whether she gets the intervention, and the ways that social practices can constrain her alternatives.

In this paper, I focus on how pressures to achieve appearance norms align with similar and troubling pressures to meet functioning and beauty norms, and how such pressure can undermine or diminish individual autonomy. Put another way, I’m less interested in what the particular aimed-for appearance is, and more interested in what motivates a person to seek it. As a secondary point, though, I think we need to be aware of how social expectations shift in accordance with what many individuals do, even if each individual does so autonomously, and they do not aim for a collective end. When many people seek surgery to enhance their looks, they exacerbate pressures on others to meet similar standards.

Cosmetic surgery is a relatively widely accepted practice that still raises the hackles of many feminists. In philosophical debates over its moral acceptability, criticisms sometimes focus on how autonomous choices for cosmetic surgery really are. That is, although women certainly can be said to “choose” such surgery, and even sometimes adamantly insist that they are doing it for themselves (not for anyone else, or due to any troubling interference), critics have expressed concern about two possibilities: 1) that such women don’t have sufficient alternatives, at least with respect to maintaining their social status, given sexism in society; 2) that such women may have internalized oppression that undercuts the apparent authenticity of their choice. When people act within unduly constrained circumstances (“your money or your life” spoken at gunpoint is obvious coercion; “get a face lift or lose your broadcasting job” may similarly be coercive, even if it is not directly threatened but clearly understood), or when they accept norms that denigrate them, learning to see themselves as problematic or of lesser value than others, we need to pay close attention to how much weight we give their individual decisions in terms of their responsibility and our duty to respect their autonomy. Saying “she knew what she was getting into, and she chose it” seems troubling if a woman who gets cosmetic surgery deeply felt that she could not be acceptable or employable without it. It sets an overly narrow scope on the moral dimensions of the issue at hand. Instead, the widespread use of cosmetic surgery, particularly by women, means that we need to attend to the broader social forces—such as continuing oppression of women—that constrain women’s action and may undercut their senses of self.³ Sexism in norms of appearance hasn’t gone away, despite the efforts of third wave feminists to try to seize control of our ideas of beauty and appearance.

Our reasons for questioning the sexist norms of appearance underlying the use of cosmetic surgery may also be reasons for questioning the norms of appearance that motivate people with visible bodily abnormalities (e.g., facial “wine stains,” cleft palate, atypical limb growth, scars from burns or trauma) to seek to “correct” their appearance. That is, we should also be asking whether or not such individuals have sufficient alternatives to treatment (or do they feel unduly pressured to receive treatment?), and is their choice among alternatives possibly the result of internalized oppression? In what follows, I will explore how norms of appearance influence decisions about medical interventions for people with visible abnormalities. In particular, I want to examine a) whether those norms are morally troubling in ways similar to the norms of appearance that drive the cosmetic surgery industry; and b) how we might distinguish between internalized oppression and autonomous choice in accordance with mainstream values.

Sexist norms of appearance/ableist norms: some commonalities

What, then, might we say about how norms of appearance influence or constrain the choices of disabled people, who face a multitude of normalizing pressures? Much work has been done in disability studies to critique the norm of species-typical *functioning*, and the assumption that species-typical functioning is either a biological ideal or a normative one. Yet visibly impaired people (e.g., in wheelchairs, with limb anomalies, showing difficulties in muscular control) often face intense pressure to use available medical treatments and experimental therapies to attempt to bring their bodies back into common modes of functioning, and failing that, are left to deal with frustrating attitudes of pity, judgments of incompetence, and lowered expectations. Given that alternative modes of functioning are possible, and sometimes meet or exceed species-typical modes of functioning, these pressures are surely misplaced, and the negative consequences for failing to adhere to them are unnecessary. So, for example, why pressure someone to use crutches if she can get around more efficiently in a wheelchair? Though the crutches may appear to more closely approximate the species-typical mode of getting place to place—walking—if the wheelchair works quite well we should be open to it as an alternative mode of achieving the same general goal. So long as the built environment is designed to accommodate wheelchairs, this alternative mode of functioning may be superior for this individual.

While disability studies scholars have widely argued for a sociopolitical conception of disability that focuses on the unnecessary connection between impairment and oppression/discrimination, and have pointed to myriad ways in which available alternatives are artificially limited for disabled people in order to encourage them to approximate norms of functioning (e.g., Silvers on post-polio individuals pressured in rehab to use crutches rather than a wheelchair, or Wolbring on the pressure to use prosthetics rather than thalidomide-altered limbs), they have not typically argued that choices by disabled individuals to receive medical treatments to mitigate some of the negative consequences of their impairments are in any way less than fully autonomous due to internalized oppression.⁴ That is, few scholars have claimed that seeking treatment to meet the species-typical norm of functioning is questionable because of internalized oppressive norms, though this may well be true. Partly this absence is due, I think, to a hesitation to undercut the autonomy of already oppressed people, by calling into question the authenticity of what they say they desire (even if the socially imposed *reasons* for their desires are really the intended target of moral criticism). Similar issues arose in the women's rights movement's calls for consciousness-raising.⁵ But surely oppressed individuals can be empowered through critical engagement with their expressed values, at least when it is done sensitively and carefully.⁶ I also think the lack of attention to internalized oppression stems from the difficulty of discerning the difference between one's own identity, forged in conditions of oppression, and the parts of one's moral psychology that may be distorted by the same oppression (more on that to come in part 2).

My point for the moment, however, is that when mainstream negative attitudes about disability (i.e., that it is pitiable, that it is primarily a problem of an individual's body, that it suggests global incompetence or at least distinct "otherness") determine a disabled person's attitudes about what she desires, as well as about her own worth and competence as an individual, we *should* pay attention to the likelihood of internalized oppression. When individuals have difficulty recognizing their own value, or when they desire a medical intervention because they

think without it they can never be accepted by others, we have good reason to think their ability to make autonomous choices and act autonomously is constrained.⁷ In teaching courses in disability studies, I've found that a significant number of disabled students seemingly "find" themselves after learning about this new framework for disability. They may have submitted to diagnostic adventures, multiple therapies, and much rehabilitation in their lives, and thought they were doing so relatively autonomously, but when they discover the sociopolitical understanding of disability, they often feel newly empowered, and may reassess the authenticity or the autonomous nature of those former desires.

None of this necessitates a view that staunch disability studies activists and scholars could not autonomously seek medical treatment that might help them approximate species-typical functioning. Rather, it highlights how tricky it can be to judge the difference between when oppression infiltrates our thinking, and when it merely recognizably alters our thinking⁸; when it diminishes our autonomy, and when it merely shapes our autonomous choices (sometimes by way of resistance, sometimes by way of chosen assimilation).

So it seems to me that the pressures on disabled people to normalize in respect to functioning share many troubling features with the pressures on women to meet sexist norms of appearance. We can call the first form of oppression ableism, as it harms those who fail to meet able-bodied/species-typical forms of functioning. Ableism in respect to functioning, then, is akin to sexism in respect to beauty norms. But what are we to say about the pressures on disabled people to meet certain appearance norms? Is a species-typical appearance norm as morally troubling as a species-typical functioning norm?

The group of individuals who do not meet appearance norms intersects with but does not wholly conform to the group of people with visible functional impairments.⁹ A person with prosthetic legs may have some functional impairments but greatly exceed appearance norms (e.g., athlete-turned-model Aimee Mullins). A person without any functional limitations may nonetheless fail to meet appearance norms (e.g., an individual with a large facial "wine stain").¹⁰ It's not clear what we would call the particular form of oppression related to failing to *appear* "normal." Appearanceism? Looksism? Putting questions of terminology on hold, though, we can see that individuals who fail to meet appearance norms may well face diminished autonomy in seeking to use medical interventions to try to achieve a normal appearance, given their perceived lack of options (be stared at, stay home, or get medical help to look normal)¹¹ and the possibility that they have internalized the norms that denigrate their appearance, coming to see themselves as pitiable or lacking worth because of that appearance.¹² Furthermore, we might think that the kind of oppression imposed by an excessive focus on appearance would encompass the kinds of ableism related to disability oppression, given that many functional impairments also leave individuals outside species typicality in respect to appearance.¹³

Internalized oppression and autonomous choice in accordance with mainstream values

Of course, not all norms or values that are internalized are pernicious or oppressive. And even oppressive norms that invariably shape one's identity and desires may do so without necessarily undermining or diminishing one's autonomy. How are we to tell the difference between someone who has internalized oppressive norms of ableism and seeks surgery to more closely approximate those norms in a way that suggests a diminishment of autonomy, and someone who has *not*

internalized the norms, but instead accepts that they exist, regrets it, perhaps even fights against them in some respects, but still autonomously seeks surgery to meet them as a calculated means of improving her social standing? It seems to me that our moral assessment of these two situations ought to be different (though in both cases we will regret the harmful norms of appearance). Resistance to the oppressive norms may be taken as a clear sign of independence from them, but surely we need not require complete resistance for autonomy.

Two points are worth considering here: *recognizing* oppression in the world (acknowledging its existence in respect to one's group) is part of gaining autonomy, and being open to the idea that one's own desires may be the result of internalized oppression seems important as well. So, for instance, a person who cannot see or refuses to acknowledge the ways in which a group she belongs to gets exploited, marginalized, or systematically denied power¹⁴ seems a likely victim of internalized oppression. Oppression operates in an insidious manner: both agents of oppression and many subjects of oppression may rationalize, naturalize, and attempt to justify the negative consequences of the oppression (e.g., "due to their impairments, disabled people are necessarily unable to perform in many jobs, and so are better off staying out of the workforce" or "mothers are less able to handle the stress and time commitments of work outside the home, and so ought to devote their time to their children"). Learning to see alternatives, to recognize that what appears natural or normal may be artificially imposed, is thus part of recognizing oppression and separating oneself from it. Of course, even as one sees oppression in the world, one might still believe it is a problem for others, not for oneself. "I know that women are held to unreasonable standards of beauty, but my own particular case was different—my body was outside the bounds of what can be accepted" is a close approximation of what many women cosmetic surgery recipients claim.¹⁵ Thus, acknowledging the existence of oppression is far from sufficient for enhancing autonomy; one must also at least be open to the possibility that one's own desires are the result of internalized oppression. It's decidedly more difficult to specify what such openness consists in. Perhaps all that can be said is that the individual must be open to dialogue on the matter; she must have a willingness/capacity to answer to others about her choices, to defend them.¹⁶

Given those constraints, let's consider two disabled people with similar conditions who seek an appearance-normalizing therapy (let's say they each have scoliosis and each seeks surgery to straighten her spine, primarily for aesthetic reasons). One such person may claim that she does it because it's the only way she can be relatively normal and feel good about herself; she may despise her scoliosis and feel that it ruins her opportunities for a reasonable life. She may report that she chooses the surgery because it's the only alternative to a life in which she is afraid to be seen in public. When asked about whether or not the appearance norm she's trying to meet might be somewhat unfairly imposed on her, she may adamantly deny the possibility, believing instead that it's just what anyone would want. These features suggest a problem of internalized oppression. Another individual with the identical condition might also seek such a surgery. But she might note that it's unfortunate that appearance matters so much in respect to doing well in this world, and agree that her need to undergo surgery in order to gain certain conveniences that follow from meeting appearance norms (no stares, fewer probing questions from strangers, greater ease in getting and keeping a job) is troubling. Furthermore, she may acknowledge that it's possible that part of her desire for the surgery is really about meeting a norm that is difficult to resist, but still claim that she wants the

surgery because she has to choose her fights, and she thinks it will be easier to combat ableist oppression generally if other people don't find it so difficult to accept her appearance.¹⁷

So where does this leave us? I've tried to show that norms of species-typical appearance, like norms of species-typical functioning and norms of feminine beauty, are troubling in that they can undermine an individual's sense of herself as a valuable agent, and through limiting available alternatives and/or leading to internalized oppression, can result in a diminishment of autonomy.

