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APA NEWSLETTER ON

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FROM THE EDITORS

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Welcome to the spring 2014 edition of the *Newsletter on Philosophy and Medicine*. Your friendly neighborhood newsletter editors announce another ecclectic issue for your delectation, with the usual cheery spread ranging from birth to death, with detours into incarceration and torture. . . . Hmm.

Pacific Division's Seattle meeting featured a panel on health care for prisoners—a recurring and increasingly contentious issue for press, courts, and legislatures as the number of incarcerated in the United States continues to soar. John Kleinig and Nadia Gligorov respond in this issue to a paper by Ken Kipnis, in which he argues that if persons have been properly convicted for serious crimes, punishment may be a proper (retributive) response, and restriction of freedom can count as such. These considerations generate a reciprocal responsibility on the part of those restricting that freedom to provide what the prisoners are therefore unable to provide for themselves: "wardens . . . are properly charged with the legal obligation to make needed medical services available to those in their custody." Since problems associated with penal health care are problems of responsibility, Kipnis invokes the "common-sense ethical principle" that institutions and individuals should not assume responsibilities they are unable to carry out, and suggests several routes of legal reform and prison reform to mitigate the circumstances leading to endemic failures of custodial responsibility. CUNY's John Kleinig calls into question the implications of several of the implications of Kipnis's premises, and Gligorov argues that the custodial responsibility argument is even stronger if one abandons a retributivist approach to criminal justice.

Also in this issue appear several papers from the Baltimore meeting. Jan Narveson poses to jihadists the question of the Euthyphro, and Melinda Roberts wrestles with whether there are obligations to bear children. Dave Chambers explores issues of depersonalization in the clinical encounter, and whether ethical "principles" can adequately address the problem.

In addition, Felicia Nimue Ackerman has provided us with another one of her poems. And a particular pleasure of this issue is a review of Sheri Fink's *Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital* in what is for us a novel format: a discussion between Deborah Barnbaum, a philosopher, and her sociologist colleage at Kent State, Susan Roxburgh, about the clinical and organizational ethics implications of that tragedy.

More book reviews! More involvement of you, our readers, in your newsletter!

Reading an interesting book in your area of interest? Review it for the newsletter. If you would like to read a new book, contact us and ask for a review copy. Delighted or outraged by our authors? Send a letter for our comments column.

FROM THE CHAIR

Is Chance a Proper Currency of Distributive Justice?

Nir Eyal
HARVARD UNIVERSITY

The committee on philosophy and medicine is planning a number of promising events for the academic year 2014-15. Johann Frick (Princeton University) is putting together a panel on justice and risk distribution for the committee. Let me say a word to introduce this relatively unfamiliar topic.

Questions of distributive justice can be thought to touch on the distribution of good and bad chances. Take an example. In America, lung patients who are black, Latino, rural, or on Medicaid are listed for a lung transplant later in the progression of their disease than white lung patients. That gives them lower chances for a successful transplantation and a healthy future than white patients have. When we ask whether that's fair, our question seems to be about the fair distribution of chance. Likewise, poor nations ask themselves whether they should use scarce resources to fund only the highly cost-effective treatment for ordinary tuberculosis, or also treatment for multi-drug resistant tuberculosis, which is far less cost effective but that gives a chance to those tuberculosis patients whose bacteria turns out to resist ordinary drugs. Their question also seems to bear on the fair distribution of chance.

By contrast, when we ask whether it is fair to prioritize the young in access to ventilators during an avian flu pandemic

on the ground that, should they die now, they will have benefited from fewer life years than the old would should *they* die now, factual uncertainty matters less. Premature death involves fewer life years by definition. So the avian flu allocation question is less clearly about the distribution of good or bad chance. It may be about how to distribute good or bad personal outcomes.

Partly for didactic reasons, many philosophical discussions of distributive justice focus on good and bad outcomes (and on real opportunities to secure good outcomes). They ask what is the most ethical way to allocate personal good. But when resources (or opportunities, etc.) are allocated in the real world, there is no way of telling with certainty how they will affect a given individual. Uncertainty remains. Even receiving the better of two medications can cause one's early, painful death—for example, if a rare side effect of that superior medication materializes in one's case. Indeed, in rare cases, even the process of being connected to a ventilator can cause immediate death. What we can debate at the time when the medication or the ventilator are being allocated is primarily who will receive those craved resources and the alteration in personal prospects and risks that they represent. Since the future remains outside our full control and our perfect knowledge, we cannot debate at that point the fairness of any pattern of actual-world future outcomes.

Some thinkers provide deeper reasons to consider chances a proper "currency" of justice. When there is nothing that we can do to ensure fairness in the distribution of good and bad outcomes, the intuition is often that we should at least distribute chances more equally or in some other "fair" manner. For instance, assume that two patients with liver failure and equal claims to a liver transplant compete for the only available liver lobe. Their outcomes will probably be very unequal. A liver lobe cannot be split in two, so one patient will have to die, though the other may live. We have a strong intuition that it would be fairest to decide who will receive that liver lobe and who will not by using a lottery that gives each an equal chance—for example, by flipping an even coin. We shouldn't reason, "Since outcomes will be unequal and unfair either way, we might as well give the lobe to the patient who is our buddy, without a lottery, or rig the lottery in her favor." That intuition might be thought to show that fairness pertains not only to the distribution of outcomes but also to that of chances. To decide in favor of our chum without a lottery or to flip a rigged coin would intuitively seem unfair toward the other patient. So-called "fair" lotteries and many "fair" procedures often assume that the distribution of chance falls within the ambit of fairness considerations.

Is it correct to extend distributive justice considerations to the area of chance, though? By virtue of what would justice considerations apply to chancy currencies? My personal position, these introductory comments notwithstanding, is that justice does not properly apply to chance. Although there are often good reasons to use even coins and other lotteries, chance is not a proper currency of distributive justice. I plan to defend my position elsewhere. But suppose that I am wrong, and distributive justice does apply to considerations of chance, another question arises: Do distributive "patterns" that work best for good or bad outcomes as currencies also work best for good or bad chances? Suppose that on matters of personal good, you believe in distributive patterns such as equality, priority to the worse off, and proportion to desert. Should you endorse the same patterns when it comes to personal chance and risk? These are some of the questions that our 2015 Pacific APA panel will address.

Here's hoping to discuss these questions with many of you in Vancouver, and other questions at the intersection of philosophy and medicine in Philadelphia and in St. Louis.

ARTICLES

Correctional Health Care: Further Reflections

John Kleinig
JOHN JAY COLLEGE (CUNY)

In his articulate and impressive framing of the broad ethical issues surrounding correctional health care, Ken Kipnis makes three important assumptions:

> that punishment is a permissible response to those who have been identified as having committed serious wrongdoings;
>
> that all those so identified have either been properly convicted of serious wrongdoing, or are being properly held in temporary custody pending definitive adjudication; and
>
> that the penal forfeiture of liberty is, here and now, an appropriate form of punishment; that the prison—more or less as we understand it—is an appropriate means of implementing such a punishment.[1]

There are often decent philosophical reasons for making certain assumptions or bracketing certain issues so that others may become the object of concentrated attention. It's a complicated world out there and we want to focus specifically and narrowly on one issue without being distracted by others. That is, we want to ask what responsibility correctional officers have for the health care needs of inmates. And that may be sufficient to enable us to identify rights or develop principles that should govern prison health care. But *once we have to apply those precepts*, once we have to draw conclusions about what they mean in practice, the brackets must come off, especially if there exists a situation in which the principles are not being observed. It is my contention that when it comes to Kipnis's prescriptions on the basis of those rights or principles, then these bracketed assumptions come back to haunt him. That, at least, is the burden of my paper.

In the course of drawing attention to rights and responsibilities regarding health care, Kipnis notes that

as captives of the state, inmates have certain rights, not only by virtue of their personhood but also by virtue of their custodial situation. In particular, they have rights to appropriate living conditions in the context of their custodial situation—not, perhaps, the same entitlements that people have on the outside, but nevertheless certain important minima. Kipnis guides us through some Supreme Court decisions concerning this, and then confronts the fact that many prisoners in the United States get far less health care than is due to them. And because "individuals and agencies should not take on responsibilities they cannot manage" (383) some action is called for. What action?

Kipnis is a bit slippery on this. His initial response is that if, as is true in a number of states, "funds are insufficient to provide a decent minimum for inmates, . . . the only solution is to reduce the inmate population to a level at which the available resources will be sufficient" (383), but later he goes on to suggest that "we should decriminalize the least harmful [offenses]" (ibid.). And then, in closing, he offers without comment the following options: "decriminalization, amnesty, prison alternatives, and reduced sentences, so that the available resources can meet the needs of a smaller inmate population" (ibid.).

In an earlier draft of his paper, Kipnis referred to a pending Supreme Court case that has now been decided and which, he notes in passing, was decided in a way that is "largely consistent with the conclusions" for which he argues.

Now I don't want to hold Kipnis too strictly to this observation. However, insofar as the case in question, *Brown v. Plata*,[2] was related to correctional health care, I want to bring it or at least the arguments it raises to bear on some of the issues at stake. I'm not sure that Kipnis would disagree with all that I have to say here, even by way of criticism, for some of my remarks may simply clarify and develop a position with which he would otherwise be sympathetic. I say this because most of his prescriptive remarks come near the end of the paper and are not developed at any great length.

BROWN V. PLATA

Briefly put, *Brown v. Plata* had its origins in a 1990 case, *Coleman v. Brown*, in which it was found that Californian prisoners with serious mental illnesses did not receive minimally adequate care for their mental health conditions. That led to some oversight of the Californian system. Ten years later, in another case, it was argued that the general medical well-being of Californian prisoners had not improved but was deteriorating even further, to the point that inmates' Eighth Amendment rights were not being met. By 2005, there still had been no compliance with an injunction that was stipulated in 2001 (*Plata v. Brown*), and a three-judge court, which accepted that overpopulation was the prime cause of deficient health care, then used a provision of the federal Prison Litigation Reform Act (PLRA, 1996) to mandate reductions in the prison population, and ordered the state of California to reduce its prison population—within a couple of years—from almost double to 137.5 percent of its capacity. The effect of this would have been to release, all told, up to 46,000 prisoners. It was this decision that, in *Brown v. Plata*, the Supreme Court reviewed and affirmed.[3] As has become common in the Roberts Court, the decision was 5-4, with the usual suspects—the liberals lining up on one side, with Kennedy providing the swing vote in their favor, and, for the minority, Thomas backing Scalia, and Roberts backing Alito. I'll return to some of the sticking points a bit later.

The majority in *Plata* accept that failures in correctional health care—for both mentally disturbed and other medically needy prisoners—is *primarily the result of overcrowding in prisons*, with its consequent dilution of resources, and that this dilution is not practicably fixable by an infusion of money from the state of California, because the latter is financially too cash-strapped to do so.[4] That is the main reason why it accepts the earlier court's decision that the state should divest itself of 46,000 inmates. Releasing prisoners will increase the availability of resources. And that is the option toward which Kipnis initially gravitates.

As a relatively quick-fix solution, the release option has something to be said for (as well as against) it, though what I think it should also have done in Kipnis's case is force a review of his initial assumptions. For, *given those assumptions*, prematurely releasing 46,000 inmates into the community would constitute a fairly drastic solution. That is an issue on which the minority tends to harp. If, however, we question some of those assumptions, then a rationale for release becomes much more plausible.

REVIEWING THE CASE AND KIPNIS

(A) IMPRISONMENT AND THE MENTALLY ILL

One factor that might trigger our immediate concern is the association of mental illness with imprisonment. Some dimensions of that concern relate simply to the conditions under which the mentally ill are incarcerated, especially, though not exclusively, in view of the overcrowding. Data provided in *Plata* concerning prison suicides, assaults by mentally disturbed prisoners, the isolation of mentally disturbed prisoners without treatment and the consequent worsening of their condition, and so on, make it pretty clear that a Californian prison, and maybe prison itself, is not a good place for a mentally disturbed person to be.

There have been various studies of mental disorder in prisons, and estimates of significant disorder tend to range between 15 percent to 25 percent of those incarcerated. Given the *Plata* figures, that amounts to between 23,440 and 39,000 of prisoners suffering from significant mental disorders.

Now, I accept that mental illness per se does not relieve one of responsibility for wrongdoing, and may also not relieve one of responsibility for crime. But the numbers are worrying enough to suggest that a significant number of people in prison should probably be in different facilities or, alternatively, be receiving treatment on the outside. Since the de-institutionalization initiatives of the 1960s and 1970s, and the subsequent collapse of alternative treatment initiatives, prison has become a convenient way of dealing with people whose mental disorders have given rise to social disruptions or violations of one kind or other.

Already we are nibbling at Kipnis's assumptions about the legitimacy of imprisoning those who are currently incarcerated. The problem is not that some of these people are getting inadequate care in prison—presuming that it would be possible to get adequate care there—but that they should probably not be in prison in the first place. Maybe some of them should be in another secure facility; but it is just as likely that some of them should simply be receiving a different kind of care from what, even in better circumstances, a prison would offer them.[5]

(B) OVERCRIMINALIZATION

The majority in *Plata* allow that prison overcrowding is the "primary" reason for the California's correctional health care deficiencies. "Primary" is the weasel word here. It is certainly a convenient reason. It is, however, the plausibly primary reason only if you make the kinds of assumptions that Kipnis does at the beginning of his paper. I would be more inclined to say that overcrowding provides a good reason not only for the parlous state of correctional health services in Californian prisons but also for reviewing the paper's initial assumptions and perhaps questioning them. That may give us better (whether or not more politically viable) insight into the most acceptable practical strategy for dealing with the correctional health problem. Let me explain.

The United States has by far the highest incarceration rate in the world—in 2009, 743 per 100,000 residents compared to 577 per 100,000 in Russia, the runner up. By contrast, the figures for the United Kingdom were about 155 and, for Canada, 117. Obviously we can speculate about the possible reasons—Does the United States have more bad citizens than others? Does it have a more efficient criminal justice system? Does it incarcerate people for longer periods than other comparable societies? and so on—The simplest truth of the matter is that American society and its criminal justice system are very punitive. Furthermore, many of those in prison are there because of American attitudes to drug use—the criminalization and punishment of drug use. Many drug offenders are non-violent, yet there has been a massive increase in the prosecution and imprisonment of non-violent drug offenders since the mid 1980s.

Were the American response to drugs and drug-related offenses, and to criminalization more generally, different from what it is—more like that in comparable countries—the prison population would look very different and be much smaller.

In his recent book, *Overcriminalization*, Douglas Husak powerfully argues that a distinguishing feature of the United States is its tendency to overcriminalize, one of the effects of this being an inordinate and successful if questionable reliance on plea bargaining.[6] Some 95 percent of U.S. criminal cases are resolved as a result of plea bargains, and although there are supposed to be safeguards to ensure that defendants get a fair shake, the simple fact of the matter is that plea bargaining is more efficient than fair. Because of overcriminalization, defendants are hit with a fistful of charges for single acts deemed to have violated a large number of criminal rules, and then offered the opportunity to have most of them dropped if they plead guilty to one or two. Such offers are often irresistible and, no doubt, sometimes coercive, especially for the resource-poor, as the plea-bargained offense is likely to result in a significantly lighter sentence than would be the case were the multiple charges to succeed in court.[7] Even so, offenses in the United States tend to attract longer prison sentences than elsewhere.

Overcriminalization is, of course, a reason for moving in the direction in which Kipnis wants to go. But it—along, perhaps, with mental illness—also helps to identify the 46,000 (or more) people who ought to be released from prison. Kipnis speaks generally about releasing people. But he doesn't really have anything to say about who they might be. Is it those who are currently getting inadequate treatment, or should they stay so that they can get better treatment while others are released? Should other criteria—such as dangerousness, length of time to serve, etc.—be involved? These are questions to which I will return.

THE IMPORTANCE OF GOING BACK TO ASSUMPTIONS

One of the problems of bracketing off the sort of issues that Kipnis does is that it easily skews the range of practical options that are seen to be available and that ought to be considered. Or, if not that, it leaves us without a practical handle on release decisions. What is noticeable about the minority responses to the *Plata* decision is their firm belief in the reasonableness of Kipnis's initial assumptions and therefore of—as they see it—the very radical nature of any decision to release prisoners. They do their best to argue for alternatives. They point to the potential problems involved in releasing prisoners and use these to advocate other options.

As usual, Justice Scalia seeks to press the buttons of fear. He says of such releasees: "Most of them will not be prisoners with medical conditions or severe mental illness; and many will undoubtedly be fine physical specimens who have developed intimidating muscles pumping iron in the prison gym" [5]. A similar worry is also expressed by Justice Alito. Given that the overpopulation of Californian prisons is not itself unconstitutional, he argues that the remedy needs to be tailored to the need, and writes: "Instead of crafting a remedy to attack the specific constitutional violations that were found—which related solely to prisoners in the two plaintiff classes—the lower court issued a decree that will at best provide only modest help to those prisoners but is very likely to have a major and deleterious effect on public safety" [2]. He talks of "the premature release of approximately *46,000 criminals—the equivalent of three army divisions*" [2, his emphasis]. If the public safety issue can be pumped up sufficiently, a search for alternatives to release becomes much more plausible and pressing.

I happen to disagree with the fear mongering, and think that there are ways of releasing prisoners that are socially unproblematic. But it does require some weakening of the initial assumptions. The majority does not say so in so many words, partly because it is not in a position to say so. It is, however, willing to indicate ways of discriminating among

prisoners. Although it leaves it to California to decide how it might go forward with the prisoner release,[8] it talks about the use of good-time credits, and the diversion of low-risk offenders and technical parole violators to community-based programs [3, 33, 39]. It is not difficult to read between the lines and see that the majority is of the opinion that some of the people who are behind bars can be safely released or ought not to be there.

There is, unfortunately, an ambiguity about "release" that Kipnis does not pick up on but which partly meets the Californian dilemma. And that is the shifting of prisoners from overcrowded facilities to less overcrowded but still incarcerative ones. In the majority's opinion, Justice Kennedy notes that since the time of and in response to the three-judge court decision and the Supreme Court's hearings, some 9,000 prisoners had been released, leaving only 37,000 to go. It turns out though, that many of these prisoners had simply been shifted to less crowded *county jails*. Although that may have ameliorated the situation that led to the Supreme Court decision, it almost certainly did not constitute a morally adequate alternative—*unless of course you accept the legitimacy of Kipnis's background assumptions*. Even though I think that Kipnis is on the side of the angels, this Californian strategy does, unfortunately, go some way to responding to his "release" prescription.

The court majority refrained from greater prescriptivity as a matter of policy. Even so, affirming the earlier court's decision aroused the ire of the minority. They argued, albeit not on the basis of a different principle, that how a state runs its prisons is for the state itself to determine, and that by affirming the earlier court's decision the majority overstepped the bounds of its competence and mandate. Although the Supreme Court is to some extent the guardian of the Constitution and its interpretation, it is for the states themselves to determine how best to run their prison systems.

There may be some justification for this in the political division of labor that underlies federalism. There is at least an argument for saying that states are generally better placed to run their own institutions than the federal government or federal courts. Although that won't always be the case, it might be argued that it is true often enough to make the federal courts extremely wary of intervening, restricting their interventions to cases in which constitutional violations have become embedded.

It is also arguable that the courts are not well equipped to administer prisons. Justice Scalia quotes from an earlier case in which the court stated: "Running a prison is an inordinately difficult undertaking that requires expertise, planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government" [11, quoting from *Turner v. Safley*, 482 US 78, 84-85 (1987)]. Now, that may be true as a general matter, just as we may think it appropriate for parents to determine the needs of their children. But on some occasions parents overstep important moral or other boundaries and others must intervene. So it might also be argued here. Scalia cannot go from what may be true as a general principle to what must be true in every case.[9]

Justice Scalia also has a different, though related, jurisprudential concern when he claims that the majority's decision constitutes a "structural injunction," by means of which judges "engage in a form of factfinding-as-policymaking that is outside the traditional judicial role" [7]. In its deliberations the court accepts as fact findings that are part of the record and therefore not open to review. As Scalia puts it, "it is impossible for judges to make 'factual findings' without inserting their own policy judgments, when the factual findings *are* policy judgments" [9]. He takes this kind of "dressing up of policy judgments as factual findings" to be "an unavoidable concomitant of institutional-reform litigation" [9]. Structural injunctions invite "judges to indulge *incompetent* policy preferences" [9].

CONSTITUTIONAL VIOLATIONS

Kipnis is right to draw attention to the constitutional protections that prisoners have, first of all, as "captives" of the state, and then as entitled to a level of care that does not violate the Eighth Amendment protection against "cruel and unusual punishment."

Neither the liberal nor the conservative members of the court disagree about the state's responsibility for correctional health care. What they disagree about is whether the problems in the Californian system constitute the kind of Eighth Amendment violation for which the response that Kipnis canvasses is appropriate:

> Medical needs are not being met.
>
> As a result some prisoners are suffering from what amounts to cruel and unusual punishment.
>
> The failure to meet those medical needs arises primarily from a dilution of resources arising from prison overcrowding.
>
> Therefore enough prisoners need to be released to alleviate the burden on resources.

This is not a very tight argument, and the conservative members of the court do what they can to drive a truck through it. They accept that some medical needs are not being met. They even accept that some prisoners are thereby suffering what sinks to the level of "cruel and unusual punishment," though they are not convinced that all of these cases display the "deliberate indifference" that *Estelle* requires before an Eighth Amendment violation can be said to occur. Such "deliberate indifference" is said to reside in the fact that, for well over a decade, the Californian system had shown little improvement, despite mandates that it should. Now there is a factual issue here about which the majority and minority disagreed, but which I will not pursue.[10] And, of course, even if it could be shown that the Californian system had shown little improvement, it still needs to be established that this constitutes "deliberate indifference." Failing to respond to needs adequately because one is strapped for cash or resources or even gridlocked does not automatically translate into "deliberate indifference."

