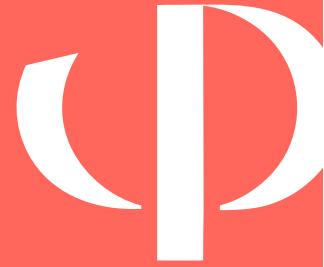


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APA NEWSLETTER ON

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MARY RORTY AND MARK SHELDON, CO-EDITORS

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FROM THE EDITORS

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Welcome to the spring 2015 edition of the *APA Newsletter on Philosophy and Medicine*. This volume of the newsletter contains some very thoughtful pieces on topics that have been with us for a number of years—enhancement, allocation of resources, the patient's will, how to think about disability, and care ethics. But each author makes clear how complicated the issues are and how much more attention and discussion is required in relation to these topics.

The first paper, "The Weight of the 'Will' of Competent and Incompetent Persons" by Jennifer Blumenthal Barby, focuses on a problem that has been with us from the beginning of the modern period of medical ethics. What weight should be placed on the will of competent and incompetent persons? She takes as her focus a recent paper by Daniel Groll and in her analysis advances the idea that the will is not "structurally decisive," as Groll argues, but more appropriately "substantially weighty." She points to the importance of ascertaining the status of the will, and thinking further about "the person's well-being."

In the second paper, "Moral Relevance in the Concepts and Language of Human Synthetic Moral Enhancement," Christian Carrozzo takes up a topic that also has concerned us for a long time, and that is "enhancement." But rather than focus on the issue of enhancement in relation to the question of justice in access, he focuses instead on the issue of "synthetically enhancing human morality," and here he takes on recent work in neuroscience, raising very fundamental questions about that work.

Further focus on enhancement occurred at the Central Division meeting in St. Louis on February 21, 2015. Fabrice Jotterand moderated a panel with contributions from Veljiko Dubljevic, Nicole A. Vincent, and Jeffrey P. Bishop. The panelists address the meaning of moral enhancement, current developments in neuroscience in relation to moral enhancement, and a description of philosophical and ethical questions posed by moral enhancement.

With Michael Boylan's paper, we move from enhancement to disability. In "Thinking about Disability via Agency and Human Rights," Boylan aims to re-think the "conceptual paradigm regarding disability." Two particular ideas he advances are the "Disability Fallacy," where we mistakenly identify a localized disability with the whole person. The other problem is if we inappropriately think about "fault" in relation to a person's disability. Avoiding both of these mistakes, he argues, we should begin to move in a direction where, in relation to the disabled, we eliminate negative liberty and enhance positive liberty.

Felicia Nimue Ackerman's wonderful poem, "You Are Old, Father William (with apologies to Lewis Carroll)," seems like the perfect poem to read before diving into the next section on care ethics.

"Care Ethics and Pragmatism: Care as Pragmatic Meliorism," by Justin Bell, and "Care Ethics and Pragmatism: Cultivating Empathy with Nonhuman Others through Moral Imagination," by Tess Varner, do at least two things. The first is that, making use of John Dewey's ethics, they thoughtfully develop care ethics in a way that permits more explicit or concrete engagement with persons. Second, they make clear a way in which the personal also becomes political, specifically political as in democracy. Varner sees "caring that can be implemented in communities and institutions," as well as beyond, to nonhumans.

In the final paper, "Rationing in the ICU, First-Come, First-Served?," Leonard Fleck considers propositions put forward by the Bioethics Task Force of the American Thoracic Society that should serve as a basis for allocating space in the ICU. Fleck focuses on proposition number six, which endorses the principle of first-come, first-served. Through a series of examples, he raises serious questions about what weight this proposition should actually have.

The last word from the editors. We are always looking for book reviews for the newsletter, works in progress, stories, and poems. Please send them to us, and feel free as well to comment on any of the papers that appear here. We will publish them in the next issue. Even though the newsletter only appears twice a year, we are always happy to include a sustained focus on a topic that might not otherwise get the attention that it needs.

FROM THE CHAIR

Different Notions of Equality in Political Philosophy and in Public Health

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Should we be bothered by the following variance? In political philosophy and in economics, unfair inequality is usually assessed between individuals. You have more than I do (through no fault of my own), and that's unfair. By contrast, in public health and in sociology, unfair inequality is most often assessed between groups. More is concentrated among people of your class or race than among people of mine, and that's unfair.

If you're an egalitarian, should you change political philosophy, to bring it in line with public health scholarship and practice? Or should you change the latter, to reconcile it with political philosophy?

Public health experts often explain that not every inequality between individuals is an "inequity" (as they put it). Only inequality between groups marked out by consistent disadvantage, such as many different races and classes, is unfair. Only such inequality stems from partiality, discrimination, and oppression. Only it correlates with certain inequality-related population health problems. It alone is actionable. They contrast this with inequality between individuals, for example, in longevity. The latter, they argue, is natural, inevitable, less important, or otherwise less informative—not unjust.

Egalitarian public health experts can mobilize powerful examples in support of their position. Intuitively, there is something undeniably unjust about the higher risk of an African-American child dying in any given period, in comparison with that of a white American child: roughly, 1.5 times higher. That intuitive injustice may initially seem easy for luck egalitarian political philosophers to explain: because children should not be held culpable for any choices, and because dying is disproportionate to even the most culpable acts, it is particularly clear that this inequality is not justified by the disadvantaged party's own choice or fault.

However, who is the disadvantaged party here? Not any particular African-American child, at least not in any straightforward way, because most do not die. Should we say, then, that one race is worse off than another through no fault or choice of its own—and that injustice inheres in *that*? Should we say that interracial gaps are sufficient for inequality of status, and that the injustice inheres in *that*?

What should luck egalitarians, democratic egalitarians, and other egalitarian philosophers make of this challenge?

My own position is that the public health experts' approach is often useful, but remains entirely compatible with fundamental concern for equality between individuals.

The political philosophy tradition is philosophically correct. Defending that position, however, is a task that I shall leave for another day.

ARTICLES

The Weight of the "Will" of Competent and Incompetent Persons

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In a recent *Ethics* article, Daniel Groll takes on the important project of examining, clarifying, and re-conceptualizing the roles that the wills of competent and incompetent people should play in third-party deliberations about their welfare.¹ Groll's argument has two major points: (1) we can fail to respect a competent person's will even if we are acting in accordance with it/not overriding it (i.e., we can fail to treat his will as "structurally decisive"), and (2) there are ways in which an incompetent person's will should play a role in third-party decisions about how to act towards him despite the fact that he is incompetent (i.e., his will should be "substantially relevant"). In this paper, I argue against Groll's claim that respecting a competent person's will requires treating it as structurally decisive. In fact, I argue that treating the will as structurally decisive as Groll describes it actually disrespects a person's will. I will also argue that Groll's argument about the role that incompetent persons' wills should play faces a dilemma: either he takes a position that is underdeveloped and sufficiently vague to offer little to no practical normative guidance, or he takes a position that is not at all new and affords the will itself a very small role, contrary to his claim to give it a substantially relevant role.

Before beginning, it is worth briefly explaining Groll's motivation. Groll is motivated by two things: first, by what he perceives to be an unclarity about what role an incompetent person's will should play, since some clinicians and scholars think that "his current wishes count for nothing," and others think that "respecting the patient's will (or respecting his autonomy, as it is sometimes put) is still centrally important in deciding what to do, even though proponents of this idea admitted that the patient was incompetent."² Second, he is motivated by an opposition to the predominant view that the only way we can disrespect a competent person's will is by acting contrary to it (e.g., overriding someone's choice or action, or forcing him to act or forbear).³ Groll believes that there are other morally important ways that we can fail to respect a competent person's will even if we follow it; namely, we can fail to treat it as [structurally] decisive.⁴

TREATING COMPETENT PERSONS' WILLS AS "STRUCTURALLY DECISIVE"

According to Groll, failure to respect a person's will occurs when we behave in a way towards that person *in part* because the person wills it, and in part because there is

more good to be produced from following the person's will than from overriding it. The example that Groll gives is a physician who accepts his [competent] patient, Bob's, wish to refuse a PEG tube, but who does so in part because the refusal is the patient's wish *and* in part because she thinks that overriding the patient's wish and placing a PEG tube against his will would do more harm than good. In order to have respected the patient's will, Groll argues, the physician should have accepted the PEG tube refusal *just because* the patient willed it.⁵ To consider whether or not the PEG tube, even if inserted against the patient's will, would do more harm than good for the patient is to have, what Bernard Williams would call, "one thought too many."⁶ To respect a person's will, we must treat it as "structurally decisive," according to Groll, which is to abide by it *just because* it is her will.⁷

Groll's concept of "structurally decisive" is going to be the main target of my analysis, so it is worth making sure that we fully understand the concept. According to Groll, to treat a will as *structurally decisive*, which is normatively how one always ought to treat a will expressed by a competent person about actions concerning his own person, is

To treat it as a "sufficiently weighty consideration" (697), "determining the course of action" (699), "authoritative" (700), "an order" (701), and "grounding a legitimate demand" (701).

To not weigh it against other considerations (700), to treat it as "supplanting the reason-giving force of other considerations not because it outweighs them but because it silences or excludes them" (701), as "trumping whatever other considerations are on the table" (701), and as insensitive to considerations of the person's good (701), for those appeals are irrelevant. (702)

Groll writes that his point "basically amounts to the claim that some practical reasons function to silence, or preempt other considerations, and this is the idea behind the conception of someone's will being structurally decisive."⁸

In what follows I will argue that Groll's picture is *not* the normative position that we ought to adopt towards a person's will. I will argue that respect for a person's will requires attitudes and behaviors that result in a picture that is very different from Groll's structurally decisive one.

AN ALTERNATIVE TO "STRUCTURALLY DECISIVE": SUBSTANTIALLY WEIGHTY

Harry Frankfurt famously distinguished between the will as "first order desire," the will as "second order desire," and the will as "second order volition."⁹ Whether or not one is persuaded by Frankfurt's hierarchical theory of free will, there are undoubtedly important normative differences between the different "types" of will that Frankfurt discusses, which Groll's account ignores. To briefly recall Frankfurt's distinctions, Frankfurt argues that a unique characteristic of persons is that they have the ability to reflect on their drives and desires (i.e., on their "first order desires"), and to take a stance on whether they want to have them (i.e., to form

"second order desires"), and determine which of them they want to be effective in their actions (i.e., to form "second order volitions").¹⁰ Thus, a smoker may have a first order desire to smoke, and may or may not want to continue to have that desire, but may not want that desire to actually be effective in his action. In other words, he might have a second order volition not to smoke even though he has a first order desire to smoke (and possibly even a second order one).

To transfer these distinctions to Groll's example of Bob, the competent patient who is refusing a PEG tube after a stroke, we know that Bob has a first order desire to avoid the PEG tube because he tells us so, but we know nothing about why he has that desire, what his stance is towards that desire, and whether that is the desire that he wants to be effective in action. In other words, we know nothing about Bob's second order desires and volitions. Imagine, quite plausibly, that Bob is refusing the PEG tube because he is scared or because he overestimates the duration and intensity of his negative feelings about life with a PEG tube. This is not to say that Bob is not competent, for as Groll notes, Bob fully understands and appreciates the risks and benefits of accepting and refusing the PEG tube.¹¹ I would argue that we should *not* treat Bob's "will" as structurally decisive as Groll describes. Far from treating his "will" as authoritative, we should instead challenge Bob's will, pointing out to him that the PEG tube would save his life, and that he should re-weigh this good and his "will" to avoid the unpleasantness of the PEG tube. We should dig deeper, challenging Bob to articulate his fears and concerns, pointing out to him that research indicates that people tend to overestimate the length and duration of their negative feelings and underestimate their power to adapt. Far from taking his will to be a silencer, a conversation ender, we should take his will to be the beginning of a conversation about the other reasons that Bob might have to accept the PEG tube, including reasons that have to do with his own good. Bob's "will" to not have the PEG tube should be weighed, by Bob, with our input through exchange and dialogue, against the good that is his life. Bob's life is not necessarily the ultimate good, but it is certainly not a good whose reasons in support of it should be silenced.

In putting forth the normative stance that we should take towards Bob's or any competent person's will, I am reminded of Diana Meyers's "skills-based, process view of autonomy."¹² The purpose of the skills that Meyers lists is to "[h]elp differentiate one's own desires, values, and goals from the clamor of subordinating discourses and overwhelming social demands and how one can articulate and enact one's own desires, values, and goals."¹³ The skills that are employed towards this aim are introspection skills, communication skills that enable individuals to get the benefit of others' perceptions and advice, memory skills that enable one to recall similar experiences, analytical and reasoning skills that enable individuals to assess the merits of the different visions of what their life could be like, self-nurturing skills, volitional skills that enable individuals to resist pressure, and interpersonal skills that enable individuals to join forces with others and challenge and change cultural and institutional arrangements that pathologize or marginalize certain persons or projects.¹⁴

The idea basically amounts to the claim that ideally the will is something that is formed and maintained by some sort of reflection process and by communicating with others to get their advice and perspectives. Challenging a person's will, I would argue, enriches the epistemic and normative value of it, and is far from disrespectful.

Groll might respond that he does not mean for his account to preclude the sort of challenging that I have just advocated. In fact, he even writes in a footnote that respecting Bob's will "[i]s consistent with thinking that she [the doctor] ought to try to persuade Bob to change his mind."¹⁵ Groll could claim that his account of structurally decisive just applies to the "end of the day" way in which we treat a competent person's will respectfully. That up until final decision time we can challenge a person's decision, critically engaging them with other options, arguments, empirical evidence, and other methods of persuasion.

I do not, however, think that Groll's account of structurally decisive treatment is compatible with this. He stresses, "The account I favor doesn't pin the issue of permissibility to whether the paternalized subject has authority with respect to the choice/action in question. Instead, it pins it to the attitude of the person who does not treat the other person's will as structurally decisive."¹⁶ And that "the key question, then, for judging whether an instance of paternalism is (im) permissible turns on whether the paternalist is (partly) moved by the belief that her judgment is needed as a check or possible corrective on the judgment of the paternalized subject, and that this is at least part of why the paternalized subject's will is not treated as structurally decisive."¹⁷

Groll could also argue that he is not making any larger normative claims about what one ought to do all things considered. He is articulating requirements for respecting a person's will, but perhaps there are cases where the morally right thing to do is to *not* respect the person's will in order to achieve some other good such as the person's well-being. This could be right but there is no indication that Groll believes this. All of the evidence points to the fact that the will trumps everything, so long as we are talking about a situation where there are no harms to third parties, of course. Moreover, it would be an odd position to hold (and to have worked hard to establish) that it is disrespectful to fail to treat the will as structurally decisive, but then conclude that perhaps respecting the will is not so normatively important after all.

All this having been said, I think that Groll is correct that we can fail to respect a person's will if we fail to give it proper due. What I do not think Groll is correct about is that the way to respect "the will" is to give it some sort of silencing power. There is something in between disregarding someone's will as part of the consideration of how one should act towards them and making it the only consideration on which one acts. Put simply, I think Groll over-corrected. What he should have said is that in order to respect a person's will it must count as a *substantially weighty reason* in third-party deliberations about how to behave towards that person. Moreover, he should have paid attention to the Frankfurtian distinction between will as first order desire or drive, and one's stance towards the

desire or drives one finds oneself having. Surely it is the latter type of will that has the normative force that Groll attributes to "the will," yet his account makes no mention of this.

TREATING INCOMPETENT PERSONS' WILLS AS "SUBSTANTIALLY RELEVANT"

Groll's second major argument is that there are ways in which an incompetent person's will should play a role in third-party decisions about how to act towards him despite the fact that he is incompetent (i.e., his will should be "substantially relevant" and not just for reasons derivative of well-being, that it would make him happy).¹⁸ I will argue that Groll faces a dilemma in this line of reasoning: either he takes a position that is underdeveloped and sufficiently vague to offer little to no practical normative guidance, or he takes a position that is not at all new and affords the will itself a very small role despite his claim to give it a substantially relevant role.

Groll argues that when dealing with an incompetent person, third-person parties should be guided in part by what the person wills *because* he wills it.¹⁹ In Groll's terms, the incompetent person's will should still be treated as "substantially relevant."²⁰ Groll gives the example of Carl, who, like Bob, needs a PEG tube. But unlike Bob, Carl is incompetent. He is confused about where he is and why, and he does not understand the risks and benefits of refusing and accepting the PEG tube.²¹ Nonetheless, Carl does not want the PEG tube. What the physician (or rather, Carl's legally designated surrogate decision maker) should do in this case, Groll argues, is think about how following Carl's will contributes to his greater overall good, noting that overriding people's wills generally upsets them.²² When thinking along these lines, the physician or the surrogate is letting Carl's will play a substantially relevant role, even though Carl is incompetent.

Now, Groll admits that the role that the will is playing here is a minor role, derivative of the impact that overriding it versus following it has on well-being. But Groll argues that the will has a much more powerful, "non-derivative," role in determining how we third parties ought to behave towards incompetent Carl.²³ Groll writes, "[I] want to suggest that there is a second, and less obvious, way the incompetent patient's will can contribute to his good: it can do so non-derivatively, that is, simply in virtue of being followed."²⁴ Complicating Groll's claim is his admission that "Some incompetent patients cannot plausibly be said to have wills at all. Others perhaps do but they are sufficiently distorted by mental illness or some other affliction that we accord following them no non-derivative value."²⁵

There are two problems with this proposal. One is the lack of any account of *why* the incompetent person's will has non-derivative value such that it is in some way fundamentally good. But perhaps more concerning for the realm of medical ethics is what the theory would mean in practice. The first task in implementing this account in practice would be to decide where Carl falls in the "will spectrum" (e.g., not having a will, having a will that is "sufficiently distorted" to have no non-derivative value,"

having a will that is distorted or impaired in some way (after all, he is incompetent) but not enough to have no non-derivative value). But Groll gives us no guidance on this key determinant of what sort of role Carl's will should play. The closest guide he gives us is to say, "One might . . . have enough of a picture of how one's life should go to have autonomy be a constituent part of one's well-being."²⁶ But this is unhelpful. Does Carl have "enough" of a picture about how his life should go, a picture that is expressed in his statements about not wanting to have a PEG tube, to have a "will that has some non-derivative value"? All that we know about Carl is that he is confused about where he is and why and that he does not understand the risks and the benefits of the PEG tube. Even if we could identify where on the "will spectrum" Carl falls (e.g., having a will that is "somewhat" distorted but still retains some non-derivative value), this characterization is not action-guiding. Our second task would be to decide how to behave with respect to Carl, and the position that his "will" ought to have "some" non-derivative value is sufficiently vague to offer little to no practical normative guidance.