Two very quick final points are in order. One might object to my view by noting that while this may be true of a certain variety of appearance abnormalities, surely at the very edges of the "normal curve" we can understand that failure to meet appearance norms is clearly a problem of the body, and not at all about oppression. Here I think about the young Afghani woman who appeared on a recent cover of *Time* magazine, her nose cut off by relatives threatened by her willingness to run away from an abusive husband. That she is oppressed seems clear, but the oppression is not primarily about appearances. As she moves forward in life, should we really be concerned if she decides to seek surgery to create a new nose, because of a worry about troubling appearance norms? No doubt even more extreme cases could be found. I don't think there's an easy way to answer that objection. For anyone experienced in friendship with a person whose appearance is far from the norm, it seems appropriate to argue that oppression is still a key part of the problem, though perhaps action to address the individual body is more understandable or even justifiable, given the other difficulties to be faced by such an individual. But again, recognition and regret about the reality of those difficulties would have to be part of the explanation.¹⁸

Finally, while I have here focused on questions about whether or not pressures to normalize appearances are oppressive, and whether actions to seek appearance-normalizing interventions are morally troubling in their capacity to constrain autonomy, I do think there's an important further question about the consequences of receiving such interventions even when they are autonomously sought. That is, if enough individuals take action to meet a suspect norm of appearance, their actions will have a combined effect that exacerbates the strength of the questionable norm and the pressure put on others to meet it.¹⁹

Endnotes

1. For example, see Susan Bordo, *Unbearable Weight: Feminism, Western Culture and the Body* (Berkeley: University of California Press, 1993) and Margaret Olivia Little, "Cosmetic Surgery, Suspect Norms, and the Ethics of Complicity," in *Enhancing Human Traits*, ed. Parens (Washington, DC: Georgetown University Press, 1998), 162-76.
2. For example, see Anita Silvers, "A Fatal Attraction to Normalizing: Treating Disabilities as Deviations from 'Species-Typical' Functioning," in *Enhancing Human Traits*, ed. Parens (Washington, DC: Georgetown University Press, 1998), 95-123; Ron Amundson, "Disability, Ideology and Quality of Life: A Bias in Biomedical Ethics," in *Quality of Life and Human Difference*, ed. Wasserman, Bickenbach, & Wachbroit (Cambridge University Press, 2005), 101-24.
3. As relational autonomy theorists argue, unjust social conditions can sometimes be as constraining and inhibitory for autonomous choice and action as the more paradigmatic case of a coercive individual. See Susan Sherwin, ed. "A Relational Approach to Autonomy in Health Care," in *The Politics of Women's Health: Exploring Autonomy and Agency*, ed. Sherwin (Philadelphia, PA: Temple University Press), 1998; also the edited volume *Relational Autonomy*, ed. Catriona Mackenzie and Natalie Stoljar (Oxford University Press, 2000).

4. Though there have certainly been arguments about the relative autonomy of disabled individuals considering assisted suicide or refusal of life-sustaining treatment. Furthermore, some disability studies scholars may raise this possibility (e.g., Micheline Mason, "Internalized Oppression" <http://www.leeds.ac.uk/disability-studies/archiveuk/Mason,%20Micheline/mason.pdf>) though they tend not to focus on it.
5. Note that feminist debates about cosmetic surgery sometimes use the regrettable and non-agency-respecting language of "cultural dopes," even as their arguments point to much broader social structures as the main bearers of responsibility for inhibited autonomy in this realm (see Susan Bordo, *Unbearable Weight*; Kathy Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery*, 1994).
6. And, I might add, more powerful discussants can learn equally valuable lessons from the interchange, as when feminists recognized the need to acknowledge the value of connection and motherhood, even as they challenged the patriarchal norms of mothering and family life. In DS circles, such engagement may be part of what moved the field to clearer recognition of the significance of negative "impairment effects" that are often part of experiencing disability (Liz Crow, "Renewing the Social Model of Disability," *Coalition*, July 5-9, 1992; Carol Thomas, "Disability and Impairment," in *Disabling Barriers – Enabling Environments*, 2nd ed., ed. Swain, French, Barnes, and Thomas, (London: Sage Publications Ltd., 2004), 21-27.
7. Relational autonomy theorists have noted the importance of self-worth, self-trust, and self-esteem for gaining autonomy competency (see Meyers, McLeod, etc. in *Relational Autonomy*).
8. In the former case, I imagine that we may not even be aware of its effects on us—I may think of myself as a relatively insecure individual, without recognizing the ways in which deeply engrained sexism often undermines women's judgments about our competence.
9. It would be interesting to consider other intersecting oppressions as well, though I don't have space to do so here. For instance, disabled women face the same pressures as nondisabled women in respect to looking a particular way, though given presumptions about a link between impairment and loss of sexuality, I suppose those pressures may be somewhat differently experienced. Women in general feel pressure to appear young, wrinkle-free, fat-or-bulge free, and busty. Disabled women may find themselves caught in a worse bind—they might be expected to meet such norms, but treated as suspicious when they do.
10. It might be interesting to consider whether certain appearance standards might qualify as required for social functioning, and so collapse back into questions about species-typical functioning.
11. Think of Jerry Lewis, who runs the muscular dystrophy telethon saying (in *Parade Magazine*) that people in wheelchairs should stay at home if they don't want to be stared at; then read Harriet McBryde Johnson's book *Too Late to Die Young*, including the chapter focusing on her protest of the telethon.
12. I worry about these concerns in respect to the individuals who have undergone facial transplantations—though I understand their desire to achieve a relatively normal appearance, one wonders whether their choice to take such a risk could be understood as autonomous given a lack of alternatives, the relative risk they take on, and the difficulty they experience in making a public life given their disfigurements.
13. Certainly not all, given the many forms of invisible impairments. See N. Ann Davis, "Invisible Disability," *Ethics* 116, no. 1 (2005): 153-213.
14. See Iris Young, "The Five Faces of Oppression," in *Justice and the Politics of Difference* (Princeton University Press, 1990).
15. Davis, *Reshaping the Female Body*, 1994.
16. This is the position adopted by Andrea Westlund in "Rethinking Relational Autonomy," *Hypatia* 24, no. 4 (2009): 26-49. She notes that "Being impervious to critical challenge is an excellent candidate for what it is to be gripped by an action-guiding commitment or bit of practical reasoning as opposed to governing it" (p. 34). Being "gripped" by a commitment is, for Westlund, a sign of autonomy deficiency.
17. I think a similar explanation may be at play when disabled women seek cosmetic surgeries to meet sexist norms of appearance; they need not be unaware of the problematic norms of appearance, but rather may be concerned about their ability to resist multiple oppressions simultaneously, or to be taken seriously *given* the problematic norms that are widespread. Indeed, doing so may be a form of resisting the stereotype that treats disability and beauty/sexuality as fully distinct sets.
18. I know I haven't done this objection justice here given space limitations, but wanted to raise it for discussion with the audience.
19. For more on this problem, see Goering, "The Ethics of Making the Body Beautiful: What Cosmetic Genetics Can Learn from Cosmetic Surgery," *Philosophy & Public Policy Quarterly* 21, no. 1 (2001): 21-27.

Comments on Talks by Silvers, Goering, and Brand, APA December 2010

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Anita Silvers addresses two questions: What are medicine's capabilities to bring about beauty? And, should medicine do this?

She begins by distinguishing beauty from attractiveness and normality. Under the category of attractiveness, we may put cosmetic surgery, or "merely" cosmetic surgery: surgery that is not needed to restore normal functioning, but to improve one's appearance. However, as Silvers points out, a middle-aged divorced woman may be at a disadvantage in the job market if she looks old. Plastic surgery in this instance has a functional purpose, and insofar as it enables older women to combat the injustices to which they are subjected, justice-based moral or political prohibitions of this use of medicine are unwarranted.

Should physicians acquiesce to this sort of ageism? Are they even complicit in ageism if they do cosmetic surgery? Silvers does not directly address this question, but she does say that victims of social injustice should not have to bear the brunt of fighting it. I take this to mean that women who think they need plastic surgery to compete on the job market should not be made to feel bad about having it. And why should they—even if the reason is not to compete on the job market, but just to feel better about oneself?

Here I would like to distinguish between a personal issue and a social issue. The personal issue is the individual's use of medicine and surgery for merely cosmetic purposes. Sara Goering says that this raises the hackles of many feminists, partly because they question how autonomous the choice of plastic surgery is. Clearly many women are pressured to go under the knife, as in her example of someone faced with losing her broadcasting job unless she has a face lift. The pressure is particularly acute for actresses, although it is not limited to women: witness Al Pacino who is barely recognizable.

I think it is a shame when so many actresses (and some actors) feel the need to look exactly alike. Ingrid Bergman did

not look like Joan Crawford who did not look like Myrna Loy. These days it's hard to tell Clare Danes from Gwyneth Paltrow and either one from Kate Hudson. But I don't see this as a moral issue. Some women do not need plastic surgery to get or keep jobs. They just want to look better. Quite honestly, I don't see why that is anyone else's business. I'm glad we're a long way from my graduate school days when the wearing of lipstick was a political statement, not to mention shaving your legs or arms.

There is a serious social issue, however, and that has to do with the increasing popularity of plastic surgery as a specialization. According to an article in the *New York Times* in 2008, dermatology and plastic surgery are among the most competitive fields for residencies. It's not a mystery why. The hours are better and the pay is way better. As one dermatologist put it, "It is an unfortunate circumstance that you can spend an hour with a patient treating them for diabetes and hypertension and make \$100, or you can do Botox and make \$2,000 in the same time." Such discrepancies are dissuading some top students in American medical schools from going into family practice—and that is a serious social problem that needs to be addressed.

Regarding face transplants and surgery on children with facial anomalies, Silvers bases the acceptability of such interventions on the likelihood of "meaningfully improving social and/or biological functionality," while recognizing that drastic interventions are risky, and may leave the patient worse off. In fact, not only are such interventions a justifiable use of medical expertise, but insofar as they enable individuals to participate fully in society, justice may require that they are paid for. Face transplants not only enable patients who need them to eat, breathe, and speak better, but they also reduce the number of encounters in which people turn away, and that, too, Silvers suggests, has a significant value.

By contrast, Goering suggests that there may be internalized oppression at work in the desire of people with facial anomalies to look normal. She writes, "When individuals...desire a medical intervention because they think without it they can never be accepted by others, we have good reason to think their ability to make autonomous choices and act autonomously is constrained." Presumably, she finds the appeal to benefit and risk to be less than totally helpful, since the question is, Are people with facial anomalies benefited by surgery (assuming it's successful) if it is chosen because other people turn away? Goering acknowledges the difficulty of determining whether someone who chooses surgery does so autonomously, in recognition of social realities and in order to improve her own situation, or does so out of internalized oppression.

The only way to find out, it seems, is for people to engage in dialogue about what they want and why they want it. The value of that is that sometimes they may come to realize that they don't really want what they thought they wanted, or that they aren't willing to undergo the cost and pain and risk of surgical alterations just to meet someone else's conception of attractiveness or normality.

What about beauty? If beauty is distinct from attractiveness, what is it? Silvers doesn't provide an analysis, although she says that it can't be banal or bland. She relates the notion of beauty to art, and points out that sometimes artists get us to see the world differently. If we can appreciate a Picasso Cubist portrait as beautiful, we may also be able to perceive a condition characterized as a deformity as beautiful. (Here, I must say that it does not take much to view the photo Anita provides as attractive and engaging, and certainly not repellent.)

What are the normative implications? Silvers suggests that physicians have at least a mild moral obligation to view

biological anomalies aesthetically, which means, I take it, as beautiful, and she says that this is a requirement of inclusive justice. However, this seems to conflict with her view that facial surgery to make children with disfigurements more attractive may be justified, depending on the benefit-risk ratio, and even required by considerations of social justice. So, should the physicians perform facial surgery to make people more conventionally attractive? Or should they try to see the beauty in biological anomalies, and counsel against surgery? Does the resolution of this question lie in what the individual person, free from internalized oppression, really wants, as suggested by Professor Goering? Perhaps she could say something about how she thinks adults might approach this question if they are choosing for not-yet-autonomous children, since often facial surgery is easier if done on young children (or even perhaps fetuses) since there is less risk of scarring.

Peg Brand takes up the challenge of viewing disability aesthetically. She is not primarily interested in the normative implications in terms of corrective surgery, but rather explores the social implications of art that portrays what is known as disability pride. The two subjects are connected, however, because they both reject the "medical model" of disability as something lacking, something to be fixed.

Here, things get very complicated. On the one hand, you have Ann Millett-Gallant, who argues that photographs of people with disabilities can be empowering and liberating, as they reject the view that their disability is something to hide or overcome. On the other hand, you have David Hevey, who argues that photography "enfreaks" disabled people. Brand suggests that both are possible results, which raises the question: How do you distinguish between representations that gawk at disability, which is voyeuristic and offensive, and genuine aesthetic appreciation of disability? Brand suggests that the key is the attitude of the model, that is, whether he or she feels empowered, proud, and beautiful as opposed to exploited and cheapened. She writes, "Beauty trumps offensiveness. Pride wins." But she goes on to note that not everyone will agree, and Brand herself suggests that there are limits to justifications based on the model's attitude. For example, Sally Mann took nude photos of her children, which some see as beautiful and others as pornography. Brand asks, "Is it enough for Mann's daughter to report, later in life, that 'we enjoyed being photographed. It gave us a sense of beauty?'" Not for Cynthia Freeland, who likens Mann's photos of her children to little girl beauty pageants. Both hyper-sexualize and objectify children, which is wrong even if they enjoyed it at the time. Freeland comments, "Sally Mann is like any other stage mom (or dad) using a child as means to an end."