Of course, pointing out the difficulties in a constitutional argument is not the same as pointing out difficulties in a moral argument. Even without a constitutional claim we can assert with some confidence that the Californian authorities had badly failed their medically needy inmates (and no doubt their inmates more generally) in not providing adequate space and health care resources and, further, that strong rectificatory measures were—*morally speaking*—called for. Failure does not have to sink to the level of "cruel and unusual punishment" for correctional authorities to be morally obligated to address it.

The minority gives qualified acceptance to the idea that the problems have arisen primarily as a result of overcrowding. But they are very skeptical that the proposed remedy is the only one available. As I've noted, part of their motivation for pointing out the gaps in the argument lies in their acceptance of Kipnis's original assumptions: these people belong behind bars, and we should look for solutions that keep them where they belong.

Probably the main contention of both Alito and Scalia is that there is a mismatch between the problem and the remedy. Starting from the contention of almost all court witnesses that the primary problem in the Californian system is overcrowding, they point out that overcrowding as such does not constitute a constitutional violation. Only a subgroup of prisoners—and only a proportion of those with medical needs—fail to get "the minimal civilized measure of life's necessities" that the Eighth Amendment requires [Alito, 2].[11] There is, Alito thinks, therefore no clear or direct connection between releasing 46,000 inmates and remedying the situation of that subgroup.

What about the argument that the court makes, and that I think Kipnis accepts, that if 46,000 inmates are released, there will be enough medical services to go around, thus remedying the situation of such people? Although I have no doubt that there is something to this argument, there may not be as much as we would like. It surely depends on who the 46,000 will be.

(1) Allow that some [perhaps all] of them will be people with medical and mental health needs. Will they have those needs met "on the outside"? Not obviously. Some of them might receive appropriate treatment because, as non-captives, they will be at liberty to access suitable health care. At least they will not be prevented from getting it by virtue of their captivity. But whether they will get it, or get adequate care on the outside, is more problematic. They might simply find themselves in the position of a lot of people in the country who do not have, for reasons of cash or geography, access to the care that they need. Of course, they will no longer be a *constitutional* problem, as only inmates have a constitutional right to health care.[12]

(2) Now allow that some (perhaps all) of the prisoners who remain inside are those with medical needs but who are now in circumstances in which their constitutional right to adequate health care can be met. Will their needs be met? Well, they are likely to be better off than they were. But how much better off will depend on a number of considerations to which both the majority and minority allude but to which they do not give a great deal of attention. Insofar as the remedy is not directed specifically at the health care needs of those whose constitutional rights are being violated, there is plenty of room for slippage between the remedy and the cure. There are several factors involved here:

(a) A general factor is that the court did not want to be too hands-on with regard to its remedy. It saw the task of running prisons to be that of the state and its agents. I will say no more about that. The court itself is going to do little about ensuring better health care.

(b) Another factor is distributional. What the court required was an overall reduction in the number of inmates to 137 percent of capacity. But—as the court itself acknowledged—that did not prevent the state from making reductions in a way that left some facilities grossly overcrowded and without adequate health care resources.

(c) A third factor is that in any case the prison system had a large number of correctional health care vacancies that it had budgeted for and had been unable to fill. In other words, it was not a simple matter of inadequate financial resources but also an inability to attract qualified staff. It was reported to the court that budgeted vacancy rates ranged as high as 20 percent for surgeons, 25 percent for physicians, 39 percent for nurses, and 54 percent for psychiatrists [20]. Even with 137.5 percent overcrowding, it is unlikely that correctional health care would have been an attractive option for most competent and professional providers.

(d) Unfortunately, "qualified staff" in a prison setting does not always amount to much. Those who offer services in prisons often do so because their services are not wanted elsewhere. In the 2001 *Plata* case, it was reported that prisons were reduced to hiring "any doctor who had a license, a pulse, and a pair of shoes'" [10, citing the District Court, 926]. That's not always true, of course, and I don't mean it to cast aspersions on those who work within prisons, but it may be true often enough to make it unlikely that prison health care is very good overall.[13] True, it may be better than the health care that prisoners will actually get on the outside. It may not fail constitutional standards, but it may be poorer than the care that prisoners need.

(e) Yet another factor that is often overlooked is the conflict that health care professionals may experience within a prison setting. The institutional demands for security and order may well clash with health care best practice, and particularly, though certainly not exclusively, where the provision of mental health services is concerned.

WHO SHOULD BE RELEASED?

I've already made certain comments on this that encroach back on Kipnis's assumptions. And, of course, when it comes to the practical crunch, Kipnis himself does. At the very end of his paper he talks about decriminalization—presumably because some of the people who are in prison don't deserve to be labelled as criminals, and are therefore not meet for imprisonment. And when he refers to prison alternatives, he concedes that though the deprivation of liberty may be a punishment option, it need not be the

appropriate option for all. The option of reduced sentences also takes us back to the initial assumptions: some may be punished too severely. And that then leaves us with amnesty.

Now, as I hope I have made clear, I do not think we should dismiss the release option. It does, however, need to be implemented in a way that, on the one hand meets the constitutional claims of those who are currently being shortchanged and, on the other hand, does not create an unacceptable public safety problem. We have already noted some of the problems associated with either releasing those with medical needs so that they are no longer constitutionally violated or, not releasing them so that adequate medical resources will be available to them.

As I have also noted, in the majority opinion several other options are canvassed without being mandated—moving inmates to other, less crowded facilities, parole reform (including the release to community programs of people who have been re-admitted for technical violations of parole), sentencing reform (including the use of good time credits, the release of inmates who appear to pose no social danger). These all represent legitimate ways of selecting among inmates, though all of them require some qualification of Kipnis's background assumptions. One of Kipnis's background assumptions in particular should come up for reconsideration. Even if, in a liberal society, it makes good sense to punish people by depriving them of one of their most important liberal goods, it is at least arguable that that form of punishment should be largely restricted to those who would otherwise pose an ongoing danger to society. In that case, the release of those who pose no ongoing social danger would not merely satisfy the public safety concerns of release but also provide a moral argument for not ordinarily using imprisonment as punishment in the absence of some ongoing social danger.

NOTES

1. These principles are stated in Kenneth Kipnis, "Social Justice and Correctional Health Services," *Medicine and Social Justice*, ed. Rosamond Rhodes, Margaret Battin, and Anita Silvers, 375–76 (Oxford University Press, 2012). Page numbers in round brackets refer to this paper.
2. *Brown v. Plata* 563 U.S. ____ (2011) [No. 09–1233. Argued November 30, 2010—Decided May 23, 2011], available at http://www.supremecourt.gov/opinions/10pdf/09-1233.pdf.
3. The minority makes something of a meal of the number in question (46,000) because, by the time the court decided the case, the number had been reduced to 37,000, and the system was not prevented from releasing the remainder in a measured way—say, by using good-time credits and diversion of low-risk offenders and technical parole violators to community-based programs.
4. Proposals to ship prisoners out of state had not been implemented and building new facilities was not budgetarily possible. Furthermore, even budgeted health-care positions were not being filled. There was only a remote possibility that diminished numbers would make the provision of health-care services in Californian prisons a more attractive option for health-care providers.
5. This involves what may be a questionable assumption—viz. that the mental health care they receive on the outside is *likely to* (and not simply *could*) be better than the care received in prison. As Kipnis notes, prisoners are the only people with a constitutional right to health care (*Estelle*), and it is arguable that, with all its faults—and they are many—people *actually* do better in prison than they would on the outside, even though one *can* get better quality health care outside prison. See Sung-Suk Violet Yu, Jeff Mellow, Hung-En Sung, and Carl Koenigsmann, "When Incarceration Leads to Improved Health Outcomes: Importance of Previous Health in Predicting Health Outcomes in Custody," unpublished, submitted *to Journal of Urban Health*.
6. Douglas Husak, *Overcriminalization: The Limits of the Criminal Law* (NY: Oxford University Press, 2008).
7. Although plea agreements are judicially reviewed, such reviews are often perfunctory. On plea bargaining generally, see Richard L. Lippke, *The Ethics of Plea Bargaining* (NY: Oxford University Press, 2011).
8. *Brown v. Plata*, 35. See Jennifer Medina, "California Sheds Prisoners but Grapples with Courts," *New York Times*, January 21, 2013, available at http://www.nytimes.com/2013/01/22/us/22prisons.html?_r=0.
9. Moreover, as I suggested earlier, it is not just an issue about how to run a prison but of what gets or keeps people in prison in the first place. The Supreme Court may feel some obligation to make Kipnis's initial assumptions. Kipnis himself is not under a similar constraint.
10. Whereas the minority argued that an earlier court deliberately excluded evidence of improvement, the majority argued that there was no salient evidence.
11. From *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).
12. We have some evidence from the studies conducted by Yu and Pezzella that the general health of prisoners with pre-existing health problems is likely to improve inside prison.
13. There have been a number of studies and exposés to this effect. Prison health care is usually tendered, and the companies who win such tenders are often flawed providers.

Undermining Retributivism

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1. INTRODUCTION

The focus of my paper is the relationship between free will and conceptions of punishment. In particular, I wish to examine how our conception of free will is related to the notion of retributive punishment. Retributivist conceptions of punishment rely on the notion of "desert," which requires that individuals be able to choose their actions.

In this paper, I will review some empirical evidence that is sometimes used to argue that the concept of free will required to buttress the notion of moral and legal responsibility is either entirely false or very different from what has been previously assumed. I will discuss how this empirical evidence points to the more general problem of the purported incompatibility between scientific determinism and free will. I argue that in so far as there are limitations to the human ability to control behavior, then the notion of retributive punishment is undermined because decreased free will results in decreased responsibility. My argument, however, does not follow from a defense of scientific determinism. Finally, I will argue that if incarceration is not conceived of as punishment in the retributive sense, this is further reason to argue that the state has custodial responsibilities towards prisoners with regards to their health care.

2. THE DEFINITION AND THE TYPES OF PUNISHMENT

Legal punishment is the authorized deprivation of freedom, privacy, or any other goods to which persons usually have rights. The imposition of these burdens is the result of a person being found guilty of some criminal violation.[1] Given this definition there are several different ways of justifying punishment. The two most prominent are consequentialist and retributivist. Consequentialist approaches to punishment justify it by referring to its socially beneficial outcomes, including deterrence of future crimes or any other social good. I will not focus on the consequentialist view in this paper.[2]

The retributive justification for punishment is that the guilty deserve to be punished and that there are no other relevant considerations that could outweigh this desert. Retributivism assumes the proportionality principle, which is that the severity of punishment must be proportional to the gravity of the offense. The proportionality between crime and punishment is difficult to establish, especially if one abandons the *lex talionis* principle of retribution.[3]

The notion of desert for either positive or negative actions assumes some sort of ability of people to control their actions; that is, it presumes a version of free will. There are a number of different ways to define free will, but most generally it can be defined as the ability to choose one's actions from among a number of different alternatives. This ability is considered a requirement for moral behavior, or in the very least it seems to be a requirement for responsibility. In order to hold a person responsible for his or her actions, it is necessary that we be able to attribute to that person the ability to do a number of different things as well as the ability to select one among those alternatives.

If in the midst of a musical performance, a person starts cursing loudly, we would hold that person responsible for disturbing the performance as well as for diminishing the enjoyment of the other members of the audience. In this scenario, perhaps the appropriate punishment would require that the person be thrown out of the concert hall. If we later found out that the person who loudly uttered profanities during the most engaging moment of the musical performance suffered from Tourette syndrome, we would not hold her responsible for her inconsiderate behavior. Thus, the ascription of choice to the person who cursed is required for the ascription of blame. Applying this to the notion of retributive punishment, in order for an individual to deserve punishment she ought to be able to choose her actions. Once we know that the person could not have done otherwise, as would be the case with the person with Tourette syndrome, we might change our mind about punishment. We might either decide not to punish the individual by making her leave, or we might politely ask her to leave not in order to deprive her of their enjoyment of the musical performance, but in order to enable the rest of the audience to continue enjoying the concert. In the latter case, asking the person with Tourette to leave would not be a form of retributive punishment, although it will prevent that person from hearing the remainder of the performance.

3. EVIDENCE AGAINST FREE WILL

Among the empirical evidence considered challenging to the concept of free will are the experiments performed by Benjamin Libet. Libet's operational definition of free will captures what he thinks are common views on the subject (Libet 1999). There are two elements to this common view. The first element is the idea that an action needs to be free of any external control. According to Libet, an action free of external control is an action caused endogenously. The second element is the conscious experience of willing, or the notion that an act is free if the agent has *the feeling of wanting to do it*. This feeling would be causally required for an action, and not just the awareness of a decision and an action. In order to test this common notion of free will, Libet et al. (1982) asked the participants in one study to flick their wrist whenever they felt like it. The subjects were simultaneously monitored by an electroencephalogram (EEG) and an electromyogram (EMG). The EEG machine records electrical currents in the scalp, which are correlates of brain activity. The EMG machine detects the electrical currents in the subject's hand that are caused by the actual movement of the muscles of the wrist. In this experiment, the movement of the wrist, and the activity recorded on the EMG, was preceded by an electric charge that was recorded by the EEG. The brain became active before the wrist. This burst of electrical activity in the scalp was called the "readiness potential" (RP). The RP preceded the movement of the wrist by an average of 550msec.[4]

Libet (1983a) was also interested in measuring the conscious intention to perform an action. He called this *the first awareness of the wish to act* (W). In order to capture W, Libet and his colleagues constructed an oscilloscope "clock."[5] The subjects were told to look at the center of the clock. For each voluntary wrist flexion, the subjects were asked to indicate where the moving spot on the oscilloscope clock was located when they first experienced to conscious intention to move their wrist. This procedure was intended to capture the time the subjects had experienced W.

In this study, as in the previous one, there was a lag between the muscular activity in the wrist, an RP by about 550 ms on average. Surprisingly, there was also a lag between W and RP; the unconscious preparatory brain activity preceded the conscious intention to perform the action. Libet's findings challenge the common assumption, as described in Libet (1999), that conscious intention is required for voluntary action. In an attempt to accommodate the finding, Libet proposed that although conscious willing is not the cause of the preparatory brain activity that precedes the action, once the action is activated, the will has veto power. In other words, the brain can ready us for certain kinds of actions, but the will can inhibit some actions from completing. Libet argues that the conscious veto is a control function and not just a mere awareness of the unconscious brain activity. Furthermore, he argues against the idea that even the conscious veto is preceded by an unconscious brain process. Libet dissociates the unconscious processes perhaps necessary for the veto from the content of the decision. He argues, there might be some preparatory activity in the brain necessary for one to make the decision to veto or not to veto, but the actual content, to veto for example, has to be due to the conscious will.[6]

This last hypothesis was actually tested by Soon et al. in a study using functional Magnetic Resonance Imaging (fMRI).[7] In this study, subjects were asked to fixate on the center of the computer screen as a stream of letters was presented to them. They were asked to press one of two buttons using either their left or right index fingers at any point they felt the urge to do so. To capture conscious intent, Soon et al. asked the subjects to remember the letter that was on the screen when they first felt the pangs of conscious will. Both the left and right responses were pressed equally often and almost 89 percent of subjects reported having formed a conscious intention to move in 1,000ms before the movement (Soon et al. 2008).

Soon et al. determined that using the fMRI they could actually determine based on brain activity alone which action would be performed. The fMRI could be used to predict whether the subject was getting ready to press the right or left button. This, of course, is contrary to the claim that the activity in the brain preceding the action is unspecific preparatory motor activity—one can actually guess the content of the action based on brain activity alone. Moreover, they were able to predict what the person was going to do before he actually experienced the conscious intention to press either the left or right button.

There is further scientific evidence for the dissociation of motor behavior and conscious willing. One such dissociation is illustrated by Panfield's finding that certain kinds of behavior could be induced by direct stimulation of the relevant areas of the brain.[8] Panfield stimulated the motor cortex of patients whose brain was exposed under conscious sedation. He found that the stimulation could produce complex, multi-staged movements that appeared to be voluntary. The subjects, however, reported that they did not feel like it was them doing the action.

Further evidence of the dissociation between conscious willing and action includes experiments utilizing Transcranial Magnetic Stimulation (TMS).[9] In this study, TMS was applied to either the left or right motor cortex, again with the intent to influence movement of either the left or right finger. Participants in this study were not able to identify the influence of TMS on their movements. Instead they reported feeling as if they were willing to move either the right or left finger.

Given that most of the studies presented seem to show dissociation between conscious willing and action, this dissociation has been interpreted as compromising to the common notion of free will. However, the argument that the common notion of free will is intrinsically tied to conscious willing is flawed. There are numerous examples in everyday life where there is dissociation between conscious willing and action, but the tendency to ascribe free will remains. Many of the examples pertain to automated behavior such as tying shoelaces or driving. Imagine, for example, the action of tying one's shoelaces. Many people remember the first time they learned to tie their shoes, and recall that the learning process was a result of a number of deliberate, putatively conscious actions. The child needs to learn the elements of tying shoelaces separately and attend to the performance of each. To aid in that process, there are songs designed to help children memorize the various stages of tying shoelaces. But after a lot of practice, and perhaps a lot of singing, the child becomes an expert at tying shoelaces and the process becomes automated. When a practiced adult ties her shoelaces, the process is entirely automated and does not require the adult to attend to any of the discrete movements necessary to tie shoelaces. Some of us can even attend to different tasks, such as reading the paper, while successfully putting on shoes. It would be awkward, however, to argue that a person capable of reading the paper while tying her shoelaces is not performing a volitional action because she is not attending to each discrete action required to tie her shoes.

The judgment that the person tying her shoelaces while reading the paper is still willingly performing that action is rooted in the presumption that automated processes, like tying one's shoes, retain other elements of volitional action. We said that some of the often-presumed elements of free will are that the action be endogenous and that the person was capable of selecting that one action out of a number of alternatives. Both of those elements of free will can be properly attributed to the person tying her shoes. She has decided to leave the house and put on a particular pair of shoes. Her decision was not externally influenced. She decided to wear that particular pair of shoes. She was not forced by physical means or verbal coercion. She presumably could have both chosen to wear a different pair of shoes and to not tie her shoelaces. These two elements taken together lead to the conclusion that she willingly tied her shoes. Perhaps this also might show that the other two elements of free will are prioritized over the element of conscious willing. In the very least, the fact that attribution of free will does sometimes dissociate from the attribution of conscious willing is an indication that consciousness is not always a necessary element for the attribution of free will.

Let us now turn to the issue of determinism as the threat to free will. The summative implication of all the presented studies perilous to the concept of free will is that they lend support to the broader project of psychophysical reduction. Libet succeeds in showing a correlation between brain activity and motor movements and shows that the mental state of conscious willing has a smaller role than previously expected. Penfield shows that conscious willing to move one's limb can be circumvented entirely using direct electrical stimulation of the relevant areas in the brain. The Soon et al. (2008) study shows that one could even make predictions about what a person will do based on the amount of activity in certain parts of the brain. Reduction is a problem for free will because if most of our psychological states, including those that underpin volitional behavior, are reducible to brain processes, then our behavior is determined by scientific laws that govern physical states of which brain states are a subset.

The reduction of psychological states becomes a threat to free will when it is coupled with determinism. Determinism is the claim that, given a certain set of initial conditions (for example, conditions that existed at the time of the Big Bang), and given the laws of physics that specify a cause for each event, every event from the onset of the universe can be

explained and predicted (using just those laws). Assuming the view of the unity of science presented by Oppenheim and Putnam (1958), scientific inquiry can be subdivided into different levels of explanation, with physics being the most basic one, then chemistry, biology, neuroscience, and so forth.[10] Assuming further that the higher levels of explanation can be reduced to the more basic levels of explanation, the distinct levels form a collapsible hierarchy that in due time will result in a complete reduction of all higher levels to the lowest possible level—i.e., physics. Thus, if the laws of physics are deterministic, then all scientific laws will acquire that feature, including those that govern human psychology. It would be false, then, to say that persons are free to make choices; in the same way it would be false to say that a ball falling from a height has the choice to follow the law of gravity. The decision one makes is caused by events preceding that decision, and those events in turn were caused by events before them, and so on, forming a long causal chain that reaches all the way back to the beginning of the universe. On this picture, things could not have been other then they are and any individual could not have done otherwise.

As psychiatry, neurology, and neuroscience continue to advance, we will be able to explain more of human psychology in terms of brain activity. If all psychological phenomena that underlie what we regard as moral reasoning and action can ultimately be explained in terms of brain processes, then those psychological capabilities required for morality could be viewed as nothing but a physical process.

There are several problems with the argument from reduction and determination, and I will sketch those shortcomings in brief. In the way that I have presented the issues, determinism at higher levels of explanation results from the reduction of those levels to more basic levels of explanation, but there are alternative views on which science is not comprised of different levels of explanation. On such views, there is interconnection between different scientific fields, but they do not separate into discreet levels of explanation, although they may overlap.[11] If there are not distinct levels of explanation, then there is not a collapsible hierarchy of levels, which will one day unite into a deterministic scientific theory.

Even if we retain the assumption that there are levels of explanation, determinism might not be a feature of every level of scientific explanation. Adina Roskies argues that determinism does not yet seem to be a feature of neuroscience.[12] "The picture that neuroscience has yielded so far is one of mechanisms infused with indeterministic or stochastic (random or probabilistic) processes. Whether or not a neuron will fire, what pattern of action potentials it generates, or how many synaptic vesicles are released have all been characterized as stochastic phenomena in our current best models."[13] Finally, there are arguments against the possibility of ever reducing psychological phenomena, which might include free will, to any more basic level of explanation such as neuroscience.[14]

3. DIMINISHED WILL

An argument against the threat of determinism, however, is not an argument for freedom of the will. One does not have to require neuroscience to generate deterministic laws in order for neuroscientists to make predictions about human behavior based on observed regularities. Probabilities can be enough for an argument that some individuals have a limited ability to control their behavior when compared to other individuals. And ascriptions of praise or blame should be modulated based on facts about human beings, especially facts about the degree to which people can control their behavior.