Groll seems to recognize the problems with the non-derivative role of an incompetent person's will, for he immediately turns back to the derivative thesis, writing that "Even if one rejects this idea, the first, uncontroversial point about how following an incompetent patient's will can contribute to his well-being is all I need for the central contention I'm making here, namely, that it can make perfect sense for the surrogate to give considerable weight . . . to Carl's will, to the point of doing what Carl wants entirely because he wants it."²⁷ But it is incorrect to characterize the "because he wants it" (i.e., the will) as doing the heavy lifting as far as reason-giving power goes. If the surrogate follows incompetent Carl's will, it will be because not following his will *upsets him*, or causes more harm than good. Thus Groll has a dilemma. Either he holds that the will of an incompetent person has a non-derivative role to play, in which case, he is saying something new and giving the will a substantial role, but offering a position that is ungrounded and offers limited practical normative guidance. Or, he holds that the will of an incompetent person has only a derivative role to play, in which case he is saying something that is not at all new and is offering a position that affords the will itself a small role. Neither of these is necessarily bad, but not what Groll is after.

I say "not at all new" because in deciding how to behave with respect to incompetent patients, clinicians and scholars *already do* consider exactly what Groll proposes, namely, the question of whether there is more good to be produced from following the patient's will than from overriding it. In other words, they already do treat the wills of incompetent persons as "substantially relevant." It is for this reason that in psychiatric inpatient units, patients, even when incompetent, are not strapped down and injected with medications against their will unless they are at risk of immediate harm to self or other, or that when a patient who lacks decision making capacity refuses a surgery the clinicians try to wait out the situation as long as they can as opposed to wheeling her into surgery at that moment. In these cases, it is not the patient's will as such that is the central normative concern (or playing a large reason giving

role), but the patient's well-being and the extent to which overriding his or her expressions (or "will"), even when incompetent, would cause him or her physical distress or harm. And this is the exact sort of role that an incompetent person's will should play in third-party deliberations about how to treat him.

CONCLUSION

I have argued that Groll's account of the role that competent persons' wills should play in third-party deliberations about their welfare should be rejected. Treating a competent person's will as "silencing" (i.e., as "structurally decisive") fails to enrich the epistemic and normative value of it. Moreover, doing so fails to allow us to answer questions about the status of the "will," which is certainly of relevance to the question of the weight that the person's will should afford. Respect does not require that the will be treated as "structurally decisive," as Groll argues, but merely as "substantially weighty," where the weight is determined by considerations of the status of the will, in addition to the person's well-being. I have also argued that Groll's account of the role that incompetent persons' wills should play in third-party deliberations about their welfare is in need of an explanation of the threshold at which an incompetent person's will no longer has any "non-derivative value," and is also in need of an account of how having "some" non-derivative value would translate into actual practice with respect to giving incompetent persons' wills weight. Finally, I have argued that Groll's proposal that incompetent persons' wills have derivative value in third-party deliberations about their welfare is not as novel as he presents it to be, but is the predominant way in which incompetent persons' wills are considered in such deliberations.

NOTES

1. Daniel Groll, "Paternalism, Respect, and the Will," *Ethics* 122 (2012): 692–720. I am aware that generally the terms "competent" and "incompetent" refer to legal designations of persons' abilities to manage their lives in several broad areas (e.g., financial, health), and that the more appropriate terminology in clinical setting (and what Groll likely means) is "capacitated" and "incapacitated," but I use the terminology that Groll uses since I am reconstructing and evaluating his arguments.
2. *Ibid.*, 694.
3. *Ibid.*, 696.
4. Groll also believes that the "contrary to will criterion" for disrespect has two additional limitations. First, it cannot account for how we could disrespect the will of someone with no will since there is nothing to act contrary to. Second, it cannot account for how we could disrespect the will of someone by doing things that just happen to accidentally accord with her will. *Ibid.*, 698.
5. *Ibid.*, 700.
6. Bernard Williams, *Moral Luck* (Cambridge University Press, 1981), 19.
7. Groll, "Paternalism, Respect, and the Will," 701.
8. *Ibid.*, 701, fn. 19.
9. Harry Frankfurt, "Freedom of the Will and the Concept of a Person," *The Journal of Philosophy* 68 (1971): 5–20.
10. *Ibid.*
11. Groll, "Paternalism, Respect, and the Will," 692.
12. Diana Meyers, *Gender in the Mirror: Cultural Imagery and Women's Agency* (Oxford: Oxford University Press, 2002), 19.

13. *Ibid.*, 20.
14. *Ibid.*; Diana Meyers, "Intersectional Identity and the Authentic Self: Opposites Attract," in *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*, ed. D. Mackenzie and S. Stoljar (Oxford: Oxford University Press, 2000).
15. Groll, "Paternalism, Respect, and the Will," 692, fn. 2.
16. *Ibid.*, 717.
17. *Ibid.*, 718.
18. At times, Groll argues for something even stronger than "substantially relevant"—namely, that the wills of incompetent persons should be treated as "substantially decisive" (705). He seems, however, to backpedal on this in a footnote where he writes, "It is, of course, possible that Carl's will figures as a weighty, or merely relevant, part of his good without being decisive in my sense. In such a case, we might call his will substantially relevant . . . my central point . . . goes through even if in almost all cases an incompetent person's will is merely substantially relevant" (705, fn 29). (Carl is the name of the incompetent man in the PEG tube example described in the next paragraph.) Substantial relevance is a more conservative and less problematic position than substantial decisiveness, and so for purposes of charitableness, I characterize Groll's position as substantial relevance for my analysis.
19. *Ibid.*, 702.
20. *Ibid.*, 699.
21. *Ibid.*, 700.
22. *Ibid.*, 703.
23. *Ibid.*, 704.
24. *Ibid.*
25. *Ibid.*
26. *Ibid.*
27. *Ibid.*, 705.

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Moral Relevance in the Concepts and Language of Human Synthetic Moral Enhancement

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Philosophers and neuroscientists contributing to the literature on human synthetic enhancement are increasingly concentrated on its ethical implications. Synthetic human enhancement broadly concerns itself with cognitive, motor, or other effects on some human biological function, achieved by modalities other than the traditional. Although this increasing body of important work is well received in light of its worthwhile contributions to many traditional

problems in moral philosophy,¹ and though its original thesis appears relatively modest, as the literature expands and specific concepts and language begin to concretize as those most relevant and articulate, increasingly, confusion has also emerged as a result of what appear to be differing understandings and use of some of the core terms and concepts. This is more evident when the issue becomes more metaphysically focused on *synthetically enhancing human morality*, because of its conceptual, highly relativistic, and psychologically nuanced language, and its employment of questionable scientific assumptions, sometimes resulting in objectionable inconsistency or incoherence.

Modalities of human synthetic enhancement are often only explored for their relevance to such matters of social equity as access, but are often dismissed as having any other legitimate moral relevance.² This seems rather peculiar in my view, as some neuroscientists, geneticists, and chemists, not to mention bioengineers themselves, whether or not their professional designations involve bioethics, specifically engage in research conducted to inform or directly assist in the development of biotechnologies. Philosophers, and certainly those under the expanding umbrella of neuroethics, guide their moral investigations and to some degree determine the borders of their specializations by those very technological advancements, usually in the form of some new synthetic modality.³ Bypassing an analysis of modalities seems to miss the point as to why these specific developments, demanding such contemporary academic rigor, are presently salient to a significant interdisciplinary stratum concerned with value-based social import. No one has entered the human and moral enhancement debates to discuss the ethical dangers or the scientific plausibility of *traditional* modalities like education, socialization, rehabilitation, and so on. It is only the invasiveness and abruptness of bioengineered *synthetic* modalities for human and moral enhancement, alongside what some believe is their potential for elevating human moral status to a degree hitherto unknown, that have generated new questions regarding what ethical consequences could result, and whether we are being coherent (or responsible) in debating such propositions at all.

To be clear: this paper is not intended to address the proposition of human synthetic enhancement in general, nor any moral responsibilities said to be generated from that general proposition, such as the occurrence of a synthetically driven, dramatic acceleration of cognitive functions, with which, some have argued, our traditional moral development would have trouble keeping pace;⁴ or the use of such possibly effectual but potentially unsafe biologically invasive methods, as opposed to traditional means. I do not specifically address their implications for health, access, or the social and political oppression of any resulting theoretical sub-group of the "unenhanced." In fact, this paper does not address the normative question of whether or not human synthetic enhancements *ought* to be pursued at all. Certainly, an answer to the general question of the societal and moral appropriateness of the human inclination to synthetically enhance I believe to be evidenced historically both in that very inclination itself, as well as in present human practices reflective of it.

Rather, the purpose of this essay is to examine the moral relevance of some general modalities and whether those *traditionally* conceived as relevant to the development of moral character can lend coherence to notions of moral enhancement as accomplished by *synthetic* means. That will be addressed both directly and through an examination of some problems with the common use of certain relativistic concepts, namely, *moral status* (when understood as defined by a threshold of personhood) and the term *enhancement* (when understood as an improvement). The essay also serves as commentary on the possible need to accept what I call a disintegration of traditional metaphysical concepts through scientific reduction for the sake of interdisciplinary conceptual coherence, and the importance of employing accurate scientific knowledge (or at least scientific prudence) when discussing proposals which can be subjected to charges of fanciful science, or even fiction.

MORAL STATUS AS A THRESHOLD CONCEPT

Within discussions of human synthetic enhancement are concerns over moral enhancements so profound they could lead to the creation of a new tier of moral status—one previously unknown, perhaps even beyond that of mere humans. Such speculations are often supported by the notion of biotechnologies that could somehow make us ontologically transcendent of our own personhood, creating “post-persons,” “supra-humans,” as it were. This may sound like science fiction, but the concern arises from how moral status traditionally (though not without bioethical controversy) has been attributed to beings. The two most significant categories of moral status are those of human and non-human beings, distinguished by criteria largely sympathetic to those of personhood. Until recently, the two categories were mostly used to distinguish the moral considerations we give ourselves against those which we offer non-human animals. Allen Buchanan (2009) reminds us that moral status is commonly assumed to be equally distributed among humans; it is treated as a threshold concept when we adhere to the notion that personhood carries the core criteria for having it. That is, should something hold those cognitive features understood to be defining of personhood, then the moral status presently understood to be the highest is appropriately attributed equally to all who satisfy those criteria. The proposition is tricky because even the criteria associated with personhood remain unclear in terms of whether humans are the only ones who may lay claim to them, particularly the cognitive criteria. The problem is also in part philosophically inherited from the widely accepted Kantian notion that moral standing is determined by the capacity for practical rationality, which is peculiarly human. Generally, the criteria for personhood, and thus the justification for attribution of the highest known moral status, is understood to include rationality, the use of language, self-awareness, agency, and moral worth or moral standing. As Hauskeller (2013) notes, our general tendency to ascribe moral status is for the convenience of not running through this weighty list when indicating a difference in the capacities that strike us as morally relevant.

Although often used and defined interchangeably, an important distinction is made between moral *status* and

moral *standing* by Buchanan (2009). The concept of moral *status* is a comparative one; various beings may have different moral status. To what moral *standing* refers, on the other hand, is a matter of an appreciable and intrinsic moral claim on behalf of one’s values.⁵ The following may be a useful practical distinction. An ideal animal ethics notwithstanding, humans would seem to attribute moral *status* across all sentient things and in accordance with biologically informed moral values. But I can value an organism by as fundamental a biological virtue as it simply being a living thing, giving it moral standing without the need to project onto it a metaphysics of moral status. Or, I can choose not to intrinsically value an organism and merely value it for the food it will provide, or the practical assistance it offers, in moral disregard of its consciousness and thus its moral standing, obviating thereby any considerations of status, per se. This distinction, however, will help better define what role *moral status* could possibly play in the examination to follow.

Moral status is now topical for those exploring human synthetic enhancement because of the concern for the possibility of synthetically reaching a status beyond that which humans currently have, one which would then be understood to be the highest, creating new categories of beings, with the social and ontological implications already mentioned. Charges of science fiction aside, the term *status* in the context of human enhancement bears with it quite a few difficulties, most of which seem to come from the common assumption that it is a threshold concept. Buchanan believes that moral status as a threshold notion is the most intuitive appreciation of the concept. This may have been the case when the concept was mainly used in bioethical discourse to distinguish the moral position of humans over non-human animals, but it becomes problematic when discussing the potential effect of human enhancement to our present use of the concept.

Including non-human animals in our assessment of moral status satisfies the comparative quality requisite of the definition of a status, but it does so only by contrasting human with non-human beings. If we follow Buchanan’s distinction between status and standing, “two beings can have moral standing, but one may be of higher moral status” (2009), but also remain consistent with Kant’s criteria that in order to have moral standing a being must hold an appreciable capacity for practical rationality, then both those two beings must of necessity be human, and we are left only with human subjects between which to determine higher or lower status (and non-humans are left out of contention entirely since according to Kant they lack even base moral standing). This is, of course, contradictory to the “moral equality assumption” (Buchanan 2009), and therefore precludes any notion of personhood or moral status as a threshold concept, since it now appears we can establish different statuses among those persons and can no longer claim they have the same status by simply meeting the criteria for personhood. This, without the need of establishing a threat to that assumption by way of a new moral status category indicative of an even higher imaginative threshold, demanding of as yet undefined and unforeseeable criteria for supra-personhood as a result of human synthetic enhancement.⁶

If we follow what Buchanan reminds us is Bentham's view of moral standing under Buchanan's definition of the term, then the only criterion for moral standing is sentience, which would require our assessment of status then to be adjudicated across all sentient beings, human and non-human. This take on standing would seem to support a threshold notion, as it once again allows the criteria for personhood to be what defines a higher moral status for humans against all other sentient, non-human beings. Again, personhood is defined as demanding rationality, the use of language, self-consciousness, agency, and having moral worth or standing. In some ways the claim that these criteria are met only by human beings is simply biologically antiquated. The concept of rationality may be defined in a way in which it remains only applicable to human beings, but the use of language (which was claimed to be fundamental to our ability for rational thought),⁷ self-awareness,⁸ agency, and as we have just explored, moral worth or standing, are all capacities to some degree contemporarily verifiable—or at least biologically worth investigation—in non-human animals as well, evidence for the more appropriate notion that non-humans are located elsewhere than us, but nonetheless on the same continuum or gradient of personhood. If there is no threshold for personhood, then of what significance is attributing status at all, except to distinguish different *degrees* of facility and capacity for those things we say constitute personhood? And if this is the case, should not moral status also be on a gradient between all beings? Or if the use of the term status carries inherently the notion of a threshold, than why not do away with it entirely?⁹ Regardless of the truth of our ethical relations with other non-human beings, or with one another, this would appear the more appropriate appreciation in the twenty-first century.

Indeed, the notion of merely all humans (let alone non-humans) having equal moral status is an *ethical and social ideal*. How humans view and assess moral status is rarely consistent with such an ideal. Historical evidence of this is well exemplified by the ethical tradition of utilitarianism, the most broadly applied of consequentialist ethical theories, which has been formulated and adopted in explicit disregard of the "moral equality assumption," on its own moral grounds, for centuries. Surely, utilitarians take the view that moral status is a matter of moral considerability, and not a threshold concept. It is not the basic moral standing of what it is to be a person that guides a utilitarian decision to elect among many satisfying that basic criterion, who will be ethically sacrificed for the greater good. It is instead a definition and appreciation of a consequentialist greater good. As Buchanan at least theoretically speculates about how to define moral status for utilitarians, "there is only gradation, a continuum of beings with lesser or greater capacity for well-being and harm, and sacrificing some beings for the sake of others further along the continuum is always in principle not only permissible, but even required" (2009).

Interesting here is the ironic neo-Aristotelian notion about virtue theory as in practice fundamental to not only the development of contextually appropriate morality and moral character, but therefore also underlying a developed moral agent's structuring of any consequentialist theories,

including utilitarianism. Philosophers have indicated a belief that the *moral* aspect of an enhancement would likely come from an improvement to those cognitive capacities that "jointly constitute our practical reasoning," and as a result those enhanced would be "better informed, and better able to reason about relevant moral facts than we are,"¹⁰ perhaps determining themselves to be of higher moral status by virtue of something we can't imagine,¹¹ but nevertheless based on criteria indicative of an improved moral agency. Should we be convinced of a cognitive superiority in those enhanced, this would in no way indicate that they know things that we do not.¹² Those determined to have an enhanced moral status would still need to recognize and reason through the morally salient facts of any given matter; they may simply be better equipped in their capacity to do so. Assessing differing moral statuses among humans by way of utilitarianism is, of course, inconsistent with a virtue ethics, which although unfortunately contradicted by human practical realities would support moral status (regardless of what may be considered the most intuitive or contemporarily appropriate use of the term) as a threshold concept, as this would be most theoretically consistent with the precepts of its founding theory. Virtue, after all, defines and refines itself by the practical insistence on an *ideal*.