Of course, the notion of using someone as a means (more accurately, mere means) to an end is notoriously difficult to flesh out. Onora O'Neill characterizes it as engaging someone in a plan to which they could not in principle consent—which works well for explaining the wrong of deception and coercion, but is unhelpful in this context. If we see taking nude pictures of children as hyper-sexualizing them, we are likely to think that they are being exploited and therefore treated as mere means. If we think that there's nothing necessarily sexual about the nude bodies of children, we probably won't. In any event, children, who cannot give autonomous consent, are probably the wrong model for thinking about "enfreakment." The real question is whether the attitudes of autonomous adults toward the portrayal of their disability settle the question of exploitation. This question is not limited to the portrayal of disability in art. It comes up in discussions of surrogate motherhood (or contract pregnancy, if you prefer) and prostitution. In all of these cases, it seems to me, the mere consent of the agent is not sufficient

to overcome a charge of exploitation, since even autonomous agents can be wrong about their situation, for reasons such as false consciousness, lack of awareness, or social pressure. Indeed, even consent that is based on thoughtful reflection, based on the facts, and free of undue pressure would probably not be enough. In addition, others in the social milieu need to respect the person and whatever it is she is doing. Given the way prostitutes are viewed in most societies, it's hard not to think of them as being objectified and exploited, but it's not impossible to imagine a society in which being a sex worker is viewed as comparable to being a massage therapist, and in which both professions and the people who occupy them are respected. In such a society, a woman (or man) who chose to be a sex worker, and took pride in her work would have a good case for saying that she wasn't being objectified in any objectionable sense, or exploited, or wronged.

However, it might be objected that just because society has out-dated, moralistic attitudes toward sex, it doesn't follow that someone who autonomously chooses prostitution is necessarily being exploited. Perhaps social attitudes will change only if some brave souls make choices that run contrary to social values. This is often the function of art, so perhaps photos of disabled people will change the way society sees them and their disabilities. To the extent that such a change enables people with disabilities to live happier, more fulfilling lives, this would seem to be a good thing.

Brand ends with a photo which portrays an amputated limb. (I think. Brand refers to performing amputation, but it seems the leg has already been amputated and the photo shows her having removed her prosthesis.) Does the photograph embody agency, pride, and beauty, or something darker and unpleasant? If a photo of an amputation is beautiful, does that suggest we're on a slippery slope, to validating or normalizing Body Integrity Identity Disorder (BIID), in which people want to have one or more of their limbs or hands amputated, believing they would be happier living as an amputee?

Irene and Beth

Felicia Nimue Ackerman
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Irene has shining golden hair,
And fame and glory without end,
And greater wealth than even she
Could ever find a way to spend.

But Beth cannot afford to buy
What goes beyond her basic needs.
She must make do with what she has
And squeeze each penny till it bleeds.

Which woman hates her empty days?
Whose sadness makes her hard and mean?
Who yearns and yearns to change her life?
I'm sorry, but...it's not Irene.

Existential Suffering and the Ethics of Palliative Sedation

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Introduction

The nature and ethical implications of human suffering should be critical considerations to both moral philosophy in general and biomedical ethics in particular. Except perhaps for certain religious views about the redemptive, and therefore potentially positive, aspects of suffering, this phenomenon is usually considered an experience to be avoided whenever possible. A core value of medicine has been the relief of suffering associated with illness. Articulations of this value in the literature of the health professions reveal no effort to parse the nuances of the term suffering or engage in any sort of ethical analysis of circumstances in which the relief of suffering would be problematic. In both a figurative and literal sense, the physician and medical ethicist Eric Cassell has “written the book” on suffering from the clinical perspective, beginning with his seminal 1982 article in the *New England Journal of Medicine*,¹ and continuing with the first (1991) and second (2004) edition of his book of the same title, *The Nature of Suffering and the Goals of Medicine*.²

Essential to Cassell's conceptual analysis of suffering is the nature of persons, for he insists that “bodies do not suffer; persons suffer.” Consequently, physicians cannot effectively respond to suffering if they do not engage with the person (the patient) who suffers. Cassell offers a topology of the person in the fully formed sense that would not necessarily encompass neonates or the profoundly demented. The essential attributes of persons from Cassell's perspective include the following: personality and character, a past consisting of many life experiences, a family (however fragmented or dysfunctional), a cultural background, social roles, political status, behavioral patterns, a body, a secret life, a perceived future, and, finally, a transcendent dimension.³

Suffering, from Cassell's perspective, occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. Consistent with this concept of suffering, it can be defined as the state of severe distress associated with events that threaten the intactness of the person. It follows from this, he maintains, that while suffering may often coincide with the experience of pain or other physiological symptoms, such symptoms do not always engender suffering nor may suffering be reduced to pathophysiology. Cassell openly and pointedly challenges earlier inclinations by the medical profession to accept mind/body dualism. Dualistic notions are pernicious because under such a construct suffering is either subjective and not within the scope of the physician's responsibility, or it is reduced to bodily pain, which on his view would be factually erroneous and ethically unacceptable.

One cannot extensively review the literature of the health professions without realizing how influential, pervasively cited, and seemingly authoritative Cassell's work on suffering has become. The operative word here is “seemingly” because recent work in the field of palliative medicine strongly suggests that mind/body dualism persists. Moreover, while citing Cassell's work on suffering approvingly, the thrust of this recent work is radically inconsistent with his conception of suffering and his antagonism to dualism. The focus of this paper will be

an elucidation of this phenomenon and an exploration of the ethical implications of dualistic thinking within the domain of palliative medicine.

Recent Policies and Position Statements on Palliative Sedation

In 2001 the American College of Physicians-American Society of Internal Medicine's (ACP-ASIM) Ethics and Human Rights Committee published a position paper expressing its opposition to physician-assisted suicide in general and as authorized under the Oregon Death With Dignity Act. An analysis of the arguments set forth therein is beyond the scope of this paper. However, what is of critical concern here is the ACP-ASIM discussion of suffering in the context of terminal illness. Consider the following language:

When patients continue to suffer from physical symptoms or psychiatric syndromes despite the best efforts at palliation, physicians should vigorously pursue the alleviation of these syndromes, even at the risk of unintentionally hastening death. But when the patient's suffering is interpersonal, existential, or spiritual, the tasks of the physician are to remain present to "suffer with" the patient in compassion, and to enlist the support of clergy, social workers, family, and friends in healing the aspects of suffering that are beyond the legitimate scope of medical care.⁴

I shall return to further consider this language and its implications shortly. But first let us fast forward the calendar to 2008 and a report published by the Council on Ethical and Judicial Affairs (CEJA) of the American Medical Association (AMA) that was formally adopted as the official policy of that organization. Its title is "Sedation to Unconsciousness in End-of-Life Care." After citing earlier AMA opinions that the obligation of a physician includes "providing effective palliative treatment even though it may foreseeably hasten death," the report moves to the primary focus of palliative sedation and states the following:

Palliative sedation to unconsciousness is only appropriate for terminally ill patients as an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that have not been relieved by aggressive symptom-specific palliation. ...Severe psychological distress may also warrant palliative sedation to unconsciousness when potentially treatable mental health conditions have been excluded.⁵

We now come to the critical distinction initially introduced in the ACP-ASIM position paper that finds its way into the AMA-CEJA report on palliative sedation, which reads as follows:

Purely existential suffering may be defined as the experience of agony and distress that results from living in an unbearable state of existence including, for example, death anxiety, isolation, and loss of control...the Council concurs with those who argue that existential suffering distinct from the previously listed symptoms is not an appropriate indication for treatment with sedation to unconsciousness because the causes of this type of suffering are better addressed by other interventions.⁶

The other interventions are not otherwise specified, but one might reasonably infer that those mentioned in the ACP-ASIM position, i.e., clergy, social workers, family and friends of the patient, are prime candidates.

Let us be perfectly clear about the underlying proposition inherent in these two official pronouncements by major medical

organizations: persons confronting terminal illness are likely to experience two quite different types or categories of suffering as they approach death. One of them is "clinical" in nature, is a responsibility of the physician to address, and when it proves refractory to other palliative measures may warrant sedation to unconsciousness. Another type of suffering, labeled existential, spiritual, or interpersonal, is nonclinical in nature, is not necessarily the responsibility of the physician, and does not warrant sedation to unconsciousness even when it proves refractory to all other palliative measures.

Neither report makes any reference to Cassell's conceptual analysis of suffering, nor does it offer one of its own to explain and justify the proposition that human suffering associated with terminal illness partakes of two distinct varieties which require quite different palliative interventions and make widely disparate demands upon the physician. Further review of the literature does reveal a highly relevant instance in which the germ of an argument in support of this distinction is offered. Interestingly, one of the co-authors of that publication was also a member and one of two lead authors of the ACP-ASIM report, Dr. Daniel Sulmasy. To that article and its theses I now turn.

A Dualistic Account of Terminal Suffering

In an article entitled "Proportionality, Terminal Suffering, and the Restorative Goals of Medicine," Lynn Jansen and Daniel Sulmasy (hereinafter J-S) argue that two distinctly different types of suffering may afflict the terminally ill, each of which makes different professional demands upon the clinician.⁷ Failure to recognize this dichotomy of suffering, they worry, may lead physicians to engage in unethical conduct in the care of the dying. The two distinct types of suffering they identify are strikingly similar to that described by the ACP-ASIM and the AMA-CEJA. J-S ascribe to them the terms "neurocognitive" and "agent-narrative" suffering. Neurocognitive suffering, which purportedly includes such "symptoms" as anxiety disorder, clinical depression, seizures, and bone pain, is described as "suffering that has a direct causal relationship to the patient's underlying medical condition" and would be reasonably expected to induce suffering in most patients who experience them. Agent-narrative suffering, which purportedly includes such "symptoms" as fear, sadness, worthlessness, loss of independence, is described as "suffering that has an indirect causal relationship to the patient's underlying medical condition" and arises because of a particular patient's attitudes and beliefs about his or her situation.⁸

There are two propositions that are critical to the J-S position that palliative sedation is never an ethically acceptable option for agent-narrative suffering, even when severe and refractory. The first is their belief that even in the case of the imminently dying patient, there is always the potential for restoration or healing, if not of physical, then of psychosocial well-being. Interestingly, however, their focus on the legitimate medical goal of restoring psychosocial well-being is entirely upon the patient afflicted with agent-narrative suffering. Thus, like the AMA, if a psychiatric diagnosis can be placed upon the patient's distress and it is refractory to other therapeutic or palliative measures, then sedation to unconsciousness is an acceptable palliative option of last resort. In other words, additional and probably futile efforts at restoring psychosocial well-being need not be undertaken. However, if no acceptable psychiatric diagnosis is made and the patient's distress is labeled agent-narrative or existential suffering, then sedation to unconsciousness is never acceptable and the physician is admonished to redouble the efforts of spiritual and social counselors and families to relieve the patient's distress and the physician urged to remain present to suffer with the patient in compassion.

It is also important to note that J-S focus on the restorative goals of medicine, not the patient. They do at one point acknowledge the possibility that “Some terminally ill patients will reject all efforts to restore them to a state of psychosocial well-being....” Nevertheless, they insist that to accede to the request of a patient afflicted with agent-narrative suffering would be unacceptable. The reason, they suggest, is that it would violate “the principle of therapeutic responsiveness,” their second core proposition.

J-S offer no authority or reference for this principle and an Internet search failed to reveal any source for it other than their article, so we must assume it is original to them. They offer the principle as a limitation upon or further qualification of the proportionality principle that is a critical feature of the Doctrine of Double Effect. In that context, the benefits derived by performing the act in question must be proportionate to the harms that can be reasonably anticipated. In this context, J-S refer specifically to an article by Quill, Lo, and Brock which suggests that “The greater the patient’s suffering, the greater the risk the physician can take of potentially contributing to the patient’s death, so long as the patient understands and accepts the risk.”⁹ J-S critique this articulation of the principle for its failure to acknowledge the existence of distinct types or categories of suffering and the impact such distinctions would have on acceptable risks that may be taken to alleviate them. As an antidote, they propose a revised proportionality principle that incorporates their principle of therapeutic responsiveness and which reads as follows:

A physician’s therapeutic response to terminal suffering is justified, even if it imposes a high risk of hastening the patient’s death, if and only if (i) the measures implemented are directly proportionate to the intensity of the patient’s suffering; (ii) the measures implemented are appropriate for the type of suffering the patient is experiencing and, therefore, are properly responsive to the patient’s restorative interests; and (iii) the patient or the patient’s legal surrogate understands and accepts the risks associated with the measures.¹⁰

J-S argue that if it would be inappropriate, according to their analysis, to provide palliative sedation to a patient with severe and intractable agent-narrative suffering who does not have a terminal condition, then it would also be inappropriate for a patient who does because the imminence of death does not eliminate the patient’s restorative interests. Moreover, a terminal patient’s refusal to pursue those interests and plea for palliative sedation will not justify the physician’s abandonment of medicine’s restorative goals.