We seldom, for example, blame people for their physical attributes. It would seem at best strange, and in some instances even cruel, to blame people for attributes such as short stature or eye color. It would be even more inappropriate to ascribe personal blame to an individual for becoming ill, for example, for developing cancer. When it comes to physical attributes, individuals have little or no agency; they cannot change their physical features or prevent the onset of many diseases.

Understanding that Tourette syndrome is a neurological condition that causes people who suffer from it to blurt out obscenities makes us less likely to blame that person for their behavior. Knowing that the person who has this neurological disorder has diminished control over her actions allows us to think that she could not have acted in a different way. Even understanding of psychiatric diseases makes us more hesitant to blame those who have psychiatric conditions. For example, people who have schizophrenia and commit violent acts are not considered responsible in the same way as people without such diagnoses who commit the same acts. They might be confined to a psychiatric hospital, but the cause of their violent acts is attributed to their biologically based mental illness, not to choice.

The expansion of the scientific understanding of human psychology and human behavior has an impact on our tendency to ascribe praise or blame. Although psychiatric illness is still stigmatizing, the stigma is diminishing. The classification of some conditions as medically treatable conditions encourages their reinterpretation as a condition with physical causes. Clinical depression is an example of such a reinterpretation. If a condition can be either identified with a neurological cause, or can be cured by changing aspects of brain functioning, we are more likely to accept it as a medical condition and absolve the person of responsibility for some of their behavior.

The expansion of the scientific understanding of human psychology should also change how we conceive of incarceration. The notion of desert as it underlines the retributivist view of punishment relies on the human ability to control behavior. I do not think that the notion of desert is obsolete, but I do think that one could make an argument that some people who engage in criminal behavior do have diminished control of their behavior. This does not mean that they should not be incarcerated and have their liberty limited; but it might mean that such incarceration should be conceived less as a form of punishment. It might be beneficial to imprison a violent offender to prevent her from committing more crimes, especially if there are not

better alternatives. But the imprisonment cannot properly be characterized as punishment if the offender *could not have done otherwise*. Reconceptualizing incarceration as something other than retributive punishment does have implications for how we think about what we owe prisoners, especially as it pertains to providing them with health care. I will discuss this issue in the last section of the paper. But first, I will identify which individuals might have diminished control over their actions.

There are individuals with mental illness who cannot be considered responsible for their behavior, but I will not focus on those who under our current legal system would not be considered legally responsible by the courts. I will focus on individuals who might not currently qualify for the insanity defense, but for whom there is reason to believe that they are not as fully capable of choosing their actions. More specifically, I will discuss individuals who can be classified as psychopaths and individuals who suffer from drug addiction. Both of those groups of individuals are sometimes incarcerated for their behavior: psychopaths when they engage in criminal or violent behavior and addicts because they use illegal substances.

There is a plethora of studies illustrating the differences between psychopaths and normal individuals. There are two main theoretical approaches to the explanation of these differences. There is the somatic marker hypothesis championed by Antonio Damasio. This hypothesis suggests that prefrontal damage leads to impaired decision-making abilities, which is reflected in the diminished ability to activate the autonomic somatic states associated with the anticipation of reward and punishment. Persons with psychopathy have been found to show reduced electrodermal response to anxiety or punishment-related stimuli and have been found to be unable to learn from negative experiences like punishment. These disturbances are associated with different from normal activation in the ventromedial prefrontal cortex.[15]

An alternative, but not incompatible, approach to psychopathy is the violence inhibition mechanism model, championed by James Blair. The inability of psychopaths to control their aggressive behavior is associated with the different from normal activation in the amygdala. This view is based on the idea that submission cues should inhibit the violent reaction of an aggressor. Psychopaths have been shown deficient in their ability to process sad and fearful faces, resulting in an overall deficit of empathy. Therefore, they are less able to inhibit their violent reactions based on social cues.[16]

In a recent study, Birbaumer et al.[17] showed that psychopaths were significantly different from normal when it came to brain activation in regions associated with fear conditioning. Those regions include the amygdala, orbitofrontal cortex, anterior cingulate, and anterior insula.[18] These fMRI results supported the previous findings that the amygdala and the orbitofrontal cortex have been implicated in deficits in emotional processing observed in psychopaths. Activation of the orbitofrontal cortex has been associated with the anticipation of punishment and reward as well as social cognition in general.

People suffering from drug addiction also might have diminished capacity to control their behavior with regard to drug use. Neuroimaging studies suggest that people with drug additions have different levels of and different sensitivity to certain neurotransmitters, specifically the neurotransmitter dopamine,[19] which may contribute to both the rewarding properties of substances and difficulties in abstaining despite punishing consequences. The prefrontal cortex has been identified as being crucial for assessing award potential of decision-making and vulnerability to relapse, and addicts have been found to have abnormal activity in the prefrontal cortex.[20] Addicts have also been found to have abnormal hippocampus and anterior cingulate functioning. Those areas of the brain are associated with problems with inhibitory control and motivation.[21] A study by Uhl et al. supports the claim that there is a neurogenetic contribution to addiction, making some people genetically more vulnerable to developing that condition.[22]

4. PUNISHMENT AND HEALTH CARE

Ken Kipnis presents a type of retributivist argument for punishment and makes the assumption that punishment is permissible for those who have been identified as having committed serious wrongdoing and that forfeiture of liberty is an appropriate form of punishment.[23] Based on my argument, however, forfeiture of liberty, although sometimes warranted, might not be properly interpreted as punishment for those who have limited ability to control their behavior. Rather, restricting liberty in some cases is there to achieve a social goal of decreasing the incidence of crime.

Kipnis argues that the state has a custodial responsibility towards prisoners to provide them with a certain standard of incarceration, including health care. He argues that prisoners, despite their lack of liberty, have some residual rights, including the right to be fed and given legal counsel. Those residual rights also include the right to decent living conditions as well as the right to be free of cruel and unusual punishment. Moreover, because the state has deprived them of their liberty and limited their ability to obtain health care for themselves, the state now has the responsibility to provide them with health care. It seems to me that the argument for custodial responsibilities becomes even stronger on a conception of punishment that is not retributivist.

Given what was presented about the diminished ability of control among psychopaths and those who suffer from addiction, we can argue that some individuals who commit crimes are less able to control their actions. Psychopaths are less able to learn from punishment and modulate their behavior accordingly, while addicts are unable to stop their drug use even with the threat of severe punishment. Perhaps there is no better alternative but to incarcerate psychopaths to prevent them from committing further violent crimes, especially because there are no known ways of curing psychopathy. But if incarceration is not at the same time characterized as punishment, there is an argument that confinement of prisoners should avoid violating rights other than liberty and that prisoners have similar claims to health-care resources as other individuals. This includes

the argument that health-care professionals working in prisons will have similar fiduciary responsibilities towards patient prisoners as they would towards free patients.

As health-care resources are limited in most contexts, their scarcity is even more pronounced in prisons where there are limits to medical resources as well as shortages of qualified medical professionals.[24] Thus, the argument that prisoners should be allowed a certain level of medical care might not amount to much in circumstances of such scarcity. To ease the demand on health-care resources, Kipnis argues for the decriminalization of certain offenses as a solution to overcrowding in prisons. Kipnis proposes triage as a method of determining who should be incarcerated, with those who have committed the most serious crimes at the top of the list. I agree with Kipnis's solution, but a retributive model of punishment would not afford us such a resolution. Based on the retributivist model of justice, individuals who have committed crimes and are in prison should serve out their sentence regardless of whether they will ever pose danger to society again. Incarceration is punishment for wrongdoing and serving out the sentence is a good in itself even if it does not serve a social purpose. To support decriminalization as a solution to overcrowding, one is required to abandon the notion of retribution as the basis of incarceration.

NOTES

1. Hugo Adam Bedau and Erin Kelly, "Punishment," *The Stanford Encyclopedia of Philosophy* (Spring 2010 Edition), ed. Edward N. Zalta, http://plato.stanford.edu/archives/spr2010/entries/punishment/.
2. For more on how the concept of free will underlines both retributivist and consequentialist views of legal punishment, see Joshua Greene and Jonathan Cohen, "For the Law, Neuroscience Changes Nothing and Everything," *Philos Trans R Soc Lond B Biol Sci* 359, no. 1451 (2004): 1775–85.
3. For more on the principle of proportionality, see Bedau and Kelly, "Punishment," especially section 3.
4. B. Libet, E. W. Wright, and C. A. Gleason, "Readiness Potentials Preceding Unrestricted Spontaneous Pre-planned Voluntary Acts," *Electroenceph. & Clinical Neurophysiology* 54 (1982): 322–25.
5. On the clock, a spot of light revolved around the periphery of the clock faster than the usual 60-second sweep of the second hand of the clock. The spot of light made a full circle in just 2.56 seconds. Each second on the oscilloscope was about 43 seconds of real time.
6. For additional studies that confirm Libet's results, see William P. Banks and Eve A. Ischam, "We Infer Rather Than Perceive the Moment WE Decided to Act," *Psychological Science* 20 (2009): 17–21; Hakwan C. Lau, Robert D. Rogers, and Richard Passingham, "Manipulating the Experience Onset of Intention after Action Execution," *Journal of Cognitive Neuroscience* 19 (2007): 81–90.
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11. See L. Darden and N. Maull. "Interfield Theories," *Philosophy of Science* 44 (1977): 43–64; L. Darden, *Reasoning in Biological Discoveries: Essays on Mechanisms, Interfield Theories, and Anomaly Resolution* (Cambridge: Cambridge University Press, 2006).
12. A. Roskies, "Neuroscientific Challenges to Free Will and Responsibility," *Trends in Cognitive Science* 10 (2006): 420.
13. Ibid.
14. For more on this, see Jerry Fodor, "Special Sciences: Still Autonomous After All These Years," in "Philosophical Perspectives, 11, Mind, Causation, and World," suppl., *Noûs* 31 (1997): 149–63.
15. Ibid., 11–13.
16. Ibid.
17. N.Birbaumer, R. Veit, M. Lotze, et al. "Deficient Fear Conditioning in Psychopathy: A Functional Magnetic Resonance Imaging Study," *Archives of General Psychiatry* 62 (2005): 799–805.
18. They used a classic aversive differential delay conditioning—using four male neutral faces, two with mustaches and two without. The presentation of some of these photographs would be followed by a painful stimulus. They measured contingency, valance, arousal, and skin conductor responses.
19. N. Volkow and T.-K. Li. "The Neuroscience of Addiction," *Nature Neuroscience* 8 (2005): 1429–30.
20. G. Dom, B. Sabbe, W. Hulstijn, and W. Van Den Brink, "Substance Use Disorders and the Orbitofrontal Cortex," *British Journal of Psychiatry* 187 (2005): 209–20.
21. S. E. Hyman, "The Neurobiology of Addiction: Implications for Voluntary Control of Behavior," *American Journal of Bioethics* 7, no. 1 (2007): 8–11.
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24. Ibid.

Terrorism's Apologia, and the Relevance of Philosophical Analysis

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Despite the title, this isn't exactly about terrorism, and I won't be entirely fussy about how the term is defined. I want, however, to seize on one familiar vein of definition: that terrorism is the deliberate targeting, for violent death, of noncombatants or (in a more controversial wording) innocents. This sort of activity is by no means unique to those usually called "terrorists," and that this paper, as I say, is "not exactly" about terrorism is why that doesn't bother me much.

I lean considerably here on a recent good book by Alex Bellamy about all this.[1] He does want to emphasize the wrongness of killing noncombatants. But I want to insist that the reasons why we should consider the killing of noncombatants as wrong is also a reason why the killing of some combatants would also be wrong. And so my general program here is also a short essay about war and what makes it wrong when it is.

Let's go back, though, to terrorism ordinarily so called for the moment. Our most prominent cases of terrorism in the recent past, no doubt, are jihadists, or Islamic fanatics. (I have to emphasize the word "fanatics." By far not all Muslims are fanatics, nor perhaps "Islamists" either, as that term has come to be used of late. The fact that most of our prominent examples these days are Muslims is not intended to impugn that religion specifically, or any religion necessarily. However, the standard examples of terrorists, as it were, do display quite prominently a feature that is my central concern in this discussion, and which I call "fanaticism.") Namely, Jihadis are distinguished—insofar as they are—from mere thugs and the lesser-order fanatics especially by claiming divine sanction for their activities. As analyst Scott Stewart notes,

> "It is very important to understand that jihadists are theologically motivated. In fact, in their ideology there is no real distinction between religion, politics and culture. They believe that it is their religious duty to propagate their own strain of Islam along with the government, legal system and cultural norms that go with it."[2]

Their activities are also political, which is something of a giveaway. Those religious proclamations, of course, promote their political ends in two ways. First, they inspire the fanaticism that is such a prominent feature of jihadi activities. And second, they cement good relations on the "home front." Most Muslims are not jihadis, to be sure. But they tend to have a general sympathy at least with the fundamental aims of the jihadis, if not with their methods.

The idea is to ennoble their stature, as it were, by putting forth visions of the Good for Man, and by claiming to be on the right side, if not to be the right hand, of God. Good credentials, no? And so when they proclaim that this or that group are "infidels" or some such thing, their idea is to bring the weight of theology on behalf of their programs of intense violence.

Are those, as they think, "good credentials"? Well, no. We need to understand why the jihadis' shrill sermons need to be firmly rejected. What they present is, to be precise, a *ploy*. Undoubtedly it's an effective one among some—and that's what provides the motivation for this paper. For the truth is, it doesn't deserve anyone's favorable response. It is, to be blunt about it, a loser. That is, it's a *philosophical* loser. The jihadis build on a house of sand.

Liberal tolerance, especially, inhibits people from speaking out about the basic paucity of conceptual appeal in the jihadis' case. But wrongly, I think. Liberalism should never prevent a careful critique of ideas put forward on behalf of social causes. And that goes double for causes so potentially calamitous as this one.

Here's why. It's not a new story, but perhaps it is one whose importance for present purposes has been under appreciated.

According to jihadis, the apparently (as we would say) innocent people they blow up or shoot are not, actually, really *innocent*. After all, they are infidels! And as to the many Muslims among those victims, well, so worthy is this cause that they too should feel honored to be selected for this treatment. That's the sort of thing they would reply to critics who accuse them of moral wrong in their terrorist attacks. It is, after all, the only thing they *can* say.

But it doesn't fly.

The reasons for this were well understood by Socrates, but can be solidified for our day and age.

We need to ask the jihadi why he is so confident that Allah is on *his* side, especially in this respect and to this extent. Or, we need to ask him why he thinks that the presumed preference by Allah constitutes a morally good reason for carrying on as he does. (The two questions are closely related.)

Islam belongs to the sizable group of world religions that proclaim a universal god who is supposed to have created the whole show, *and* who is supposed to have some kind of very special moral authority. It is the latter we are especially concerned about here, of course. So, why does Jihadi think that if Allah approves of x, then that is sufficient reason to think that x is *right*?

To this the answer is familiar: Allah is a good being ("God is good," "Allah the great, the merciful," etc.) This should lead the philosophically curious among us to ask, Well, what *makes* him a good being?

There are two sorts of answers that have been floated. According to one of them, Allah's power enables him simply to *make* things right—anything whatever. He says it's right, and that's *it*! According to the other, Allah in his wisdom etc. *knows* what's right and wrong, and, being such a good being, is of course firmly in favor of what's right.

Every thinking religious person has seen the absurdity of the first idea. We should be careful here. What would be absurd is that God creates the universe *as it is* and that *nevertheless*, morality is, as it were, a totally independent variable that can be absolutely subordinate to somebody's will. That was the idea that St. Thomas Aquinas refuted with his theory of "natural" law. What makes that law natural is the way we, and things, are. Even if the world had somehow *not* been created by an intelligent being, it is those facts that would determine what's right—not the *independently* operating will of the creator. Once God creates the world with features x, y, and z, what's right and wrong is thereby determined. There is no space for, and no sense to, the idea that nevertheless God is free, just on a whim, to make murder right and assisting the lame wrong. Maybe in some weirdly different universe, which, let us assume, he could have created had he felt like it, things would be different—but in ours, that's how it is.

This means that we have to take the second option. What God does is to see that this and that are right, and then on some (perhaps the usual) account, he acts as universal administrator and, perhaps, policeman as it were. But what *is* right is so for reasons fundamentally independent of God.

There is no coherent alternative to that sort of view. And so the question we must ask the Jihadi is this: How can you think that God is in favor of various actions that look to be totally immoral—blowing up peaceful people, for example?

It would follow also that God can't play favorites among people: "he" *couldn't* have created the world for the special benefit of some smallish fraction, or any fraction, of the world's people, for all of whom (after all) he is in some way responsible for their creation. And so if, for example, the jihadi's military actions are directed toward the erection of a theocracy, then that looks flatly impossible.

This all interacts with his other general problem. He supposes that his religion is a distinct one, different from and incompatible with those of millions of others, such as the Christians and Jews. But there is no way he can *prove* that his is the right one among these, any more than the Christians or Jews could prove that *their* view is the right one.

But this matter of being "the right one" is important because he's proclaiming to the whole world that this is how things ought to be, and purports to justify his actions on just those premises. But proclaiming this is pointless if you don't have solid reasons you could present to the others to persuade them of your way. Needless to say, neither the jihadi nor any other proponent of any religion can do that.

Consequently, the jihadi is in the position of fighting a sort of war against everyone else—a war that he can't justify and which is *prima facie* thoroughly immoral. The fact that I, or you, or Mohammed, *believes* that p is not any sort of reason why any of the others should accept p. And if they don't, then the jihadi, or any other religious fanatic, has no basis for claiming that his view is reasonable. He needs to go back to the beginning and provide credible moral reasons why it is okay, or even obligatory, to blow miscellaneous people to smithereens.

But, when we come to social interactions, what this means is that terrorism *isn't* reasonable. It is, instead, quite simply outrageous.

So we should not think that somehow jihadis are noble or worthy of some kind of recognition for their supposedly elevated motivations. They're not. They're just sophomore philosophy students, only a lot more dangerous.

All of this makes us justified in attributing to them the same old motivations that every other murderer, conquerer, or would-be potentate has always had: the desire to enhance their own position by controlling everyone else's. Jihadis look like a gang of cutthroats because they *are* a gang of cutthroats.

If this sounds pathological, it's because it *is*. Jihadis deserve no sympathy whatever. What they deserve, like everyone else, is a hearing; but it's a hearing that we can see from the general features of their "case" is doomed to failure. And when what it's supporting is wholesale murder, that is *not* okay. The fact that someone is not of the same religion cannot constitute any justification for using violence against that person. Until the jihadi comes to see that, there can be no peace with them.

The "war on terrorism" has more than its share of problems. But one of them *isn't* that our position lacks foundations.

NOTES

1. Alex Bellamy, *Fighting Terror: Ethical Dilemmas* (London: Zed Books, 2008).
2. Scott Stewart, "Gauging the Jihadist Movement, Part 1: The Goals of the Jihadists," *Security Weekly*, December 19, 2013.

Can Procreation Impose Morally Significant Harms or Benefits On the Child? And So What If It Can?

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We need a theory of existential choice—a moral theory that instructs when we must, and when we may, and when we can't bring a new person into existence; when bringing a new person into existence makes things morally better, when it makes things morally worse, and when it leaves things, morally, just as they are (when it is, that is, morally *neutral*).[1]

Of course, theories of existential choice that seem unsatisfactory in some important way abound. What we need is a theory that seems able to stand up to plausible challenges.

A theory of existential choice I have elsewhere called *Person-Based Consequentialism*—a theory that (when correctly formulated) abides by a principle I have called *Variabilism*—is itself vulnerable to certain challenges. The main purpose of this paper is to suggest that there is good reason to think that at least two of those challenges can be met.

* * *

One of my own motivations for working in this area has been to figure out whether we can both recognize certain unassailable constraints that seem to be at play in procreative ethics and still hold onto the strong intuition that moral law in many cases of procreative choice leaves agents with a certain amount of *discretion*. Indeed it leaves them with what may seem at first glance to be *more* discretion than agents have in more routine cases. Thus, ordinarily, I do not have the discretion, morally speaking, not to confer some significant benefit on—not to make things significantly better for—my daughter in a case where whether I confer that benefit or not matters to no one other than my daughter. But, where the benefit we are talking about is the well-being that would inevitably (let's suppose) come with the existence of any child I might have produced, I *do* retain discretion. It's morally permissible for me *to bring* the happy child into existence *and* it's morally permissible for me *not* to bring the happy child into

existence—in any case in which whether I bring that happy child into existence or not matters to no one other than (arguably) that happy child.[2]

In other words, moral law in such cases remains *morally neutral* on the question whether agents ought to bring the additional happy child into existence or not. As Narveson put it, agents have to "mak[e] people happy" but they do not have to "mak[e] happy people."[3]

The question has been whether that neutrality is in effect completely eliminated—whether that discretion is completely undone—by certain constraints on moral law that we have no choice but to accept. The question has been whether those constraints taken together mean that one has managed to contradict oneself when one insists that it's permissible not to bring the happy child into existence to begin with.

Just how the tension arises and Variabilism helps to resolve it is outlined in part 2 below. Then, in parts 3 and 4, I describe two challenges that Variabilism must face and explain why I think it can. But first, in part 1, some background.

1. BACKGROUND

1.1. At first glance it seems plausible that existential choices can make things better or worse for the people those choices bring into existence. It is better for me that I have the existence I have than that I never exist at all. And, at least in theory, it can be worse for a person to have whatever existence that person has than for that person never to exist to begin with. Let's call the idea that such comparisons can be both true and meaningful—that they can be cogent—even though the person we are comparing things in respect of never exists at all in one of the outcomes (or possible futures, or possible *worlds*) under scrutiny *Comparability*.