ENHANCEMENT AS IMPROVEMENT

This pushes us to an appreciation of the relativistic nature of the term *enhancement* itself. If we are supposedly measuring some type of improvement, betterment, or positive alteration, and depending upon what kind, that itself also requires ethical qualification by contrast to contextual particulars. This, I think, is further important when considering proposed synthetic alterations to traditional morality. Synthetic enhancements, by the nature of the modality, simply bypass any practical reasoning or moral prudence from which the agent develops anything directly contributive to his or her moral character as traditionally defined. As John Harris rightly points out, the kinds of traits or behavioral dispositions that lead us to "wickedness or immorality" (2010), are also those associated with the development of virtues and any sense whatever of a moral life.

How could moral agency be influenced synthetically? That presupposes a sufficiently adequate, reductive understanding of the biology behind moral agency, which would necessarily include coming to terms with science's current state of knowledge of related causal biological mechanisms, which is presently insufficient, if not contradictory, to the cause. At best, a proposal for synthetic *moral* influence at all would likely consist in affecting the outcome of moral deliberation by its effects on how we tend to behave. What cannot be said about a change in tendency is that an *enhancement* of any sort has necessarily occurred. Buchanan takes for granted the definition of the term as signifying to "augment, increase, improve, to make better" (2009). His claim is that enhancement is best understood in this context and in this way because it pertains strictly to affecting human biological capacities as evaluated only against the functional norm of those capacities, and isolated from external influence, accepting that it thus does not guarantee said improved capacities would "make us better, overall."¹³

Establishing a functional norm is clearly a metaphysical requirement for the concept of a functional enhancement. In my view, one cannot discuss any enhancement, in particular those that attempt to affect a socially influenced concept such as morality, as physically isolated, involving just the biological capacity only in contrast to that capacity's functional norm without dragging in at least some external, human-relational considerations. Even the pre-enhanced norm of that biological capacity is developmentally informed, at least in part, in accordance to human interactions with environmental particulars. Use of such language otherwise sounds suspiciously dualistic, as it would imply that environmental circumstances in effect during human biological development as physicalists understand it are distinct from what developmentally affects the mind. Certainly cognitive synthetic *enhancements* targeting the brain, the biological system responsible for the conceptual understanding and exercising of morality or, at a minimum, housing the psychological basis for our affective and behavioral dispositions, cannot be considered *moral enhancements as improvements* or as having made anything *better* through an isolated evaluation of the system and through a mere physicalist lens without some reference to the external factors that have biologically influenced its development and sustain its necessary *normal* function.

As mentioned, this paper does not address the general proposition of human synthetic enhancement's ethical implications, nor does it address transhumanism. This is not intended to be insensitive to the concerns of transhumanism, and we can certainly learn from a few specific examples of novel and sophisticated biotechnological applications in order to shed light on the moral relevance of human synthetic enhancement. Neil Harbisson was diagnosed with achromatopsia. He teamed with Adam Montandon, associate professor at Erhvervsakademiet Lillebaelt Academy, to develop a device that was subsequently implanted into Harbisson's cortex and protrudes externally from his brain while capturing with a small camera color data which is then interpreted by Harbisson as distinct sounds, each consistently representative of a distinct color.¹⁴ Harbisson's experience may have nothing to do with transhumanism due to the biotechnology in this case being of a corrective nature, rather than purposed to provide a human being with a capacity beyond what is considered normal (which is a standard precept of a transhumanistic modality), but it helps to clarify the moral relevance of modalities and the contextually relativistic charges against how to interpret a notion of *enhancement*. Although the specific kind of synthetic modality which he has chosen can clearly be said to have caused an alteration of an abnormal biological capacity to something more consistent with the human functional norm—an alteration which sufficiently meets Buchanan's biologically isolating definition of *enhancement as improvement*—part of why the enhancement is of value to Harbisson (i.e., why color was so important to him, why he doesn't mind an artifact semi-permanently protruding from his brain, why he accepts and enjoys the change in his thinking and cognitive processes, and so on) remains subject to his moral character, and that character remains developmentally subject to the complex variety of moral, social, and biologically influential particulars to which he

has been exposed throughout the course of his life. Any synthetic enhancement to any biological function will eventuate in a value judgment in the form of a comparison relative to what is considered normal. The key here is that what is *normal* is itself constituted by an assessment of the enhanced function within its extended environment, and that in turn is what allows the subject to which it has occurred to be able to call it an *improvement* or not, as defined by its relative social and moral import. A value judgment is necessary even within the most physicalist appreciation of any "enhancement" to biological function. Clearly, the demand for moral relevance is made more complicated when we claim to have achieved a synthetic enhancement to morality itself. Without a morally qualifying context, an enhancement is merely an alteration and not an improvement. The common definition and use of the term enhancement are taken for granted as value-laden because the term itself carries with it an anticipation of such a context.

REDUCING THE LANGUAGE OF MORAL ENHANCEMENT

Once we start speaking of morality in its psychologically defining terms, such as "behavioral and affective dispositions," we have already performed a partial reduction or translation, and therefore can be more clear about how synthetic, non-traditional modalities have an effect on those things. What may be a primary responsibility for those who wish to engage in scientifically coherent debates over the ethical implications of *moral* enhancement is the development of an agreed-upon conception of morality that detaches it from the traditional notion.

The concept of morality presently articulated in debates about synthetic enhancement is that conceived by traditional philosophy, the metaphysics and practical development of which can be found in virtue theory, and therefore conceptually disallow any synthetic modalities as relevant to moral character. Synthetic modalities, however, are appropriately scientific as they relate to affecting or assisting human biological functioning through scientifically developed technologies. *Morality* is not a human biological function. It would seem, then, that to hold coherent debates over moral enhancement by synthetic modalities requires that the concept of morality be subject to scientific reduction, a translation which could render the language of morality consistent with the language of the proposed biologically affective synthetic modality. Clearly, that is not an easy task, as it is tantamount to the neuroscientific goal of discovering biological correlates to those complex behaviors understood to be manifestations of human morality. However, it is one thing to accomplish this lofty goal, and another to sufficiently translate in order to begin to implement terminology which at our present stage of discovery we could claim is epistemically safe to use. Beginning to discuss moral character as "behavioral and affective dispositions" takes us a step in that direction, as we make the reductive move away from the language of moral philosophy (with all of its metaphysical hazards in a scientific context) to the language of psychology. We are now in the scientific realm, at least, and thus closer to being able to be coherent about synthetic, scientifically based

enhancements ever having an effect on something like moral character. Though not the project of this paper, one could then carefully continue the translation or correlation process from “behavioral and affective dispositions” to, for instance, known complex behavioral and emotional correlates to these dispositions at the neurological or endocrinal level, further developing a possible causal relation between proposed modalities known to affect these particular human systems. Again, although the necessary science has yet to arrive at a stage in which this kind of reduction can be completed, some scientists already use this terminology without invoking the metaphysics of morality as traditionally defined to complete their propositions. However, this, too, sometimes also results in tacit assumptions when dealing with complex philosophical concepts, adding to interdisciplinary incoherence. Two thousand and some odd years of moral philosophy in the old tradition could not anticipate the scientific revelations related to human function to which we are now being exposed, and which contribute to our reasoning and present investigations—things inconsistent with many prior metaphysical commitments. To employ a less than accurate or adequate knowledge of the relevant science in philosophical discussions over the alteration of particular human biological functioning, and to causally relate the consequences of those alterations to things metaphysical without something like an established reductive process which makes clear how the biological elements can be bridged to the features of what we understand to be the associated metaphysical concepts, would seem a less than productive philosophical exercise and rather scientifically obtuse.

The most problematic proposals associated with the pursuit of synthetic, scientifically based moral enhancement are any that suggest that what is to be enhanced is not simply (though there is nothing simple about it) moral character but specific *virtues*. In light of current promising biotechnologies, and initiating proactive efforts in research explicitly dedicated to applicable advancements, Mark Walker believes we may someday be capable of identifying *genetic* correlates to personality traits which psychologists have claimed to be related to aspects of human character, and manipulate them in order for their expression to result in an enhancement of those traits and thus, in his view, with enough specificity to affect particular virtues. In short, his proposed Genetic Virtue Program (GVP) is for a “research program designed to discover whether there are genetic correlates of virtue that are clear, strong, and open to manipulation.”¹⁵ Responses to this work of fiction, as Walker himself put it, were “largely unsympathetic.” This is a proposition the scientific basis of which is considered entirely erroneous by biologists, since genes play absolutely no role in encoding neurons, let alone complex human behavior. This was pointed out in response to Walker by Athena Andreadis, a prominent cell biologist, who claimed that “the notion that any complex behavior can be changed by pressing the button of a single gene is entirely unsupported by biological evidence of any scale, whether genomic, molecular, cellular, or organismic.”¹⁶

Any suggestion that virtues as traditionally conceived can be synthetically enhanced combines in the most

blatant and erroneous manner the two main dangers of incoherence I’ve attempted to articulate throughout this paper. Virtues, by definition, can only be acquired, refined, or enhanced by exercising our practical reasoning, with continued exposure to often highly complicated circumstances in which excessive and thus ethically objectionable dispositions of moral character are truncated in efforts to identify what is ethically optimal, leading to the identification of a more contextually appropriate good and thus an inclination to act in one manner as opposed to another. Nick Agar expresses his confusion about the use of the term virtue here as “slightly puzzling considering that the idea of moral enhancement seems against the spirit of virtue ethics. One of the central themes of virtue ethics is the importance of striking a balance.”¹⁷ To say that one is virtuous in the ways of justice is merely to say that one has been exposed to enough scenarios in which one has exercised this balance, despite circumstances that could have led one to react in either excess or deficiency of what would be considered morally appropriate. Here, again, are the conceptual problems we have already discussed related to the use of terms such as *moral character*, further complicating the metaphysical inheritance of our language by using the term *virtue*. A synthetic enhancement to be more *just* is incoherent, as the moral particulars must be present and subject to reasoning in order to determine what, in fact, justice *is* in any given case. Some conceptual reduction may be in order to either develop a new concept that can “converse” with scientific fact, or translate to terms which make the conversation coherent. Of course, there is no assurance that whether attempting this with morality, moral character, or something even more conspicuously problematic in light of its theoretical intricacies such as virtue would result in anything but the disintegration or all-out elimination of those concepts. This is perhaps something we should be willing to accept for the sake of being able to move forward with such investigations in a productive manner. Even if the science were anywhere near developing the precise capacity to identify personality subtraits correlated to the genetic expressions by which they manifest, in no way does that provide us with coherence when discussing matters related to synthetic *virtue*. As R. H. Sprinkle comments on what Aristotle himself would think in relation to genetic enhancement of moral character, “the enduring behaviors that we recognize as moral character or collectively as human nature—or even primate nature—must be counted as especially complex and unlikely to be reducible to single genes or to single dominant, co-dominant, recessive, or sex-linked alleles.”¹⁸ To entertain the possibility that *virtue* is able to be enhanced synthetically through *genetic* intervention takes both the incoherence problem between traditionally conceived moral language and biologically based concepts, as well as the issue of considering the ethical implications of fanciful science, to an unfortunate degree. There is great difference between discussing through conjecture the plausibility of the field of behavioral genetics someday reaching its as-of-yet theoretical and reductive goals of discovering complex behavioral correlates in single genes alongside ruminations of the morally relevant sort, and the proposal of a distinct interdisciplinary project to somehow synthetically enhance virtue for the sake of human good and the elimination of “evil,” as it were. Persson and Savulescu, having come

under attack for generating what may be interpreted as a similar moral imperative, at least concede responsibly to the requirement of significant advances in science before something like moral enhancement can happen.¹⁹

As William K. Frankena once put it, "I think that moral philosophers cannot insist too much on the importance of factual knowledge and conceptual clarity for the solution of moral and social problems."²⁰ Traditional concepts of morality and moral character are developed through traditional modalities, making their relevance to matters of moral enhancement central, and underlining the need for scientific translation if we intend to articulate a convincing and coherent causal relationship with synthetic enhancements. Reductive processes may be necessary even if they result in conceptual disintegration or the necessity for novel, interdisciplinary conceptions altogether. Further, certain philosophical considerations in all of this seem to be either significantly ahead of or sufficiently vague in relation to the norms of the science that would be required; or at times simply oblivious to what is in fact a particular scientific subject's present status. It may be a simple matter of philosophical prudence.

NOTES

1. Moral development and responsibility, human moral status and/or standing to include non-human animal rights and personhood, theories of knowledge and intelligence, to name a few.
2. This seemed to be the general consensus at the most recent meeting of the Presidential Commission for the Study of Bioethical Issues in Washington, D.C., focused on the ethical implications of human enhancements. In attendance as invited speakers were Peter Reiner and Nick Bostrom who, upon being asked by Commission Chair Amy Gutmann, conceded that the ethical implications of human synthetic enhancements could be analyzed without consideration for the source modality. Once this was concluded, the question of access was raised, at which point Peter Reiner amended his answer to say that all other considerations being equal (including access), modalities remained morally irrelevant. See <http://bioethics.gov/meetings>.
3. As may be obvious in the literature referenced, philosophers do not require the science to be anywhere as advanced as would be needed for a legitimately *normative* assessment of ethical implications in order to presently speculate on what implications *could* arise given certain kinds of biotechnological advances. Indeed, given the subject matter, some of these speculations have been charged with bordering on science fiction.
4. Ingmar Persson and Julian Savulescu, "The Perils of Cognitive Enhancement and the Urgent Imperative to Enhance the Moral Character of Humanity," *Journal of Applied Philosophy* 25, no. 3 (2008): 162–77.
5. As Buchanan further illustrates the point, Bentham's value of mere sentience led him to the ethical assertion that all such beings have moral standing. For Kant, it was his value of the capacity for practical rationality that determined whom (or what) he believed deserved this moral qualification.
6. Though explicitly not the subject of this paper, this rids us also of the necessity to fictionalize "post-persons" and the like on behalf of a new tier of moral status, and therefore avoids the social and political tyranny to the "unenanced" suggested by some to be a result of the creation of such beings. In light of an elevation on a continuum or gradient of the capacities known to define personhood, there could instead be great optimism for an enlightenment of sorts, as opposed to the pessimism of an expected oppression by new beings who would, though improved in their moral agency, somehow regard us unsympathetically. (Fair to both positions is the recognition that these contemplations are all, for the time being, quite fictional.)
7. See Bekoff, Kako, and Hauser et al. for studies related to the use of language or its cognitive precepts in non-human animals.

8. See Patterson and Cohn, and Parker et al. for studies related to self-awareness in non-human animals.
9. A possible third option in addition to the commonly debated *threshold* or *continuum/gradient* understanding of moral enhancement, referred to as *plateau*, is proposed by Douglas in response to Buchanan.
10. Nicholas Agar, "Still Afraid of Needy Post-Persons," *Journal of Medical Ethics* (2012). doi: 10.1136/medethics-2012-101095.
11. Agar calls this the inexpressibility problem.
12. Michael Hauskeller, "The Moral Status of Post-Persons," *Journal of Medical Ethics* 39, no. 2 (2013): 76–77.
13. Allen Buchanan, "Moral Status and Human Enhancement," *Philosophy and Public Affairs* 37, no. 4 (2009): 346–81. Assuming here that by "overall" he means once we evaluate the "enhancement" against the outside world and thus are able to weigh-in the ethical implications.
14. Liz Else, "A Cyborg Makes Art Using Seventh Sense," *New Scientist* 215, no. 2877 (2012): 50.
15. Mark Walker, "In Defense of the Genetic Virtue Program: A Rejoinder," *Politics and the Life Sciences* 29, no. 1 (2010): 90–96.
16. This isn't to say that the field of behavioral genetics has not seen its share of advances along with failures in reaching this goal. Athena Andreadis, "The Tempting Illusion of Genetic Virtue," *Politics and the Life Sciences* 29, no. 1 (2010): 76–78.
17. Nicholas Agar, "Enhancing Genetic Virtue?" *Politics and the Life Sciences* 29, no. 1 (2012): 73–75.
18. R. H. Sprinkle, "Moral Suasion, Installed," *Politics and the Life Sciences* 29, no. 1 (2010): 88–89.
19. Persson and Savulescu, "The Perils of Cognitive Enhancement."
20. William K. Frankena, *Frankena's Ethics*, Foundations of Philosophy Series (Prentice Hall, 1973), 25.

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Moral Enhancement

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Under the auspices of the Committee on Philosophy and Medicine, a panel on the topic of moral enhancement was organized at the Central Division meeting of the American Philosophical Association in St. Louis, MO, on February 21, 2015. The panel was composed of Nicole Vincent, Jeffrey Bishop, and Veljko Dubljevic, and was moderated by Fabrice Jotterand. The panelists were invited to address issues surrounding the philosophical implications of moral enhancement including 1) the background on the meaning of moral enhancement, 2) an update of the latest developments in neuroscience related to moral enhancement, and 3) the philosophical/ethical questions raised by moral enhancement. In what follows, each panelist provides a short summary of his or her presentation.

The first essay, by Veljko Dubljevic, suggests an approach to moral judgment (ADC model) and outlines its implications for the moral enhancement debate.

Implications of the ADC Model of Moral Judgment for the Theoretical Feasibility of "Moral Enhancement"

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The ADC framework (Dubljevic and Racine 2014a,b) proposes a novel integrative approach to moral judgment that could explain how unconscious heuristic processes are transformed into consciously accessible moral intuitions: it uses the heuristic principle of "attribute substitution" to explain how people make intuitive judgments. The target attributes of moral judgments are moral blameworthiness and praiseworthiness, which are substituted with more accessible and computable information about (A) an agent's virtues and vices, (D) right/wrong deeds, and (C) good/bad consequences.