Critiquing Dualism in Palliative Medicine

First, we should be clear that most certainly there are some manifestations of suffering in the context of terminal illness whose aspects partake more of the physiological than the psychological or spiritual. This observation is entirely consistent with Cassell’s topological analysis of the person and the multiple dimensions in which persons live their lives and experience the world. It is quite another thing entirely to insist upon the existence and ethical significance of quite rigid and categorical distinctions concerning the nature of suffering engendered by terminal illness. The effort to fully and accurately grasp the nature of terminal suffering, which is essential to the responsible formulation of ethical principles to support the provision of palliative options of last resort, is in important ways analogous to the largely philosophical inquiry into the nature of persons or selves that has been re-energized lately by the rise of neuroethics.

Just as the majority of contemporary philosophers and cognitive neuroscientists reject dualism between mind and body or mind and brain, so too ought we to be wary of efforts to impose such dualistic views on the nature of suffering. The very suggestion that a person in a far advanced stage of a terminal illness may experience a type of suffering that has little or no connection to the underlying pathophysiology of the disease runs counter to all that we know about the basic inter-relationship between the physical, the mental, and the situational in the lives of persons. Philosopher Walter Glannon has written most cogently on this subject recently. In arguing against what he refers to as neuroreductionism, the proposition that who we are as persons is essentially a function of neurons and synapses of the brain and central nervous system, he takes the position that there is compelling evidence that we are “embodied and embedded minds.”¹¹ By that he means that our mental states (and here of course I would include the experience of all forms of suffering) are “generated and sustained by the brain and its interaction with external and internal features of our bodies,” but also that the “content and felt quality of our mental states is shaped by how we are situated and act in the natural and social environment.”

If Glannon’s account is reasonably accurate, as I believe it is, then it is strongly supportive of Cassell’s stance with regard to suffering in the context of serious, and most particularly terminal illness. We can do no better than to consider precisely what Cassell has written on this issue.

It is evident that in thinking about suffering it is not possible to divide the problem into physical, psychological, and social aspects without losing our grasp of it. In fact, reflecting on suffering should make it possible to see that there is nothing about the body that is not also psychological and social, nothing social that is not physical and psychological, and nothing psychological that is not physical and social. We are of a piece. What happens to one part of us happens to the whole and what happens to the whole happens to every part.¹²

I would offer only one minor semantic qualification. Rather than being of a piece, we are as persons, or so it would seem from the perspectives of Glannon, Cassell, and others, a seamless whole. Suffering, particularly of the dying, is an experience of the whole person that is inescapably existential regardless of the elements of the typology that may appear to predominate at any given moment in the trajectory of illness.

In a very real sense the approach to suffering advocated by the ACP, AMA, and J-S reaches beyond mind-body dualism to a triadic system of body, brain, and mind. According to this system, bodily suffering, primarily in the form of pain, and brain associated suffering, such as delirium or clinical depression, can be palliated with the sedation to unconsciousness. However, suffering attributable to the mind or self, so-called existential suffering, may not be addressed in this fashion even when severe and otherwise intractable. This trifurcated structuring of persons is radically inconsistent with all that we know of how persons experience living, dying, and suffering.

J-S published another article on palliative sedation in a medical journal the same year (2002) as the one we have been considering, in which their distinction between clinical and nonclinical (existential) suffering was much less thoroughly presented.¹³ A subsequent letter to the editor of the journal critiqued their approach in the following terms: “To argue that physical pain can be teased out of the multidimensional suffering of terminal illness and then used as [the] sole basis for the application of appropriate palliative options, to the disregard

of the whole person, is archaic mind-body dualism.”¹⁴ In their response, J-S deny without argument or explanation that their distinction between physical and existential suffering rests on dualism of any form, archaic or otherwise. Moreover, they offer no further support for their ethical stance that palliative sedation is inappropriate for even severe, refractory suffering of an existential nature in the imminently dying other than their belief that there exists a strong consensus view that it would never be appropriate for a nonterminal patient.¹⁵

Implications for Palliative Options of Last Resort

The policies I have noted above and the argumentation of J-S would have us believe the following. First, that human suffering is not only an entity that can be diagnosed by physicians, at least when it is associated with illness, but that there are two discrete types or categories of suffering which must be accurately diagnosed because they call for markedly different palliative measures. Second, that there is a category of terminal suffering that may be refractory to all other pharmacological or nonpharmacological measures which nevertheless may not be acceptably addressed by the two most notable palliative options of last resort, i.e., sedation to unconsciousness or a lethal prescription.

The ethical implications of this position are significant and disturbing. Beyond any reasonable doubt properly administered and maintained sedation to unconsciousness will remove the patient’s ability to experience suffering. To proscribe it for patients for whom other attempts at relief have failed comes perilously close to willfully inflicting it, in the words of David Morris. It is to consign them and their families to a death without dignity in contravention of a core principle of medical ethics. Even philosophers such as David Velleman, who have argued cogently from a deontological stance against a right to a lethal prescription, have acknowledged an exception. “When a person cannot sustain both life and dignity,” he writes, “his death may indeed be morally justified.” Thus when severe and intractable pain (or presumably suffering) has irretrievably undermined the patient’s dignity by becoming the entire focus of her life, then it can be said that the patient may reasonably choose death for the sake of dignity and not merely out of self-interest. This argument quite comfortably comports with Cassell’s definition of suffering as an actual or impending threat to the integrity of the person. When that threat cannot be eliminated or integrity restored in some other manner, the suffering is intractable and palliative options of last resort clearly indicated.

Before closing I wish to also point out the strong note, not just of paternalism, but of therapeutic belligerence in the J-S stance on the ethical response to intractable agent-narrative suffering. Some of these patients may not wish to be subjected to the type of interventions often recommended for suffering that has been labeled “existential” or “spiritual.” This is particularly true when they are provided, as they usually are, by social workers, pastoral counselors, or clinical psychologists. Although J-S deny that they are dismissive of agent-narrative suffering as being real and engendering distress as severe as neuro-cognitive suffering, the fact remains that if a patient’s agent-narrative suffering is truly refractory, their approach leaves the patient to suffer until death, whereas those afflicted with neuro-cognitive suffering may achieve release with palliative sedation.

Even organizations whose policies and guidelines do not preclude palliative sedation for “existential suffering” often caution that it is much more difficult for the clinician to definitively determine that it is intractable.¹⁶ One means of doing so would be for the patient to submit to multiple psychosocial or spiritual interventions and yet find adequate relief from

none. Patients who choose to exercise their right to decline such measures may be denied palliative sedation because their suffering has not been clearly shown to be intractable.

Conclusion

An adequate understanding of the nature of suffering is essential to professionals whose foundational principles include its relief. The recently developed policies and guidelines discussed herein strongly suggest that the consensus that had seemingly coalesced around Eric Cassell’s conceptual analysis of suffering was illusory. Moreover, the recent formulations appear to be grounded on dualistic notions that medicine was thought finally to have abandoned. The consequence is that patients with advanced terminal illness are in peril of being “diagnosed” with a “nonclinical” variety of suffering for which otherwise effective relief, i.e., palliative sedation, is precluded, thereby leaving them to endure their suffering unto death.

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Habilitation into Healthy Agency and Theorizing about Imperfect Justice

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To borrow a phrase from Lawrence Becker's description of Amartya Sen's work, how "gently normative" can a theory of justice be? More specifically, how much of a theory of the good, or a theory about a theory of the good, must a theory of justice presuppose? Can such a theory simply be a neutral framework, within which diverse entities with different conceptions of their good, may flourish? Or, must the theory begin with assumptions about the nature of the relevant entities, their good, or both? Is the answer to these questions different depending upon whether one is engaged in ideal theory, or in theorizing of some variety for circumstances recognized to be less than fully just?

In *Habilitation, Health, and Agency*, Becker develops the idea of "habilitation into healthy agency" as a meta-theory that aims to prescind disputes among various substantive theories of justice. In this enterprise, Becker hopes to avoid the normativity of, for example, the World Health Organization's famously protean definition of "health": "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Instead, Becker aims to develop a conception of healthy agency to unify both negative aspects of human life (disease, disability) and positive (flourishing) sides of the ledger, drawing out basic elements of well-being in addition to health in a narrower medical sense. In other words, a descriptive account of healthy agency, and habilitative factors that foster it, can replace much of the contentiousness about the nature of the good life. Such an account can point to what theories of justice have in common, rather than the accounts of the good life that drive them apart. As Becker fully realizes, however, teasing out the descriptive from the normative in this area is not a simple task.

In this discussion, I hope to do three things with Becker's rich and prescient discussion. First, I will sketch what I believe to be particularly important aspects of the move from "health" as a basic indexing characteristic for justice, to the move to "habilitation into healthy agency," and then "habilitation into robustly healthy agency," as such a good. This move, in my judgment, casts doubt on Becker's claim to be doing meta-theory about theories of justice, rather than theorizing directly about justice. So my second task will be to sketch briefly how I believe that the account of "habilitation into robustly healthy agency" is more normative than acknowledged. This will enable me to accomplish my third goal: illustrating why "habilitation into healthy agency" is a particularly useful rubric for pursuing justice under circumstances of grave injustice. Given our world, this is a very important accomplishment indeed.

Habilitation into Robustly Healthy Agency

Becker defends "habilitation into healthy agency" as a metric and as an index good for theories of justice to employ. Although this account begins with a definition of "health," the definition is not a limited one, but rather more of a signpost. And for good reason.

Here is the definition of "health," as Becker gives it in the manuscript: "The health of an individual human being is a set of functionally significant traits and/or states defined on a range running from non-survivable forms of disease, deficit, disorder, impairment, injury, or distress (ill health) to states or traits of physical or psychological strength, resistance, resilience, momentum, energy and activity (good health) that have

reciprocal causal connections to ill health." Health in this sense has both a negative side—illness—and a positive side: traits that reduce the risk of falling back onto the negative side.

On this view, judgments about whether any particular trait—say, guinea worm infection—contributes to health or detracts from it are empirical claims. We can observe the natural history of this infection and determine the likelihood of death from it as well as its impact on physical energy, ability to resist other infectious disease, and so on. Traits that might be core to at least some normative accounts of well-being—say, developing the capacity for practical reason—are (at least to some extent) observable contributors to the ability of a creature to avoid falling back onto the negative side of the ledger. One needs, after all, a certain understanding of the life cycle of the worm and the nature of water pollution in order to avoid contributing to its continuation. (People acquire the infection by drinking water contaminated by a tiny flea. The worm matures in the body, ultimately erupting through the skin. To soothe pain from the eruption, people bathe in water also used for drinking, thus releasing the worm to another cycle.)

Several other features of this definition, and the role it plays in habilitation into healthy agency, are noteworthy as well. First, health in this sense is not a static feature of human life, to be observed in any particular time slice. It is dynamic; traits that detract from or contribute to health are always changing. Any assessment of the health status of a being must take this dynamism into account. The absence of guinea worm infection at a particular moment in the life of an infant in the Sudan, for example, does not mean that the infant is healthy with respect to guinea worm disease. It may only mean that the infant has not yet gained the mobility to bathe in nearby infested waters.

Second, health in this sense is not merely a matter of the individual's physical characteristics. It is a matter of the environment as well. An environment in which the individual cannot drink water without the likelihood of contracting guinea worm disease, and in which people do not know how to extract the worms without contributing to the ongoing cycle of infestation, is not an environment in which people have the trait of health with respect to the disease. In such environments, people who are temporarily free of the infestation are not free of the risk that they will acquire it, and so not healthy in this sense.

Third, an important aspect of maintaining health in this sense is the creature's own agency. To maintain health, resistance, resilience, and regenerative factors must be complemented by generative factors: energy, momentum, and self-initiation. To continue with the guinea worm example, individual decisions and actions, such as whether to drink polluted water, contribute to the ongoing cycle of this disease. Other actions contribute, too: ranging from local resistance to pollution, to largely successful eradication efforts by the United Nations, to the war in the southern Sudan that has undermined these efforts in that region.

These additional factors—the dynamic, environmental, and agential aspects of health—are core to why Becker's is a theory not just about health, but about habilitation into healthy agency. *Habilitation* is about the creation of the "objective necessities for human survival, physical and psychological development." As such, it is ongoing—as Becker says, *into*. And it is environmental and agential; these necessities are a matter of the world, individuals, and the interactions among them: "Habilitation is about what we provide for others and about what we provide for ourselves." So it must involve *agency*, *agency* that is sufficiently *healthy* to be both regenerative and generative.