It also seems, on due consideration though not at first glance, that people *matter morally* at a given world even if they never exist at that world at all. People who never exist at a given world—people who are *merely possible* relative to that world—have *moral status* for the purpose of evaluating what is done at that world and determining how that world compares against others. The plights of those who remain merely possible relative to one world can, that is, *bear on* the permissibility of what is done at that one world and how that one world is to be compared against others. In effect, people who *never exist* at one world can have *moral claims* against the real, live, flesh-and-blood agents who *do* exist at that one world: claims they obviously can never articulate but claims we actual agents must nonetheless take into account in figuring out what moral law requires us to do.

And just to be clear, what *due consideration* seems to suggest—what cases like Double Wrongful Life seem to show; we will come back to that case in part 2 below—is that it's not just that the people who are merely possible relative to one world have just a *little* moral status at that one world or that they matter morally but matter *less than* the people who do or will exist at that one world. It's not just (for example) that the merely possible relative to, say, the uniquely *actual* world matter morally but matter *less* than we *actual* people do or that they may have moral claims against *actual* agents but that their moral claims are *less weighty* than our own *actual* moral claims are. Rather, people who remain merely possible relative to a given world have *exactly the same moral status* the people who do or will exist at that world have.

We all matter morally. And we all matter morally in exactly the same way. Let's call this non-obvious though now widely shared insight the *Universal Moral Status of All Persons*, or *Universality* for short.

A third and final constraint. It seems clear that any correct theory of existential choice is going to have to make room for a plausible analysis of cases in which an agent brings a child into an irremediably *miserable* life, a life *less* than worth having. Specifically, any correct theory must be at least consistent with the following view:

> *Wrongful Life*: In a case where whether a miserable person m exists or not matters not at all to anyone other than (arguably) m, agents are obligated *not* to bring m into existence; moreover, other things equal, m's never existing at a world w and m's existing at an alternate world w' grounds the position that w' is *morally worse* than w is.

Consider, then, the following case (Graph 1). The agent's only choices are to bring the miserable child m into existence or to leave that miserable child m out of existence. How the choice is made matters to no one other than (arguably) m.

	w1	w2
	m	
10		**m**

Graph 1. Wrongful Life

What Wrongful Life insists on is that no plausible theory can take the position that both choices are permissible. No plausible theory can, in other words, deny the moral reality of *wrongful life*. We must instead find a way to say that agents are obligated to leave the miserable child m out of existence altogether.

Even as we accept these three critical constraints, we may well find the following two beliefs at least plausible:

> *Belief 1*: In a case where whether a given happy person h exists or not matters not at all to anyone

> other than (arguably) h, agents are under no moral obligation to bring h into existence.

And:

> *Belief 2*: In the same kind of case, the fact that h never exists at a world w and the fact that h exists at an alternate world w' together fail to ground the position that w' is morally better than w is. Other things equal, w and w' are equally good.

The question is whether we can consistently accept all three constraints itemized above—Comparability, Universality, and Wrongful Life—and still adopt the (*highly* restricted) form of what I will call *Procreative Neutrality* that Belief 1 and Belief 2 aim to describe. Can we, in other words, accept all three constraints and still reject the view that, in a case in which an additional happy person's coming into existence does not matter to anyone other than (arguably) that person, moral law will remain *neutral* and deem *both* such choices permissible (and neither such choice morally obligatory and neither such choice morally wrong)? Can we accept all three constraints and still reject *Morally Obligatory Procreative Beneficence*?

I have argued elsewhere that the trick to saying yes here seems to be to set aside the question of *who* matters morally and *who* does not in favor of the question *what losses*—that is, what *harms*, or *differentials in well-being* from one world to another for a given person—matter morally and *what losses* do not. The moment we ask that alternate question it pretty much answers itself (in the form of *Variabilism*) and the cases then work out nicely.

But my main goal in this paper is to defend Variabilism against two objections. The first objection challenges Comparability. That objection turns a *concession* that I made into a deficiency. That is, I *conceded* that existential choice *can* make things better (or worse) for a given person. I accepted that point as a constraint on any plausible moral theory. I then want to argue that, even having accepted Comparability, we are free to accept Procreative Neutrality. This first objection states that my way of reconciling these two points works *only if* Comparability holds but that Comparability is either false or not cogent.

The second objection notes that Variabilism implies that (A) the existence of a person at a world always imbues *losses* that person sustains at that world with moral significance but (B) the existence of a person at a world does not always imbue *gains* that person accrues at that world with moral significance. The objection is that these results taken together are arbitrary, inconsistent, and ad hoc.[4]

1.2. I need to say a bit more to show just why it's been so hard—has, indeed, seemed such a puzzle—to retain Procreative Neutrality in the face of these three constraints. Without that discussion, we can't identify the various pieces of the puzzle or see how they may be fit together to obtain a solution. But first I want to suggest how Procreative Neutrality relates to two further issues in procreative ethics.

(1) Nonidentity problem. One such issue involves a certain type of *nonidentity problem*. The issue arises in the case where (A) agents *could not* have produced any additional well-being for a child p whose life is clearly worth living but is less worth living than is the life of a distinct (*nonidentical*) child q agents could have produced instead; (B) what agents do does not matter to anyone other than (arguably) p and q themselves; and (C) agents are somehow certain that (A) and (B) both hold at that critical moment prior to choice. Is there anything morally problematic about the agents' choice to produce the less well-off p in place of the more well-off q? Suppose we accept Procreative Neutrality. Then it seems to me that we can readily—consistently, easily, naturally, plausibly, and in a principled manner—take the further position that agents—other things equal—really are morally free to produce p in place of q.

Let me be clear that the case I have in mind here is a *very special* type of nonidentity problem, what I have elsewhere called the "can't-*do*-better" problem.[5] I'm *not* talking about the usual, run-of-the-mill type of nonidentity problem, like Parfit's depletion example or risky policy case or Kavka's slave child or pleasure pill case or cases involving historical injustice, which I collect as the "can't-*expect*-better" problem. The distinctive feature of those cases is that agents in each one possessed *some* means and *some* chance of creating additional well-being for the apparent victim of the questionable conduct. I have argued elsewhere, moreover, that in all those cases we can see on close inspection—*close inspection* meaning that we take care to calculate the apparent victim v's chances of coming into existence at that moment just prior to choice for *both* options and *not* commit the fallacy of calculating prior to choice for one option and after the fact for the other—that the questionable conduct produced *no more chance than that* that person v would ever come into existence at all. Factoring that probability point into our calculation of expected well-being and taking for granted that (for example) a depletion outcome in which v happens to exist is worse for (produces less well-being for) v than is a conservation outcome in which v happens to exist, we have ample room to say that the *apparent* victim v *really is* victimized by—is *harmed* by, in an intuitive, comparative sense of that term—the depletion choice. This *can't*-expect-better case, in other words, resolves, on close inspection, into a *can*-expect-better case. Agents can both expect to do better, and in fact do better, for the apparent victim v than they in fact have.

For that type of nonidentity problem, I want to say (as do most other philosophers) that the choice of depletion is wrong. And, for the reasons just described, I think we can explain in person-affecting terms just why that choice is wrong. In contrast, in the type of problem in which I think Procreative Neutrality plausibly holds—the can't-*do*-better problem—there is *no* chance, *no* way, agents could have made the less well-off child any better off at all. The child—e.g., the Down syndrome child—really *could not* have existed at all in the absence of the impairment. Agents as of now really don't have any available means of conferring on that particular child an unimpaired existence. (We might say: the world where that same child exists unimpaired, while logically and metaphysically *possible*,

is not *accessible* to agents at the relevant time; no matter what they do, the future will not unfold from the past in such a way as to contain that child unimpaired.) They can't *correct* the Down syndrome; they can only arrange for the child who has it *never to exist to begin with*.

In the case where what is done matters to no one other than (arguably) p and q, just as there's nothing wrong with not bringing the happy child h into existence to begin with, so is there nothing wrong with bringing p into existence in place of q. Procreative Neutrality, in other words, seems to extend naturally to include not just the choice whether or not to bring the happy child h into existence but also the choice whether to bring the less well-off child p or the more well-off child q into existence.

(2) Early abortion. The second such issue is early abortion. I think philosophers who feel we must endorse Morally Obligatory Procreative Beneficence have a difficult time then explaining why early abortion—again, in a case where the choice matters to no one at all other than (arguably) the potential future person—is perfectly permissible. It's tough to say that we should all work to bring additional happy people into existence—or even that doing so makes the world morally better—and then justify a very liberal view on early abortion. The same point seems to hold for non-conception. In contrast, if we reject Morally Obligatory Procreative Beneficence in favor of Procreative Neutrality, and we accept as well that the early abortion does not involve the destruction or killing of a person but rather is a means (along with non-conception) of not bringing that person into existence to begin with, then the way seems paved for a very liberal view on early abortion.[6]

2. THE PUZZLE

2.1. Two questions are useful for launching the puzzle. (1) Can the existential choice that brings a given person into existence be better or worse *for that person*? (2) And, if we say that it can, do we then immediately find ourselves under pressure to reject Procreative Neutrality?

As to (1): my own suspicion is that it's going to be hard to show that existence *can't* be better (or worse) for a person than never existing at all. To date I've gotten a lot out of my own existence. I'm sure the same is so for you. I think that our particular existences are *better for us* than our never having existed at all would have been—and by the same token that worlds where we never exist are worse for us than this world, the actual world, in fact is. Now, things might have been different. Nature or human agency could have conferred on us existences *less* than worth having—existences that would have made things *worse* for us than never existing at all. We could have been saddled with *wrongful lives*. But I take it that what could have been isn't what is—that it's at least highly probable that, while we all have our bad days, our existences themselves will turn out overall to have been worth having and better for us than never existing at all would have been.

Then, as to (2): Does accepting Comparability compel us then to say leaving the happy child out of existence would be wrong?[7] Can we, in other words, accept Comparability but still preserve Narveson's witticism that our moral obligations have to do not with *making* happy people but with making *people happy*?[8]

The feeling that perhaps we can't intensifies when we bring Universality into the mix. According to that principle, *all* people—whether present or future, whether actual or (relative to the uniquely actual world) merely possible, whether in existence under the act under evaluation or not, have moral status. They all matter morally and in exactly the same way. And—as Double Wrongful Life and many other cases seem clearly to show—the moral significance, the moral sway, that they have, according to Universality, isn't limited to just those worlds where they do or will exist. They don't just matter at *those* worlds and not at others. Their power is more potent and more sweeping and more occult than that.[9]

Universality means that we can't just dismiss out of hand the notion that we have the moral obligation to produce additional happy people by noting that (A) if we don't bring them into existence, they won't exist; (B) if they don't exist, they don't matter morally; and (C) if they don't matter morally, we can't have any obligation to make things better for them by bringing them into existence. For (B) is false.

Finally, we seem bound to accept Wrongful Life. Comparability and Universality together seem clearly to open the door to Wrongful Life—and it's, intuitively, something we'd want to endorse even if they did not. Consider a child whose life would be less than worth living, and suppose that agents in fact refrain from bringing that child into existence. That miserable child m, according to Universality, matters morally. And, according to Comparability, bringing m into existence would have been worse for m than m's never existing at all, in fact, is. We seem, with these points, to have a foundation for the highly plausible position that what the agents have, in fact, done was obligatory and what they refrained from doing was wrong. But if Comparability and Universality support the claim of Wrongful Life, how do they manage at the same time *not* to support Morally Obligatory Procreative Beneficence? How do they manage to avoid Procreative Neutrality?

2.2. One might quickly decide that any effort to reconcile Procreative Neutrality against these various constraints would be fruitless. One might quickly decide that it's just a matter of deciding which claim will have to go. And it's then that things get really interesting. For, while letting go of one or more of those claims arguably helps on the *consistency* front, if anything it leads to further deterioration on the *moral* front.

2.2.1. David Heyd has perhaps addressed these issues with more care and insight than anyone else.[10] Core to his position is his rejection of Comparability.[11] Combining that rejection of Comparability with a certain person-affecting approach, he can easily support his further view that we have no obligation to produce the additional happy child.[12] That person-affecting approach itself endorses the following *necessary* (*not* sufficient) condition on wrongdoing:

> *Person-Affecting Intuition*: An act is wrong *only if* it makes things *worse for* some person or another; wrongs are of necessity rooted in making some person or another *worse off*.[13]

Since the choice to leave the happy child out of existence cannot make things *worse for* that child, that choice cannot be wrong.

But while Heyd's view is internally consistent, it seems clearly not just to allow us to accept Procreative Neutrality but also—as Heyd himself acknowledges—to force us to reject Wrongful Life.[14] According to Heyd, the choice to bring the miserable child into existence cannot make things worse for that child. That choice, therefore, cannot according to Heyd's person-affecting approach be wrong. But surely it is. Wrongful Life is not a position we can plausibly reject.

My suspicion is that the approach Heyd wants to take goes astray when it tries to draw a line between people who will exist *independently* of how the existential choice under scrutiny is made—they matter morally—and the people whose existence *depends on* how the existential choice is made—they don't.[15] Put otherwise, his view in effect draws a line between routine, non-existential choices and existential choices. But it seems that that may be just the kind of line it's a mistake to try to draw—a line between *who* matters morally and *who* does not. We are going to have to recognize that the miserable child matters morally even though that child's coming into existence *depends on* how the existential choice is, in fact, made. Indeed, the miserable child matters morally even if agents never bring that child into existence to begin with. We can't otherwise explain—between just those two choices—why the one choice is obligatory and the other wrong.

2.2.2. Another strategy for saving Procreative Neutrality that at first glance seems promising is to reject Universality. Universality is, after all, on its face at least surprising if not wildly implausible. How can the merely possible matter morally just as much as you and I do?

A view Rivka Weinberg has outlined in an effort to solve the nonidentity problem deploys that strategy. On her view, the people who matter morally at a given world—for example, the actual world—are limited to the people who do or will exist at that world. Those are the only people whose well-being agents at such a world need to worry about since they are the only ones who will ever exist at that world. The idea that anyone else—any never-existing person; any person who remains merely possible relative to that world—might have some moral claim against us is a non-starter.[16]

Weinberg's rejection of Universality—or, we might say, her conception of just how limited the scope of Universality really is—may be rooted just as much in metaphysics as it is in any moral view.[17] I don't do anything wrong in failing to take care of the litter of puppies in the garage because there is no litter of puppies in the garage. We don't do anything wrong in leaving the additional happy child out of existence because there is no such thing as the additional happy child whom we might or might not leave out of existence.

But the case of Double Wrongful Life (Graph 2) suggests that this sort of approach is going to run into trouble.[18] In that case, agents have just two alternate courses of action and—whatever they do—they'll end up producing a single miserable child. But it won't be the *same* child. Under one choice, they will produce one miserable child, and under the other they'll produce a *distinct* miserable child.

	w1	w2
	m2	*m1*
10	**m1**	**m2**

Graph 2. Double Wrongful Life

Suppose that the question before us is the evaluation of what the agents do at w1—their act, that is, of bringing the miserable child m1 into existence. Call that act a1. According to Weinberg, for the purpose of evaluating a1, m1, and m1 alone matters morally. It is m1 and m1 alone whose interests agents are at w1 obligated to protect; it is m1 and m1 alone whose plight at w1 must be considered to have any moral significance whatsoever.

From there, we seem compelled to conclude that a1 is wrong. And, given that moral law would always seem to accord agents *at least* one permissible option and that whenever agents have *exactly one* permissible option that one option becomes *obligatory*, we seem compelled to conclude as well that agents ought to have chosen a2 in place of a1; they ought to have brought the miserable child m2, who matters not at all for the purpose of evaluating a1, into existence in place of m1. But those results do not seem plausible. In point of fact, neither choice and neither world is morally better than the other or even morally distinguishable from the other. And the agents by hypothesis have no options beyond a1 and a2 and hence no option better than a1 and a2. We thus seem left to conclude that, as regrettable as both choices might be, they are both morally permissible.

But *what makes* the choice at w1 to produce the miserable m1 permissible? It can only be the merely possible plight faced by the merely possible miserable m2 under the merely possible alternative a2. Thus m2 matters morally—not just at w2 and for the purpose of evaluating a2, but at w1 and for the purpose of evaluating a1 as well.

What Double Wrongful Life shows is that it is not going to work to evaluate what is done at a given world by drawing a line between who matters morally and who does not on the

basis of who does or will exist at that world and who does not. *All* people matter morally; *all* their plights bear on our evaluation of what is done at worlds where those people do or will exist and also on what is done at worlds where those same people *never exist at all*.[19]

There is another problem with Weinberg's view. So far, we have focused on the evaluation of a1. When we turn to evaluate a2, we find that for that purpose m2 and m2 alone matters morally. We now seem compelled to conclude that a2 is wrong—that agents ought to have brought the miserable m1, who matters not at all for purposes of evaluating a2, into existence in place of m2. But now we have results that are hard to reconcile. It is unclear, that is, how we are to sort things out when the view under consideration seems to take us both to the conclusion that a2 is both wrong *and* obligatory.

Does it help to adopt a still stronger form of what Caspar Hare calls "moral actualism"—a view that insists that it is only the people who do or will exist at the uniquely *actual* world who matter morally?[20] We avoid the inconsistency just discussed. But we still get implausible results in Double Wrongful Life. Thus, suppose that w1 is the actual world. We then seem compelled to conclude—as before—that a1 is wrong and a2 obligatory. It's true we never get to the further result that a2 is wrong (m2, on this revised view, doesn't matter morally even for the purpose of evaluating a2). But the results we do obtain are still implausible.

2.2.3. Elizabeth Harman suggests still another approach in the context of her discussion of early abortion. Her primary concern is to specify when agents in that context have *moral reasons* for making one choice rather than another. In this connection, it is important for Harman to distinguish between *reasons to benefit* and *reasons against harming*. Reasons against harming have stronger force than reasons to benefit."[21] It's that distinction that she will in the end rely on to make her case in favor of a "very liberal view" on early abortion.[22]

Thus, consider the pregnant woman who chooses not to have an early abortion and after several months gives birth to a happy, healthy child. On Harman's view, that woman, prior to choice, had a moral reason not to have the early abortion. Two points go into that result. First, the woman's choice to continue the pregnancy—which involves, of course, the choice not to have the early abortion—*benefits* the early fetus and, ultimately, the child. And, second, the early fetus that is benefitted itself has "moral status."[23] Thus, the fact that a choice *benefits* a thing does not, on its own, generate a *moral reason* for the agent to confer that benefit. Before the agent can have a moral reason to benefit, it is necessary for the thing benefited itself to have "moral status."

A critical question, then, is how the early fetus comes to have, on Harman's view, moral status. Here is where Harman innovates. On her view, the early fetus has moral status at a given world only if it "will become a person. An early fetus that will die while it is still an early fetus has no moral status."[24] Early fetuses thus "have their moral statuses contingently."[25] So in the case at hand—the case where the woman chooses not to have the early abortion and instead produces the happy child—the early fetus has moral status.

Moreover, the woman does not just have a moral reason not to have the early abortion in the case where—we can say in the world where—she chooses not to have the early abortion. She has that same moral reason in the case where—the world where—she *does* choose to have the early abortion.[26] The moral status of the fetus is contingent, but the matter of whether the agent has a moral reason or not is not contingent. Her moral reason not to have the early abortion does not evaporate just because the happy, moral-status-conferring baby never exists at all. In that alternate case as well the woman still has a moral reason—indeed, the very same moral reason—to benefit the early fetus by not having the early abortion. Thus Harman writes: "on my view, we do have some reason to create every happy child we could create."[27]

At the same time, Harman means to provide a "very liberal view" on the question of early abortion. How does that goal—which I share—fit with the principles just laid out? On her view, reasons *to benefit*—to be distinguished from reasons *not to harm*—are relatively *weak*. They accordingly cannot give rise to a moral obligation *not* to have the early abortion.[28] The choice of early abortion thus remains, according to Harman, perfectly permissible.

In contrast, reasons against harming are relatively weighty; and they can in some cases give rise to obligations. Moreover, the choice of early abortion harms the early fetus in a particularly devastating way. Why, then, on Harman's view does the agent *not* have strong moral reason, indeed, an obligation, not to have the early abortion? Here again Harman's view on moral status is critical. Agents don't have a moral reason not to harm the early fetus *unless* that early fetus that is harmed has moral status. But in the case of early abortion the harm that is imposed, however devastating, is—by dint of the early abortion itself—imposed on a thing that has no moral status at all since in that case the early fetus never develops into the happy, moral-status-conferring-child. Despite the fact, then, that the choice of early abortion imposes a particularly devastating form of harm on the early fetus, the woman has no strong moral reason not to have the early abortion.[29]

A plus for Harman's view is that it supports *both* the result that the woman has no strong moral reason against early abortion *and* the result that the woman has a strong moral reason against the *combination* of choices that includes harming the early fetus—by inducing in it, e.g., conditions sufficient for the development of fetal alcohol syndrome—*and* bringing the resulting child into existence. For in that case the woman's choice harms an early fetus which has moral status—a moral status that the woman herself accords to that fetus by her choice not to have the early abortion.[30]

I have three questions about Harman's view. First, it isn't clear to me how moral *reasons* and the moral *evaluation* of the acts that those reasons favor or disfavor are connected. Specifically, it isn't clear to me why, in the case where the

agent has (i) a weak moral reason *not* to have the early abortion—a weak moral reason, that is, to bring the happy child into existence—and (ii) no reason at all to *have* the early abortion and (iii) a strong moral reason not to harm the early fetus by (for example) drinking heavily during pregnancy, the woman does not also have at least some corresponding *obligation* not to have the early abortion. The moral reasons all seem to align in one direction. If a weak moral reason not to have the early abortion were counterbalanced by a weak or strong moral reason to *have* the early abortion, things would be different. I could then understand how the woman could escape the charge that she is obligated not to have the early abortion. But that's not the case we face here.