The ADC framework has implications for empirical research of moral judgment and for the moral enhancement debate—namely, an important constraint was the question of the normative baseline according to which any "enhancement" effect can be measured. The standard approach assumes the epistemic authority of the dual systems model of moral

judgment (e.g., Greene 2008), which postulates that System 1 processes generate intuitive moral judgments, which are fallible, whereas System 2 processes generate deliberate reasoning. Moral enhancement, then, could consist in inhibiting the System 1, while at the same time enhancing System 2 processes (Persson and Savulescu 2012). Even those critical of the moral enhancement project seem to endorse this dual process view (see, e.g., Shook 2012). Indeed, this view resonates with traditional philosophical views—the idea that, in order to act morally, a person's rational side needs to prevail over the instinctive nature.

However, with the advent of the integrative ADC model and empirical support it garnered from cognitive psychology (Bialek et al. 2014), the dynamics of System 1 and System 2 processes in moral judgment are put in a different perspective: all moral judgments seem to be intuitive and heuristics driven. Thus, direct interventions that affect the environment-heuristic fit and perhaps motivation to act after evaluation has been performed are more likely to succeed.

Notwithstanding the practical limitations of moral enhancement (see Specker et al. 2014), the drive to supplant traditional approaches with evidence-based interventions to moral improvement has face-validity. However, even though there is some evidence that stimulants (e.g., Adderall) may offer motivational enhancement (Ranisch et al. 2013), an important implication of the ADC model is that most currently proposed interventions are "blunt instruments."

A different approach (more in line with the ADC view) involves aligning social norms with motivational "nudges" at specific, morally relevant decisions. The classic example concerns organ donation. Even though the vast majority consciously supports organ donation as morally laudable, the actual decisions are constrained by the environment-heuristic fit. Certain countries like Austria use an "opt-out" organ donation system (one is automatically a donor unless registering to not be). As a result, 99 percent of the population are registered organ donors. Other countries use a "consent-in" policy. The result is that a mere 12 percent are registered organ donors (Johnson and Goldstein 2003). As there is empirical support to the ADC approach supposition that "default heuristic" and social norm processing are connected (Everett et al. 2014), future research into empirical feasibility and normative applicability of the approach seems promising, especially in the context of the "moral enhancement" debate.

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The second essay, by Nicole A. Vincent, addresses questions related to the unexpected consequences of emerging technologies, with a particular focus on cognitive enhancement technologies.

OUTSMARTED: Cognitive Enhancement and the Unexpected Consequences of Emerging Technologies

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The presentation, delivered by Nicole A. Vincent, provided an overview of the four main ideas behind a book that we are writing under the same title as this talk. One, that without adequate regulation, cognitive enhancement may become a new "normal"—a de facto standard that pressures everyone to enhance themselves. Two, that such pressure would be regrettable since, in addition to eroding our freedom, it would also hand over control in shaping society to the invisible hand of competition. Three, that it is fruitful to understand such pressure to enhance as an unexpected social side effect of an emerging technology. And four, that risks of such social side effects are just as important as risks of medical side effects.

What binds these four ideas together is our contention that, to exercise adequate control over our lives, how we regulate emerging technologies should be informed by an ongoing—and, where possible, an antecedent—discussion about what kind of society would foster human flourishing. In contrast with the all too common disinclination in modern liberal democracies to build substantive political conceptions of the good into regulatory regimes, we argue that this is precisely what is needed for responsible human agency. To glimpse why we contend this, consider a stark contrast between debates over physical and mental performance enhancement.

The dominant stance on physical performance enhancement in professional sport is shaped not just by concerns about effectiveness, safety, and equity of access. Rather, it is also shaped by a clear vision of what sport is and should be about—namely, athletes, their efforts, and their achievements. Admittedly, many of the substances and techniques currently used are medically unsafe, and so regulators indeed implement bans on doping in part so that athletes do not feel pressured to dope just to remain competitive (because for all they know others already do, and so too must they if they wish to remain competitive). But note that reasons to retain anti-doping regulations in professional sports would remain even if doping was medically safe and available to everyone. For instance, we simply may not wish sport to become (even more) dominated by a technological and scientific arms race in which athletes and their achievements increasingly recede into the background.

Yet, such teleological and perhaps even aesthetic considerations are often marginalized in the debate about mental performance enhancement. The pressure to enhance by using side-effect-free and effective medications and devices is seen as morally on a par with professionals needing to keep their skills up to date. Cognitive enhancers are likened to caffeine and pain killers, which are viewed as innocuous. People who would rather opt out of cognitively enhancing themselves—especially once their concerns about safety, effectiveness, and equity of access are allayed—are ridiculed by enhancement enthusiasts as anti-progressive technophobic Luddites. And neither the desire to avoid a cognitive enhancement arms race nor a distaste for the vision of a faster-paced and more efficient future society where everyone enhances themselves to keep up with this new "normal" is seen as a legitimate reason for us right now to refrain from cognitively enhancing ourselves.

How we regulate mental performance enhancement has the potential to affect many aspects of how we live our whole lives. On the other hand, how physical performance enhancement is regulated affects human conduct in the domain of sport. And yet, despite the significantly higher stakes in the cognitive enhancement debate, paradoxically that is precisely where more resistance is encountered to recognizing the urgent need for regulation in order to avoid undesirable and to secure desirable social outcomes. In a way, such resistance to regulation in the broader context is understandable. After all, how we choose to regulate cognitive enhancement technology has the potential to have impact on so many aspects of our lives. But given that a "hands-off" approach to the regulation of cognitive enhancement simply hands over control in shaping society to processes that are unconcerned with human flourishing, we think that a hands-off approach is not just unwise but actually irresponsible.

Law and morality often play catch-up to science and technology. Scientific and technological developments shape our lives—often imperceptibly—by gradually changing our values and the moral, legal, and social landscape in which we operate as agents. Against this backdrop, our book's aim is neither to advocate for cognitive enhancement nor to portend of dystopic brave

new worlds that lurk around the bend, but to reflect on how development of this emerging technology should be regulated so that people flourish, rather than allowing its effects on society to determine how we shall live our lives.

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The third and last essay, by Jeffrey P. Bishop, looks at the context in which the debate over moral enhancement takes place.

Neuroscience and Other Political Schemes

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Neuroscience is really a combination of two distinct realms of science. On one side sits neurobiology, which has its concepts, theories, models, empirical methods, technical apparatuses, and statistical approaches to interpreting its findings. On the other side sits the psychological and social sciences, which carry their own concepts, theories, models, empirical methods, and statistical approaches to interpreting its findings. Neuroscience, then, is the attempt to bring together these two distinct sciences and to attempt to find statistically significant correlations between them. The social and psychological sciences have been known to carry both political and moral valence into their creation of conceptual and operation definitions for the objects of their interest. For example, Jonathan Haidt, a developmental psychologist, and Paul Zak, a neuroeconomist, both trace their intellectual heritage to Hume's theory of moral sentiment; thus they carry with them into their conceptual and operational definitions, as well as their experimental models, a certain kind of moral valence.

Of course, there has been a long history of attempting to understand moral behavior through the lens of psychiatry or neurobiology. In fact, immoral behavior seems to have been defined conceptually as antisocial behavior, and antisocial behavior seems to have been operationalized along the lines of psychiatrically grounded tests for impulsivity, sociopathy, and psychopathy. Thus, we find studies like those of Meyer-Lindenberg et al., who claims to have found the missing link between the genome and the behavior in the neural substrates of brain structure and function. On the positive end of morality, Meeks and Jeste conceptualize wisdom, in part, as prosocial attitudes and behaviors, and attempt to reinterpret multiple genomic and neurotransmitter studies, attempting to find the gene and neurotransmitters that mediate prosocial attitudes and behaviors. They also reinterpret brain studies, attempting to locate various prosocial behaviors in various regions of the brain.

When the psychological and social scientists bring their sciences into conversation with studies that examine genome and neurotransmitter activity, or into conversation with studies of fMRI and PET scanning, those same biases are then mapped onto the genome and the brains of people.

When this science is popularized, for example, in the work of Sam Harris or Adrian Raine, we see a neuroscience become a "science" very much like that of phrenology, where—instead of cranial measurements—brain activity becomes a predictor of antisocial behavior, and the hope of doing good with science enters into the popular imagination.

Thinking about Disability via Agency and Human Rights

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Epitome: One important hurdle in properly thinking about disability is our very great bias toward homogeneity. What is different is bad; it's *abnormal*. If human nature is best described as individuals seeking to commit purposive action to achieve his or her aims that s/he believes are good, then this opens a door of re-thinking the conceptual paradigm regarding disability.

Key Words: Disability, human rights, negative/positive liberty, health, self-fulfillment

Like snowflakes falling from the sky, each of us is unique in our place on this earth. Even identical twins are unique.¹ So what does it mean to be "unique"? It means that we are one-of-a-kind—though not *sui generis*. The "kind" is *homo sapiens*. But we are all singularly different. What are we to make of this difference? Is it a mere fact? Can some facts entail value? Can some values entail rights and duties? These are just a few of the central questions concerning public policy and disability.

CENTRAL DEFINITIONS

To begin our quest we must sort out the background conditions for comparison. This involves a journey into systematics and physiology. In systematics, various biological taxa are identified via anatomy and the corresponding physiology.² There is always variation within each taxon. This is a dogma of evolutionary biology which this author accepts.³

The way that anatomical organs, bones, and systems interact is physiology. This is viewed on the same scale: How can the various body parts work together so that the individual can perform the actions that he or she wants to perform? For simplicity let us call this *the successful purposive agent*. From my perspective this is a firm statement of human nature: *We all desire to be able purposively to act toward ends that we believe to be good.*

If we accept this characterization of human nature, then what follows from this? I contend that there is a hierarchical set of goods to which we all aspire and which can be judged according to how proximate these ends are to the possibility of purposive action.⁴ Thus any person on earth has a positive rights claim to these in descending order (the level-one basic goods trump all other claims, and so forth). I base this rights claim in what it would take to understand

one's humanity as a prospective purposive agent, and what it would take to get there. I call this argument "The Moral Status of Basic Goods,"⁵ discussed at more length elsewhere.⁶

When there are impediments to some particular individual possessing these goods—basic goods (levels one and two) and secondary goods (level one)—then it is the duty of all other people to provide these goods to those without them.⁷ For example, take food. The United Nations has set out that the minimum calorie intake on a regular basis is 500 (given some variation for soma type).⁸ Seven hundred fifty calories is better and 1,000 calories is the aspirational goal. These nutritional needs allow the brain to operate in such a way that purposive action toward that which we consider to be good is possible.

There are many reasons why some individual may not be successful at garnering level-one, level-two basic goods, and level-one secondary goods. These generally include socio-economic deprivation, a position in the community such that one's ability to commit purposive action toward one's conception of the good is restricted. One may be born into this state or descend there due to factors both within and not within one's power. This essay will understand the word *disability* to refer to just such a state, one in which one faces a negative liberty road block or does not have the positive liberty to be able effectively to seek after those goods.

Positive liberty will be taken to be the power one possesses to be able to effect purposive action that leads towards the ends that one believes are good (both prudentially and morally). The power is demonstrated in the activity of the agent as she seeks to move in the direction of realizing the desired end.⁹

Negative liberty will be taken to refer to barriers from either within the agent or without that prevents the agent from fulfilling what he desires to do. Examples of "within the agent" include physiological impairments either mental, emotional, or in the operation of one's muscular/skeletal system and its support systems.¹⁰ Examples of "without" include environmental restraints either natural or social/political. For example, if one were born with the ability to concentrate for a long period of time before acting, this might be an advantage if one were born into a hunting society where one had to have the patience to wait for game before making his move. However, if one were a Wall Street broker, that same characteristic would mean that you might be always short on the one critical trade for your clients. Is being deliberate and patient, by nature, an advantage or a disability? It all depends upon the environment and whether it rewards or creates barriers for action.

ENVIRONMENTAL DISABILITY

At the end of the last section the suggestive notion was raised about disability being environmentally as well as intrinsically focused. The famous experiment of Kettlewell underscores this.¹¹ The experiment goes like this. Take a region, e.g., an industrial region in northern England where factories have been spewing out soot for years. This soot lands on forests and changes the normal variegated

color setting of an un-altered forest into one that is now predominately black. Living in this ecosystem are two subspecies of moth: one sub-species_a has variegated wing color, and the other sub-species_b has black wing color. In Environment₁ the trees that constitute the habitat before pollution, the moths whose wing coloring is variegated dominated in population (meaning could avoid predators and successfully reproduce). In Environment₂ pollution has made the trees black with soot and so the normal patterns changed.

Kettlewell noticed that the normally populous sub-species_a [in Environment₁] were giving way to sub-species_b. This was due to industrial pollution [creating Environment₂]. By cleaning the trees, Kettlewell was able to reverse the trend (making sub-species_a more populous again by re-creating Environment₁).

Does this mean that sub-species_a is *better* than sub-species_b? Certainly not. For in Environment₂, sub-species_b flourished and dominated sub-species_a. All that it shows is that no traits are "good" or "bad" *per se*, but are only so within certain environments.

Another example is the gene that expresses sickle hemoglobin. Hemoglobin is the oxygen carrying protein in red cells, and a specific mutation in the beta polypeptide chain of hemoglobin leads to sickle hemoglobin, so called because the erythrocytes assume a sickle shape in conditions of low oxygen. Not only are such cells more rapidly cleared from the circulation than normal cells, leading to sickle cell anemia, but especially in individuals who are homozygous for the gene, such sickle cells can aggregate, block blood vessels and organs, and lead to the extremely painful and life-threatening sickle cell crisis. However, having erythrocytes that contain the sickle hemoglobin in an environment that contains malaria are beneficial. When such cells are infected with malaria, the red cells sickle and the parasites die. In addition, the parasite proteins are released to the circulation and the body can mount an immune response and abort the infection before full-blown malaria ensues. Thus, although being homozygous for sickle hemoglobin is deleterious, in an environment in which there is malaria, those who are heterozygous for the sickle hemoglobin gene will have a selective advantage, and be superior reproducers to those without the gene. However, in an environment in which there is no malaria, the sickle hemoglobin gene will make those that have it less fit for reproduction. Thus genetic fitness is seen to be a function of a particular gene in a particular environment.

From the perspective of philosophy, phenotypic and genotypic traits are not "good" or "bad." They simply "are." Variation in any species is a dogmatic given. This is what allows the species to survive in changing environments.

In each case there is no real "good" or "bad" with these cases of environmental disability. It is merely a term that is environmentally relative. However, in human cases this environmental factor can also be the source of unjust discrimination.¹² What makes this case unjust is that preferment for the more desired positions in

the community often go to those with undeserved background qualifications, as judged by work performed by the individual herself—as opposed to privilege given by birth. These so called “accidents of birth” or “accidents of circumstance” are not deserved. For example, when I submitted the manuscript for my first novel, *Far Into the Sound*, it went directly to the publisher rather than going through an agent. This was called the *slush pile*. Well, this hard-working editor was going through the slush pile one day and then stopped and decided to go to lunch to meet her boyfriend. My manuscript was at the top of the pile when she left for lunch. At the luncheon the editor’s boyfriend asked her to marry him, a proposition that the editor greeted positively. When she got back to the office I was at the top of the slush pile. Guess what? She liked my novel and published it.

Did I deserve this good fortune? No. It was out of my control. It is very possible that several manuscripts better than my own were turned down in the morning because the editor might have been in a depressed mood. She looked at my manuscript in an “up” mood. I gained at the expense of other manuscripts that may have been superior.

This is what I am talking about in external environmental factors that can make a positive or negative impact. No environmental factor is “deserved.” When people’s ability to act is accentuated or diminished due to environmental factors that are not within their control, then properly there is no praise or blame involved.¹³

However, we all know that the world does not revolve around “properly.” This is the battle that ethics faces with prudential factors. One example that I have cited in the past illustrates this paradox in the contrast between positive and negative undeserved environmental factors.¹⁴ For example, say there are two individuals: Mr. A and Ms. B. Mr. A comes from a very affluent, well-connected background that is rewarded by the mainstream society. Ms. B comes from a poor, discriminated-against background that the mainstream society subjects to unwarranted prejudice. Mr. A’s position entering life is to be *en-abled* while Ms. B is *dis-abled*. Neither individual’s competitive status in the game of life is fair. Mr. A gets his enabled advantage via an accident of birth; Ms. B’s disadvantage comes about also via an accident of birth. Thus, if this is a proper paradigm of much of life on earth, then many who are enabled or disabled due to environmental factors are not to be praised or blamed because those factors are out of their power.¹⁵

DISABILITY AND STIGMA

Thus disability can occur from factors within the agent or from without the agent. In the former case it is either by genetics (not under the agent’s control) or accidents peculiar to the agent (whether they are under the control of the agent or not).¹⁶ Let us call this sort of disability clinical, individualized disability. It refers to conditions that confront the agent herself in her own personal history. For example, a person may be born with severe curvature of the spine or suffer from a car accident that limits one’s ability to commit various sorts of purposive action. In the popular press, most discussion of *disability* refers to these sorts of cases.

In the latter instance, the disability arises from environmental factors that are out of the control of the agent. This can be termed public health disability, which affects a population differentially. For example, the Love Canal case involved the leakage of toxic chemicals that made its way into the public drinking water so that the citizens of Love Canal (a neighborhood in Niagara Falls, New York) were severely affected.¹⁷ Many were hurt, from children with seizures to adults with cancer. The story here is general with particular people reacting in various ways—some were harmed more than others.

In each case disability occurs. Disability incurs stigma. Whether a person was disabled due to his own behavior—such as emphysema from smoking—or not—such as a genetic disorder, accident or falling prey to a public health disaster—there is stigma. This is because most community worldviews¹⁸ pretend to a self-description of happiness and prosperity. Even countries that have regular mass starvation, such as North Korea, create songs and public art that present the vision of everything being happy and wonderful.¹⁹ Disability (however caused) gets in the way of this fairy tale.