But what of the adverb that Becker adds in the final version of his longer account: habilitation into *robustly* healthy

agency? What does it add, and what does the addition tell us about the view? I start with the difference between *health* and *robust health*, as Becker develops it. One can be healthy if one has traits that are stable in certain kinds of environments, but not in others. So, one might be a healthy diabetic, if one's diabetes is well controlled, one has ready access to needed medical supplies, and access as well to means to prevent or manage any co-morbid conditions. In such circumstances, however, the judgment of "health" would be accompanied by an asterisk signifying that under less favorable conditions, the current good state would be expected to deteriorate. *Robust health*, in contrast, describes the situation in "which all the factors are stable and strong in a wide range of environments, with respect to a wide variety of ordinary health conditions, given merely competent habilitation of the sorts available in these environments." And, *robustly healthy agency* is a critical component of this situation: "Without robustly healthy agency, one lacks abilities necessary for the self-monitored and self-initiated activity often involved with sustaining other aspects of health at a robust level." Note the qualification "often": it reflects, I believe, a recognition of the turn from the descriptive to the normative.

Habilitation into Healthy Agency as Meta-theory?

Becker characterizes his enterprise as meta-theory. By this, he means the effort to create tools that can be used by "any plausible, normative account of distributive justice that philosophers now, or in the near future, are likely to advance." This is indeed a daunting task. In this section, I want to suggest some concerns about achieving this goal for ideal theories of justice. But this is far from a negative analysis; these concerns also point to why the conception of habilitation into healthy agency that Becker develops may be critical to thinking about justice under circumstances of injustice.

If I understand Becker correctly, crucial to the claim to be doing meta-theory is avoiding assumptions that would conflict with the normative commitments of any plausible theory of distributive justice. Specifications of the particular form of the good life to be achieved by the just society—what Rawls and others have called comprehensive conceptions of the good—would violate this stricture. Assuming that we can separate out empirical claims from normative ones—and this is a significant assumption—one way to do meta-theory would be to identify a set of empirical claims that must be taken into account by any plausible theory of distributive justice and that can be used to measure that theory's conclusions. If we assume that plausible theories of distributive justice will not tolerate death by early adulthood on a wide scale, for example, then all such theories should take into account empirical evidence about what factors are needed both to remedy circumstances that are likely to produce such deaths and to guard in a relatively stable way against the likely return of such circumstances. To be sure, no theory of justice can prevent earthquakes, but some theories when institutionalized, in contrast with others, reduce the likelihood of widespread death from such earthquakes or provide societies with the resilience to respond when they do occur.

Habilitation into healthy agency is meant as such a measuring tool and, to some extent, it is perfect for this job. Descriptively, we can identify factors that will result virtually immediately in death and specify a variety of preventive or ameliorative means to avoid them (although at the edges we might need to think about the relevance of interventions in these vital functions that can stave off mortality for at least a time). Starvation exemplifies; minimal daily rations ameliorate. Similarly, we can identify factors that will make it difficult to sustain vital functions over time: desertification, pollution, and

resulting crop loss exemplify. Identifying ameliorative factors is a more complicated matter, however, particularly if there are choices among institutions: property rights, international trade, emissions controls, and more. How a society is doing on these measures, as a matter of bare survival, will be part of a metric of any theory of justice that is committed to avoiding widespread early death in that society.

Things get much harder, however, when we move beyond survival. Another use of habilitation into healthy agency is to distinguish between "the region of health that is relevant to basic justice and the region beyond..." In other words, the concept is supposed to be able to help us to set out the range of what any theory of justice must address. Here, Becker relies heavily on the idea that some aspects of good health—in his words, "call them physical and psychological strengths"—are integrally necessary to the prevention of ill health, again in his words, "the presence of functionally significant physical or psychological disease, deficit, disorder, injury, or distress in a given range of environments." If serious ill health in this sense is part of basic justice, then these needed factors of good health will be so as well.

But at this point, I fear the theory becomes normatively inflected. Consider, first, whether agency is an individual matter. Becker says that many of the coping abilities required for healthy agency must be self-supplied, or they do not "develop beyond rudimentary, fragile impulses." If this is an empirical claim, questions of verification remain. On the other hand, it may be a definitional claim: agency is not healthy unless it is self supplied, in part at least. Or a metaphysical claim: an entity does not count as an agent unless it has the capacity for self-supplied motivation. Or a normative claim: that activities are more valuable, or that agents are more worthy, if they are self-supplied. The challenge I would put is this: Why should it be agency, something about being self-propelling, which matters as a way of generating health? Is agency simply more reliable, as an empirical matter, or is it more desirable from the perspective of a life well lived?

As I see it, the difficulty here is the move from health, to healthy agency, and beyond to robustly healthy agency. Individual motivation and freedom may be more reliable in a wide range of environments, but they may not be in others. On the other hand, they surely are part of, again in Becker's words, "a high level of robustly healthy agency and the budding eudaimonistic virtues embedded in it." There is a move here, from survival to freedom. It is a move I applaud, but see as deeply rooted in comprehensive conceptions of the good that value freedom.

Healthy Agency and Circumstances of Injustice

At the same time, there is much that seems exactly right about a focus on habilitation into healthy agency under circumstances of grave injustice. And there is much for us to keep thinking about in this territory.

First, consider the use of healthy agency as a metric. In circumstances of extreme poverty, making progress on survival, and then increasing its security, is arguably a unitary measure. More complex comparative judgments are unnecessary. Without this progress, nothing else is possible.

Then, consider the use of healthy agency as an index good. An alternative index good might be resources or wealth. Here, Becker would seem to be on firm ground in the empirical claim that health takes precedence over resources or wealth. How the latter might be used is unstable; stories of corruption are legion. But if health is improved, people are more likely to have the capacity to generate resources or wealth; they will have the energy to go to school, or to work, which they might

not otherwise have. There is something of this even in more affluent societies. The judgment seems reasonable that if someone is injured and loses access to wealth (e.g., a job), a more successful strategy may be to restore the agency which can be used to restore the health, than to restore the wealth. Compare this empirical observation to the clearly normative point Becker makes in passing, that we are more willing to use common resources to restore the health of someone who was at fault for his injury, than to restore the individual's wealth.

Moreover, considering healthy agency as an index good for the scope of justice reminds us of the problems involved in extrapolating from ideal to non-ideal contexts. Rawls, for example, contended that as a matter of ideal justice, first principle liberties should be taken as lexically prior to economic arrangements. However, there are well-known examples of how liberties of speech and conscience have undermined health, and not just as a matter of sparking immediate violence. The Nigerian imams who inveighed against polio vaccine were responsible for the spread of an outbreak which eventually extended to some twenty-six countries. If we understand this, we can see why it would be wrong to prioritize the freedom of conscience and expression of the Nigerian imams who spread fears of vaccination against polio—and thus spread polio itself. Yet on the Rawlsian view, as a matter of ideal justice freedom of conscience and speech—the freedoms invoked by the imams—must be set aside for lexically prioritized protection, as long as they are compatible with maximizing similar freedoms for others.

Much has been accomplished and will be accomplished in this and other work of Lawrence Becker's, even if meta-theory may not have been.

How Medicine Saved the Life of Ethics

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During the first 60 years or so of the twentieth century, two things characterized the discussion of ethical issues in the United States, and to some extent other English-speaking countries also. On the one hand, the theoretical analyses of moral philosophers concentrated on questions of so-called metaethics. Most professional philosophers assumed that their proper business was not to take sides on substantive ethical questions but rather to consider in a more formal way what *kinds* of issues and judgments are properly classified as moral in the first place. On the other hand, in less academic circles, ethical debates repeatedly ran into stale-mate. A hard-line group of dogmatists, who appealed either to a code of universal rules or to the authority of a religious system or teacher, confronted a rival group of relativists and subjectivists, who found in the anthropological and psychological diversity of human attitudes evidence to justify a corresponding diversity in moral convictions and feelings.¹

For those who sought some "rational" way of settling ethical disagreements, there developed a period of frustration and perplexity.² Faced with the spectacle of rival camps taking up sharply opposed ethical positions (e.g., toward premarital sex or anti-Semitism), they turned in vain to the philosophers for guidance. Hoping for intelligent and perceptive comments on the actual substance of such issues, they were offered only

analytical classifications, which sought to locate the realm of moral issues, not to decide them.

Two novel factors contributed to this standoff by making the issue of subjectivity an active and urgent one. For a start, developments in psychology—not least, the public impact of the new psychoanalytic movement—focused attention on the role of feelings in our experience and so reinforced the suspicion that moral opinions have to do more with our emotional reactions to that experience than with our actions in it [3]. So, those opinions came to appear less matters of reason than matters of taste, falling under the old tag, *quot homines, tot sententiae*. This view of ethics was strengthened by the arguments of the ethnographers and anthropologists, who emphasized the differences to be found between the practices and attitudes of different peoples rather than the common core of problems, institutions, and patterns of life that they share. To cap it all, the anthropologist Edward Westermarck took over Albert Einstein's term "relativity" from physics and discussed the moral implications of anthropology under the title of *Ethical Relativity* [4].

Between them, the new twentieth-century behavioral and social sciences were widely regarded as supporting subjectivist and relativist positions in ethics; this in turn provoked a counterinsistence on the universal and unconditional character of moral principles; and so a battle was joined which could have no satisfactory outcome. For, in case of substantive disagreement, the absolutists had no further reasons to offer for their positions: all they could do was shout more insistently or bring up heavier theological guns. In return, the relativists could only turn away and shrug their shoulders. The final answers to ethical problems thus came, on one side, from unquestioned principles and authoritative commands; on the other, from variable and diverse wishes, feelings, or attitudes; and no agreed procedure for settling disagreements by reasonable argument was acceptable to both sides.

How did the fresh attention that philosophers began paying to the ethics of medicine, beginning around 1960, move the ethical debate beyond this standoff? It did so in four different ways. In place of the earlier concern with attitudes, feelings, and wishes, it substituted a new preoccupation with situations, needs, and interests; it required writers on applied ethics to go beyond the discussion of general principles and rules to a more scrupulous analysis of the particular kinds of "cases" in which they find their application; it redirected that analysis to the professional enterprises within which so many human tasks and duties typically arise; and, finally, it pointed philosophers back to the ideas of "equity," "reasonableness," and "human relationships," which played central roles in the *Ethics* of Aristotle but subsequently dropped out of sight [5, esp. 5.10.1136b30-1137b32]. Here, these four points may be considered in turn.

The Objectivity of Interests

The topics that preoccupied psychologists and anthropologists alike during the first half of the twentieth century were foreign to the concerns of physicians, and they tended to distract attention from those shared features of human nature which define the physiological aspects of human medicine and so help to determine the associated ethical demands. To begin with, the novel anthropological discoveries that exerted most charm over the general public were those customs, or modes of behavior, which appeared odd, unexpected, or even bizarre, as compared with the normal patterns of life familiar in modern industrial societies. The distinctive features of unfamiliar cultures (rain dances, witch doctors, initiation ceremonies, taboos, and the like) captured the imaginations of general readers far more powerfully than those which manifested the

common heritage of humanity: the universal need to eat and drink, the shared interest in tending wounds and injuries, and so on. Theoretically, likewise, field anthropologists focused primarily on the differences among cultures, leaving the universals of social structure to the sister science of sociology. In their eyes, the essential thing was to explain the modes of life and activity typical of any culture in terms appropriate to that particular culture, not in terms brought in from outside with the anthropologist's own cultural baggage.

As a result, the whole field of medicine was something of a stumbling block to anthropology. If one studied the procedures employed in handling cases of tuberculosis among, say, pygmies in the Kalahari Desert, it might well turn out that they did not recognize this affliction as being, by Western standards, a true "disease." In that case it might—anthropologically speaking—be inappropriate to comment on their procedures in medical terms at all. On the contrary, witch doctoring must be appraised in "ethnomedical" terms, by standards adapted to the conception of witch doctoring current inside the culture in question.

For those who were concerned with the internal systematicity of a given culture, this might be an acceptable method. In adopting it, however, one was obliged to set aside some of the basic presuppositions of the modern Western (and international) profession of medicine: notably, the assumption that human beings in all cultures share, in most respects, common bodily frames and physiological functions. While the epidemiology of, say, heart disease may in some respects be significantly affected by such cultural factors as diet, the evils of heart disease speak no particular language, and to that extent the efficacy of different procedures for dealing with that condition can be appraised in transcultural terms.

So, the *cross-cultural* study of epidemiology and kindred subjects—what may be called "comparative medicine"—has to be distinguished sharply from the *intracultural* study of "ethnomedicine." The latter is concerned with the attitudes, customs, and feelings current within exotic cultures in the face of those afflictions that we ourselves know to be diseases, whether or not the people concerned so perceive them. The former, by contrast, is concerned with the treatments available in different countries or cultures, regardless of the special attitudes, customs, or feelings that may cluster around those conditions locally, in one place or another. Fieldworkers from the World Health Organization, for instance, are concerned with comparative medicine and are not deterred from investigating the links between, say, eye disease and polluted water supplies just because members of the affected community do not recognize these links. The central subject matter of medicine thus comprises those objective, universal conditions, afflictions, and needs that can affect human beings in *every* culture, as contrasted with those relative, subjective conditions, complaints, and wishes that are topics for anthropological study in *any given* culture.