Second, a related point. Harman relies on the distinction between reasons to benefit and reasons not to harm: reasons to benefit are weaker and don't give rise to obligations, and reasons not to harm are stronger and can (depending on the facts of the case) give rise to obligations. It is not clear to me how sturdy this distinction is. Suppose in the midst of a polio epidemic I can *benefit* a small child by simply notifying the pediatrician that my own child has already been inoculated and that other child is welcome to have the dose that had otherwise been set aside for my child. If I fail to notify the pediatrician and thereby fail to extend the benefit, the child will contract polio. Suppose in the midst of a common cold epidemic I can *harm* a small child by simply notifying the pediatrician that the vitamin C capsule the pediatrician has just dispensed to another child was one that my own child was entitled to and that had been set aside for my child. If I notify the pediatrician and thereby impose the harm, the child will contract a cold. It is unclear to me why my reason not to harm in the second case is not weaker than, rather than stronger than, my reason to benefit is in the first case. Moreover, if there's a moral obligation to be found in either of these two cases—and my guess is that there is—surely it's in the first case and not the second. Finally, the distinction between *benefiting* and *not harming* itself in both these cases seems rickety: How can we actually have a choice not to benefit in the first case without also finding in that case a choice that imposes harm? How can we have a choice to harm in the second case without also finding a choice that fails to benefit?

Third, it isn't clear to me that Harman's view does not generate what are in effect *too many* moral reasons. It isn't clear to me, in other words, that the *limiting principle* on what counts as a moral reason that Harman herself accepts is one we will be willing to accept. Thus, let's go back to the case in which the woman chooses not to have the early abortion and the happy child eventually exists. At that world, the early fetus has moral status. Accordingly, the woman at that world has a moral reason not to harm the early fetus. And, since we're dealing with a reason not to harm rather than a reason to benefit, the moral reason the woman has not to harm the early fetus is a *strong* moral reason. Thus, this early fetus is "the kind of thing[] we are prohibited from harming."[31] The woman is, accordingly, obligated not to drink heavily early in pregnancy. All this we noted above. But if the woman is prohibited from harming this early fetus in virtue of its moral status by drinking heavily, the question arises why the woman *isn't* also prohibited from harming this early fetus in a far more severe way, that is, by having the early abortion?

Put otherwise, why *doesn't* the woman in this case have a strong moral reason not to have the early abortion—given that that choice, if selected, would harm her early fetus, which has moral status, in a particularly devastating way?

We've already outlined the elements of Harman's response. On her view, the woman has no strong moral reason not to have the early abortion—no moral reason, that is, not to harm the early fetus notwithstanding the fact that the fetus itself has moral status. Why not? According to Harman, it's because, counterfactually, if the woman *did* have the early abortion, the fetus *would not* have moral status; at the alternate world, that is, where the woman *does* have the early abortion, the fetus has no moral status.

The problem is that it's unclear that this point can serve as an effective limiting principle. After all, whatever counterfactuals might obtain, the fetus in point of fact at the one world *does* have moral status. The moral status that the early fetus *in fact has at the one world* would seem the salient fact for determining whether the woman is permitted to have the early abortion at that world and has a strong moral reason against the early abortion at that world—not the early fetus's *lack* of moral status *in some alternate world*. It isn't clear, in other words, why the fact that the early fetus lacks moral status at some alternate world is relevant.

Suppose, for example, that an abortion clinic counselor tells me that my early fetus has moral status—perhaps the counselor sees right through me and knows that though I'm mulling over my options I'm in fact going to proceed with the pregnancy—and that the early abortion would harm the fetus in a particularly devastating way. I think I would *think* that someone was trying to tell me I had a moral reason not to have the early abortion. Suppose, then, that that same counselor noted further that if I *were* to proceed with the abortion the fetus *would be* devoid of moral status and that that is why I do *not* have a moral reason not to have the early abortion. I would be confused, I think, rather than convinced. And confused still further if the counselor felt inclined then to point out that I at the same time *do* have a weak moral reason to benefit the early fetus—and more generally to "create every happy child we could create."[32]

Harman's prerogative here is just to insist that, while the counselor's statements accurately reflect her view, it is just a mistake to think they leave me with any strong moral reason not to have the early abortion. *Why*? Because if, contrary to fact, I did have the early abortion, the fetus then would have no moral status.

But that last "because" is not enough. It might explain why on her view I *don't* have a moral reason not to have an early abortion. But it isn't going to explain why it's not also the case on her view that I *do* have a moral reason not to have the early abortion. The bare fact that one part of Harman's view (together with various ancillary principles we are willing to accept) implies "no strong moral reason not to have the

early abortion" does not on its own block another part of Harman's view (together with various ancillary principles we are going to find it hard to deny) from implying "strong moral reason not to have the early abortion." (That the first premise of an argument implies "P" doesn't on its own do a *thing* to block the second premise from implying "~P.")

What we need is a *limiting principle* on what counts as a moral reason—an understanding of why what one would *quite reasonably think* in the case at hand does not constitute a *moral reason*. We would then have the explanation we need to understand why the inference to the result that the agent has a strong moral reason not to have the early abortion fails.

It should be noted that the difficulty cannot be resolved through a simple amendment to Harman's view. It is not going to work to say that our moral reasons should be understood to be *relativized* to particular worlds—that they themselves, just like the moral status of the early fetus, are *contingent* in nature. On that position, the world where the woman proceeds with the early abortion is one in which she has no strong moral reason not to have the early abortion, and the alternate world where the woman doesn't proceed with the early abortion is one in which she has a strong moral reason not to proceed with the early abortion. The link, which Harman doesn't deny and which seems compelling, between having a strong moral reason and having a moral obligation makes this position unworkable. At the world where the woman chooses early abortion, she has no strong moral reason not to do just that and her choice of early abortion is, accordingly, *permissible*. But at the world where she does not choose the early abortion she then has a strong moral reason, indeed an *obligation*, not to have the early abortion. But if she has an *obligation* at the alternate world not to have the early abortion, then the choice that she makes at the one world as a matter of deontic principle is *wrong*. Where we have an obligation to do one thing, moral law makes it wrong to do any other thing. But that result is inconsistent with the result we obtained before: that the choice of early abortion was perfectly *permissible*.

2.3. I am persuaded that it is not going to work to divide people up into who matters morally and who does not. And I question whether it will work to divide early fetuses up into those which matter morally and those which don't. More plausibly, the moral status of the early fetus is not going to depend on whether or not the woman chooses early abortion.

We should, in other words, not try to contest Universality. We should concede that all people matter morally (even as we understand that that concession is itself perfectly consistent with the position that early human fetuses as non-persons do *not* matter morally). Moreover, we should understand that the form of Universality we have no choice but to accept is the *broad* form. People don't just matter morally at their own worlds but at other worlds as well. The person who never exists at all at a given world w1 but does or will exist at an alternate world w2 not only matters morally for purposes of evaluating acts performed at w2 but also for purposes of evaluating acts performed at that one world w1. Accordingly, any plausible view must reflect the *cross-world moral pull* that the *merely possible* plight of a *merely possible* person can exert on the *actual* moral status of an *actual* act, a *possible* plight that is fully capable of rendering an actual and otherwise morally *wrong* act perfectly *permissible*.

But we should recognize as well that the fact that it's not going to work to divide *people* up according to who matters morally and who does not doesn't mean that it's not going to work to divide up their *losses* according to which matter morally and which do not.

Thus, we can acknowledge that the merely possible have exactly the same moral status that actual people have and that you and I have, and that all persons matter morally for purposes of evaluating the acts under which they do or will exist and (cross world) for purposes of evaluating acts under which they never exist at all. We can acknowledge that all people matter morally in exactly the same way. But we can also say that, *for each of us*, some of our losses matter morally and others matter not at all. We all matter morally but we all matter *variably*.

The principle is this.

> *Variabilism*: A loss a person p sustains at a world w1 relative to any alternate world w2—that lower well-being level p has at w1 as compared against what p has at w2—has *moral significance* for the purpose of evaluating both what is done at w1 and what is done at any alternate world w3 *if and only if* p does or will exist at w1.[33]

This principle presumes that a person h sustains a *loss* at a given world w1 upon being left out of existence at w1 relative to an alternate world w2 at which that person h exists and is happy; it presumes a difference in well-being level for h from w1 to w2; it presumes that never existing is worse for h than is existence at w2. But, according to Variabilism, h's loss has *no moral significance whatsoever*. It does not count against the choice to leave h out of existence at w1. Nor does it count (cross-world) in favor of bringing h into existence at w2. That result, when combined with a handful of additional plausible principles governing when a given choice is permissible or what is going to make one world better than another, will support the further result that the choice to leave h out of existence at w1 is perfectly *permissible*—and that the addition of h to w2 is not going to make w2 *morally better* than w1.

Procreative Neutrality, thus, can be retained. What about Wrongful Life? According to Variabilism, the loss the miserable person m sustains upon being brought into existence at a given world w1 relative to an alternate world w2 at which m never exists has *full moral significance*. It counts against the choice to bring m into existence at w1 and in a roundabout way in favor of the choice not to bring m into existence at w2. That result, again combined with additional plausible permissibility principles (Variabilism decides which losses appear on our moral radar but does not in itself determine when acts that impose morally significant losses are permissible), supports the further

results that the choice to bring m into existence at w1 is wrong and that the choice that avoids that result at w2 is obligatory. We thus retain Wrongful Life.

The principle produces equally salutary results in Double Wrongful Life and a host of other cases.[34]

2.4 Variabilism supports the positions that I identified earlier as fitting nicely with Procreative Neutrality—positions relating to the one very special type of nonidentity problem (the can't-do-better problem) and to early abortion.

I should first note that Variabilism recommends a certain revision—really, an extension—of the Person-Affecting Intuition—that is, that *necessary* (*not* sufficient) condition on wrongdoing that Heyd, Narveson, and others have wanted to defend.

> *Revised Person-Affecting Intuition*: An act performed at a world w1 is wrong *only if* a person p sustains a loss at w1 relative to some alternate world w2 and that loss is morally significant. A world w1 is morally worse than a world w3 only if a person p sustains a loss at w1 relative to some alternate world w2 and that loss is morally significant.[35]

And I should just underline that, throughout, I've taken for granted that it is an intuitive, comparative concept of *loss*—or, if one prefers, *harm*—that should be understood to be at play here. I agree, in other words, with Parfit that the fact that a person may endure pain or discomfort as a result of a surgical procedure does not qualify as *harm* in a "morally relevant sense" when what the surgeon has done maximizes well-being for that person—for example, saves the life worth living that could not otherwise be saved.[36] Thus, a person sustains a *loss* at a world w1 *only if* agents at w1 had *some means* of making things better for that person—only if, that is, there is some alternate world w2 accessible to agents such that that person has more well-being in w2 than that same person has in w1.

The can't-do-better problem. The critical point to make about the can't-do-better case, then, is that agents by hypothesis have *no means* of making things better for the less well-off child. There exists, that is, no such alternate world w2 accessible to agents such that the less well-off child has any more well-being than that same child has at w1. And of course—as always—we are in a case in which how the particular choice is made will matter not at all to anyone other than (arguably) the children themselves.

On those facts, the Revised Person-Affecting Intuition implies that it is permissible for agents to bring the less well-off child into existence in place of the more well-off child. While both children matter morally, neither sustains any *loss*, or *harm*, whatsoever. Accordingly, neither sustains any *morally significant* loss. And since, according to the Revised Person-Affecting Intuition, a morally significant loss is necessary for wrongdoing, we can conclude that the choice to bring the less well-off child into existence is perfectly permissible.

Early abortion. Early abortion requires a different analysis. Here, I concede—indeed, I believe—that the person who never exists as a result of the early abortion and who could have had an existence worth having sustains a *loss*. The same is so of the person who never exists as a result of non-conception. But, according to Variabilism, in both such cases the loss is devoid of any *moral significance*. Hence, it does not count against the choice of early abortion. Or—in revised person-affecting terms—since there is no morally significant loss there can be no wrong done. The woman—other things equal—may proceed to choose the early abortion for a good reason, a bad reason, or no reason at all.

Now, the very world where the never-existing person sustains the loss just described may well be one in which the early fetus itself *does* exist. Does Variabilism imply, then, that the loss to the fetus itself is morally significant?[37] No. Variabilism applies to *persons* and for a thing to be a person, thinking—in some conscious or unconscious form—must have taken place. We are persons and we, plausibly, do not commence our own existences until at least the moment at which that first thought is processed at some level within our little minds, that first feeling flows through our little bodies. Similarly, we cease to exist, leaving only our corpses behind, at that moment our own last thoughts conclude. The early abortion does not, then, remove a person from existence through its destruction of the existing early fetus. It rather, just like non-conception, keeps a person from ever coming into existence to begin with.

Similarly, the world where the early abortion does not take place and the person eventually emerges will also be one in which the early fetus exists. If, of course, the early fetus is *identical* to the person who eventually emerges, we'd be compelled to say that the *person* exists early in pregnancy as well and to say that the early abortion, rather than keeping a person from coming into existence, removes a person from existence. We would then have a loss sustained by a person at a world at which that person exists—and hence, according to Variabilism, a loss that is itself morally significant and counts against the early abortion. But I think the more plausible view will reject the identity between early fetus and person—and on the very grounds stated above (*persons* don't commence their existence until at least the moment of that first thought).

An implication of this view is that (i) the *late* human fetus, which is plausibly identical to the *earlier* human fetus that it is spatially contiguous with, and (ii) the person *overlap spatially for a period of time*. But we have no compelling reason to think that *overlapping spatially for a period of time* implies *identity* between the late fetus (and hence the early fetus) and the person. That's so, even if the property of thinking is one that we want to say is shared by the late fetus and the person; the position here is not that thinking is *sufficient* for a thing's being a person but rather that it's *necessary*. More plausibly, the early fetus—just like the human embryo and even the human gametes that cling together immediately prior to conception—may roughly be said to *develop into* a person but is not *itself* a person.

3. OBJECTIONS TO COMPARABILITY

I believe, then, that we can accept Procreative Neutrality even as we concede Comparability. And we can accept Procreative Neutrality—as I've just argued—even if we go further and accept Universality. And, finally, we can accept Procreative Neutrality without giving up Wrongful Life.

An interesting question is whether it becomes even easier to accept Procreative Neutrality if we *resist* Comparability. That would mean, of course, that we would then need to find some way of endorsing Wrongful Life that does not involve Comparability. We would have to explain why the choice of wrongful life is wrong even though it makes things no worse for the miserable child that choice brings into existence.

Perhaps we can do that; perhaps it's just a matter of noting that the overall level of positive well-being for the particular child is outweighed by the overall level of negative well-being—not that the existence in question is worse than, or less than, never existing at all, but that that existence is less than the existences of *all those other people* whose existences *are* worth having. Since all such "plights" will be ones where the person exists, we might then insist (appealing, perhaps, to some alternate version of Variabilism) that all such plights have full moral significance.

The problem is this: Why does the fact that *my* well-being level is less than *yours* on its own count against the choice that gives rise to my having that particular well-being level? Why does the fact that the well-being level of the miserable child is less than the well-being level of, say, you or me, count against the choice that gives rise to that child's coming into existence?

We could stipulate that it does. But that brings up still another worry: If we can't make comparisons against never existing at all, then how do we even identify the class of existences that are, like yours or mine, worth having?

My tentative view is that Variabilism and Wrongful Life together remain more secure if Comparability is in place. Accordingly, what I want to do is understand why some philosophers object to Comparability and then defend Comparability against those objections.

* * *

Objection from logic. Here, we focus on the original Wrongful Life case. According to this objection, to say that w2 is worse for a person m than w1 is where m never exists at w1 is to violate an axiom of logic according to which the assertion of a two-place (or perhaps we'd want to say a four-place) relation isn't well-formed—and the proposition expressed isn't cogent—in the absence of a second (or fourth) term. Similarly, to say the number 4 is greater than the number ___ isn't well-formed; it doesn't express a proposition that can itself be either true or false. Ditto George Bush is older than ___; ditto San Antonio makes me happier than London makes __ happy.

I won't say this objection takes logic too seriously. But my understanding is that logicians are neutral on the underlying metaphysics—that is, that logicians don't consider modal actualism a necessary implication of or constraint on logic. It's true that, if the claim was that w2 is worse for m than w1 is for __, we'd have a problem. But that's not the claim: the m we are talking about things being worse for at w2 than at w1 is the very m who exists in w2 and there is completely miserable. We then turn to say, not that w2 is worse for m than w1 is for __, but that w2 is worse for m than w1 is *for m*.

Objection from language. Presumably in the context of a wrongful life case speakers at w2 can, in view of the fact that the miserable child exists at w2, talk about that child and cogently discuss how terrible things are for that child. Some of those speakers can at w2 even make *de re* attributions to that child. So speakers at w2 are in a position to say—and agents to figure out—that the existential choice that gives rise to that child's coming into existence at w2 is wrong.

But speakers at worlds where the miserable child *never exists at all* should also be able to say—and agents to be able to figure out—this same sort of thing as well. They should be able to understand and explain, in such a case, why their choice not to bring that miserable child into existence was obligatory. They should be able to understand and explain, in the context of Double Wrongful Life, why it was permissible to bring the miserable child into existence. And, in still other cases, they should be able to understand and explain why it was permissible *not* to make an existing person better off by bringing still another person, a merely possible person, into existence and making that person's existence less than worth having.[38] This is the cross-world effect in action.

We now have the elements of an objection. For Comparability and Variabilism together (in combination with a set of otherwise plausible permissibility principles) to generate all of these felicitous results, speakers at the worlds where the people those speakers—those agents—must concern themselves with never exist at all need to be able to say things about those never-existing people. But—to return, now, to the original Wrongful Life case—speakers at w1 obviously can't make *de re* attributions to m. It might, accordingly, be objected that Comparability therefore cannot operate as advertised. Perhaps, from some extra-world perspective, we the designers of these alternate possible worlds can make the assertions we need to make to show how the relevant principles are supposed to work. But that's going to do little good if the speakers at w1 can't do exactly the same.

Two responses are in order here. First, it's true that the w1 speakers cannot make *de re* attributions to m. But for the objection to go forward, we would need an argument that says that they must—that indefinite description alone, in combination with the arbitrarily introduced constant, can't do all the work that Comparability and Variabilism together require. Even at w2, the agents can't in advance of m's existence—at the time when evaluation would be best done—make *de re* attributions to m. Yet we still think they

are perfectly capable of reasoning that the choice to bring m into existence will be wrong if performed. Why should things be different for agents at w1?

Second, it's unclear why the agents at w1 can't produce the same sorts of explanations we can produce from our own extra-world perspective. We can't make *de re* attributions to our fictional m who inhabits our fictional world w2 (but not w1!), either. Yet we can nonetheless eagerly discuss and investigate how the moral analysis should itself proceed.

Attribution objection (objection from modal actualism). This objection, too, can be articulated in the context of the original Wrongful Life case. The idea here is that when we say w2 is worse for m than w1 is for m, we are claiming that m has a certain property at a world where m never exists. We are saying that w1 is better for m than w2 is. But w1—where m never exists—can't be better for m than w2 is unless m is there—at w1—for w1 to be *better for*. Rudolph doesn't have a red nose, Pegasus doesn't have wings, and w1 can't be better for m than w2 is.

But even modal actualists have for decades accepted that things are more complicated than this. Thus, even the modal actualist accepts that the sentence "JFK could have had a third child who would have grown up to be a senator but could have been an astronaut" must be given an interpretation that makes it both true and meaningful, notwithstanding that there exists no actual individual who meets the relevant description.[39] The fact that it's a puzzle in metaphysics to explain how this works has not led modal actualists to disavow the point. Rather, they try to meet the challenge. Similarly, it perhaps seems a little odd to say a person who doesn't exist at a given world might be better (or worse) off at that world. But that something "seems a little odd" in itself gives us no ground—even if we are modal actualists—to disavow the claim as either false or as meaningless.

The clearest objections against Comparability thus seem ineffective. The claims it permits seem perfectly natural and intuitive, and it's useful. Absent more telling objections, we should accordingly feel free to use of it.

4. OBJECTION TO VARIABILISM

It has been objected more than once that Variabilism treats *decreases* in well-being levels from one world to another for a person—*losses*—one way and *increases* in well-being levels from the other world to the one for the same person—*gains*—differently, and that such a differential treatment is anathema to the sort of consequentialist framework that I purport to adopt, and that it is, moreover, ad hoc, inconsistent, and irrational.

In fact, however, I don't privilege losses over gains in any way. On my view, losses and gains are two sides of the same coin, two names for the same phenomenon. I do distinguish *among* losses and accordingly *among* gains. But I do not think that the distinction is ad hoc or irrational.

So let's take a look. According to Variabilism, the loss sustained at a world where the person who sustains that loss does or will exist has moral significance and the loss sustained by that same person at a world where that person never exists doesn't. I can't imagine anyone could reasonably consider this an arbitrary distinction. Suppose an existing child's level of well-being is reduced to zero by something her parents did (whether negligently or intentionally, no matter) before she was even conceived. Suppose that that same child's level of well-being is reduced to zero by her parents never bringing her into existence to begin with. Even conceding the Universality, even conceding Comparability, we are surely going to find it reasonable to consider these two losses two different kettles of fish. One might reject this distinction or argue against it. But simply labeling it ad hoc or irrational without any further argument when the distinction is clearly there to be made doesn't take us very far.

That thought in mind, is Variabilism inconsistent or irrational in virtue of the fact that it treats gains one way and losses another? Let's just first note: that can't, literally, be what Variabilism is doing; losses *are* just gains *are* just differences in a given person's well-being levels from one world to another. The objection must rather be that Variabilism entails—and this it *must* do, both to preserve its own reason-to-be *and* its consistency—that any *loss* sustained at a world where the person exists has moral significance but some *gains* accrued by a person at a world where that person exists do not have moral significance. Specifically, according to Variabilism, any particular gain will have moral significance if and only if *the loss it reverses* itself has moral significance.