Stigma is a social term that increases the pain and suffering of the affected individuals and *a fortiori* further diminishes the capability for action. This is because social recognition of a disabled person as the *other* puts them into the stream of double consciousness, which restricts effective action.²⁰ When one becomes the *other*, then he is saddled with a double consciousness that further inhibits effective purposive action.²¹ In double consciousness one acquires two identities: the agent as he sees himself from his inner consciousness (what I call personal worldview)²² and a second identity, which is that of the *disabled individual*. This second consciousness comes to play in every life action and can sometimes affect the way one reacts in life. Because another factor is brought into the picture, purposive action becomes more complicated (and *a fortiori* less effective).

Two examples of this from the interior and exterior vantage points can be set out as follows: *Interior*: The agent has trouble doing stairs because of damage to his knees. He is always keen on knowing beforehand (if possible) whether there are a lot of stairs and whether there is a handrail to help him navigate the stairs. If he is in a chair or walker, he needs to know whether there is an elevator. This applies to almost every locomotion decision that he makes beyond his immediate dwelling. *Exterior*: Say I am an African American living in the United States. When I go outside my dwelling by foot or in a motorized vehicle I must be wary of police and skinheads. (Skinheads are racists of European descent who try to make life difficult for African Americans and others who are different from themselves.) There is no justifiable reason for the loathing of the *other*. I have speculated about this before, but there may be strong strains of desire for homogeneity that is behind this.²³ This is a vain telos. Racial homogeneity (sometimes called “purity”)²⁴ is itself a vehicle of disability, as we have seen in so-called genetic drift populations.²⁵

There is no objective value to general exterior judgments that confer disability. As we saw in the Kettlewell experiment environments, physical characteristics such as race are random, and various genotypes perform differentially in these different settings. It is not a value judgment on this level, but merely a fact about one individual in her uniqueness within a given set of circumstances.²⁶ Therefore, those who discriminate against those with interior or exterior disability are engaged in a logical inconsistency. And as *per* Kant, all consciously held logical inconsistencies are flawed.²⁷ I also characterize such logical inconsistencies as failures in the personal worldview imperative.²⁸ In either case, those who freely discriminate against those disabled from within or without are ethically flawed and should alter their personal worldviews.

This and the previous section have sought to set out that difference (whether from interior or exterior factors) is only functionally related to purposive action. It is not *bad*. But socially, many communities around the world understand physical, mental, or emotional *difference* as a tag of being bad. It does not have to be this way. In the ancient world, epilepsy began as being viewed as *sacred* (as per Cassandra in the *Iliad*, XIII, 366; XXIV, 690) and then took on a double meaning with the early Hippocratic writers (*The Sacred Disease*).²⁹ Why should we assume that this difference is inherently good or bad? It is a fact that according to the situation may be functionally useful or not. But there is nothing *per se* good or bad about variations in anatomy or physiology. They just are.

HOW WE SHOULD REGARD THE DISABLED?

The first thing that is of utmost importance is the attitude that many in most societies take on: *if one is disabled in one area of his physiology, then he is to be viewed as totally without the capacity for positive action*. I call this attitude the *Disability Fallacy*. Employers seeing a person who cannot walk quickly or do stairs believes them to be fully incapable. Other individuals who have autism or Asperger's Syndrome are thought to be fit only for not good work. *The disability fallacy is illogical*. Since disability is anatomically or physiologically localized and depends upon environment, other powers of the individual must be viewed separately. Of course, a well-known example of this is Stephen Hawking. He suffers from amyotrophic lateral sclerosis (ALS) and yet he has made some of the most important contributions to cosmology in the past thirty years. His mind is brilliant though his body faces challenges in normal daily tasks. Hawking is an example of why we should all resist the disability fallacy.

Another issue that frequently arises in how we view the disabled is *fault*. This author has taken the stance that one should not speculate on *how* one has become disabled. This is irrelevant to the argument on the moral status of basic goods and the table of embeddedness. This argument and its interpretation via the table of embeddedness create positive rights that all people possess.³⁰ It does not stipulate how one became incapacitated. One has a proportional right according to the level of embeddedness to all goods on the table. Since goods entail duties, it is the duty of everyone on earth to provide access to these goods, subject only to the caveat of "ought implies can."

A secondary justification for providing the disabled access to the goods included on the table of embeddedness comes from the personhood account within my theory of human rights.³¹ This comes from the personal worldview imperative: "All people must develop a single comprehensive and internally coherent worldview that is good and that we strive to act out in our daily lives." There are four parts to this personal worldview imperative: completeness, coherence, connection to a theory of the good, and practicality. Let's briefly say something about each.

First is *completeness*. Completeness refers to the ability of a theory or ethical system to handle all cases put before it and to determine an answer based upon the system's recommendations. This is functionally achieved via the good will. The good will is a mechanism by which we decide how to act in the world. The good will provides completeness to everyone who develops one. There are two senses of the good will. The first is the *rational good will*, which means that each agent will develop an understanding about what reason requires of us as we go about our business in the world. Completeness means that reason (governed by the personal worldview and its operational ethical standpoint) should always be able to come up with an answer to a difficult life decision. In the case of ethics, the rational good will requires engaging in a rationally based philosophical ethics and abiding by what reason demands. Often this plays out practically in examining and justifying various moral maxims, such as, "one has a moral responsibility to follow-through on one's commitments, *ceteris paribus*." This maxim is about promise making—call it maxim alpha. For example, one could imagine that an employer named Fred hired Olga on the basis of her résumé and a Skype interview, which did not reveal her mobility challenges (she needs a walker to get from points A to B for perambulation). Fred promises Olga the job, but when she shows up to work Fred determines that Olga does not fit the *image* of the company that he wishes to exude: *vibrant, athletic, and potent*. A person in a walker is discordant to this image. Even though the job is a desk job (sitting in a cubicle), Fred wants to fire Olga. What should Fred do? The rational good will (as Fred, himself, has developed it via maxim alpha) says that Fred should carry through with his promise to Olga, since there is no conflicting moral issue that would invoke the *ceteris paribus* clause in the maxim. For Fred to act otherwise would be an instance of denying completeness based upon the rational good will. Fred should keep his promise to Olga and let her work for him.

Another sort of goodwill is the *affective or emotional good will*. We are more than just rational machines. We have an affective nature, too. Our feelings are important, but just as was the case with reason, some guidelines are in order. For the emotional good will we begin with sympathy. Sympathy will be taken to be the emotional connection that one forms with other humans. This emotional connection must be one in which the parties are considered to be on a level basis. The sort of emotional connection I am talking about is open and between equals. It is not that of a superior "feeling sorry" for an inferior. Those who engage in interactive human sympathy that is open and level will respond to another with care. Care is an action-guiding response

that gives moral motivation to assisting another in need. Together, sympathy, openness, and care constitute love.

In the above case on promise-making, Fred wouldn't be engaging in making and justifying moral maxims such as maxim-alpha. Instead, Fred would be developing his capacity sympathetically to connect with other people—call this maxim-beta. If Fred sympathetically connected with Olga and a disability that has nothing to do with her ability to carry out the job as advertised, his caring response would guide him toward maintaining his promise to Olga because to do otherwise would sever the sympathetic connection. Fred would not be acting like a loving person to do otherwise. The shared community worldview of *vibrant, athletic, and potent* need not be compromised because these are basically characteristics of the human spirit and not of the physical body. Olga can do her desk job with a *joie de vivre* that reflects the company's shared community worldview. Thus, Fred acting on maxim-beta should refrain from firing Olga.

Thus, the two sorts of good will (affective and rational—set out via maxims alpha and beta) work together to promote keeping Olga on the job so long as she can do the work—disability should not be a factor here.³²

When confronted with any novel situation one should utilize the two dimensions of the good will to generate a response. Because these two orientations act differently, it is possible that they may contradict each other. When this is the case, I would allot the tiebreaker to reason. Others demur.³³ Each reader should consider her own response to such an occurrence.

A second part of the personal worldview imperative is *coherence*. People should have coherent worldviews. This also has two varieties: deductive and inductive. Deductive coherence speaks to our not having overt contradictions in our worldview. An example of an overt contradiction in one's worldview would be for Sasha to tell her friend Sharad that she has no prejudice against disabled individuals while in another context she tells jokes about disabled persons. The coherence provision of the personal worldview imperative says that you shouldn't change who you are and what you stand for depending upon the context in which you happen to be: you should either support people with disabilities or excoriate them. Waffling between the two is incoherent.

Inductive coherence is different. It is about adopting different life strategies that work against each other. In inductive logic a conflicting strategy is called a sure-loss contract.³⁴ For example, if a person wanted to be a devoted husband and family man and yet also engaged in extramarital affairs, he would involve himself in inductive incoherence. The very traits that make him a good family man: loyalty, keeping your word, sincere interest in the well-being of others—would impede one in being a philanderer, which requires selfish manipulation of others for one's own pleasure. The good family man will be a bad philanderer, and vice versa. To try to do both well involves a sure-loss contract. Such an individual will fail at both. This is what inductive incoherence means. From the point of view of a disabled person, this second form of coherence involves a

self-assessment of what can and cannot be done: to seek for both will lead to a sure-loss contract. This creates a reality of the possible in which the disabled person can try to find self-fulfillment (see below under health).

Third is *connection to a theory of the good*—the most prominent being ethics.³⁵ The personal worldview imperative enjoins that we consider and adopt an ethical theory.³⁶ It does not give us direction, as such, to which theory to choose, except that the chosen theory must not violate any of the other three conditions of completeness, coherence, and practicability. What is demanded is that we connect to a theory of ethics and use it to guide our actions.

The final criterion is *practicability*. It is important that the demands of ethics and social/political philosophy (including human rights) be doable and its goals be attainable. This is especially important to consider when one is disabled. One must accept the body one is in at the moment and consider what is possible for it. This does not mean to "settle" for something less. But it also does not mean that one should hang upon scientifically unwarranted dreams of having one's disability reversed. A *utopian* command may have logically valid arguments behind it but also be existentially unsound—meaning that some of the premises in the action-guiding argument are untrue by virtue of their being unrealizable in practical terms. If, in a theory of global ethics, for example, we required that everyone in a rich country give up three-quarters of their income so that they might support the legitimate plight of the poor, then this would be a utopian vision. Philosophers are all too often attracted to tidy, if perhaps radical, utopian visions. However, unless philosophers want to be marginalized, we must formulate our prescriptions in terms that can actually be used by policymakers. Philosophers involved in human rights discourse must remember that these theories are to apply to real people living in the world. In taxation policy, for example, at some point—let's say at the point of a 50 percent income-tax rate—even the very wealthy among us will feel unjustly burdened and will rebel and refuse to comply with the policy. Thus, it is utopian to base a policy upon the expectation that the rich will submit to giving up 75 percent of their income. An *aspirational* goal (by contrast) is one that may be hard to reach but is at least possible to achieve; it does not violate principles of human nature or structural facts about the communities that inhabit the world. For the purposes of this essay, an aspirational perspective will be chosen over the utopian.

The purview of the personal worldview imperative is the individual as she interacts with other individuals in the world. Each of us has to do as much as possible to take stock of who we are and what we realistically think we can and should be. Our personal consciousness is our power to change what is within our power. Though factors of environment and genetics are not to be dismissed, in the end it is the free operation of our will that allows us to confront the personal worldview imperative as a challenge for personal renewal. The acceptance of the personal worldview account means that it is in our power to create our ethical selves. The personal worldview imperative thus grounds my theory of personhood, part of the foundation of natural human rights of which disability rights is a subset.

Thus, there are two ways to justify public policy that supports the rights of the disabled: (a) rationally based arguments on rights, and (b) a personhood account that seeks to integrate rational and emotive dispositions in an integrated good will that dictates people improve upon empathy that can open the opportunity for level-sympathy, care, and action, all of which constitute love.

DISABILITY, HEALTH, AND SELF-FULLMENT

In the second edition of my text on *Medical Ethics*, I bring together three philosophers (Rosemarie Tong, Anita Silvers, and myself) to write about health.³⁷ Medicine's mission is to advance health. Disability is connected to health. If we don't know what health is, then medicine is lost without a map, and we have no ground to judge the etiology of disability. In all three of these essays there are a few common answers to the problem that are in some ways useful, but certainly not comprehensive. For example, is being healthy to be at the median within some reference class? Certainly this is the way medical test results are often presented to the patient. However, there are certainly instances when being far away from the median is thought to be a desirable condition—such as being smart, or being athletically gifted, or being artistically talented. Perhaps there is more to the story? These essays seek to explore this question.

Rosemarie Tong's point of focus is upon infertility—especially female infertility. Sometimes infertility is seen as a disability in which there are potential positive liberty options. Now healthcare delivery can be seen from at least two critical vantage points: *clinical medicine* that focuses upon a particular patient seeing her particular doctor about a particular problem and *public health medicine* that focuses upon groups of people sharing a particular condition that either is itself unhealthy or is a stepping stone to a chronic or fatal disease. For example, smoking and obesity among the general population lead to more respiratory diseases and lung cancer (the former) and diabetes along with muscular skeletal disorders (the latter). Using this bifurcated approach, Tong examines how infertility can be addressed. The clinical approach looks at how IVF treatment performs as an answer along with freezing female eggs before age thirty-five so that they are more viable.³⁸

Under the public health approach, various diseases (such as chlamydia) need to be routinely checked and treated to keep women's reproductive tracts in the best possible condition. Also, there are exposures to chemicals in the workplace, etc. Tong makes a strong case for treating infertility first as a public health problem and then as a clinical treatment in order to promote positive liberty and impede negative liberty.

In Anita Silvers's essay, the issue of health among the elderly is examined. Being old is often viewed by society as a disability. This is certainly an important segment of the population to look at because elderly people go to the doctor more often and have higher medical expenses. Silvers asks the question of whether old people should be thought of as "greedy geezers." This perception can come about in the United States because Medicare (the social

service medical plan that covers most of the elderly in this country) is funded by young people through payroll taxes. But Silvers argues against this charge. People are living longer lives and must adjust what they expect to be able to do. This is important for the personal worldviews of those who may have specific impairments as they age. The healthcare community must also adjust their expectations about what is healthy among the elderly. Without this adjustment, it might very well be the case that care may be denied "because those relying on prosthetics and mobility devices to locomote is not considered to be healthy enough." Silvers highlights some key issues in clinical medicine and healthcare policy. If we accept Silvers's argument, then what might be a disability in a person of twenty, like limitations on mobility—stair walking, needing a cane, etc.—might not be considered a disability in someone who is eighty-five. This does return us to the concept of a reference class for a limited application (in a different sense from above) regarding lab tests that are applied to all ages equally.

Finally, in the last essay of this trio, I set out various ways of understanding health: functional approaches (objectivism, uncompromised life-span, and functionalism/dysfunctionalism). All three are shown to provide several key insights to health but are not sufficient to ground a general theory. Next, I examine the public health approach. Like Tong, I am very interested in this approach, especially because of its ability to be translated into coherent public policy. Finally, there are subjectivist approaches to health. Many of the subjectivist theories concentrate upon well-being. However, there are some difficulties here. For this reason, I advocate for a self-fulfillment approach that is evaluated by an independent measure (to avoid the circularity problems of the well-being approach). The independent measure involves a particular understanding of personal worldview. It is my contention that though all the aforesaid approaches to understanding health have merit, the strongest overall is the self-fulfillment approach that centers around making progress toward what the individual considers to be good in life. Unlike various zero-sum analyses of life where there can only be a few winners, the self-fulfillment approach allows *everyone* to be a winner.³⁹

ELIMINATING NEGATIVE LIBERTY AND ENHANCING POSITIVE LIBERTY

Ultimately, public policy approaches require two poles: elimination of negative liberty impediments and the creation of positive liberty capability programs that will assist the disabled to live a healthy life (as defined above) in which they can pursue their vision of the good. This was briefly touched upon in the last section concerning health.

Negative liberty concerns the impediments that face a person with a disability so they cannot perform in a setting for which they are entirely capable. One of the most common of these accommodations is the presence of elevators on public transport.⁴⁰ Another common negative liberty hurdle is the imposition of health requirements for employment. For example, people with certain diseases (like HIV) have often been discriminated against, partly because of an unscientific understanding of how the disease spreads,

and partly because of homophobic worldviews. Today, any travel to West Africa carries the same sort of stigma due to the Ebola epidemic. Often, employers create barriers where they need not be.

Then there are the barriers for governmental services—such as voting booths, governmental building design, access to communication devices for the hearing and visually impaired, access to public recreation facilities (especially pools), or availability of service animals such as seeing eye dogs.

Concerning positive liberty (creating opportunities where they might not presently exist), there is the perspective of the present and the perspective of the future. Concerning the present, various accommodations that do exist can (and should) be publicized to the general public within a given municipality. Also, the use of new technology needs to be integrated into the workplace. For example, there are modern computers that can be operated without the use of hands. This can be a boon to the paraplegic and quadriplegic and can change the nature of so-called white collar jobs. Modern technology that exists right now can be applied to a variety of situations to promote positive liberty.

For the future, it is important for public policy to encourage scientific research into the causes and treatments of birth defects, diseases, and severe accidents. Genetic engineering promises to be a very big player in the future in expanding positive liberty among the disabled.⁴¹

SUPPORT OF COMMUNITIES

In a practical way, no public legislation will allow a disabled individual to create a personal life plan that is realistic within the scope of the disability without the support of the community. This means a commitment in the shared community worldview. Community worldviews are viewed variously around the world. My conception of a functioning moral community worldview is one that embraces diversity, subject to the personal worldview imperative.⁴² It *requires* participation by all members of the community. Those who wish to reap the benefits of the community without making their proportional contribution will be deemed to be free riders (a community parasitism that arises from selfish-egoism).⁴³

The reason that communities should support policies that eliminate negative liberty obstacles and support positive liberty enhancements is because of the characterization of the rational and emotional good will as set out above. Rationally set out duties as per “The Moral Right to Basic Goods” and the Table of Embeddedness ground a logical positive right/duty. Emotionally, level sympathy that leads to care (love) dictates no other response.