Now we are in a position to see how needlessly moral philosophers thrust themselves into the arms of the "ethical relativists" when they adopted anthropology as their example and foundation. An ethics built around cultural differences quickly became an ethics of local attitudes. The same fate overtook those philosophers who sought their example and foundation in the new ideas of early twentieth-century psychology. For they were quickly led into seeing ethical disagreements between one human being and another as rooted in their personal responses to and feelings about the topics in debate; as a result, questions about the soundness of rival moral views were submerged by questions about their origins.

Contrast, for instance, the statement, "She regards premarital sex as wrong *because* her own straitlaced upbringing

left her jealous of, and censorious toward, today's less puritanical young"—which offers us a psychological account of the causes by which the ethical view in question was supposedly generated—with the statement, "She regards it as wrong *because* of the unhappiness which the current wave of teenage pregnancies is creating for mothers and offspring alike"—which states the interests with which the view is concerned and the reasons by which it is supported. Modeling ethics on psychology thus once again diverts attention from genuine interests and focuses them instead on labile, personal feelings.

The new attention to applied ethics (particularly medical ethics) has done much to dispel the miasma of subjectivity that was cast around ethics as a result of its association with anthropology and psychology. At least within broad limits, an ethics of "needs" and "interests" is objective and generalizable in a way that an ethics of "wishes" and "attitudes" cannot be. Stated crudely, the question of whether one person's actions put another person's health at risk is normally a question of ascertainable fact, to which there is a straightforward "yes" or "no" answer, not a question of fashion, custom, or taste, about which (as the saying goes) "there is no arguing." This being so, the objections to that person's actions can be presented and discussed in "objective" terms. So, proper attention to the example of medicine has helped to pave the way for a reintroduction of "objective" standards of good and harm and for a return to methods of practical reasoning about moral issues that are not available to either the dogmatists or the relativists.

The Importance of Cases

One writer who was already contributing to the renewed discussion of applied ethics as early as the 1950s was Joseph Fletcher of the University of Virginia, who has recently been the object of harsh criticism from more dogmatic thinkers for introducing the phrase "situation ethics."³ To judge from his critics' tone, you might think that he was the spokesman for laxity and amorality, whereas he belongs, in fact, to a very respectable line of Protestant (specifically, Episcopalian) moral theologians. A main influence on him in his youth was Bishop Kenneth Kirk, whose book on *Conscience and Its Problems*, published in 1927 [9], was one of the few systematic works by an early twentieth-century Protestant theologian to employ the "case method" more usually associated with the Catholic casuists. Via Kirk, Fletcher thus became an inheritor of the older Evangelical tradition of Frederick Dennison Maurice.⁴

Like his predecessors in the consideration of "cases of conscience," Kirk was less concerned to discuss conduct in terms of abstract rules and principles than he was to address in concrete detail the moral quandaries in which real people actually find themselves. Like his distinguished predecessors—from Aristotle and Hermagoras to Boethius, Aquinas, and the seventeenth-century Jesuits—he understood very well the force of the old maxim, "circumstances alter cases." As that maxim indicates, we can understand fully what is at stake in any human situation and how it creates moral problems for the agents involved in it only if we know the precise circumstances "both of the agent and of the act": if we lack that knowledge, we are in no position to say anything of substance about the situation, and all our appeals to general rules and principles will be mere hot air. So, in retrospect, Joseph Fletcher's introduction of the phrase "situation ethics" can be viewed as one further chapter in a history of "the ethics of *cases*," as contrasted with "the ethics of *rules and principles*"; this is another area in which the ethics of medicine has recently given philosophers some useful pointers for the analysis of moral issues.

Let me here mention one of these, which comes out of my own personal experience. From 1975 to 1978 I worked as a consultant and staff member with the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, based in Washington, D.C.; I was struck by the extent to which the commissioners were able to reach agreement in making recommendations about ethical issues of great complexity and delicacy.⁵ If the earlier theorists had been right, and ethical considerations really depended on variable cultural attitudes or labile personal feelings, one would have expected 11 people of such different backgrounds as the members of the commission to be far more divided over such moral questions than they ever proved to be in actual fact. Even on such thorny subjects as research involving prisoners, mental patients, and human fetuses, it did not take the commissioners long to identify the crucial issues that they needed to address, and, after patient analysis of these issues, any residual differences of opinion were rarely more than marginal, with different commissioners inclined to be somewhat more conservative, or somewhat more liberal, in their recommendations. Never, as I recall, did their deliberations end in deadlock, with supporters of rival principles locking horns and refusing to budge. The problems that had to be argued through at length arose, not on the level of the principles themselves, but at the point of applying them: when difficult moral balances had to be struck between, for example, the general claims of medical discovery and its future beneficiaries and the present welfare or autonomy of individual research subjects.

How was the commission's consensus possible? It rested precisely on this last feature of their agenda: namely, its close concentration on specific types of problematic cases. Faced with "hard cases," they inquired what particular conflicts of claim or interest were exemplified in them, and they usually ended by balancing off those claims in very similar ways. Only when the individual members of the commission went on to explain their own particular "reasons" for supporting the general consensus did they begin to go seriously different ways. For, then, commissioners from different backgrounds and faiths "justified" their votes by appealing to general views and abstract principles which differed far more deeply than their opinions about particular substantive questions. Instead of "deducing" their opinions about particular cases from general principles that could lend strength and conviction to those specific opinions, they showed a far greater certitude about particular cases than they ever achieved about general matters.

This outcome of the commission's work should not come as any great surprise to physicians who have reflected deeply about the nature of clinical judgment in medicine. In traditional case morality, as in medical practice, the first indispensable step is to assemble a rich enough "case history." Until that has been done, the wise physician will suspend judgment. If he is too quick to let theoretical considerations influence his clinical analysis, they may prejudice the collection of a full and accurate case record and so distract him from what later turn out to have been crucial clues. Nor would this outcome have been any surprise to Aristotle, either. Ethics and clinical medicine are both prime examples of the concrete fields of thought and reasoning in which (as he insisted) the theoretical rigor of geometrical argument is unattainable: fields in which we should above all strive to be *reasonable* rather than insisting on a kind of *exactness* that "the nature of the case" does not allow [5, 1.3.1094b12- 27].

This same understanding of the differences between practical and theoretical reasoning was taken over by Aquinas, who built it into his own account of "natural law" and "case morality," and so it became part of the established teaching of

Catholic moral theologians. As such, it was in harmony with the pastoral practices of the confessional [12, D.3, Q.5, A.2, Solutio]. Thus, Aquinas's own version of the fundamental maxim was framed as an injunction to the confessor—"like a prudent physician"—to take into account *peccatoris circumstantiae atque peccati*, that is, "the circumstances both of the sinner and of the sin." Later, however, the alleged readiness of confessors to soften their judgments in the light of irrelevant "circumstances" exposed them to criticism. In particular, the seventeenth-century French Jesuits were attacked by their Jansenist coreligionists on the ground that they "made allowances" in favor of rich and high-born penitents that they denied to those who were less well favored. And, when the Jansenist Arnauld was brought before an ecclesiastical court on a charge of heterodoxy, his friend Pascal launched a vigorous counterattack on the Jesuit casuists of his time by publishing the series of anonymous *Lettres provinciales* which from that time on gave "casuistry" its unsavory reputation.⁶

Looking back, however, we may wonder how far this reputation was really justified. No doubt, a venal priest could corrupt the confessional by showing undue favor to penitents of wealth or power: for example, by fabricating specious "extenuating circumstances" to excuse conduct that was basically inexcusable. But we have no reliable way of knowing how often this really happened, and the mere possibility of such corruption does nothing to change the original point—namely, that practical decisions in ethics can never be made by appeal to "self-evident principles" alone and rest rather on a clinical appreciation of the significant details characteristic of particular cases. No doubt, we are free to use the word "casuistry"—like the parallel words "wizardry" and "sophistry"—to refer to "the dishonest use of the casuist's (or the clinician's) arts,"⁷ but that does no more to discredit the honest use of "case morality" than it does the honest use of case methods in clinical medicine.

By taking one step further, indeed, we may view the problems of clinical medicine and the problems of applied ethics as two varieties of a common species. Defined in purely general terms, such ethical categories as "cruelty" and "kindness," "laziness" and "conscientiousness," have a certain abstract, truistical quality: before they can acquire any specific relevance, we have to identify some *actual* person, or piece of conduct, as "kind" or "cruel," "conscientious" or "lazy," and there is often disagreement even about that preliminary step. Similarly, in medicine: if described in general terms alone, diseases too are "abstract entities," and they acquire a practical relevance only for those who have learned the diagnostic art of identifying real-life cases as being cases of one disease rather than another.

In its form (if not entirely in its point) the *art* of practical judgment in ethics thus resembles the art of clinical diagnosis and prescription. In both fields, theoretical generalities are helpful to us only up to a point, and their actual application to particular cases demands, also, a human capacity to recognize the slight but significant features that mark off, say, a "case" of minor muscular strain from a life-threatening disease or a "case" of decent reticence from one of cowardly silence. Once brought to the bedside, so to say, applied ethics and clinical medicine use just the same Aristotelean kinds of "practical reasoning," and a correct choice of therapeutic procedure in medicine is the *right* treatment to pursue, not just as a matter of medical technique but for ethical reasons also.

"My Station and Its Duties"

In the last decades of the nineteenth century, F. H. Bradley of Oxford University expounded an ethical position that placed "duties" in the center of the philosophical picture, and the recent concern of moral philosophers with applied ethics

(most specifically, medical ethics) has given them a new insight into his arguments also. It was a mistake (Bradley argued) to discuss moral obligations purely in universalistic terms, as though nobody was subject to moral claims unless they applied to everybody—unless we could, according to the Kantian formula, “will them to become universal laws.” On the contrary, different people are subject to different moral claims, depending on where they “stand” toward the other people with whom they have to deal, for example, their families, colleagues, and fellow citizens [13].

For Bradley, that is to say, the central consideration in practical ethics was the agent’s standing, status, or station. He himself preferred to use the last of these three words (i.e., “station”), and this led his liberal contemporaries to undervalue his arguments. They suspected him of subscribing to the conservative sentiments of the old couplet, “God bless the Squire and his relations,/ And keep us in our proper stations”—that is, the stations to which “it *has pleased* [rather than *shall please*] God to call us.” Yet this was an unfortunate response since, as we now realize, Bradley was drawing attention to points of real importance. As the modern discussion of medical ethics has taught us, professional affiliations and concerns play a significant part in shaping a physician’s obligations and commitments, and this insight has stimulated detailed discussions both about professionalism in general and, more specifically, about the relevance of “the physician/patient relationship” to the medical practitioner’s duties and obligations.⁸

Once embarked on, the subject of professionalism has proved to be rich and fruitful. It has led, for instance, to a renewed interest in Max Weber’s sociological analysis of vocation (*Beruf*) and bureaucracy, and this in turn has had implications of two kinds for the ethics of the professions. For, on the one hand, the manner in which professionals perceive their position as providers of services influences both their sense of calling and also the obligations which they acknowledge on that account. And, on the other hand, the professionalization of medicine, law, and similar activities has exposed practitioners to new conflicts of interest between, for example, the individual physician’s duties to a patient and his loyalty to the profession, as when his conduct is criticized as “unprofessional” for harming, not his clients, but rather his colleagues.

In recent years, as a result, moral philosophers have begun to look specifically and in greater detail at the situations within which ethical problems typically arise and to pay closer attention to the human relationships that are embodied in those situations. In ethics, as elsewhere, the tradition of radical individualism for too long encouraged people to overlook the “mediating structures” and “intermediate institutions” (family, profession, voluntary associations, etc.) which stand between the individual agent and the larger scale context of his actions. So, in political theory, the obligation of the individual toward the state was seen as the only problem worth focusing on; meanwhile, in moral theory, the differences of’ status (or station) which in practice expose us to different sets of obligations (or duties) were ignored in favor of a theory of justice (or rights) that deliberately concealed these differences behind a “veil of ignorance.”⁹

On this alternative view, the only just—even, properly speaking, the only moral—obligations are those that apply to us all equally, regardless of our standing. By undertaking the tasks of a profession, an agent will no doubt accept certain special duties, but so it will be for us all. The obligation to perform those duties is “just” or “moral” only because it exemplifies more general and universalizable obligations of trust, which require us to do what we have undertaken to do. So, any exclusive emphasis on the universal aspects of morality can end by

distracting attention from just those things which the student of applied ethics finds most absorbing—namely, the specific tasks and obligations that any profession lays on its practitioners.