But even here we are not treating gains and losses in a way that's not entirely even-handed; we're not, after all, saying that losses, categorically, have moral significance while gains don't. Thus, just as we say that the loss sustained at a world *where the person exists* has moral significance but the gain accrued by a person at a world *where that person exists* may not have moral significance, we can say that the gain accrued at a world for a person *from a world where that person exists* has moral significance but the loss sustained by a person *from a world where that person exists* may not have moral significance.

Why does the person's existence automatically "light up" a loss as having moral significance but fail to do exactly the same for a gain? Why does existence necessarily put losses on the moral radar but not gains? How does the fact of existence create moral salience for the one but not the other?

Why is the number 7 a prime number when the number 12 isn't? At some point, explanations come to an end. But here, I think, we can say more.

What I here want to rely on is the person-affecting intuition itself. That intuition historically has marked the *beginning* of the philosopher's critical thinking about the obligations we have in respect of bringing additional happy people into existence. But the better place for it may well be at the *end* of the analysis, where it can function as a way of grounding that analysis. Wrongdoing itself at a given world w1 always involves making a person who does or will exist at w1 *worse off* than that same person is at some alternate

world w2 that is also accessible to agents.[40] When, at a given world, no such existing or future person is ever made worse off—ever endures a well-being level that is anything short of *maximized*—there is nothing to count against that world or what is done or left undone there.

To back up, we can agree that any loss sustained by any existing or future person at any world w will count against whatever choice imposes that loss at w and indeed against w. When the loss is, however, sustained by a person who never exists at all w, there is nothing to count against that choice or against w. It's as though it never happened. Hence we explain why some losses have moral significance and others do not. Since talk about "losses" is equivalent to talk about "gains," we've in the same breath explained why some gains have moral significance and others do not.

5. CONCLUSION

Thus we can accept Comparability, Universality, and Wrongful Life and also accept Procreative Neutrality. We can explain why we have the obligation not to produce the miserable child but no obligation—other things equal—to produce the happy child.[41]

NOTES

1. For comments on earlier drafts of this paper, I am deeply grateful to discussants at my presentation at the University of Nebraska (Lincoln 2013) and to attendees at the session on procreative ethics held at the Eastern Division meeting of the American Philosophical Association (Society for Applied Ethics, Baltimore, 2013). For comments on a still more recent draft of this paper, I am particularly indebted to David Wasserman, Elizabeth Harman, and Mark Van Roojen.

2. Of course, that the child will be happy if she exists isn't *sufficient* to ensure that the choice to bring her into that particular existence is permissible. If agents had some means of bringing that same child into a still *happier* existence—more precisely, to confer on her still more well-being in a case where it matters to no one else whether they do so or not—then what they have done in bringing her into the one existence would be wrong.

3. Jan Narveson, "Moral Problems of Population," in *Ethics and Population*, ed. Michael Bayles (Schenkman 1976), 73.

4. I will argue here that I don't privilege losses over gains in any way; on my view, they are two sides of the same coin, two descriptions of the same phenomenon. I do distinguish among losses, that is, gains. But in my view the distinction isn't inconsistent; no contradiction follows; and it's not ad hoc and it's not irrational.

5. See Roberts, "The Nonidentity Problem and the Two-Envelope Problem," in *Harming Future Persons: Ethics, Genetics and the Nonidentity Problem*, ed. Melinda A. Roberts and David T. Wasserman (Springer 2009), 201–28; and also Roberts, "The Nonidentity Fallacy: Harm, Probability, and Another Look at Parfit's Depletion Example," *Utilitas* 9 (2007): 267–311.

6. Here, I take for granted that the early abortion does not involve the destruction of a person. While the early human fetus (if left alone) "develops into" a person, it is not identical to a person; no continuing person, I take for granted here, can begin to exist until there is thinking in some form or another and until that thinking episode is linked by memory or a similar psychological relation to some future episode of the same. Late abortion—say, in the ninth month of pregnancy—may accordingly be subject to quite different analysis. You, the person, might perfectly overlap in space with the fetus who thrived in your mother's womb during her ninth month of pregnancy—but not, I take for granted here, during her first.

7. I am assuming, here and throughout, that the choice whether to bring the additional person into existence matters not at all to anyone other than (arguably) that additional person.

8. Narveson, "Moral Problems," 73.

9. For discussion, see especially Caspar Hare, "Voices from Another World: Must We Respect the Interests of People Who Do Not, and Will Never, Exist?" *Ethics* 117 (2007): 498–523.

10. See Heyd, *Genethics: Moral Issues in the Creation of People* (University of California Press 1992), especially the introduction and chapters 1 and 4.

11. His rejection of the possibility of this kind of comparison is grounded by two considerations, summed up as follows: "the valuelessness of nonexistence as such and the unattributability of its alleged value to individual subjects." Heyd, *Genethics*, 37.

12. Heyd, *Genethics*, 106–11.

13. E.g., Heyd, *Genethics*, 14-15.

14. "We find it hard enough to assess the harm involved in death, yet we know at least that even if death means complete annihilation . . . it occurs *to* someone. . . . All this is of no help in the case of 'birth in defect.' Had the plaintiff in the Israeli case not been conceived, would it have been a gain for anyone, would this boy have been better off?" Heyd, *Genethics*, 30-31. Heyd concludes that it would not. "[B]y producing the miserable child, we do not inflict or cause any harm *to* him, and thus only with an impersonal view [which Heyd himself rejects] can this act of conception be in this case considered a wrongful infliction of suffering." Heyd, *Genethics*, 112. (At this point, Heyd is arguing that Narveson, who wants to say that agents are not obligated to bring the happy child into existence but are obligated to leave the miserable child out of existence, has adopted a position that is itself inconsistent.)

15. Such dependently existing people Heyd calls "potential" people. Heyd, *Genethics*, 97–99. Of them he writes: "potential people . . . have no moral status of any kind, not even a weak one." Heyd, *Genethics*, 99.

16. As noted, Weinberg's position is articulated not to preserve Procreative Neutrality but rather in an attempt to solve the nonidentity problem. Still, there seems to be some carry-over. Thus she writes: "People who can possibly, and will actually, exist are simply future people; i.e., people who will exist in the future but do not exist now. Future people matter a great deal, but merely possible people don't matter at all." "Identifying and Dissolving the Non-Identity Problem," *Philosophical Studies* 137 (2008): 4. Using her approach to try to preserve Procreative Neutrality seems entirely natural.

    One other note. Weinberg's view is not equivalent to the view that only people who exist at the *uniquely actual* world matter morally (that only *actual* people matter morally). Rather, she "allow[s] for possible subjects in possible worlds. These possible subjects in possible worlds may merit extreme consideration in said possible worlds, but they have no rights, interests, or actuality in the actual world." Weinberg, "Identifying," 9 n. 21. But of course Universality goes beyond that seemingly commonsensical position. It asserts that people at one world can matter morally at an alternate world—indeed at the uniquely actual world—even if they *never exist at all* at that alternate world.

17. Thus she writes: "All interests are contingent upon existence (at some point), otherwise there is no real [note omitted] subject for interests. Since only beings that exist at some point have interests, merely possible people don't have interests. Therefore, they cannot have an interest in existence per se, no matter how wonderful their existence would be, hypothetically." Weinberg, "Identifying," 9.

18. Following Parfit, Hare has suggested this case as a problem case for the sorts of person-affecting approaches that aim to connect when a person matters morally to whether that person exists. See Hare, "Voices," 498–523.

19. We might want to limit this principle to *accessible* worlds but beyond that no clear endpoint is in sight.

20. Hare explores the difficulties that beset both these forms of "moral actualism," a collection of views he mistakenly, I believe, identifies with the person-affecting approach. See "Voices," 498–523. For a classic critique of Narveson's effort to work out the basic principles underlying that approach, see Jeff McMahan, "Problems of Population Choice," *Ethics* 92, no. 1 (1981): 96–127. See also McMahan, "Paradoxes of Abortion and Prenatal Injury," *Ethics* 116 (2006): 625–55.

21. Harman, "Can We Harm," 98.
22. Harman, "Creation Ethics," 310 and 313.
23. Harman, "Creation Ethics: The Moral Status of Early Fetuses and the Ethics of Abortion," *Philosophy & Public Affairs* 28, no. 4 (2000): 311.
24. See her "Actual Future Principle." Harman, "Creation Ethics," 311.
25. Harman, "Creation Ethics," 321.
26. Here, I am applying, to the case of a choice that *benefits*, Harman's account of the "good method" of "finding out whether there are any reasons against an action due to harm." Harman, "Can We Harm and Benefit in Creating," *Philosophical Perspectives* 18 (2004): 107. This application is not one I think she would deny. According to Harman, "we do have some reason to create every happy child we could create." Harman, "Can We Harm," 98.
27. Harman, "Can We Harm," 98.
28. "[O]n my view, we do have some reason to create every happy child we could create. But these are reasons *to benefit*; they stem from the way it would be non-relatively good for someone if we acted in a particular way. These reasons are very different from reasons *against harming*. . . . Reasons against harming have stronger force than reasons to benefit. . . . The couple who does not create a happy child does not do anything bad; they merely fail to do something that would be good." Harman, "Can We Harm," 98.
29. Here, I am summing up Harman's "good method" for identifying moral reasons. See note 26 above and Harman, "Can We Harm," 107.
30. Harman, "Creation Ethics," 315 and 319.
31. Ibid., 315.
32. Harman, "Can We Harm," p. 98.
33. w3 may for purposes of applying this principle just be w2, but it need not be. We see the importance of this point not in the simple, two alternative case of Wrongful Life or even in Double Wrongful Life, but rather in cases like Addition Plus and indeed in the Mere Addition Paradox. See Roberts, "The Asymmetry: A Solution," *Theoria* 77 (2011): 333–67.
34. Ibid.
35. Again, w3 may, but need not, be identical to w2. See note 33 above.
36. Parfit, *Reasons and Persons* (Oxford, 1987), 374.
37. I am grateful to Evan Williams for pointing out that I need to make the points in this paragraph and in the next two explicit for purposes of this discussion. Obviously these points do not exhaust the issue; they, rather, represent my own sense of how our inquiries will end up. For additional discussion, see Roberts, *Abortion and the Moral Significance of Merely Possible People* (Springer 2011), 145–64.
38. See, e.g., note 33 above (and specifically the case of Addition Plus).
39. Alan McMichael, "A Problem for Actualism about Possible Worlds," *The Philosophical Review* 92, no. 1 (1983): 49–66.
40. It's worth noting here that the (rough) converse of this principle fails: a person may be treated permissibly at a world w even if that person exists at w and is made worse off at w and no other person who does or will exist at w is made better off at w. Both Double Wrongful Life and Addition Plus make that point.
41. Parfit, of course, had still other grounds for objecting to the results I claim here. My results are premised on a person-affecting approach; Parfit, of course, thinks that the nonidentity problem shows that that approach cannot be made to work.

Doctor Will See Your IDC-9 Now

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I have heard something like this conversation several times while teaching in dental schools.

"You'll never guess who I saw in the clinic last week—Mrs. Jellyby." "Who?" "Jellyby, you know the one with missions in Africa. . . . The distal extension on #30?" "Right. That was some time ago, but I remember it perfectly. What a challenge, but gorgeous result. How is the partial holding up? But of course we would just do an implant today. So how does Mrs. . . . Jollybee like it?"

Losing track of the patient because of a firm focus on the treatment is not unusual in health care. Mrs. Jellyby is a character in *Bleak House* by Charles Dickens who loves the concept of little children so much she abuses her own through neglect. The title of this essay would make Michel Foucault smile. The International Classification of Diseases (version 9) is a code system universally used to link treatable conditions with billing. All acute gastritis is 535, for example, despite other particularities. The term "doctor" without an article or name is a complete abstraction. I want to explore the prospect that even when we get the concepts right, we may not be providing good care or doing good philosophy.

This essay is about what kinds of answers count as "the right sort" when we are making choices about good and poor care. I begin with five beautiful stories about a certain habit of misperception common in professional-patient relationships. I end with samples of research from the fields of microeconomics, social psychology, decision theory, and neurobiology. My intent is to demonstrate that we often remain uncomfortable with health-care practices and policies despite all the principles having been honored.

Traditionally we know what sorts of things are because they conform with norms. I want to set up camp in a new location. More fruitful answers to our worries about health care might come from considering whether moral agency is extended to all parties in the relationship. To accomplish this, a nontraditional grounding in humanities and empirical sciences is necessary. If we begin by asking what questions a "principles" approach to bioethics will answer, we beg the question and restrict the range of interesting topics that engage us.

THE SURGICAL EXCISION OF MORAL AGENCY

Ernest Hemingway's short story "Indian Camp" (1987) is a good place to start. In only three and a half pages, Hemingway recounts how Nick accompanies his father and Uncle George on a boat trip to an Indian village where the father—a physician—performs a Caesarean section for a woman who has been two days in breach labor. The women of the village were available to help, but the men had moved as a group some distance up the road. The only remaining man was the husband, who because he had injured his foot and could not move occupies a bunk above

his wife. He turns toward the wall at the approach of the help.

The story has a characteristic Hemingway primitive directness as the father tells the story to young Nick (and us) in the most basic terms. "But [the woman's] screams are not important. I don't hear them because they are not important." The mother and her child came through fine. The doctor, "feeling exalted and talkative as football players are in the dressing room after a game," says, "that's one for the medical journal, George." "Doing a Caesarian with a jack-knife and sewing it up with nine-foot, tapered gut leader." As the mother and child rest, attention is turned to the father. During the operation he had slit his throat with a razor and lay in a pool of blood.

This story certainly contains autobiographical elements. As a youth, Hemingway spent summers at the family cottage on Waloom Lake in upper Michigan. Hemingway's father was a physician and a suicide.

The boy asks the question that is on all reader's minds. "Why did he kill himself, Daddy?" "I don't know, Nick. He couldn't stand things, I guess." We do not feel comfortable with that as an answer. The question seems to be out of the doctor's area of expertise or concern. The physical welfare of the patient is preeminent, and the boundary line for responsibility seems to extend only to the edges of the incision.

Gustave Flaubert's *Madame Bovary* is well worth the read as good literature (1856). It has much to say about doctoring as well. In the story, Monsieur Bovary was a two-bit country doctor in Normandy. Flaubert made it clear that we were to pity him, if we bothered to give him any thought at all. The future Madame B was a poor farm girl who seduced the doctor into marrying her as a way of escaping a dead-end life in mid-ninteenth-century rural France.

Madame Bovary, having no intention whatsoever of being petty bourgeois, overspent and ruined the family financially. She indulged in a string of illicit love affairs, partly as self-indulgence and eventually with frustrated hopes of getting money to pay off the mounting debts. Emma grew desperate and, talking her way past the idiot servant into the apothecary shop, she swallowed a handful of powered arsenic.

Her death was protracted over several days and described in disgusting detail. Truly learned doctors were bought in to consult because Bovey was distraught beyond competent functioning. Although the learned professionals were more pompous, they were no more effective. They looked briefly at Madame in the various stages of a convulsive death, but did not even so much as venture a diagnosis, and only criticized others' attempts at palliative care. They enjoyed Bovey's hospitality, including dinner, but were careful to depart in sufficient time before the final outcome. Flaubert describes the chief among the doctors as "belonging to that great line of surgeons, that now-vanished generation of philosopher-healers who cherished their art with a fanatical love and practiced it with zeal and sagacity." After dinner the top-docs sneaked out of the house, "being no less reluctant to have Emma die under their care. And so they went their way, in all the easy majesty that comes of the consciousness of great talent, wealth, and forty years of hard work and irreproachable living."

The doctors saw immediately that it was not in their interests to be associated with a likely failure from an ugly condition, and there would be no glory in any case in saving such a low and unworthy woman. They defined the relationship to their advantage, and then played by the rules.

Charlotte Perkins Gilman was another matter entirely. Diagnosed in 1898 or 1899 as hysterical by one Dr. S. Weir Mitchell, she "took the cure" consisting of three months of complete seclusion with no activities such as useful work, reading, or conversation with others. Freud had figured out that women, especially those with ornamental positions in established families, sometimes suffered from an affliction of their sex that could only be treated by zeroing-out the woman's nature through inactivity and starting over again. That was considered the most "benevolent" approach to these matters.

Gilman rebelled against this approach and wrote, spoke, and organized to expose it as ineffective and demeaning. Her 1899 short story "The Yellow Wallpaper" (1899) is a frightening journey into the mind of a person whose individuality was being sucked out of her. The woman is confined by her husband to rest in a beautiful country estate. The husband is a physician named John; the woman's brother is a physician who support the treatment, but appropriately enough, the woman has no name. She exists only as John's "Darling." "John is a physician, and PERHAPS—(I would not say it to a living soul, of course, but this is dead paper and a great relief to my mind)—PERHAPS that is one reason I do not get well faster."

Eventually driven mad through inactivity, the Darling is confined to a room with yellow wallpaper that becomes her new world. "I didn't realize for a long time what the thing was that showed behind [the patterns in the wallpaper], that dim sub-pattern, but now I am quite sure it is a woman." In the end, her husband faints when he enters the room and finds her crawling around the perimeter of the room. "Now why should that man have fainted? But he did, and right across my path by the wall, so that I had to creep over him every time [I crawl around the room]!"

Until recently, women were ill in a materially different ways from men. That is why we call it "paternalism." They represented a mysterious, irrational, and fatal force that threatened the rationality of male-driven science. Mary Magdalene, Joan of Arc, Abbé Prévost's Manon Lescaut and by Prosper Mérimée's Carman, as well as the heroines of Puccini operas—Turandot, Butterfly, Tosca, and Traviata—were Bovary's and Darling's girlfriends. Today, women are less mysterious and dangerous, and their position as the inconvenient and risky to treat has been taken over by the poor and the foreign born.

I am assembling a case for person-centered morality, including men, so it makes sense to ask what kind of person Leo Tolstoy's Ivan Ilyich was (1981). He was the

central figure in a 1886 study in dying called *The Death of Ivan Ilyich*. Ilyich was a judge, a government-appointed bureaucrat, a man of principle with a deep respect for duty and a pillar of his profession. He was a somebody who spent his life administering justice to nameless nobody-in-particulars. He was doing as well as one might hope in life until a chance misstep off a ladder while helping to redecorate his apartment resulted in a bump on his side.

Although never really explained, the bruise worsened until it killed Ilyich, and the story is about how people react to this process. Tolstoy gives us a rich narrative of the sequence of Ilyich's reactions that we have become familiar with today: denial, annoyance, concern, desperation, pain that blocks everything else, and a moment's reconciliation before death. For the purposes of this essay, the more interesting reactions are those of the physicians. None of them offer a diagnosis; treatment is a blizzard of herbs with contradicted indications. The only action by physicians that has a noticeable impact is the use of morphine to separate Ilyich from his condition.

> There was the waiting, the doctor's exaggerated air of importance (so familiar to him since it was the very air he assumed in court), the tapping, the listening, the questions requiring answer that were clearly superfluous since they were foregone conclusions, and the significant look that implied: "Just put yourself in our hands and we'll take care of everything; we know exactly what has to be done—we always use one and the same method for every patient, no matter who."

What Ilyich longed for most was a reason, some way to make sense of his dying.

The brilliance of Tolstoy's writing comes in showing us that doctors and patients are interchangeable as people, while professional principles provide justification for separating the person from the disease. Consider this description of appropriate care: "It was all done with clean hands, in clean shirts, and with French phrases." Here Ilyich is reflecting on the way he manages his court room, not the way Russian doctors treated patients. Ilyich bridles that "the doctor does not wish to understand such questions"—those he does not know the answer to. Yet, "Everything was just as it was in court. The celebrated doctor dealt with him in precisely the manner he dealt with men on trial. 'Prisoner, if you do not confine yourself to the questions allowed, I shall be obliged to have you expelled from the courtroom.'"

The last story is the most troubling. It is told in Richard Selzer's *Letters to a Young Doctor* (1996), and narrated in Selzer's own voice as though this actually happened to him. The story is called "Imelda" for a fourteen-year-old Honduran girl with a deforming cleft lip. A revered surgeon, Hugh Franciscus, invited Selzer to accompany him on a medical mission trip. Franciscus examines Imelda and prepares her for surgery, but the girl dies of an adverse reaction to the anesthesia just as the surgery was starting. Later that night the surgeon, alone and by lantern light, went to the hospital morgue and completed the reconstructive procedure.

The story concludes with a triumphal presentation of before and after case reports from the mission trip given by the surgeon at his home hospital. The before photograph of Imelda is displayed, but the surgeon realizes that he is physically incapable of calling for the post-surgical photograph, the one taken in the morgue. Selzer, who according to the story was operating the projector, removed the follow-up photograph, and the presentation continued with the surgeon's reputation intact.

On one reading of this story, the surgeon is a hero who responded to the mother's unspoken hopes that her daughter would be buried with a smile. Charity is intrinsically noble. The more troubling reading is that the surgeon placed his own reputation for technical accomplishments above all else. We are encouraged by Selzer to see it that way by two detailed descriptions the surgeon gives of the technical protocol for repairing a cleft lip. It is a mechanical art that proves the mastery of the operator.

These stories all make us feel uncomfortable. But in no case is it obvious that the doctor has violated a principle such as respect for autonomy, nonmaleficence, beneficence, justice, or veracity. These were eminent men, with Teflon reputations. On principle, they were substantially within the pale. Academically, we could construct indictments couched in principle language, but that does not seem to get at exactly why we find these narratives so troubling.

ABRIDGING MORAL AGENCY

I suggest that the common source of disease in these stories is that moral agency was denied to the patient. The doctors did what was right on principle and out of high, or at least professionally approved, motives. They did what they thought was right, and in each case bioethicists could be found who would justify those actions. They were covered by some rule.