Community support at the ground level, as manifested in micro communities, is the essential practical piece to bringing about effective change. You cannot change a person’s heart with laws alone.⁴⁴ The mechanics of community and personal worldview change require public leaders to come forward to generate overlap with the status quo with some vision of what can be. I call this process “The Way We Confront Novel Normative Theories.”⁴⁵

CONCLUSION

Though the ancient Greeks honored those with disabilities as being “touched by the gods”—like Cassandra in the *Iliad*—modern societies in their competitive worldviews have often treated the disabled with cruelty. In this essay I have tried to set out a shared community worldview in which this will change. By eliminating negative liberty barriers and by investing in the science/engineering that will help extend positive liberty, we (as societies in the world) can extend the range of human agency for all people—which is their basic human right.⁴⁶

NOTES

1. This is a tortured question. On the identical twin angle, see Susan L. Farber, *Identical Twins Raised Apart* (New York: Basic Books, 1981); and Niels Juel-Nielsen, *Individual and Environment: Monozygotic Twins Raised Apart* (New York: International University Press, 1980). For two more narrow analytic approaches, see Jay Joseph, “The Equal Environment Assumption of the Classical Twin Methods: A Critical Analysis,” *Journal of Mind and Behavior* 9, no. 3 (1998): 325–58; and Joseph Owens, “Semantic Comprehension, Inference, and Psychological Externalism,” *Mind and Language* 28, no. 2 (2013): 173–203.
2. I discuss this issue in the context of ancient philosophy of science in two books: *Method and Practice in Aristotle’s Biology* (New York: UPA/Rowman and Littlefield, 1983), and *The Origin of Ancient Greek Science: Blood, a Philosophical Study* (London: Routledge, 2015).
3. For an excellent outline on the basic tenets of evolutionary theory in biology and what it signifies, see Stephen Jay Gould, *The Structure of Evolutionary Theory* (Cambridge, MA: Harvard University Press, 2002).

4. BASIC GOODS

Level One: *Most Deeply Embedded* (that which is absolutely necessary for human action): food, water (including sanitation), clothing, shelter, protection from unwarranted bodily harm (including basic health care)

Level Two: *Deeply Embedded* (that which is necessary for effective basic action within any given society)

- Literacy in the language of the country
- Basic mathematical skills
- Other fundamental skills necessary to be an effective agent in that country (e.g., in the United States, some computer literacy is necessary)
- Some familiarity with the culture and history of the country in which one lives
- The assurance that those you interact with are not lying to promote their own interests
- The assurance that those you interact with will recognize your human dignity (as per above) and not exploit you as a means only
- Basic human rights such as those listed in the U.S. Bill of Rights and the United Nations Universal Declaration of Human Rights

SECONDARY GOODS

Level One: *Life Enhancing*, Medium to High-Medium on Embeddedness

- Basic societal respect
- Equal opportunity to compete for the prudential goods of society
- Ability to pursue a life plan according to the Personal Worldview Imperative
- Ability to participate equally as an agent in the Shared Community Worldview Imperative

Level Two: *Useful*, Medium to Low-Medium Embeddedness

- Ability to utilize one's real and portable property in the manner she chooses
- Ability to gain from and exploit the consequences of one's labor, regardless of starting point
- Ability to pursue goods that are generally owned by most citizens (e.g., in the United States today, a telephone, television, and automobile would fit into this class)

Level Three: *Luxurious*, Low Embeddedness

- Ability to pursue goods that are pleasant even though they are far removed from action and from the expectations of most citizens within a given country (e.g., in the United States today, a European vacation would fit into this class)
- Ability to exert one's will so that she might extract a disproportionate share of society's resources for her own use

5. "The Moral Status of Basic Goods"

1. All people, by nature, desire to be good—Fundamental Assumption
 2. In order to become good, one must be able to act—Fact
 3. All people, by nature, desire to act—1, 2
 4. People value what is natural to them—Assertion
 5. What people value they wish to protect—Assertion
 6. All people wish to protect their ability to act—3-5
 7. Fundamental interpersonal "oughts" are expressed via our highest value systems: morality, aesthetics, and religion—Assertion
 8. All people must agree, upon pain of logical contradiction, that what is natural and desirable to them individually is natural and desirable to everyone, collectively and individually—Assertion
 9. Everyone must seek personal protection for her own ability to act via morality, aesthetics, and religion—6, 7
 10. Everyone, upon pain of logical contradiction, must admit that all other humans will seek personal protection of his or her ability to act via morality, aesthetics, and religion—8, 9
 11. All people must agree, upon pain of logical contradiction, that since the attribution of the basic goods of agency are predicated generally, it is inconsistent to assert idiosyncratic preference—Fact
 12. Goods that are claimed through generic predication apply equally to each agent, and everyone has a stake in their protection—10, 11
 13. Rights and duties are correlative—Assertion
 14. Everyone has at least a moral right to the basic goods of agency, and others in the society have a duty to provide those goods to all—12, 13
6. Michael Boylan, *Natural Human Rights: A Theory* (Cambridge: Cambridge University Press, 2014), ch. 6; and *A Just Society* (Lanham, MD and New York: Rowman & Littlefield, 2004), ch. 3.
 7. Levels two and three of secondary goods are to be considered after the more embedded levels have been realized.
 8. *The 2007 Human Development Report* (New York: United Nations Development Program, 2007), 27.
 9. Many of the key distinctions I draw on liberty can be found in Isaiah Berlin, *Four Essays on Liberty* (Oxford: Oxford University Press, 1969).
 10. By support systems, I am referring to the major systems of the body, such as the circulatory, nervous, and digestive systems. These systems allow the conditions for voluntary positive liberty.
 11. H. B. D. Kettlewell, "Industrial Melanism in Moths," in *Man's Impact on the Environment*, ed. Thomas Detwyler (New York: McGraw-Hill, 1971).

12. For discussion of unjust discrimination, see my example of the puzzle-maker in Boylan, *A Just Society*, 139-45; and Boylan, *Natural Human Rights*, ch. 6.
13. Aristotle makes this point in *EN* Book 3, Chapter 1, 1109b 30-1111a 20-24.
14. Boylan, *Natural Human Rights*, 187-93.
15. I say that desert only follows from what one does himself, stripping out the influence of environmental factors: Boylan, *A Just Society*, 138-45; Boylan, *Natural Human Rights*, 187-92.
16. Some would make a distinction here. For example, say you were crippled as the result of a car accident caused by a drunken driver who ran over into your lane and hit you. This would be an example of an injury not in one's control. However, if you were the drunken driver, you might also be crippled, but the cause of the accident was in your control. This can be a critical distinction concerning "blame" and "desert," but with respect to public policy, it would be impossible to make this distinction. See Brian Smart, "Fault and the Allocation of Spare Organs," in *Medical Ethics*, 2nd ed., ed. Michael Boylan (Oxford: Wiley-Blackwell, 2014), 305-12.
17. Lois Marie Gibbs, *Love Canal and the Birth of the Environmental Health Movement* (Washington, DC: Island Press, 2010).
18. Boylan, *A Just Society*, 113-36.
19. For a fictional account, see the Pulitzer Prize winning novel by Adam Johnson, *The Orphan Master's Son* (New York: Random House, 2012).
20. Michael Boylan, *Morality and Global Justice: Justifications and Applications* (Boulder, CO: Westview, 2011), 119-31.
21. The originator of this viewpoint can be found in W. E. B. DuBois, *The Souls of Black Folk* (New York: Dover, 1994 [1903]).
22. Boylan, *A Just Society*, 21-52; and Boylan, *Natural Human Rights*, 163-70.
23. Boylan, *A Just Society*, 85, 170, 187, 245. See my reply in ch. 5.
24. An example of this can be found in the translated phrase "ethnic cleansing" that occurred in the 1990s upon the break-up of Yugoslavia. See Andrew Bell-Fialkoff, *Ethnic Cleansing* (New York: Palgrave-Macmillan, 1999).
25. Benjamin A. Pierce, *Genetics: A Conceptual Approach*, 4th ed. (New York: W. H. Freeman, 2010), ch. 26.
26. This should not be taken as any agreement on the propriety of the skinheads or any other of the various exterior public health environments, merely a factual description of what happens in the mechanics of environmental disability.
27. See my discussion of Kant and the first and second forms of the categorical imperative in *Basic Ethics*, 2nd ed. (Upper Saddle River, NJ: Prentice Hall, 2009), ch. 13.
28. In my personal worldview imperative, one of the two major mandates is the rational good will, *op. cit.*
29. "In my opinion, this disease is not more sacred than any other," I, i (my tr.) from *Hippocrates* vol. 2, ed. and trans. W. H. S. Jones (Cambridge, MA: Harvard University Press [Loeb], 1923).
30. Of course, this is not absolute for ongoing problems. For example, if one were an alcoholic or a drug addict and needed a new liver, and there were a shortage of these within a cadre of claimants, then it would seem that unless there were a way to ensure that the claimant would not abuse this new organ, the scarce organ should be allocated to one who would not abuse the organ. This is not a statement against past actions, but a statement about the use progressively of organs transplanted from here on out. For a discussion of this, see Smart, *op. cit.*
31. Boylan, *Natural Human Rights*, 163-70.
32. Since the affective goodwill comes from the completeness condition of the Personal Worldview Imperative, the conditions of the imperative also apply to this sort of philosophical love that I have set out. Some detractors think that you cannot order love (as I have done). I give a response to this argument in Michael Boylan, "Duties to Children" in *The Morality and Global Justice Reader*, ed. Michael Boylan (Boulder, CO: Westview, 2011), 385-404.

33. This is particularly true of some feminist ethicists. See Rosemarie Tong, "A Feminist Personal Worldview Imperative," in *Morality and Justice: Reading Boylan's A Just Society*, ed. John-Stewart Gordon (Lanham, MD, and Oxford: Lexington/Rowman & Littlefield, 2009), 29–38.
34. The phrase "sure loss contract" comes from the notion of betting houses. Say you were betting on the finals of the World Cup: Brazil v. Germany. If you gave 5-1 positive odds for each team, then your betting house would go out of business. A positive assessment of one team requires a complementary negative assessment of the other. Failure to observe this rule results in a sure loss contract.
35. Other aspects of the good can include commitments to aesthetics and to religion.
36. My take on the various real and anti-real theories is generally set out in my text, *Basic Ethics*, 2nd ed., Part Two (Upper Saddle River, NJ: Pearson/Prentice Hall, 2009).
37. Rosemarie Tong, "Ethics, Infertility, and Public Health: Balancing Public Good and Private Choice" [pp. 13–29]; Anita Silvers, "Too Old for the Good of Health?" [pp. 30–43]; Michael Boylan, "Health and Self-Fulfillment" [44–57], all in Michael Boylan, *Medical Ethics*, 2nd ed. (New York and Oxford: Wiley-Blackwell, 2014).
38. See my discussion with Tong on this subject: <https://www.youtube.com/watch?v=FsvQfujkKbg&noredirect=1>. Accessed January 12, 2014.
39. For a more complete exposition of this, see Michael Boylan, *The Good, the True, and the Beautiful* (London: Bloomsbury, 2008), 45–64.
40. For example, subway systems and buses should be accessible to those who cannot walk stairs. This is a real problem in large established public transportation systems around the world.
41. Of course, there are ethical issues here as well. For an examination of some of these, see Michael Boylan and Kevin Brown, *Genetic Engineering: Science and Ethics on the New Frontier* (Upper Saddle River, NJ: Prentice Hall, 2002).
42. My version of the shared community worldview imperative is this: *Each agent must contribute to a common body of knowledge that supports the creation of a shared community worldview (that is itself complete, coherent, and good) through which social institutions and their resulting policies might flourish within the constraints of the essential core commonly held values (ethics, aesthetics, and religion)*: Boylan, *A Just Society*, ch. 6.
43. Of course, there are unapologetic advocates of selfish-egoism such as Ayn Rand, *The Virtues of Selfishness* (New York: Signet, 1964); and conservative libertarians like Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), who only believe in negative duties. They are advocates of egg carton communities.
44. For example, in the United States, there have been significant gaps between legislation and practical benefit in the case of racial civil rights. The 13th and 14th amendments, which were supposed to stop slavery and unequal treatment under the law, were a failure at the level where people lived. Racism, lynchings, and other forms of overt oppression continued. Then, a century later, the Civil Rights Act and the Voting Rights Act promised an end to this discrimination. However, though life on the ground improved, it is still the case that police profile, incarcerate, and injure (kill) African Americans at a rate far above those of European descent. See Terrance J. Taylor, David Holleran, and Volkan Topalli, "Racial Bias in Case Processing," *Justice Quarterly* 26, no. 3 (2009): 562–91; and Michael Boylan, "Ethical Profiling," *The Journal of Ethics* 15 (January 2011): 131–45.
45. Michael Boylan, *Natural Human Rights*, 206–13.
46. I discuss what I consider to be the range of human rights claims in *ibid.*

You Are Old, Father William (with apologies to Lewis Carroll)

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"You are old, Father William," the young man said,
 "And the money's become very tight;
 And yet you'll spend anything not to be dead—
 Do you think, at your age, it is right?"

"In my youth," Father William replied to his son,
 "I figured that old folks should die;
 But now that I'm perfectly sure that I'm one,
 I do not see a good reason why."

"You are old," said the son, "as I mentioned before.
 So consider your grandson's position,
 Since the money that keeps you away from death's door
 Could be used for his college tuition."

"I am old," Father William replied in a yell,
 "But I've not taken leave of my wits!
 I should croak so young Willie can go to Cornell?
 Be off, or I'll blow you to bits!"

Care Ethics and Pragmatism: Care As Pragmatic Meliorism

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There is much to be learned from putting pragmatism and care ethics in dialogue. Pragmatism, especially the ethics of Dewey and Addams, is already primed to pay attention to care as a significant part of moral life. I propose that the pragmatist can and should learn a great deal from the care ethicist, and appropriate significant parts of this philosophy into his or her own ethical deliberations. Specifically, I will argue that once we allow the two ethical philosophies to cross pollinate, Deweyan ethical theory will gain clarification on growth and provide a tool to better articulate democracy as a social ethos.

The major similarity of care ethics and Deweyan pragmatism is the emphasis both philosophies put on relationships between people and on establishing a pluralist ethics based upon imaginative and creative interaction in lived situations.¹ Furthermore, both philosophies emphasize that moral rules in the style of traditional utilitarianism or deontology are untenable and thus require some sort of ethical pluralism. These similarities have been discussed by scholars in both fields. While I agree that there are some differences between Dewey's democratic ethics and care ethics, there are several points where cross-pollination is possible. Another important overlap between care ethics and Dewey's ethical thought

has to do with the role of empathetic projection in moral deliberation. Dewey's emphasis on sympathy (or *empathy*) is an important part of moral inquiry. On this the care ethicist agrees, and goes so far as to found much of the ethics of care on this emotional connection with others.

There are, of course, significant differences between the ethics of care and Dewey's ethics. I share a concern with many that care ethics does not give us a fully worked out social ethic that can inform our ethical activity in the public sphere. Another worry concerns the toll of care on the individual. Erin McKenna, for example, worries about the requirements of self-sacrifice and the potential for loss of identity toward which care ethics tends.² The potential for the annihilation of the individual in engrossment is of concern. Pragmatism, with its emphasis on *reconstruction* of the individual around actual lived situations, does a better job of embracing the growth that occurs through care and preserves the individual.³ Pragmatists such as Charlene Haddock Seigfried have criticized care ethics for not fully acknowledging other important values.⁴ Furthermore, Seigfried argues that on her pragmatist reading care is a necessary but not sufficient factor of moral life.⁵ Virginia Held, responding to these criticisms, emphasizes that care does not eclipse or supersede other values like justice and rights, and, as a matter of fact, rights and access are important to establish for women so that they can achieve a social position in which care can be acknowledged and celebrated. Justice, or any other traditional value that we might see in deontological or utilitarian accounts of the moral life, simply cannot be the only values—care must be considered. When care is not considered, we see problems like the reduction of all valuations to those of the market, for example.⁶ On the other hand, Nel Noddings (charitably) criticizes Dewey for not fully embracing care, and suggests that care ethics has tools that would complete Dewey's project.⁷ On this I agree.

The cross-pollination I propose reads care into Dewey's conception of growth. Growth as a moral end, which Dewey often calls for, requires clarification due to the vagueness of the concept. Critics are right to ask "growth toward what end?" Yet, if we read Dewey through a lens that takes care seriously we might find some guidance. It is my argument that care is an example of growth insofar as the care-giver experiences engrossment and the cared-for is integrated into an environment. This process gains some complexity when all the relationships any one individual has are taken into account.⁸ This complexity does not excuse the fundamental nature of giving and receiving care as integrative experiences which are growth-oriented.

Noddings argues that the emotional feeling of care leads to engrossment in the other. It leads the one-caring to become embedded in the relationship and be "in an attitude that warms and comforts the cared-for."⁹ The cared-for becomes engrossed in the other—a feeling of integration and empathy. This is not a "degradation of consciousness" or a reprieve from intellectual work.¹⁰ Indeed, acting from care calls for reason and intelligence and "what goes on in caring is [or ought to be] rational and carefully thought out," even when the relationship is not.¹¹ Furthermore, Noddings suggests that those we care

for should be cared for in such a way that they themselves can care in the future. Gregory Pappas agrees, holding that "care that is rightly fused with other traits of character does not fall into the kind of harmful care that stultifies the growth of those being cared for."¹² This is very similar to Dewey's moral ideal of growth. These similarities show that engrossment is itself a form of growth.