Most recently, Alasdair MacIntyre has pursued these considerations further in his new book, *After Virtue* [16]. MacIntyre argues that the public discussion of ethical issues has fallen into a kind of Babel, which largely springs from our losing any sense of the ways in which *community* creates obligations for us. One thing that can help restore that lost sense of community is the recognition that, at the present time, our professional commitments have taken on many of the roles that our communal commitments used to play. Even people who find moral philosophy generally unintelligible usually acknowledge and respect the specific ethical demands associated with their own professions or jobs, and this offers us some kind of a foundation on which to begin reconstructing our view of ethics. For it reminds us that we are in no position to fashion individual lives for ourselves, purely as *individuals*. Rather, we find ourselves born into communities in which the available ways of acting are largely laid out in advance: in which human activity takes on different *Lebensformen*, or “forms of life” (of which the professions are one special case), and our obligations are shaped by the requirements of those forms.

In this respect, the lives and obligations of professionals are no different from those of their lay brethren. Professional obligations arise out of the enterprises of the professions in just the same kinds of way that other general moral obligations arise out of our shared forms of life; if we are at odds about the *theory* of ethics, that is because we have misunderstood the basis which ethics has in our actual *practice*. Once again, in other words, it was medicine—as the first profession to which philosophers paid close attention during the new phase of “applied ethics” that opened during the 1960s—that set the example which was required in order to revive some important, and neglected, lines of argument within moral philosophy itself.

Equity and Intimacy

Two final themes have also attracted special attention as a result of the new interaction between medicine and philosophy. Both themes were presented in clear enough terms by Aristotle in the *Nicomachean Ethics*. But, as so often happens, the full force of Aristotle’s concepts and arguments was overlooked by subsequent generations of philosophers, who came to ethics with very different preoccupations. Aristotle’s own Greek terms for these notions are *epieikeia* and *philia*, which are commonly translated as “reasonableness” and “friendship,” but I shall argue here that they correspond more closely to the modern terms, “equity” and “persona] relationship” [5].

Modern readers sometimes have difficulty with the style of Aristotle’s *Ethics* and lose patience with the book, because they suspect the author of evading philosophical questions that they have their own reasons for regarding as central. Suppose, for instance, that we go to Aristotle’s text in the hope of finding some account of the things that mark off “right” from “wrong”: if we attempt to press this question, Aristotle will always slip out of our grasp. What makes one course of action better than another? We can answer that question, he replies, only if we first consider what kind of a person the agent is and what relationships he stands in toward the other people who are involved in his actions; he sets about explaining why the kinds of relationship, and the kinds of conduct, that arc possible as between “large-spirited human beings” who share the same social standing are simply not possible as between, say, master and servant, or parent and child [5].

The bond of *philia* between free and equal friends is of one kind, that between father and son of another kind,

that between master and slave of a third, and there is no common scale in which we can measure the corresponding kinds of conduct. By emphasizing this point, Aristotle draws attention to an important point about the manner in which “actions” are classified, even before we say anything ethical about them. Within two different relationships the very same deeds, or the very same words, may—from the ethical point of view—represent quite different *acts* or *actions*. Words that would be a perfectly proper command from an officer to an enlisted man, or a straightforward order from a master to a servant, might be a humiliation if uttered by a father to a son, or an insult if exchanged between friends. A judge may likewise have a positive duty to say, from the bench, things that he would never dream of saying in a situation where he was no longer acting *ex officio*, while a physician may have occasion, and even be obliged, to do things to a patient in the course of a medical consultation that he would never be permitted to do in any other context.

It is easy to let oneself be distracted by Aristotle’s use of “the master-slave relationship” to illustrate the differences between different kinds of *philia*. But the points that he wishes to emphasize have nothing to do with slavery as such, and they hold good equally well if applied instead to our old friend, “the physician-patient relationship.” For, surely, the very deed or utterance by Dr. A toward Mrs. B which would be a routine inquiry or examination within a strictly professional “physician-patient relationship”—for example, during a gynecological consultation—might he grounds for a claim of assault if performed outside that protected context. The *philia* (or relationship) between them will be quite different in the two situations, and, on this account, the “circumstances” do indeed “alter cases” in ways that are directly reflected in the demands of professional ethics.

With this as background, we can turn to Aristotle’s ideas about *epieikeia* (“reasonableness” or “equity”). As to this notion, Aristotle pioneered the general doctrine that principles never settle ethical issues by themselves: that is, that we can grasp the moral force of principles only by studying the ways in which they are applied to, and within, particular situations. The need for such a practical approach is most obvious, in judicial practice, in the exercise of “equitable jurisdiction,” where the courts are required to decide cases by appeal, not to specific, well-defined laws or statutes, but to general considerations of fairness, of “maxims of equity.” In these situations, the courts do not have the benefit of carefully drawn rules, which have been formulated with the specific aim that they should be precise and self-explanatory: rather, they are guided by rough proverbial mottoes—phrases about “clean hands” and the like. The questions at issue in such cases are, in other words, very broad questions—for example, about what would be *just* or *reasonable* as between two or more individuals when all the available facts about their respective situations have been taken into account [17-19]. Similar patterns of situations and arguments are, of course, to be found in everyday ethics also, and the Aristotelean idea of *epieikeia* is a direct intellectual ancestor of a central notion (still referred to as “epikeia”) in the Roman Catholic traditions of moral theology and pastoral care [11].

In ethics and law alike, the two ideas of *philia* (“friendship” or “relationship”) and *epieikeia* (or “equity”) are closely connected. The expectations that we place on people’s lines of conduct will differ markedly depending on who is affected and what relationships the parties stand in toward one another. Far from regarding it as “fair” or “just” to deal with everybody in a precisely *equal* fashion, as the “veil of ignorance” might suggest, we consider it perfectly *equitable*, or *reasonable*, to show some degree of partiality, or favor, in dealing with close friends and

relatives whose special needs and concerns we understand. What father, for instance, does not have an eye to his children’s individual personalities and tastes? And, apart from downright “favoritism,” who would regard such differences of treatment as unjust? Nor, surely, can it be morally offensive to discriminate, within reason, between close friends and distant acquaintances, colleagues and business rivals, neighbors and strangers? We are who we are: we stand in the human relationships we do, and our specific moral duties and obligations can be discussed in practice *only* at the point at which these questions of personal standing and relationship have been recognized and taken into the account.

Conclusion

From the mid-nineteenth century on, then, British and American moral philosophers treated ethics as a field for general theoretical inquiries and paid little attention to issues of application or particular types of cases. The philosopher who did most to inaugurate this new phase was Henry Sidgwick, and, from an autobiographical note, we know that he was reacting against the work of his contemporary, William Whewell [20, 21]. Whewell had written a textbook for use by undergraduates at Cambridge University that resembled in many respects a traditional manual of casuistics, containing separate sections on the ethics of promises or contracts, family and community, benevolence, and so on [22]. For his part, Sidgwick found Whewell’s discussion too messy: there must be some way of introducing into the subject the kinds of rigor, order, and certainty associated with, for example, mathematical reasoning. So, ignoring all of Aristotle’s cautions about the differences between the practical modes of reasoning appropriate to ethics and the formal modes appropriate to mathematics, he set out to expound the theoretical principles (or “methods”) of ethics in a systematic form.

By the early twentieth century, the new program for moral philosophy had been narrowed down still further, so initiating the era of “metaethics.” The philosopher’s task was no longer to organize our moral beliefs into comprehensive systems: that would have meant *taking sides* over substantive issues. Rather, it was his duty to stand back from the fray and hold the ring while partisans of different views argued out their differences in accordance with the general rules for the conduct of “rational debate,” or the expression of “moral attitudes,” as defined in *metaethical* terms. And this was still the general state of affairs in Anglo-American moral philosophy in the late 1950s and the early 1960s, when public attention began to turn to questions of medical ethics. By this time, the central concerns of the philosophers had become so abstract and general—above all, so definitional or analytical—that they had, in effect, lost all touch with the concrete and particular issues that arise in actual practice, whether in medicine or elsewhere.

Once this demand for intelligent discussion of the ethical problems of medical practice and research obliged them to pay fresh attention to applied ethics, however, philosophers found their subject “coming alive again” under their hands. But, now it was no longer a field for academic, theoretical, even mandarin investigation alone. Instead, it had to be debated in practical, concrete, even political terms, and before long moral philosophers (or, as they barbarously began to be called, “ethicists”) found that they were as liable as the economists to be called on to write “op ed” pieces for the *New York Times*, or to testify before congressional committees.

Have philosophers wholly risen to this new occasion? Have they done enough to modify their previous methods of analysis to meet these new practical needs? About those questions there can still be several opinions. Certainly, it would be foolhardy to claim that the discussion of “bioethics” has reached a definitive

form, or to rule out the possibility that novel methods will earn a place in the field in the years ahead. At this very moment, indeed, the style of current discussion appears to be shifting away from attempts to relate problematic cases to general theories—whether those of Kant, Rawls, or the utilitarians—to a more direct analysis of the practical cases themselves, using methods more like those of traditional “case morality.” (See, e.g., the discussion in a recent issue of the *Hastings Center Report* of the moral issues that are liable to arise in cases of sex-change surgery [23, pp. 8-13].)

Whatever the future may bring, however, these 20 years of interaction with medicine, law, and the other professions have had spectacular and irreversible effects on the methods and content of philosophical ethics. By reintroducing into ethical debate the vexed topics raised by *particular cases*, they have obliged philosophers to address once again the Aristotelean problems of *practical reasoning*, which had been on the sidelines for too long. In this sense, we may indeed say that, during the last 20 years, medicine has “saved the life of ethics,” and that it has given hack to ethics a seriousness and human relevance which it had seemed—at least, in the writings of the interwar years—to have lost for good.

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Endnotes

1. For a further exploration of the standoff, see [1].
2. It was, in fact, just this problem which presented itself to me when I wrote my doctoral dissertation [2].
3. Just how much of a pioneer Joseph Fletcher was in opening up the modern discussion of the ethics of medicine is clear from the early publication date (1954) of his first publications on this subject [6-8].
4. It was Albert Jonsen who drew my attention to the work of Kenneth Kirk and his great forerunner, the mid-nineteenth-century Evangelical teacher, F. D. Maurice [10]. For further discussion consult A. R. Jonsen [11].
5. The work of the national commission generated a whole series of government publications—mainly reports and recommendations on the ethical aspects of research involving research subjects from specially “vulnerable” groups having diminished autonomy, such as young children and prisoners. I have written a fuller discussion of the commission’s work for a forthcoming Hastings Center book on the “closure” of disputes about matters of technical policy. As a member of the commission, A. R. Jonsen was also struck by the casuistical character of its work, and this led to the research project of which this paper is one product.
6. The *Lettres provinciales* were published periodically, and anonymously, in 1656-57, but it did not take long for their authorship to be discovered, and they have remained perhaps the best-known documents on the subject of “case reasoning” in ethics. The intellectual relationship between the vigorous attack on the laxity of the Jesuits’ case morality contained in the *Lettres* and the larger program of seventeenth-century philosophy deserves closer study than it has yet received.
7. For the word “casuistry,” see the entry in the complete *Oxford English Dictionary*, which revealingly points out how many English nouns ending in “ry” (e.g., “Sophistry,” “wizardry,” and “Popery”) are dyslogistic. It seems to be no accident that the earliest use of the word “casuistry” cited in the *OED* dates only from 1725—i.e., after Pascal’s attack on the Jesuit casuists. This helps to explain, and confirm, the current derogatory tone of the word.

8. See Bledstein’s discussion [14, p. 107] of the nineteenth-century confusion between codes of ethics and codes of etiquette within such professional societies as the American Medical Association.
9. I borrow this phrase a trifle unfairly from John Rawls [15], but I have argued at greater length in [1] that *any* unbalanced emphasis on “universality,” divorced from “equity” is a recipe for the ethics of relations between strangers and leaves untouched those important issues that arise between people who are linked by more complex relationships.
10. Once again, the *Oxford English Dictionary* has a point to make. It includes the word “ethicist” but leaves it without the dignity of a definition, beyond the bare etymology, “ethics + ist.”

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BOOK REVIEW

Why Some Things Should Not Be For Sale: The Moral Limits of Markets

Debra Satz (Oxford: Oxford University Press, 2010).

Reviewed by Paulette Kidder
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Is our society's collective reluctance to legalize prostitution, establish an open market in human kidneys, or allow newborns to be sold to adoptive parents simply a set of irrational holdovers from a pre-capitalist era? Or are there good reasons to continue to keep some things out of the marketplace? Debra Satz's excellent and cogently argued book offers a framework for deciding when and why some things should not be bought and sold. In laying out this framework, Satz provides guidance in a number of important areas of bioethics in which markets and their limits play a contested role.