But in each case the patient was diminished. The Indian husband was invisible. The doctors of Normandy conspicuously distanced themselves from the dying woman because contact would have soiled them. Gilman's cure was to cease being a normal functioning individual. Ilyich was an "inconvenience." The surgeon who repaired the cleft lip in Honduras did not perform his services on a person at all.

Helping, especially sacrificing to improve the lot of others, is laudable. Some would see little difference between that and what could be called "ethical behavior" or ethical practice among professionals. But being the object of principled care is not the same thing as being a moral agent. Agency means that one can expect that others will respond to what the agent feels is important. It is a claim to be recognized as having a claim on others' actions. Thus is not the same as the one-way principle of respect for autonomy. A dentist respects the autonomy of patients by allowing them to decline an elective treatment, such as replacing amalgam fillings with composites. (Some patients and some dentists are frightened by the prospect that the mercury in amalgam fillings is systemically toxic.) Moral agency would involve the dentist being answerable for why, besides the increased business, he or she would like

to do so. Moral agency is reciprocal but extends beyond double indifference. The concept does not cover "I'll let you abuse the world if you let me do the same." It includes "I hold you responsible for what you do that affects me in exactly the same way I expect you to hold me responsible for making choices that affect you." Moral agency is the relationship professionals have with patients after they take off their white coat.

There is, in theory, a *principle* of respect for autonomy, but the relationship of moral agency exists in actual performance. The codes of the American Dental Association, the American Medical Association, and the American Nurses Association are all based on the "principles" approach. Each speaks to the interests (dentistry), rights (medicine), or dignity (nursing) of the patient. None mention the patient's claim on the professional; none state that the professional and patient should agree on what patient and professional values should guide behavior. All the codes support a reading that there are patient rights, and these constitute a minimally required set that is the same for all patients. The ADA is explicit that "society affords the profession certain privileges that are not available to members of the public at large." To the best of my knowledge, patients have never been involved in creating, modifying, or commenting on the ADA Principles of Ethics and Code of Professional Conduct.

An obvious way to deny moral agency to others is to make them invisible. In the Indian Camp, the physician could not hear the screams because they "did not matter." The physicians literally declined to be present at the suffering of Madame Bovary. Therapy by Yellow Wallpaper meant hobbling the patient by restricting exercise of meaningful activities. Imelda's defect was corrected after she was dead.

Ivan Ilyich is a subtler and thus more instructive case. His physicians related to him selectively. They answered only those questions about which they could appear authoritative, and for the rest, the patient's voice was mute. "The doctor had adopted a certain attitude toward his patients, which he could not change. . . . The doctor ignored his inappropriate questions," eventually pronouncing 'this is clearly a case of [this or that] . . .' unless, of course new evidence should come to light requiring a reconsideration. The doctors recognized two types of questions: Those for which they know the answers and those they regard as inappropriate to ask. It all has to do with control of the relationship.

My own empirical research on how dentists use information to reach decisions shows that dentists are atrocious at managing baseline and diagnostic data—a trait they share with physicians (Chambers, 2013; Chambers et al., 2010). But more telling in my studies was the significant number of professionals in the sample who simply refused to engage in the project. It was suggested that I was unethical or at least unprofessional to ask questions that could not be answered with confidence. Let's retain this as a working hypothesis: Professional ethical relationships—contexts in which ethical outcomes are possible—can be understood as requiring that the issue is rational and controllable by the professional. Ones that fail to meet this standard—either because of inherent ambiguities in the facts of the matter, or because the patient has moral agency permitting their own claims on the professional—are not manageable in the traditional "principles" ethical framework.

Let's push this idea a little farther and ask whether there are other senses in which there is a meaningful difference between relating to a person based on principle and relating to them as moral agents. An important structural element is provided by microeconomic theory.

In 2009, Elinor Ostrom won the Nobel Prize in Economics for her work on the commons, the moral use of resources that are not held in private. Ostrom was a student of Harvard professor Mancur Olson (1965) who wrote the hugely influential *Logic of Collective Action: Public Goods and the Theory of Groups* fifty years ago. Ostrom's best known research was on water rights, a topic she studies from Los Angeles to Sri Lanka (1990). Her contribution was in noting that laws, regulations, force, and the market are all relatively ineffective as just ways for managing the commons. What works best is for a small number of people to sit down and maximize their mutual interests. We seem to get farther when we ask of others and expect to be asked ourselves to give and take. When instead we stand on principle, it is difficult to get past the theoretical comparisons.

Olson noted that markets work differently depending on how many people participate. It is useful to distinguish two-person exchanges, small group exchanges, and open markets. (One person/one principle exchanges are figments of philosophers' imaginations.) Macroeconomists discuss this topic under the heading of "price making" and "price taking." Buying insurance on an exchange involves price taking. The price I get depends on characteristics of the group I belong to. I can reject the offer or accept it. My action alone (actual or potential) does not affect the market price. I am not treated as an individual but as a member of a class. By contrast, large hospital networks negotiate with insurance exchanges. Each hospital has a voice that potentially "makes" the price. The cost of new health insurance policies in rural Alabama is very high under the Affordable Care Act, precisely because there is only one provider there—many price takers, and no price makers.

Agents are relationship "makers"; ethical objects without agency are relationship "takers." The technical requirement for a small market, one that supports price making, is that all participants realize that each other party has the potential to affect their future. Treating a patient well on principle does not make them an agent. Every "patient" in the five stories that began this essay was a "taker" of a relationship—take it or leave it—that was offered to everyone like them, on principle. Even when they "consented," they were excluded from participating in defining the choice.

There is a special case in small, price-maker arrangements where there are exactly two, as opposed to several, agents. In 1994 John Nash received a Nobel Prize for proving that there is always an optimal mutual approach for two agents, one that neither agent would want to change unilaterally (1951).

The cases where there are multiple agents and multiple principles are not as reassuring as we would hope. Kenneth Arrow has argued that under five plausible assumptions (including transitivity of values, more than three agents, more than two principles, and no phantom preferences to game the system, plus one other) there is no reason to expect that participants will agree on a common allocation of resources. There is, however, one escape clause in Arrow's Indeterminacy Theorem (the fifth assumption): If a philosopher king is appointed dictator, the whole thing works out fine, just as Hobbes said it should. Much of philosophy can be read as a set of resumes supporting various candidates who are applying for that position. Arrow received the Nobel Prize in Economics in 1972 for his work (1951).

This general position has been argued persuasively in the Anglo-American critical philosophy literature by James Buchanan (1965). Michel Foucault (1973), from the Continental perspective, was adamant about the tyranny of treating patients as members of classes rather than as individuals from the Continental perspective.

Some may be skeptical of economics and decision science as a basis for improving morality, but reassurance may be available from the social sciences. Kitty Genovese (Ross & Nisbett, 1991) has become a by-word for a nasty secret regarding human nature. Ordinary, ethical people predictably do not behave morally. In 1960, in a section of Queens, New York, Genovese was assaulted and stabbed repeatedly over a thirty-minute period. Subsequent police investigations found that thirty-eight people saw or heard the incident. No one intervened; no one even called 911. It is likely that all witnesses would describe themselves as good, ethical citizens and that they would be regarded as such by their neighbors. We can even imagine that these individuals would check the box that said "yes" when asked whether we have an ethical obligation to help those in need. The Genovese case turns on the difference between one person helping a neighbor and many people endorsing an ethical principle. As the number of people involved becomes larger, there is a tipping point where we cease relating to others as agents, and begin treating them as members of a class where the correct action for the class is governed by general rules.

John Darley, Bibb Latané, and other social scientists have studied this effect under controlled conditions (1981). A typical protocol involves having research subjects complete a questionnaire (which really has nothing to do with the study) when the process is interrupted with an "emergency" that would normally reframe the situation so that a civil response is called for. In one study, smoke was piped into a ventilation panel in the room where the questionnaire is being completed. In another, a female research assistant left the room and a loud noise was heard as though she has been hit or taken a fall. There was also a variation on this where an epileptic attack was simulated in the hall outside the room. The question really being tested was whether the subject would stop filling out the survey and take helpful action.

The results are generally encouraging. In the three conditions described, the moral response of interrupting the routine and offering help was taken by 75%, 70%, and 85% of the subjects, respectively. But here is the twist. If there were three research subjects in the room, the probability that any of the three would intervene in the first case (smoke) dropped to 38%. When there were two subjects in the case of simulated fall, only 40% responded. When there were five subjects who heard the simulated epileptic attach, only 40% responded. When subjects were paired with confederates who were instructed to ignore the moral call, the proportion of responding subjects dove to the 10% range.

The lesson is that we respond to moral situations differently when we believe that the engagement involves only ourselves and another (the victim in this case) than when we frame the engagement in general terms. Framing on principle gives us cover. It is not the anonymity that matters. It is whether we define ourselves as individual agents or as members of a class. It is too easy in the one-of-a-group situation to endorse the ethical principle that "somebody should do something about this terrible situation" without noticing the obvious corollary that we are "somebody." By framing the problem ethically as everybody's responsibility it becomes no longer our responsibility.

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So far I have presented evidence from literature, microeconomics, decision science, social psychology, and philosophy all pointing in the direction that relationships based on principles—even good principles, warmly endorsed and scrupulously followed—may still lead to troubling outcomes. The next place to look would be neurobiology. Oxytocin is sexy now. It is a neuromediator hormone secreted by the pituitary gland, but only in mammals. It plays a conspicuous role in bonding and in framing relationships. Paul Zak and his colleagues (2007) studied the classical Dictator Game, where one agent is given a sum of money and asked how much he or she is willing to share with another. Typically generosity is measured in the 20% give-away range, and that across cultures and circumstances. A nasal spritz of oxytocin to the dictator, however, can increase the largess by as much as 30%.

Every salesman and philanthropic organization knows this and uses food and other inducements with the same intention. The power of Zak's research comes from dividing the dictators into two groups. One group decided how much to share with others who were like the agent, while the other group decided how much to donate to a computer. The oxytocin effect of enhancing generosity was only observed in the face-to-face situation. It is probably safe to say that humans (at least competent adults) have the capacity to recognize whether they are dealing with moral agents or with impersonal objects of their actions, and that they modify their behavior in systematic ways based on how they categorize the "other."

Before providing one last example from neurobiology, I must share a cautionary note. Putting neurological

structure and function on the same page with traditional philosophical issues is a very immature strategy and, on principle, threatening to some. Many of these studies that have entered the popular literature have not been replicated, nor do they have the theoretical nomological network structure required of good science. Almost certainly, the metaphor of brain centers specific for the traditional ethical constructs of philosophy will bedevil us. The conscience, for example, is not in BA25; but it would be wrong to ask, "Well, where is it then?" With that precaution, I will offer one final example, strictly for the purpose of further clarifying my distinction between ethical principle and moral agency.

Patricia Churchland (2011) has drawn our attention to the prefrontal cortex in our search for the neurological correlates of ethics. So-called mirror neurons have been popularized as the foundation for ethics. Rhesus monkeys show increased fMRI activity in the inferior parietal cortex when watching a cage-mate doing such tasks as eating. The brain patterns are similar in the eating monkey and the watching one. This has entered the popular literature as demonstrating some sort of "empathy" center, the very site of altruism. We are encouraged in this interpretation by the fact of this brain region's myelination (the neural sheathing necessary for rapid impulse transmission) begins to develop at about age four in humans. That age marks the emergence of a capacity to recognize emotion in others, and particularly a form of conditional projection such as "If I hit him, he will feel pain."

This "theory of mind" hypothesis, as it is known, has some conceptual weaknesses. "Knock-out function logic" is shaky. No car with one of its four wheels removed can be expected to achieve speeds above sixty miles per hour. But that does not mean that tires make automobiles go fast. Further, mirror mental responses are typically categorized as "sympathy," not "empathy." The former is feeling the same way as others; the latter is knowing how others would feel. If I am paralyzed by the sight of an oncoming train, I want to be helped by an empathetic bystander, not one with massive sympathetic firing in mirror neurons. Finally, the equation of ethics with certain shared emotional states is inadequate. Although empathy may be part of altruism, the two are not the same thing. Similarly, altruism is sometimes a useful part of an appropriate ethical response, but it is not the sum total of ethics.

The logic of the preceding paragraph can be extended to show the difference between conforming to ethical principles, on the one hand, and working with other moral agents, on the other. The capacity to recognize what would happen to others based on events, including what one might do to others, shows up in children. They can learn and appreciate rules by the time they are ready for kindergarten. But they cannot work with problems such as this: "If I treat others a certain way, what will they do that will affect me, and thus what is the most effective way for us to work together?" Treating others as moral agents is a higher order process than is following rules. Preliminary evidence locates this function in the right temporopariatal junction, not in the forebrain (Decety and Lamm, 2007; Bzdok et al., 1912; Koster-Hale et al., 2013). Disturbances experimentally inducted in this region interfere with moral judgments. The region is unique to humans and does not myelinate until late adolescence, the traditional age of moral maturity. Thus, there is a bit of evidence suggesting that conforming to principles is distinct from treating others as moral agents.

CONCLUSION

We have no word in the English language to designate a person who needs or would benefit for health care. "Patient" signifies only that an individual has agreed to be treated under the terms laid down by the provider. "Patient of record" refers to a legal status. Many patients are perfectly fit and preempt resources that others need. Sometimes patients are agents and sometimes they are interchangeable members of diagnostic or treatment categories. Members of categories can be treated with the helpful guidance of ethical principles. Agents, not so much.

ICD-9s define what it means to exist in the health-care system. Without one, and especially without an open treatment path, individuals are prone to vanish. The Indian woman's husband was three feet away from the doctor when he committed suicide unseen. The charity doctor in Honduras treated a lip and not a person. The treatment for Madame Bovary and the Darling of the yellow wallpaper was essentially to make them disappear. Since no one, doctor or family, knew what to do with Ivan Ilyich, he was "inconvenient." Dying became the process for surrendering moral claims on others.

I am not arguing that we should abandon principles and only think in terms of moral agency. Making that case would require more resources than could be crammed into this essay. I am certainly not proposing that I have defeated reliance on biomedical principles. Richard Rorty spoke eloquently in *Philosophy and the Mirror of Nature* (1979) about philosophy making progress by moving the conversation to more interesting questions. Sister disciplines such as microeconomics, decision science, social psychology, and neurobiology do not answer philosophical questions; they stretch and relocate them. Telling stories—the true "first philosophy"—is an especially attractive means of realizing Nietzsche's point that "truth is a mobile army of metaphors" (1954).

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POEM

Mina Says No to Hospice

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I entered the world with a blast:
Triumphant and ever so loud.
The room was engulfed by my cries.
My mother was weary but proud.

And now, although 90 and failing,
I still want to live as I am.
They said I came in like a lion —
I'll never go out like a lamb.

BOOK REVIEW

A Medical Sociologist and a Bioethicist Have a Conversation about Sheri Fink's Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital

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Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital was written by Sheri Fink and published by Crown Publishers (New York) in 2013. The book tells the story of a New Orleans hospital ravaged by Hurricane Katrina, allegations of euthanasia of several patients at the hospital by medical staff, and the subsequent criminal investigation. Professor Susan Roxburgh, a medical sociologist, read the book and shared it with her friend and colleague, Professor Deborah Barnbaum, a bioethicist, shortly after its publication. What follows is a discussion between the two about the book.

Roxburgh: As a medical sociologist, interested in how the structure and organization of work life contributes to variation in mental health, the lessons I draw from the book that help us understand what went wrong at Memorial fall into three general categories: the organizational structure of the environment, the definition of the situation, and experiential (phenomenological) factors. All of these contributed to the disastrous outcome that Fink describes in her book.

First, in a crisis there has to be a clear chain of command, and that chain has to be populated with people who have the authority to direct the people below them in an effective and clear way. The workers trapped at Memorial fall into four categories—physicians, nurses, ancillary staff, and hospital administrators. We learn nothing about the ancillary workers, except for references to their heroic efforts to provide food from the cafeteria and mention of a security guard who did not know how to fire his sidearm. In fact, when reading Fink's book it is easy to forget that as the water receded there were upwards of a thousand people in the hospital. Because the presence of these workers, vital to the running of hospitals, is more or less non-existent and their role and experiences during the crisis are unclear, I'll focus on the other three groups.

Barnbaum: I'm interested to see where you are going with this, and I'm also interested that you're first focusing on those who worked at the hospital, and not the patients. I'll look forward to discussing the patients at the end of our conversation.

Roxburgh: Absolutely. Our understanding of the patients is one of the places where we agree but I think many readers of this book—okay, me—are inclined to ask what the

"lessons learned" are from Memorial. How do we prevent it happening again? And, unfortunately, the patients' actions don't play much of a role in the answer to that question. First, let's consider the organizational environment for the physicians. In large hospitals, most physicians don't know their colleagues outside their specialty group. Memorial was no exception. In addition, many physicians at Memorial during the storm were contract workers, presumably with little knowledge or feelings of affiliation to Memorial. This made it hard for physicians to work together in a unified way, to stay on-message, and work with a common purpose. Their unfamiliarity with one another made it more likely that the staff who remained at Memorial during the storm would read each other incorrectly or judge each other harshly. For example, Bryant King—one of the few African American physicians and one of the few physicians who was very vocal in his opposition to plans to euthanize patients—had only worked at Memorial for a few months, and he seems to have been treated as if he was an unreliable hot-head.

Barnbaum: Many of the patients whose stories are at the center of *Five Days at Memorial* were patients at LifeCare, a long-term care facility that leased space at Memorial. The physicians at Memorial were primarily university doctors or private contractors, who did not feel an obligation to care for the LifeCare patients (pp. 98, 104). There were few deep ties between patients and the physicians. Ultimately, this arrangement not only undermined trust among the people who worked at the hospital, but it also diminished the sense of moral obligation on the part of the physicians for the patients who needed the most help.

Roxburgh: Yes, the lack of social cohesion led to significant problems. It is clear from Fink's account that rumors shared between physicians about possible euthanizing occurred in scattered groups of physicians, not in formal meetings. There does not seem to have been a point at which there was a clear message from someone in charge that no such actions were being contemplated. Seasoned physicians and physician administrators expressed opposition to this idea, but these interactions were smaller, face-to-face conversations. For example, Richard Deichmann, the chair of Internal Medicine, told Susan Mulderick, the nursing director and head of the emergency preparedness committee, that euthanasia was out of the question, and Horace Baltz, one of Memorial's longest-serving physicians, was vocal in his opposition, but dismissed some of the discussions he overheard as "loose and crazy talk" (p. 296). Other physicians expressed strong opposition but, after airing their views, left the hospital rather than trying to organize a concerted effort to stop Anna Pou and John Thiele, the two physicians whom Fink suggests performed many of the injections.

Barnbaum: Before you continue, I want to pick up on a point you just made. You mentioned the rumors circulating about euthanasia of patients. One question a bioethicist would ask is whether or not the actions performed by some staff at Memorial Hospital were in fact acts of "euthanasia" (pp. 218, 396–406). Unlike an analysis of the term "murder" (wrongful killing), there is nothing in the analysis of the term "euthanasia" which implies that the act is morally right or wrong. "Euthanasia" is a normatively neutral term, although throughout Fink's book it is invoked with the connotation of "*wrongful* actions of killing patients." Whatever the normative view of euthanasia, the term "euthanasia" is supposed to have the connotation of *a good death for the patient who dies*. While different agents appeared to have different intentions behind the injections at Memorial, it is clear that the injections were not performed solely to provide the patients a "good death" (p. 223). The injections were performed furtively and hastily, without consent of the patients or their family members. In almost all cases, the patients would have been able to offer actual consent, or had relatives on-hand who could have offered surrogate consent based on a substituted judgment, but no consent was obtained. In lieu of consent, either from patients or surrogates, only the most paternalistic application of a best interests standard could be invoked to claim that the deaths were good for the patients. In some cases the method of killing failed to be the least painful possible: in one case, after several morphine injections proved to be ineffective, a patient was smothered with a towel (p. 292). At one point the killings were described as being done "for the greater good," in order to help evacuate the hospital as quickly as possible (p. 223). Most bioethicists would not recognize these actions as acts of euthanasia (p. 293), although Fink refers to the killings throughout as "euthanasia." Just like a philosopher, I'm already getting hung up on the meaning of certain terms. For the rest of the discussion, I promise to use the term "euthanasia" in its ordinary language sense—an intentional killing of a patient—just as Fink does. Please continue!

Roxburgh: I'm used to you philosophers hijacking the debate by getting very precise on the use of certain terms! King and another doctor, Bill Armington (Fink 2009), both realized what was happening and acknowledged in their later accounts that they had heard rumors on Wednesday that some patients were not going to be evacuated and that this might involve euthanizing them. Armington had a conversation about this with Ewing Cook (the chief medical officer), but rather than intervene or gather others together to form a critical mass of people who would intervene, all the physicians who objected left (Cook, King, Kathleen Fournier), or continued efforts to help with evacuating patients from the roof (Armington). Several nurses reacted similarly—Andre Gremillion is described as "crying and shaking his head" at the news that Emmett Everett (p. 211), a patient, was going to be administered a medication by a doctor Gremillion had never seen on the LifeCare Ward before. While one might be inclined to argue that the authority of physicians over nurses makes it difficult to contradict their orders, in the routine environment of hospitals, nurses frequently see it as their role to monitor physician decisions and report any problematic decisions, particularly as it pertains to medications. It's striking that although a number of nurses and physicians objected to the "decision" to euthanize, no one felt they could stop it.

The lack of a clear command structure meant that leaders rose to the top because others above them were absent. Richard Deichmann was the top-ranking physician/administrator because the chief of medical staff was not in the hospital during the storm. He was responsible for the decision, made early on, to prioritize the DNR patients

last. He later admitted that he understood DNR to refer to patients who were terminally ill.