While care is an emotional response, this does not warrant us dismissing it as unimportant to the lived situation. Pappas reminds us that "emotional appreciation is about something that in a situation is experienced as having certain qualities."¹³ Dewey also emphasizes that emotions are not contrary to intelligent moral activity and in fact embed us in a situation (Dewey, *Ethics*, LW 7:270).¹⁴ Like care ethics, pragmatism holds that empathy is an essential part of moral inquiry.¹⁵ In his *Ethics* Dewey could very well have been responding to care ethics when he writes:

There are, however, definite limitations to the spontaneous and customary exercise of sympathetic admiration and resentment. It rarely extends beyond those near to us, members of our own family and our friends. . . . And . . . when certain acts have become thoroughly habitual, they are taken for granted like phenomenon of nature and are not judged at all. (LW 7:239)

Simply put, if we empathize immediately with those who we are immediately close to without expanding that empathy, we risk immoral activity.

Dewey, despite warning against the inadequacy of sympathy as a sufficient condition of ethical activity, holds that sympathy is a fundamental part of ethical inquiry that allows us "to put ourselves in the place of another," which allows "the surest way to appreciate what justice demands in concrete cases" (LW 7:251). Sympathy's role is that of a guide, when it is properly used, to moral inquiry. Dewey holds that sympathy "is the tool, *par excellence*, for resolving complex situations" (LW 7:270). It is not yet clear what distinguishes good sympathy, which is the best tool for resolution of moral problems, from the bad sympathy that restricts people from justly performing activities.

There are many working in pragmatism that hold empathy as important to moral inquiry. Mark Johnson holds that empathy when it acts in moral imagination is "an *imaginative rationality* through which we can participate empathetically in another's experience."¹⁶ It is important to note that Johnson sees empathy as a part of an imaginative rationality that reflects the actual way we inquire and does not hold on to empathy as "an artifact of an erroneous traditional separation of reasons, imagination, and feeling."¹⁷ Similarly, Steven Fesmire holds that empathetic imagination is a necessary part of moral inquiry. He holds that empathetic projection is a part of inquiry that takes "the attitudes of others" and "stirs us beyond our numbness so we pause to sort through others' aspirations, interest, and worries as our own."¹⁸

Allow me to rearticulate. Empathetic projection is a deeply emotional connection to the situation that allows for human inquirers to suffer with the world they find themselves in. When empathy is working well, we take on the other through empathy so that we naturally and impulsively tend to relate to others as tied to ourselves. This insight is important as it dissolves a traditional dichotomy between self and others in such a way as to avoid problems of inherent selfishness, or to raise the question of how selfishness relates to altruism. Instead, we have a case where interests and the project of growth of ordered richness, when properly informed, takes on the needs of others as self-interest. My growth becomes tied to the growth of others and the interests of others become mine.

Noddings does not disagree. She argues that empathy leads her to “receive the other into [herself], and [to] see and feel with the other.” Empathy makes one “committed to the receptivity that permits [one] to see and feel.”¹⁹ This seeing and feeling, while only temporary, gives insight and motivation to whoever is caring. Once this empathetic “invasion” occurs one is changed and is “prepared to care.”²⁰ This empathy, which the pragmatists emphasize to be necessary for moral inquiry, allows for the consummatory experience of engrossment. Noddings argues that all acts of care, to some extent, involve engrossment.²¹ She argues that there is a fundamental—one might say foundational—requirement to care in those situations where one is obligated to do so. The pragmatist will disagree insofar as this is a problematic value and not necessarily a consummatory valuation.

Engrossment is a form of consummatory experience. Particularly the value placed in feeling engrossment is one that James Gouinlock would call a consummatory value. It is particularly important to recall that Dewey’s ethical theory distinguishes between that which is valued and that which is valuable. Pappas points out that “*Valuing* is the direct, spontaneous, and pre-cognitive operation where we appreciate something by its immediate quality before it is subject to reflection,” while “the reflective process of arriving at this kind of judgment of value is called *valuation*.”²² On that other hand, what is valuable is found when what is valued becomes problematic. This problematic value is inquired into and, if it conforms with intelligent ends-in-view for activity, we have a *value* that is *valuable*. When inquiry shows that something is valuable we have good reason to pursue it. The engrossment that care gives can be valuable when that care allows for development of ends-in-view that are beneficial and compatible with other consummatory values.

Immediate goods can be developed by inquiry into consummatory valuations. Gouinlock reminds us that value “is an eventual function in nature, produced with the contrivance of intelligence and activity.” Furthermore, “that function of experience and nature which Dewey designates by the term ‘value’ is the consummatory phase of a situation which is initially problematic.”²³ Valuations as the result of a consummatory experience simply point to the valuable as the intellectualized result of activity due to a problematic situation. Engrossment becomes *valuable* insofar as it allows for greater possibilities of intelligent activity and is

negative insofar as it brings about negative possibilities or limits the end-in-view of individuals. Noddings will not take this step and allow care to be criticized as potentially negative. But, when caring decreases the potency of future activity, then it no longer is righteous and any engrossment felt in that act of “care” is engrossment at the cost of possibility for the cared-for.

Here pragmatism can contribute something back to care ethics. Pragmatism’s work on *reconstructing individualism* around what we know about the relational nature of human beings and the value of individuals for the sake of creativity, inquiry, and the respect for dignity gives care ethics a significant strengthening. Once an individual develops, they are owed autonomy as a matter of care. Individuals, once developed (such as we find not only in adults but in various levels in all human beings after infancy), require some autonomy in order to care for others and themselves.²⁴ Intelligent and moral growth begets more growth for the pragmatist.

So, what is the end of this cross-pollination? It is my proposal that instead of thinking of democracy as a top-down affair, as in most theories of justice, we take a page from care ethics and look at how democratic interactions are those that are not top-down but rather those that come from an *ethos* wherein continual and purposeful interactions with those close are transformative and exemplary of democratic interactions, as Dewey suggests. Maurice Hamington invokes Jane Addams to argue that we embody care when we actually have relationships with others and develop with them—especially with those who are different than we are. This calls for the development of social habits that reconstruct individuals into more creative and more empathetic persons.²⁵ The overlap of care and pragmatism goes further, and the contributions of pragmatism can help guard against unfair criticisms of care. When Addams calls for “sentimentalism” we are assured that it is not merely sentiment in a bare or base sense, but rather a “politics of connection that gives care ethics a viable sociopolitical dimension.”²⁶ Thus, “democracy becomes a framework for individual participation that allows for both individual and communal growth.”²⁷ Care can foster and aid intelligent growth. Hamington emphasizes that “pragmatism thus provides an ideal framework for synthesizing embodied care and the caring imagination into a social philosophy of care.”²⁸ Again, we see the tools of pragmatism allowing us to navigate care in such a way that it is growth in a moral and valuable sense.

Dewey, with Tufts, gives us some clues about how to deal with care and Justice in his 1932 *Ethics*. In criticizing Spencer specifically, but in a way applicable to other definitions of justice, Dewey argues against a “definite meaning” for justice and thinks rather that “the meaning of justice in concrete cases is something to be determined by seeing what consequences will bring about human welfare in a fair and even way” (LW 7:250). Importantly, we determine justice in concrete cases and not from any *a priori* source. Justice becomes justice in concrete cases that do not necessarily conform to rules set down with absolute precision before the lived, experienced situation. A few pages later Dewey uses the term “beneficence” to designate those parts of

moral obligation that are felt and not dictated by a rational or formal process of argumentation. He writes:

The opposition which is frequently instituted between beneficence and justice rests upon a narrow conception of the latter as well as upon a sentimental conception of the former. If beneficence is taken to signify act which exceed the necessities of legal obligation, and justice to denote the strict letter of moral law there is, if course, a wide gap between them. But in reality the score of justice is broad enough to cover all the conditions which make for social welfare, while a large part of what passes as charity and philanthropy is merely a makeshift to compensate for lack of just social conditions. (LW 7:252)

I hold that this redefinition of justice implied a reconciliation of a rights-based system of justice with a justice that takes care seriously.

There is some vagueness here. I believe that taking Dewey's theory of moral deliberation from *Human Nature and Conduct* is helpful. Here Dewey writes:

Deliberation is irrational in the degree in which an end is so fixed, a passion or interest is so absorbing, that the foresight of consequences is warped to include only what furthers execution of its premeditated bias. Deliberation is rational in the degree in which forethought flexibly remakes old aims and habits, institutes perception and love of new ends and acts. (MW 14:138)

Dewey's typically bloodless language wakes up a little here. New ends, which come through experience, are "loved." This emotional quality should not be overlooked. I do not think that his use of "love" here is an accident. Our motivations and drives are deeply emotional. Dewey never excludes feelings or emotion from the life of intelligent recreation of habits.

One realistic tool we can gain from the ethics of care when we go about asking questions about institutions is whether or not the establishment of a procedure or other structure precludes or supports individual act of care. I think this clarifies pragmatism's dedication to growth. This practical check on institutions, of course, does not dictate any particular structure but instead leaves inquiry open to investigation in concrete cases. That an institution is imperfect is accepted as a real problem which demands inquiry into actual human lives—and not going back to a merely theoretical drawing board. It is likely in the negative that we gain the most clarity by thinking in this way. Institutions are unjust by design insofar as they preclude the possibility of care. Because moral imagination develops over time to deal with the changing problems of life, institutions and social structures demand change to maintain the possibility of care. How radical the change in structures is would require, I think, individual investigations into many issues of care. This is impossible to do here, but the outcome is radical and would fulfill Dewey's demand to remake the concept of individuality. What is possible to

do here is to emphasize how incorporating care into our moral deliberations in a robust manner serves the end of meliorism—because it is through care that we identify and potentially check social and political institutions for their ability to work toward concrete human values. Dewey, memorably, implores philosophers to think of the problems of men. This is as much a warning, in this regard, to those who want a foundational theory of justice which does not take into account the real needs of those who suffer. Neoliberalism's "shocks" and institutionalized inequalities—both of which conform to a rule *a priori* to experienced suffering, are two examples that come to mind.

Understanding care and pragmatism in each other's light provides not only a deeply emotional but deeply motivating basis to see how democracy should be local before it is global, personal before it is public.²⁹ I believe the structure that care ethicists suggest is important. That is, the meaning of many growth situations is engrossment—and engrossment makes up a great deal of situations of growth. However, it is not the eclipse of the self, but rather an expansion of individual power due to integration. It is a *reconstruction of individuality* around the possibilities and meanings inherent in social life. Thus, Deweyan democratic openness occurs when individuals are willing to interact, to grow. This comes about due to group inquiry, participation in activity, and influence on others. Care ethics forces us to look at interaction at this basic level—not at the macro-level. I believe that a tendency to look at structures from the macro-level has inclined us to assume that democracy's final justification is in the whole group and not in the interactions of individuals. Care ethics would agree with pragmatism that democracy is an *ethos*—albeit articulated in a different vocabulary.³⁰ An ethics of care as intelligent and valuable is vital to pragmatism's democratic ideal.

NOTES

1. M. Regina Leffers, from the point of view of care ethics, points out that the complex philosophy of relationships that pragmatists like Dewey and Addams argue for are conducive not only to seeing how care can work in limited interpersonal manners but also how care can be extended beyond immediate relationships. Leffers, "Pragmatists Jane Addams and John Dewey Inform the Ethics of Care," *Hypatia* 8, no. 2 (Spring 1993): 73-74.
2. Erin McKenna, "The Need for a Pragmatist Feminist Self," in *Feminist Interpretations of John Dewey*, ed. Charlene Haddock Seigfried (University Park: Pennsylvania State University Press, 2002), 141.
3. James M. Albrecht, *Reconstructing Individualism: A Pragmatic Tradition from Emerson to Ellison* (New York: Fordham University Press, 2012), 191ff.
4. Charlene Haddock Seigfried, *Pragmatism and Feminism: Reweaving the Social Fabric* (Chicago: University of Chicago Press, 1996), 223.
5. *Ibid.*, 222.
6. Virginia Held, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 116-18.
7. Nel Noddings, "Dewey's Philosophy of Education: A Critique from the Perspective of Care Ethics," in *The Cambridge Companion to Dewey*, ed. Molly Cochran (Cambridge: Cambridge University Press, 2010), 265-85.
8. Held is careful to acknowledge where and how a relationship might be detrimental to a person's well-being and therefore require a break. However, this break does not change the fact that

the relationship occurred and that there are real consequences of personhood because of that relationship. Held, *The Ethics of Care*, 95-96.

9. Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education*, 2nd ed. (Berkeley: University of California Press, 1984, 2003), 19.
10. *Ibid.*, 34.
11. *Ibid.*, 61.
12. Gregory Fernando Pappas, "Dewey and Feminism: The Affective and Relationships in Dewey's Ethics," *Hypatia* 8, no. 2 (Spring 1993): 84.
13. *Ibid.*, 80.
14. All citations to the work of John Dewey are to the standard print edition, *The Collected Works of John Dewey, 1882-1952*, ed. Jo Ann Boydston (Carbondale: Southern Illinois University Press, 1969-1991), and published as *The Early Works (EW)*, *The Middle Works (MW)*, and *The Later Works (LW)*. In citations, the title of the work will be followed by the series designation, volume, and page number (where appropriate). Thus, "Art as Experience, LW 10:135" refers to volume 10 of *The Later Works*, page 135.
15. Although Dewey tended to use the term "sympathy," as was the practice at the time, I believe our contemporary term "empathy" is, for this purpose, interchangeable. Pappas makes the same claim in *John Dewey's Ethics*, 198.
16. Mark Johnson, *Moral Imagination: Implications of Cognitive Science for Ethics* (Chicago: University of Chicago Press, 1993), 200.
17. *Ibid.*, 201.
18. Steven Fesmire, *John Dewey and Moral Imagination: Pragmatism in Ethics* (Bloomington: Indiana University Press, 2003), 65.
19. Noddings, *Caring*, 31.
20. *Ibid.*, 30.
21. *Ibid.*, 17.
22. Pappas, *Dewey's Ethics*, 104-105.
23. James Gouinlock, *John Dewey's Philosophy of Value* (New York: Humanities Press, 1972), 125.
24. Michael Slote, *The Ethics of Care and Empathy* (London: Routledge, 2007), 42-53.
25. Maurice Hamington, *Embodied Care: Jane Addams, Maurice Merleau-Ponty, and Feminist Ethics* (Urbana; University of Illinois Press, 2004), 108-109.
26. *Ibid.*, 95.
27. *Ibid.*, 91.
28. *Ibid.*
29. See Albrecht, *Reconstructing Individualism*, 266ff, for a discussion of Dewey's democratic philosophy, which is local before extending out to larger intuitions.
30. Held, *The Ethics of Care*, 131-32.

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Care Ethics and Pragmatism: Cultivating Empathy with Nonhuman Others through Moral Imagination

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The political action of citizens of an organized community will not be morally satisfactory unless they have, individually, sympathetic dispositions.

– John Dewey¹

In recent years, many scholars have rightly identified fertile intersections between feminist care ethics and pragmatism, particularly in the work of John Dewey. Dewey importantly highlights radical connectedness among individuals and the creative space that such connectedness can open for growth. This connectedness is of great significance to care ethics, too, which centers on relationships and contexts, rather than on fixed rules and principles about moral adjudication. Unlike many philosophical traditions, a Deweyan ethical framework refuses to subordinate emotions and the affective to an absolutist idea of so-called rationality within moral deliberative processes, so his work should be particularly relevant to care ethicists.

Care ethics, particularly its early iterations, has been harshly criticized for what many see as unavoidable pitfalls. Twin emphases on women's natural or innate caring skills and on mothering have led to claims of essentialism, and the highly contextual nature of care ethics draws accusations of relativism. I contend, with others like Maurice Hamington, Véronique Mottier, and Deane Curtin, that a Deweyan theoretical model can help avoid some of the challenges that care ethics faces, and that a vision of community informed by Dewey's democratic ideal can help us to widen the circle of those for whom we care. Further, I claim that this care can be appropriately widened in order

to include nonhuman others. In this paper, I place Dewey's idea of the moral imagination (particularly its emphasis on empathy, which I contend deserves more attention) in conversation with care ethicists in order to explore how we can widen the circle of our care well beyond our intimates to include all members of the moral community, including nonhuman stakeholders, from domestic and wild animals to trees, plants, water sources, and more. In order to make a significant impact on our relations with nonhuman others, we need a politicized ethic of caring that understands nonhuman others to be stakeholders within our communities.

PART ONE: THE EXPANDED MORAL COMMUNITY

Many of the early iterations of care ethics focused on attempts to "name the unnamed"—to identify the moral motivations for action in our caring relationships that had often been ignored or devalued. Care ethicists raised concerns about phallogocentric biases in traditional ethical theories that fail to account for complexities in relationships, fail to address responsibilities and desires to meet the needs of others, and fail to admit our ontological connections to one another. Often framed as oppositional to traditional ethics, care ethics has, according to Hamington, been "sharply contrasted with existing accounts of morality, [those] often categorized as 'justice.'"² But this dichotomous framing has drawn serious criticism, and care theorists have attempted to resolve those tensions by insisting that care, rather than being *antithetical* to justice, is a *prerequisite* for justice.³ Kathryn Tanner, for example, insists that care and justice rely on one another: "Isolated from one another, an ethic of either care or justice has its moral dangers. Care becomes, for example, parochial and paternalistic, justice becomes inhumane, rigid, and impossible to implement. Moral vision is advanced, feminist ethicists are beginning to argue, only when both perspectives are emended, one by the other."⁴ Similarly, Virginia Held claims that "there can be care without justice . . . [but] there can be no justice without care."⁵ This reframing has provided the basis for care theorists' claim that justice at its best will always be "underwritten by care for others."⁶ This is the picture of justice that those concerned for nonhuman others may wisely appropriate. If care should underwrite our just relations with others in a moral community, one task for the ethicist is to see if we can extend the notion of the moral community to include nonhuman others as well as human others.