Four "parameters" of markets serve as criteria for identifying undesirable markets: what Satz terms "*vulnerability, weak agency, extremely harmful outcomes for individuals, and extremely harmful outcomes for society*" (9, italics in original). Participants in a market may be *vulnerable* because they urgently need a particular good and the supply is inadequate, because they are "poor and destitute," or because their need for the item is greater than that of other participants (98). *Weak agency* occurs, for example, when some market participants lack adequate information about the exchange. A market may cause *extreme harm to individuals*, or it may cause *harm to society*; for example, it may "undermine the social framework needed for people to interact as *equals*" or for them to participate as "co-deliberants" in a democratic process (95-96). Any market that registers poorly on one or more of these four parameters is considered "noxious" (98). For example, a market in which poorer countries allowed wealthy countries to dispose of toxic waste within their borders for a fee would be noxious because it would be characterized by undue vulnerability (the weaker bargaining position of poor countries), weak agency (lack of governmental representation of citizens' interests in many developing countries), and extremely harmful outcomes to individuals (the effects of exposure to toxic waste) (109-110). Of Satz's four parameters of a noxious market, the only one not directly implicated in this example is "harm to society," though Satz indicates that there are indirect social harms involved in such a market.

Contract Pregnancy

Satz develops the implications of her theory using several contested examples, including chapter-long treatments of markets in women's "reproductive labor" (Chapter 5), women's "sexual labor" (Chapter 6), child labor (Chapter 7), voluntary slavery (Chapter 8), and the sale of human kidneys (Chapter 9). Her discussion of contract pregnancy in Chapter 6 is illuminating both in the way it treats the issue itself and for the way it shows how Satz's theory differs from previous treatments of the ethics of surrogacy and of the role of markets in general. In her critique of contract pregnancy, Satz endorses the "asymmetry thesis," which holds that "markets in women's reproductive labor...are more problematic than other currently accepted labor markets" (115). Satz's central reason for finding markets in women's reproductive labor to be noxious is that they cause extreme harm to society by reinforcing the unequal

status of women (128). They do this, she argues, by giving other people control over the pregnant surrogate's diet, activities, and sense of attachment to the fetus she carries (129), but unlike similar controls exercised over, e.g., soldiers, control exercised over pregnant women "reinforces a long history of gender-based inequality" (129). Further, contract pregnancy "reinforces negative stereotypes of women as 'baby machines,'" and lastly, insofar as judicial decisions in contested cases have favored only those surrogate mothers who were also the genetic mothers of the children they carried, it fails to recognize that motherhood, like fatherhood, can arise from causes other than the contribution of DNA (131).

Satz holds that the existence of a noxious market calls for a societal or governmental response, which may take the form of regulation, of changing the background conditions in which the market operates, or of banning that market altogether (10). What, then, is the appropriate societal response to the noxious market in contract pregnancy? Because most of her objections to this market come back to the way it reinforces gender hierarchy, Satz says that "under very different background conditions [i.e., in a society in which there were overall gender equality], such contracts would be less objectionable" (131). But under current conditions of gender inequality, Satz recommends regulation of surrogacy contracts, i.e., making them unenforceable if the pregnant woman changes her mind, viewing gestational mothers as having a claim to parental rights, and disallowing "third-party brokerage" (132). Banning contract pregnancy completely, she argues, would only lead to an underground market in it.

Comparison to Classic and Contemporary Thinkers

Her discussion of contract pregnancy illustrates the way that Satz stakes out her own position in distinction from several others. In contrast to Marx, Satz recognizes that markets, including labor markets, can enhance freedom and choice (21), but she denies that they can do so without regulation by the state in order to enforce property rights, promote the flow of information, prevent monopolies, etc. (26ff). In recognizing the essential role of market regulations, Satz is critical of *laissez-faire* economics. She also objects to economists' claim to be able to study markets in an ethically neutral manner. Satz argues that "we must expand our evaluation of markets...to include the effects of such markets on the structure of our relationships with one another, on our democracy, and on human motivation" (35). In moving beyond economists' narrow claims of moral neutrality, Satz consciously recovers the "neglected and rich" theories of Adam Smith and other early economists. Satz's discussion of Smith in Chapter 2 makes a well-documented and illuminating case that Smith, usually portrayed as a champion of unfettered markets, in fact was deeply concerned about the effects of markets, particularly labor markets, on the character of individuals and societies (46). Because of these concerns, Smith "was tolerant of governmental regulation of wages on behalf of laborers" (43) and he supported public education, whose existence can be seen as a limitation on the free market in private education.

Satz's call for regulation of contract pregnancy and other noxious markets opposes, then, economists who might call for deregulation of such markets on the "morally neutral" grounds that deregulation would lead to greater efficiency. Of course, not all economic and political theorists claim moral neutrality on the subject of markets; some seek to reform markets in the name of egalitarianism. Satz distinguishes her own view from that of "general egalitarians" such as Ronald Dworkin, by questioning the premise that social inequalities can be best addressed by bringing about equality of resources (such as money that citizens could spend in light of their individual

preferences) (66). Satz argues that Dworkin fails to take into account that markets and other factors shape those preferences such that they are not simply given, nor can they necessarily be regarded as “authentic” (69). She calls for greater attention on the part of general egalitarians to shaping the social world, instead of focusing mainly on ensuring equality of individuals’ resources (71).

Satz is also critical of “specific egalitarianism,” which she understands to be the view that “certain scarce goods ‘should be distributed less unequally than the ability to pay for them’” (79). In the category of specific egalitarians, she places Michael Walzer, who sees markets in some goods, such as education, health care, and political equality, as “degrading” to the social meaning of those goods (80); Elizabeth Anderson, who argues that some goods should not be seen as commodities but rather as objects of “respect or reverence” (81); Michael Sandel, who claims “that we corrupt many moral and civic goods if they are bought for money”; and Margaret Jane Radin, who calls for regulation or blockage of exchanges of those goods that are “closely connected to personhood” (81). These thinkers all take the view that to place moral limits on markets can mean to regulate or ban the sale of particular items such as babies, organs, military service, or sexual services. Satz’s approach is much less focused on *what* is for sale than it is on the ways that *any* market can have its source in the compromised agency of some participants and on the harmful effects that may flow from it. Satz holds that any market can “in principle” become noxious, but that certain kinds of markets are more likely to become so, including those in “health care, education, labor, and political influence” (10).

Returning to the example of contract pregnancy, whereas Sandel criticizes contract pregnancy on the grounds that a parental tie to a child is not the kind of thing that should be sold,¹ and Radin approves a ban on paid surrogacy (“for now”) in part because of the potential for a “domino effect” leading to a general view that babies and their characteristics are commodities (Radin 148),² Satz’s critique of contract pregnancy rests mainly on the “externalities” (costs to third parties) of the exchange within a society characterized by gender hierarchy. In a society free of such hierarchies, contract pregnancy could be more acceptable in Satz’s view, but not, presumably, in Sandel’s or in Radin’s. (Radin considers the question of whether, in a hypothetical world where no one were desperate or subordinate to others, commodification of persons or items intrinsic to personhood in itself would no longer be objectionable, but she rejects this idea because she views commodification as a form of objectification, and objectification of persons as “one of the marks of subordination.”³)

Satz finds those approaches that focus on excluding certain kinds of things from markets (or regulating their sales) “interesting and illuminating” (81). But, she argues, “there are rival views of the meaning of many particular goods” and “there is only a tenuous connection in most cases between the meaning we give to a good and its distribution by a market” (81). As an example of the latter point, Satz describes the way a believer in religion can buy a Bible without seeing it as degrading to the book’s meaning, or the way a right to health care may be seen as compatible with a market in the provision of such care (82).

Satz’s theory, then, calls for greater moral limits on markets than do the theories of many economists, and it does so on the basis of reasons that could in principle be widely accepted in a society concerned to promote those cultural and political attitudes conducive to democratic participation. Focusing on qualities of markets rather than on the nature of goods to be sold allows Satz to argue in favor of limiting markets on moral

grounds, while avoiding a debate over the contested meaning of such goods as well as a debate over whether that meaning is degraded when the item is bought and sold.

The Sale of Human Kidneys

Satz’s chapter on the sale of human kidneys further demonstrates the bioethical implications of her approach. Consistent with her theory, she asks not about the meaning of human organs in particular societies, but about whether organ markets are likely to be compromised by vulnerability or the other parameters important to her theory. Satz finds that in a legalized kidney market most of the sellers might be poor and desperate, hence vulnerable. Sellers might also have inadequate information about the long-term effects of losing a kidney, as often seems to be the case in India (196). A market in kidneys could reinforce existing inequalities between rich and poor (198). Further, such a market could cause harm to third parties who do not wish to sell their kidneys but who would be faced with a credit market in which kidneys were considered valuable collateral and in which those who did not want to put up a kidney as collateral would find it harder to obtain credit (200).

In light of these difficulties, should the ban on kidney-selling in developed countries be maintained? Satz notes the possibility that allowing kidney sales could increase the supply of kidneys and therefore save lives (though she recognizes that, as found in Richard Titmuss’s research into blood donation, the opposite result could occur) (192-195). As well, she notes that most or all of the problems she raised regarding kidney markets could be controlled by regulations rather than by maintaining the ban (205). Satz finds that some forms of a kidney market (e.g., a pure competitive market) are more likely than others (e.g., a competitive futures market with the organ sold upon death) to violate her four parameters (205). She leaves open, then, the door to an ethically acceptable market in kidneys in the future, should it take one of the forms that avoid the problems she has identified.

In addition to her discussions of contract pregnancy and kidney sales, Satz’s work is relevant to bioethics in that her discussion of markets in education sheds light on debates over the analogous market in health care. Satz draws the parallel between education and health care at several points (100, 102, 210). Taking up insights from T.H. Marshall, Satz argues that “distributing primary and secondary education solely through a market system” is harmful to democratic societies because it fails to equip citizens with the capacities to “participate competently and meaningfully in democratic self-governance” (101). Markets in private education can coexist with public education, but they cannot substitute for it. An analogous argument could certainly be made for markets in health care.

Conclusion

Satz has taken on an important and far-reaching set of questions and has made a remarkably clear, consistent, and historically rooted case for a way to articulate and critique the reasons behind our typical resistance to the unlimited expansion of markets. For bioethics, Satz’s four parameters of noxious markets provide a very useful specification of Beauchamp’s and Childress’s four principles, in that she specifies the ways that markets may cause harm (or fail to promote sufficient benefit) both to individuals and to social values necessary to a democratic society. This point provides a nuanced expansion of the principles of nonmaleficence and beneficence. Satz’s concerns for weak agency and vulnerability suggest useful expansions of the principles of respect for autonomy and justice, respectively.

Satz’s work takes a middle path between proponents of the moral neutrality of markets and those who argue that certain

items have their meaning degraded if they are commodified. Satz's willingness to speak out on behalf of non-quantifiable values such as the overcoming of servility, the promotion of persons' ability to be co-deliberants in a democracy, and the structure of human relationships is highly admirable. But these non-quantifiable goods seem to me no less contestable (and no less worthwhile) than some of the "meanings" that Satz finds to be beyond the scope of discussion. When Satz concludes that her "endorsement" of Ronald Dworkin's view that body parts should not be viewed as social resources (and therefore kidneys should not be marketed) is "a bit tentative" because of the need of dying people to obtain kidney transplants (201), that tentativeness on Satz's part may give the reader pause. Satz's tentativeness here can be seen as the courage to question received views or as a failure to see that there may be more wisdom reflected in those received views than is contained in the four parameters of Satz's theory.

I am left, then, with some doubts as to whether Satz's four parameters fully capture everything that (rightly, in my view) leads thinkers such as Anderson, Radin, and Sandel to want to place some things outside the market (or regulate the ways they can be sold) as opposed to limiting only those markets that infringe too heavily on one or more of the four parameters that Satz has identified. Satz mentions that "some goods do have a meaning that resists commodification—think of friendship, love, and Nobel prizes—[but] the overwhelming majority of

goods do not" (84). It is not clear why these three examples "resist commodification" for Satz. Does she see markets in these items as rating poorly on one or more of the four parameters (would a market in these goods harm democratic participation or exploit the vulnerable?), or do they resist commodification for other reasons? And if there are other reasons related to the meaning of these goods (e.g., their relationship to ideas like "personhood" or "dignity"), might not those other reasons also justifiably be applied to other goods such as parental ties to their genetic offspring, even if to do so necessitates a discussion of disputed values?

In conclusion, this is an admirable, engaging, and sophisticated book that makes a major contribution to the debates about the ethics of market exchanges. For bioethicists, it brings illuminating new considerations and a depth of historical perspective to central questions in the field.

Endnotes

1. Michael Sandel, *What Money Can't Buy: The Moral Limits of Markets*, *Tanner Lectures on Human Values*, vol. 21, ed. Grete B. Peterson (Salt Lake City, Utah: University of Utah Press, 2000), 96-103.
2. Margaret Jane Radin, *Contested Commodities* (Cambridge, Massachusetts: Harvard University Press, 1996), 148.
3. Radin, 163.