On the nursing side, the command structure was clear—Susan Mulderick was in charge because she had chaired the Disaster Relief committee and because she was head of the nursing staff. But there seems to have been little coordination between Deichmann and Mulderick. Fink notes that instructions about how the evacuation should proceed were often confusing because Deichmann and Mulderick did not seem to agree and occasionally provided contradictory instructions (p. 194). In this ambiguous environment, the strongest personalities rose to the top. King notes that Mulderick "conducted every meeting" (p. 266), and she is described by Fink as "taller and more confident" (p. 291) than John Thiele, one of the physicians.

The role of hospital administrators during the crisis was also unclear. At times, decisions seem to have been made by Rene Goux, the CEO, and Mulderick; at other times, directions and instructions about the evacuation came from other individuals. No instances are described in which clearly designated representatives from each of the four major occupational groups in the hospital met together and spoke with a unified voice in a way that made it clear what they were supposed to be doing and what the people under them were supposed to be doing. For example, Goux and Mulderick told staff on Thursday morning that everyone had to be out by nightfall, which they later explained was intended to spur the evacuation effort, but this had the unintended effect of creating a sense of finality and urgency—perhaps pushing people to make decisions that they would not have made under different circumstances (p. 291).

Barnbaum: A great deal is made of Mulderick's comment that no living patient would be left behind (pp. 205, 246). This claim is ambiguous: Did it mean that the healthcare providers would be last to leave, after having evacuated all of the patients? Or, did it mean that in order to make sure that the hospital would be evacuated in a timely fashion, steps would be taken to ensure that no patients would remain alive? Certainly, if the claim meant the later, then this would be a clear violation of Kant's Second Formulation of the Categorical Imperative.

Roxburgh: Yes, I agree it's a great illustration of my point—even the people who seemed to think they were in charge were unclear about what was going to happen. The effect of this deeply chaotic environment on the actors involved should not be underestimated. It was simply unclear who was in charge, and the consequences are illustrated in dozens of both seemingly minor and other obviously pivotal situations that Fink describes. Refuse accumulated because no one felt responsible for picking it up. Nurses huffed oxygen from a working wall unit, while literally two floors away a patient died because the nurse manually bagging her was too tired to continue providing oxygen. Staff cooled off in their cars and charged their cell phones, even as the coast guard tried repeatedly to contact someone in the hospital; the radio (which was on and listened to attentively by many in the hospital) frequently warned that hospitals, including Memorial, were cut off from the outside world. Patients on the seventh floor and those waiting for evacuation at a staging area on the second floor are reported to have been shouting for water.[1] Simple and entirely manageable tasks were not attended to, such as putting someone in charge of keeping a bank of cell phones charged, keeping patients hydrated, or making sure people got needed breaks and sleep periods. On Day 3, Dr. John Thiele crossed over the bridge between the hospital to a medical building and walked through the building to the cancer center, where he "spent many hours . . . hospital administrators came and went, made coffee, charged phones, sat in front of fans" (p. 289). And yet, neither Thiele nor any administrator thought to carry patients to this area which had electricity and a semblance of order and normalcy. Why weren't the many individuals—staff and people who had sought refuge at the hospital—assigned to specific patients, and the task of making sure they were hydrated?

It is particularly important to note that no physician in Memorial during the crisis was placed in charge of the LifeCare floor. If someone *had* been put in charge, they would have been responsible for reporting on the progress of patients and on their plans for evacuation. Instead, Pou took the initiative and, consequently, the authority was *de facto* conferred on her. This gave her actions a legitimacy they would not have had if there had been clear lines of authority. For example, Therese Mendez, a nurse executive at LifeCare, said that the reason she didn't advocate for her patients was because she felt that Pou had "gotten her orders from a higher authority, and [that] she was acting under these military orders" (p. 251).

Barnbaum: I hadn't considered the structural dynamics that you mentioned, but I agree that they clearly made a difference. Your point is reinforced when one contrasts the experiences at Memorial with those at another New Orleans hospital, Charity Hospital. Charity experienced flooding, power failure, the need to evacuate patients, six days rather than five before the hospital was evacuated, twice as many patients, and a far lower staff-to-patient ratio than Memorial. Yet, only three patients at Charity died. Their success is attributed by Fink to several factors: a protocol that quashed rumors before they could spread, informational meetings for the entire staff held every four hours, the continuance of hospital routine such as physical and occupational therapy that created a semblance of normalcy in the midst of extremis (unlike Memorial, which early on switched to what they called "survival mode" [p. 64]), and even a talent show put on by the staff, lit by flashlight. Unlike Memorial, the medical staff at the public Charity Hospital did not have a distant corporate headquarters, or multiple private units like LifeCare within the hospital. Fink doesn't pull any punches when discussing the perils of for-profit hospitals (pp. 45, 78, 87, 271). In discussing Charity's success, especially in contrast with Memorial's, Fink appears to be endorsing a communitarian ethic. The lessons learned from Charity's experience dovetail nicely with a discussion of community members in Maryland who articulate conflicting views about the best way to make triage decisions (pp. 478–79), as well as a 2012 Institute of Medicine Report that recommends community input when making allocation decisions during disasters (p. 482). While

Fink is appropriately modest about what a communitarian ethic can accomplish (the Maryland community members did not come to a consensus about allocation of scarce resources during a public health emergency), Fink seems to endorse a communitarian ethic when making healthcare decisions during a natural disaster.

Roxburgh: The point you just made about private hospitals is an important one—my point is that private or public *per se* isn't the determinative difference. Rather, the public hospital was a less fragmented organizational environment—an environment in which it was possible for a few to take charge, coordinate, and create a sense of working together. Notice that at Charity, staff kept up their routines, physical therapists continued to offer therapy, nutritionists met with diabetic patients, and so forth. Many of these health professionals at Memorial would have had little to do over the days up until Thursday—keeping people busy has the effect of alleviating panic because continuing routines in the midst of a crisis creates security and prevents people from ruminating on their future or what might be going on outside the hospital. This is particularly important when one considers that rumors were circulating about lawlessness, gunfire could be heard, and many staff did not know whether or not their families were safe or whether or not their homes were completely destroyed.

There is also something very culturally specific about how the situation played out at Memorial. The lack of a command structure, a structure that would have imposed a military-style order to the chaos, made it a matter of *individual choice* whether one behaved heroically or not. Some physicians left as soon as they could, while others chose to labor on without rest. I think in part the valorizing of Pou is based on that view—Why should she be criticized when she did so much more than others, when she doggedly carried on without rest or food? But unlike Pou, people for whom battle triage or refugee camp work is relatively routine (e.g., military medics) know that in such a situation it is unwise to make decisions alone and that it is impossible to make rational decisions without rest and nourishment. Pou chose to behave "heroically" and no one stopped her. And that is precisely why she is the least reliable source to give an account of what happened or to weigh in on her own motives. While I condemn her actions and find them horrific, it doesn't surprise me in the least that she has steadfastly maintained that she did the right thing. John Thiele, equally culpable in my view, also remained avowedly certain that he had done the right thing (he died two years ago). I believe Pou should have been held responsible, but I also implicate the organizational environment that allowed individuals—Mulderick, Thiele, and Pou—to take leadership roles, bear the burden alone, and frame their actions as heroic. This conclusion reveals the heart of the sociological perspective—individuals have agency but that agency is constrained by their social environment.

Barnbaum: Actions, agency, and consequences—this is much more familiar territory to a bioethicist. I'll leave the questions about the social environment to you, and focus on the moral normative status of the actions performed by Mulderick, Thiele, and Pou. One significant ethical concern is whether or not the deaths at Memorial were appropriately instances of the Doctrine of Double Effect (DDE) (pp. 197–200, 381). A familiar articulation of the DDE is Phillipa Foot's: "It is sometimes permissible to bring about by oblique intention what one may not directly intend."[2] Giving patients in pain who are dying palliative medications which may hasten their death, such as morphine, is an example of the DDE. The direct intention is the relief of pain; the oblique intention is the foreseen, but not directly intended, effect that morphine will hasten death. Bioethicists agree that there are at least four additional requirements for the DDE to be properly applied:

(1) The act must be morally good or morally neutral, independent of its effects.

(2) The agent must intend the good effect only. The bad effect can be foreseen and permitted, but not intended.

(3) The bad effect must not be a means to the good effect (because then the agent would intend the bad effect in pursuit of the good effect).

(4) The good effect must proportionally outweigh the bad effect. This out-weighing compensates for permitting the foreseen bad effect.[3]

In *Five Days at Memorial*, a moral evaluation of the injections may depend on whether or not the direct intention was *to relieve pain*, in which case the actions would be permissible, or whether the direct intention was *to hasten death*, rendering the actions impermissible. Fink's narrative makes clear the injections were not appropriately instances of the DDE on many levels. First, in many of the cases the patients were not in pain. Thus, the intention of addressing pain, even in the face of the oblique intention of hastening death, could not have been the direct intention of the doctors and nurses who gave patients morphine. It could be said that giving morphine would have made the patients *more comfortable* than they were, but there are other medications and dosage levels that could have been administered, if comfort were the direct intention, which would not have had the oblique intention of hastening death. Second, the *bad outcome* (in this case, death) can only be *obliquely intended*, per 2 above, whereas at Memorial it appears to have been directly intended (p. 396). Finally, the DDE requires that there is proportionality between the intended (good) effect and the oblique (bad) effect, per 4, above. Thus, a true application of the DDE required proportionality between the direct intention of the pain mitigation, and the oblique intention of hastening death. In light of the fact that many of the patients were not actually in pain, let alone severe pain, this condition was not met.

Roxburgh: I'm seeing a pattern here: Bioethicists talk about individuals' actions and intentions, and the rightness or wrongness of those actions; sociologists talk about structural and organizational aspects of the environment, and how those affect agency. At Memorial, the dysfunctional organizational environment increased the probability that a few people would make ill-advised independent decisions. This reminds me of a famous sociological aphorism that

captures the second issue that helps us understand what happened at Memorial from a sociological perspective: *If men define situations as real, they are real in their consequences*.[4] At the very heart of the actions of many at Memorial was a definition of the situation as isolated, hopeless, and apocalyptic. This definition of the situation was encouraged by radio reports that martial law had been declared—this was not the case—and by other outlandish reports from a local radio station which was left running in the hospital and was heard by many (p. 179). This particular radio station, which was said to have "valiantly" continued broadcasting, probably did more harm than good because in addition to maintaining the claim that martial law had been imposed, they reported many incidents of murder and mayhem—many of which proved subsequently to be either exaggerated or completely false.[5] People trapped at Memorial heard reports of hostage situations, prison breaks, and even a deputy sheriff who said on air that he had seen a shark swimming around a hotel (p. 179).

The definition of the situation as hopeless and apocalyptic is consequential because it led to extraordinary myopia. For example, Mulderick declared "we're on our own" on Thursday morning, even as Tenet was mobilizing private helicopters to arrive at Memorial to rescue the remaining patients and staff. Pou continued to euthanize patients while the noise of helicopters arriving was so deafening that it reminded one nurse of the evacuation of the American embassy in Saigon.

Pou has publicly repeated, and in his Pulitzer prize-winning New Orleans Picayune series Jeffrey Meitrodt (2006) also asserts, that by Thursday the hospital was running out of food and water. This was patently false, yet many people in the hospital believed what they heard from others (as no doubt do Pou's many staunch supporters). When authorities entered the hospital on September 11, they found ample bottled water and plenty of food: "It astounded Schafer to see water bottles stacked to the ceiling. There were canned goods in the kitchen and food and beverages stashed and scattered throughout the hospital" (p. 258). Even the vending machines were still full. Others wondered why a difficult route to evacuate patients downstairs, through a hole in a wall, and then up a parking garage to a helipad was used, when there was an alternative route to the rooftop directly from the seventh floor (p. 258). As noted above, why didn't Thiele and others who knew there was power in the cancer center think to move patients there? The extent to which their isolation was a mirage created by the impression of chaos and fear is demonstrated by the fact that King told a friend via his cell phone on Wednesday that he thought patients might be euthanized; this was repeated on NPR (national radio) on *All Things Considered*, the next morning, as Pou was euthanizing patients!

Barnbaum: The mirage of isolation and subsequent inability to effectively communicate led to ill-informed decisions, I agree. Among these bad choices were the triage decisions that determined the order of evacuation from the hospital, a point that Fink considers in detail. Fink is not an ethicist; as such, there are no expectations that she be consistent in her use of ethical theories, although she does an admirable job discussing many of the theories and concepts in the ethicists' toolbox. The result is a fascinating mixture of different theoretical claims throughout the book: Kantian and communitarian (both of which are discussed above), as well as utilitarian. Fink spends a great deal of time looking at the history and practice of medical triage, including the 1962 *LIFE Magazi*ne story of the "God Committee," which exposed suspect methods for allocating scarce dialysis treatment (p. 139). Triage is, at its base, a utilitarian concept (p. 142–45): What is the best way of managing scarce resources so that the best outcomes for persons can result? One of the greatest mistakes at Memorial was the decision to *first* evacuate the healthiest patients, as well as hospital employees and their families who took shelter in the hospital, before evacuating the sickest patients. The result was that as the situation became increasingly dire, the neediest patients remained. This fateful decision stretched resources, undermined morale, and ultimately contributed to the death of many patients.

Roxburgh: Yes, the definition of patients as "3's"—the most severely ill, machine-dependent, and difficult to move—played a significant role in explaining what went wrong at Memorial. After the command team decided to employ a numbering system to classify patients by evacuation priority on Wednesday morning, and then moved most patients to a staging area near exit points on the first and second floors, those patients awaiting evacuation received very little treatment (p. 139). The importance of not allowing a definition to dictate action is precisely why, as Fink notes, this method of triage requires a system of continual re-assessment of each patient as the emergency situation evolves (p. 141). When Mark LeBlanc arrived by boat on Day 3 to see his mother, and asked why his mother had not received hydration, he was told that she could not be provided with intravenous fluids because the hospital, as you said above, was "in a survival mode now, not a treating mode" (p. 137). This was ostensibly the reason nurses were told not to give patients IV fluids, or even their routine medications (p. 187). Fink quotes multiple people reflecting on the appearance of patients waiting to be evacuated on Day 4 and Day 5 as looking close to death—but this was probably because of dehydration, which can certainly have the effect of making already frail patients look as if they are near death. It's also important that the LifeCare unit, the unit on the seventh floor where many of the deaths are alleged to have taken place, was independent from the rest of the hospital. Not only was it organizationally and physically separate from the rest of the hospital, it was defined by many as a unit that treated the terminally ill and "hopeless" cases. As Fink notes, LifeCare was not a hospice, but it seems to have been viewed as one. For example, Cook told Fink that he thought LifeCare patients were "chronically deathbound" (p. 198).

At Charity Hospital structure and everyday routines were imposed in spite of the extraordinary situation. This had the effect of establishing a sense of normality, whereas at Memorial all semblance of everyday routines was dropped. In the absence of a sense of normality, many individuals seem to have drawn on violent movies and cultural tropes tainted by racism to make sense of the situation. For example, in an interview with Fink, Thiele recounts thinking that some sort of racial uprising might occur: "What would

they do, these crazy black people who think they've been oppressed for all these years by white people? I mean if they're capable of shooting at somebody, why are they not capable of raping them or, you know, dismembering them? What's to prevent them from doing things like that?," he asked rhetorically (p. 8).

From a phenomenological perspective, two other factors help us understand the situation. First, the smell. It's easy to forget how important smell is to our perception of social situations because the noxious smells associated with illness and with everyday bodily functions have been largely eradicated from our daily lives. By the fourth day, the smell of decomposing bodies, unwashed living bodies, overflowing toilets, unchanged diapers, and terrified pets that filled the hospital is described by Fink as "bestial." What most struck Arthur Schafer, assistant attorney general and the lead prosecutor on the Memorial case, was the smell of death: "If you'd smelled it, you could never forget it" (p. 258). In an interesting book about the history of cholera, Steven Johnson argues that the miasma theory of cholera persisted well past the accumulation of evidence that cholera was transmitted by water because of the sheer power of the smells of Victorian London. He points to research that shows that our extreme reaction to a certain smells—the immediate reaction is to flee—is probably an adaptive response because such smells are associated with significant threats, such as exposure to disease or the possibility of consuming contaminated meat.[6] My point is, of course, that the smell contributed significantly to the panic, fear, and irrationality that seems to have been circulating throughout the hospital along with the smells—the smell was yet another reminder that the everyday world of hospital life had disappeared.

A second issue concerns the possibility that desensitization to euthanizing patients was triggered by the euthanizing of some of the pets that had been brought to the hospital by staff. All three physicians—Cook, Thiele, and Pou—who Fink suggests were actively involved in euthanizing patients were also reported to have been involved in putting pets down. In the case of Cook and Thiele, these two events were only a few hours apart. Cook euthanized a dog and one of his daughter's cats and, within hours, he is alleged to have said to a nurse about a patient, "do you mind just increasing the morphine and giving her enough until she goes?" (p. 160). Thiele and another physician, Fournier, are also described as euthanizing two cats that had been left behind by their owners. The disturbing scene includes the assertion that, in the same room, "someone else" was injecting another cat, which was thrown out a broken window into the flood water below. Within hours Thiele assisted Pou in the injecting of the nine remaining LifeCare patients. He and Wynn prayed over a "heavyset" African American man, and then Thiele held a towel over the man's face (p. 292). By his own account, Thiele may have euthanized as many as four patients.

Barnbaum: You're suggesting that having first euthanized many of the animals, the physicians at Memorial then found killing human beings less objectionable. This view echoes one famously invoked in Kant's *Lectures on Ethics*. Kant did not believe that human beings had moral duties to animals, in virtue of their lack of rationality, but he also did not think it was morally right to be wantonly cruel to animals. The person who treats animals poorly today may well treat humans poorly tomorrow:

> If a man shoots his dog because the animal is no longer capable of service, he does not fail in his duty to the dog, for the dog cannot judge, but his act is inhuman and damages in himself that humanity which it is his duty to show towards mankind. If he is not to stifle his human feelings, he must practice kindness towards animals, for he who is cruel to animals becomes hard also in his dealings with men.[7]

It is notable that the euthanasia of the animals was undertaken prior to the killing of any of the patients. Did the permissibility of killing the animals create, in people's mind, a sense that killing the patients was also morally permissible?

Roxburgh: I think so. It probably contributed to the sense of desperation felt by many in the hospital because it added to the trauma and emotional fragility of both pet owners who had reached the point where they felt they had to have their pet(s) put down, and the trauma of physicians and nurses, who were unlikely to have been prepared for the emotional impact of euthanizing a dog or cat. To return to where I started, I think this could have been avoided with a proper chain of command—a team of people should have been put in charge of the pets that remained in the hospital.

Barnbaum: Before we finish, I'd like to consider the patients, and, in particular, the way in which particular ethical theory illuminates a point about the patients. Fink's book may be an example of narrative ethics, and one which calls into question some of the more problematic aspects of narrative ethics. Many of the characters are incredibly well-drawn. Pou is seen dancing at a fundraiser held on her behalf, raising specious rhetorical questions about the last remaining bottle of water in a crisis (as mentioned above, there was an abundance of bottled water onsite at Memorial), and on other pages, compassionately caring for a disfigured cancer patient. At one point Pou's story becomes the basis of a sympathetic ripped-from-the-headlines episode of the television drama *Boston Legal*. Pou is a complex character who is never seen as entirely all good or all bad. She is not alone: other physicians, nurses, the coroners, and investigators are all presented as full and complex, if not sympathetic, characters. I'd contrast their depiction with that of the patients who were killed, almost all of whom are portrayed as sainted martyrs. One seventy-nine-year-old, Jannie Burgess, was a former beauty who left an abusive husband and lost her only son in Vietnam (p. 32), an African-American nurse who selflessly cared for patients in the very segregated hospitals to which she could not be admitted. Another, Emmett Everett, has a ceaselessly cheerful personality, waking to the expectation that he will finally be evacuated from the hospital with an exuberant "Let's rock and roll!" to his doctors (p. 461). Certainly there is a way to express that none of these patients deserved to die before their time without making each of them flawless

and angelic. Fink seems to recognize that stories, such as the one told in the *Boston Legal* episode, can significantly affect whom we empathize with, and ultimately what we think is morally right or wrong. Fink, however, falls prey to some of the same biases in her own narrative.

Roxburgh: I agree that patients who died are beatified, but perhaps Fink doesn't feel the need to present them as three-dimensional people because we don't need to try to understand their actions, the way she wants us to understand the actions of the nurses and doctors who remained at Memorial during the crisis. I appreciate her efforts in that regard—as I said earlier, I don't want to relieve Pou and others of their moral and legal responsibility, but I did come away from reading the book with a deep understanding of why the situation unfolded as it did. In terms of the patients, I think it significant that they are infantilized and silenced during the crisis, by Fink perhaps, but most certainly by nurses and physicians. There doesn't seem to have been any discussion about communicating with patients about what their wishes were or what was happening to them. This would have been possible for some of the patients—definitely in the case of Everett, but probably for others, such as Rosie Savoie. Schafer refers to Everett as the "poster child" of the case. But it's more important that he was obese, poor, and black.

Final point: Fink provides some discussion in the epilogue about the measures that should be taken to avoid the Memorial situation in the future. I think the solution would require only small adjustments—the fact that the situation at Charity was so much better, in the same disaster, supports this view.

Barnbaum: You started our discussion by saying that you wanted to focus on the "lessons learned" from the experience at Memorial. If I were to use this book in a class, I would focus on the morality of the agents' actions, and their moral psychology, but I would certainly end my discussion by talking about the lessons learned, and how people can hope to do better when the next disaster strikes. And if I do use it in a class, a lot of what you've said gives me a new way of looking at the book.

NOTES

1. Vera, 151.
2. Foot, "The Problem of Abortion," 20.
3. Beauchamp, "Introduction," 12.
4. Thomas, *The Child in America*, 572.
5. Meidrotdt, "For Dear Life."
6. Johnson, *The Ghost Map*, 129.
7. Kant, *Lectures on Ethics*, 240.

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