In keeping with many feminists and pragmatists and with Dewey in particular, I argue that we are radically social creatures—inextricably tied to one another. Dewey rejects the idea of a free, autonomous individual and presents, rather, a picture of a dynamic, ontologically social self. Because of our social situatedness, our moral evaluations cannot be impartial or abstract but must be grounded in lived experiences, including our own experiences and the experiences of others, all of which take place in a given environment. To care for others is part of caring for oneself. Dewey argues that "interest in the social whole of which one is a member necessarily carries with it interest in one's own self....To suppose that social interest is incompatible with concern for one's own health, learning, advancement, power of judgment, etc., is, literally, nonsensical."⁷

Our biotic communities are a significant part of that social whole. So we must not only acknowledge our social situatedness, but must also must acknowledge that we are ecologically situated. Our biotic communities are inextricably tied to our lived experience. Thus, in our democratic communities, we have a responsibility to attend to the interests of nonhuman others—to represent those interests—ineffable as they may be—in our ongoing conversation of democracy. A Deweyan concept of the moral imagination may be a way to approach representing those interests. Through dramatic rehearsals, informed by empathetic, imaginative caring, we can improve our understanding of the interests of nonhuman others and, in so doing, can develop genuine caring relationships that can ground our approaches to environmental justice.

PART TWO: MODELS OF CARE AND THE PROBLEMS WITH EXTENDING CARE

Many environmental pragmatists have begun to borrow directly from the language of care in order to extend beyond caring relationships with humans to caring relationships with nonhuman others. I suggest that there is a rich possibility in such an extension, but that a nuanced version of care must be established. Many of the models of care that emerge in the literature are insufficient to justify an extension of care to nonhuman others. I advocate here for a citizenship-model of caring, but I'll first consider some other possible models and what I see to be their shortcomings.

A good deal of the literature on care ethics suggests that our model of care ought to grow out of our natural relationships. Much of the emphasis is on parent-child relationships—particularly, at least in the early literature, on mothering. Our own intimate affiliations shape our view of the world and our view of ourselves. Carol Gilligan writes:

The experiences of inequality and interconnection, inherent in the relation of parent and child, then give rise to the ethics of justice and care, the ideals of human relationship—the vision that self and other will be treated as of equal worth, that despite differences in power, things will be fair; the vision that everyone will be responded to and included, that no one will be left alone or hurt. These disparate visions in their tension reflect the paradoxical truths of human experience—that we know ourselves as separate only insofar as we live in connection with others, and that we experience relationship only insofar as we differentiate other from self. (63)

Because, for most of us, our first relationship is with our mother, care ethicists have often contended that it is the image of ethical caring on which we should base our other relationships. Mothering care should then be applied to other relationships.

Yet the mothering model invites challenges. It is highly vulnerable to claims of essentialism. Even its more gender-neutral formulation, a parent-child model, raises concerns. There are numerous kinds of parenting that are unhealthy

or unsafe or at least fail to provide proper care. But the more troubling challenge, I argue, is that it is not clear why or how this model can be extended beyond one's intimates. Parenting, though certainly guided by social conventions, is discretionary. One can choose how much to care for one's child or whether to care at all. Mothering and parenting may serve well as a model for healthy caring within families or small groups, or, perhaps even for relationships with companion animals. But it is difficult to see how this model of caring will not lead to, or at least allow, an isolated kind of caring—one which is limited to one's intimates—that certainly wouldn't extend well to others with whom we have no close ties or affinities, human or nonhuman. While a mothering or parenting model may be very useful for intimate, interpersonal caring interactions, it is an insufficient model to provide the extension to those with whom we have no close ties—particularly nonhuman others.

Other models of care have similar pitfalls. In *Caring: Gender-Sensitive Ethics*, Peta Bowden looks at the kind of care found in friendships. Friendship is a relatively unstructured and informal kind of caring compared to mothering, which is thoroughly enmeshed in social institutions of the family. It is another kind of natural caring, based on one's own affinities and affections. But because expectations of friendship are not clearly defined through an institution, they are flexible. However, because there are so few expectations and principles guiding experiences of friendship, they are also vulnerable. Bowden writes, "The expansive promise of friendship, the possibility of freely choosing and being freely chosen, is conditioned by vulnerability to the vicissitudes of its participants and the exigencies of the more structured relations in which they are involved."⁸ Though friendship is an important indicator of our inclination to care, the model of caring in friendship lacks the structure that would make caring for nonhuman others secure.

Useful here is the distinction between natural and ethical caring. Natural caring, like a healthy relationship between mother and child or close friends, often takes little effort. It does involve a choice, as no one is forced to care, but the choice is often an easy one. Ethical caring, on the contrary, takes cultivation. It is, to appropriate Dewey's language, a habit. Hamington notes that ethical caring "covers those instances when we must make a reflective choice whether to care."⁹ Natural caring is expected among our family and friends, to one degree or another, but ethical caring is the kind of caring at work when we encounter others with whom it is difficult to identify. Ethical caring, then, is the sort of care needed to extend our caring relationships to nonhuman others.

The model of care which I think is more suitable for our relationship with nonhuman others is a kind of caring that is both intelligent and intentional—it involves both a natural skill and a practice to be cultivated. A citizenship model of care is the kind of caring that may have the richest potential to guide our extension of care to nonhuman others. Unlike familial caring and friendship, the bonds of citizens within a community are not typically characterized by intimacy or personal engagement. As Bowden puts it, "Citizen relations

are more likely to denote interpersonal connections that eschew the values of intimacy and personally engaged care."¹⁰ For Bowden, the term *citizens*, in this instance, simply denotes those individuals whose relationships are characterized by their "association within the public sphere."¹¹ Citizenship is denoted by our consenting to association with one another in virtue of our very presence together in community. Citizen relations are much more generalized forms of interpersonal interaction than other relationships, but it is in view of this generality that I think citizen-caring can encompass the interests of others with whom we have no intimate bonds, including a variety of nonhuman others. The strength of the care among citizens, according to Bowden, is that "predictability, stability, and control of the outcomes and activities are predominant goals."¹² Unlike other kinds of caring, citizen-caring is planned, thoughtful, and critical. Strong democratic communities participate in dialogue and debate, engaging diverse voices and considering possible outcomes of actions. In most cases, citizens do not respond with direct, immediate action to perceived needs, but intelligently attend to the various possibilities and solutions. Because citizen-caring is not care characterized by strong affections and intimacy, it provides a degree of security that does not depend on love for the other, but on commitment to the whole. It resists the charge of prejudices that natural caring falls prey to. As Lori Gruen writes, "From an ethical point of view, the interests of all who have them should be taken into account. To favor someone's interests over another's, simply because you like, want to impress, or can relate to the first person, and dislike, don't care about, or can't relate to the second person, would be objectionably prejudicial."¹³ Furthermore, citizens do not depend on direct reciprocity to one another. Instead, citizens contribute in various ways and in various degrees, and expect, also in various degrees, for their needs to be met similarly—by the community, rather than through one particular relationship.

Because natural kinds of caring are generally freely chosen and because they can fairly easily be opted out of, they cannot secure the care that is necessary for justice for nonhuman others. Furthermore—and perhaps more importantly—natural caring includes direct responses to immediate needs felt by those with whom we identify, responses often lacking critical reflection about consequences and taking on the form of "unenlightened benevolence," to borrow Dewey's words.¹⁴

The kind of care I see emerging from a reading of Dewey is a structured, politicized caring—a kind of caring that can be implemented into communities and institutions and that would provide the stability necessary to ground a caring response to nonhuman others. While admitting that our natural affinities are important to ethical caring, ethical caring does not rely solely on actual fondness for a particular person or animal or species. I do not need to actually *like* the snake that creeps around the side of my house, but I can care for snakes and their well-being without feeling a particular affection for them. The kind of caring I see emerging from Dewey is not direct caring, like the ties of affinity we feel for our family members or friends, but is instead an intellectual, thoughtful caring that allows us to look outside ourselves and into others and to

better imagine possible solutions to conflicts with others. Because I care for myself and for others, and because I care for the environment that that such care takes place in, I can recognize the responsibility to care for the subjects that comprise that environment. Critical, intelligent empathy allows me to assess my own needs and the needs of others with whom I am in community, human and nonhuman. It allows me to highlight differences and recognize similarities, challenging conventions of understanding and thus opening up space for creative dialogue and, ultimately, growth and change. It is the critical nature of this empathy that sparks the moral imagination. Dewey asserts, "Regard for self and regard for others should not . . . be *direct* motives to overt action. They should be forces which lead us to *think* of objects and consequences that would otherwise escape notice."¹⁵ That force is what moves Dewey's idea of the moral imagination.

PART THREE: BIOCITIZENSHIP AND THE MORAL IMAGINATION

Dewey posits the concept of the moral imagination as a way to approach the interests of others in moral deliberations. While he speaks of the interests of others in terms of humans, I suggest that this notion need not necessarily be limited to the human members of a moral community. It can be extended to apply to the many ways we can attend to the interests of a wider spectrum of citizens of the moral community, including the interests of nonhuman others.

There are two elements of the moral imagination that emerge in Dewey's work. The first element is "empathetic projection." Before creative solutions to moral problems can be developed, we must be able to (or perhaps, must at least attempt to) understand the interests of others. This is an active, experimental, and playful element. The second element is "dramatic rehearsal," which includes creatively tapping the possibilities within a conflict. A great deal of the current scholarship on Dewey's notion of the moral imagination seems to focus on dramatic rehearsal, yet I think that in order to expand Dewey's model to nonhuman nature in a morally responsible way, we must give more attention to the role of empathy. Hamington claims that moral imagination is crucial to care ethics. The contrapositive I suggest here is that care—particularly a politicized, imaginative, ethical, empathetic caring—is crucial to moral imagination in terms of environmental justice.

According to Hamington, "the more understanding we have or gain of the stranger, the more potential there is to imagine empathizing and caring."¹⁶ Authentic care requires knowledge of the subject being empathized with—even a limited and imperfect knowledge—for it to be likely to effect change in ethically significant ways. Hamington goes on to explain that "we care about that which we know, and it is difficult to care for that which we have little or no knowledge of. Although knowing is not a sufficient condition of caring, it is a prerequisite."¹⁷ Thus, as we approach nonhuman subjects with empathy, that empathy ought to be active and engaged, attending to the interests of the subject rather than assuming interests based on our own experiences or projecting our anthropocentric

interests. Care ethics enriches the idea of the moral imagination here, helping us see how empathy can play an important role in transactions with nonhuman nature and how it must play an important role in dramatic rehearsal.

I contend that, rather than existing as two independent pieces of the moral imagination—empathetic projection and dramatic rehearsal—the two are interwoven. Empathy is an essential component to robust dramatic rehearsal. It is only once one develops empathy for the plight of others and an understanding of those others' interests that one can creatively begin tapping possibilities embedded in problems of justice for nonhuman nature in a way that is true to the interests of the nonhuman others. The dissonance of diverse, yet interconnected, voices in community opens space for growth.

Of course, empathetic caring responses are certainly imperfect. Extended too far, empathy can be dangerous. Empathy relies on sophistication in the thought-processes of the empathizer. The empathizer must interpret feelings, needs, or interests of the subject of empathy, leaving limitless room for misinterpretation of the interests of the subject of empathy and requiring that the empathizer have a deep awareness of possible personal limitations in the ability to interpret. Empathetic responses can fall prey to imperialist, racist, and sexist pitfalls common with other responses. Empathy is thus inevitably fallible. Empathy, as we have the capacity for it, will never be empathy perfected. Yet, I contend that even flawed empathy is an essential component to a just approach to nonhuman others. Although we can never adequately know how it feels to be a suffering animal or an ecosystem in need of water, our responses to these problems are more likely to be just if approached with empathy, not pity or dominion or other kinds of responses. If we are able to imaginatively take the place of an other, we are more likely to respond to their own interests, as best as we can perceive them. Furthermore, this is why a pragmatist-feminist model of caring must be a politicized model of caring. As Catherine MacKinnon explains, we will always be for caring and empathy "without letting power off the hook."¹⁸ Josephine Donovan and Carol Adams explain further: "The care theory we advocate goes beyond compassion to include caring enough to find out who is causing harm and stopping it" (14).

Possibilities for resolution within a conflict are often left undiscovered if one only approaches the conflict with fixed rules and principles. Dewey's challenge to the traditional idea that rules and principles are what tether us to moral decision-making is the basis for the emergence of the moral imagination. As Steven Fesmire explains, for Dewey, "principles and rules supplement but do not constitute ethics."¹⁹ Thus, instead of relying on rules and principles, Dewey turns the focus of moral deliberation to imagination in the form of dramatic rehearsal, a creative exercise which can unearth possibilities for growth and change.

Fesmire writes, "If there is a single lesson of the sciences, for Dewey it is that beliefs that mature through ongoing interactive engagement with the world are truer to the mark."²⁰ Passive speculation about possibilities and

heavy reliance on conventions of thought leave avenues unexplored and ideas untapped, but imagination, which, for Dewey, is active and experimental, “ventures beyond restatements of contention to grasp undisclosed opportunities to generate new ideals and ends.”²¹ When intimately tied to empathy, dramatic rehearsal looks beyond the immediate environment and surroundings. It extends the environment to which we can appropriately respond. Thus, the interests of others which might otherwise go unnoticed are revealed when imagination becomes involved. In addition to being active, this kind of deliberation, according to Dewey, is “dramatic” because it deals with life’s dramas. Dewey looks to conflicts in terms of narrative—a life story which the decision-maker is part of, not separate from, disengaged, and indifferent. When the decision-maker recognizes his or her role in the drama, he or she becomes “co-author to a dramatic story with environing conditions in community with others.”²² Imagination at its best, for Dewey, is always consultative. It engages as many co-authors to the narrative as it can identify, requiring communication in various forms since it is ever-changing and experimental. Through colloquy, “we place ourselves in the emerging drama of others’ lives to discover actions that may meaningfully continue their life-stories alongside our own.”²³

So many responses to environmental crises fail to take into account the importance of knowing the other. Yet, as Hamington suggests, knowledge is an essential part of caring. He writes: “One needs to know the individuals and situation of those involved to richly think through the implications of moral decisions. Failure to acquire such understanding will result in a truncated or superficial dramatic rehearsal that can degenerate into simple rule application or an ethical calculus.”²⁴ Our best caring practices emerge when our care is based on acknowledgement of both our interconnectedness and our existential differences, though, of course, this is no small task.

Feminists and care ethicists have drawn attention to the myriad problems associated with communication across difference. While the discourse about communication across difference has primarily been in the context of cross-racial dialogue, it is applicable to representing or understanding interests of any others with whom communication barriers exist, including nonhuman others. María Lugones develops an idea of playful world-traveling that may further enrich our idea of the moral imagination. Lugones’s work addresses the problems associated with any attempt to have a productive dialogue between two subjects who come from radically different cultures and different contexts—“cross-racial loving,”²⁵ as she deems it. Noticing a tendency towards perceiving others arrogantly, Lugones develops a concept of playful world-traveling that includes skillful and creative ways of being flexible enough to enter, exit, and return again to one another’s worlds. Replacing arrogance and imperialism with loving perception and playfulness allows us to consult something other than our own will in our inquiries, and, perhaps, to find new ways to represent the voices of distant others, even nonhuman others. Once one develops empathy for the plight of others and an understanding of those others’

interests, one can begin to creatively tap the possibilities embedded in the conflict. This, to my mind, is precisely the kind of dramatic rehearsal we can see in a Deweyan approach to nonhuman others.

When we see ourselves as necessarily both socially and ecologically situated as citizens in a moral community that includes diverse members, we can begin to recognize the importance of giving all stakeholders within a community a voice in democratic colloquy. Still, we cannot know exactly how to speak for a diminishing species or a threatened watershed. The exercise will necessarily be experimental and playful and creative. But when our attempts are informed by caring relationship and an understanding of the plurality of values of the stakeholders, we can come closer to the kind of justice and care we seek.

CONCLUSION

The radical connectedness that is a central tenet of many care ethicists and, indeed, of John Dewey, is what makes an extension of care to nonhuman others conceivable. This radical connectedness, Regina Leffers writes, “provides the theoretical foundation that can explain why the caring response at the highest level of moral reasoning in these ethics of care includes both self and other and also why it is capable of moving beyond particularity, including others who ostensibly exist outside of our individual human circles.”²⁶ Our best moral deliberation, that which engages the moral imagination in order to open space for growth and change and creative solutions to conflicts, is deliberation that takes into account the entirety of our life-narrative as citizens of a moral community—a community which encompasses our close, caring relations with our intimates, friends, and acquaintances and intelligent, empathetic care for the nonhuman stakeholders within our communities.

NOTES

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3. Ibid.
4. Kathryn Tanner, “The Care That Does Justice: Recent Writings in Feminist Ethics and Theology,” *Journal of Religious Ethics* 24, no. 1 (1996): 172-73.
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6. Ibid., 179.
7. Guinlock, *The Moral Writings of John Dewey*, 117.
8. Ibid., 60.
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10. Ibid., 141.
11. Ibid.
12. Peta Bowden, *Caring: Gender-Sensitive Ethics* (Routledge, 1996), 142.
13. Lori Gruen, *Ethics and Animals: An Introduction* (New York: Cambridge, 2011).
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16. Hamington, "Will to Care," 676.
17. Hamington, "Learning Ethics from Our Relationships with Animals," 179.
18. Josephine Donovan and Carol Adams, *The Feminist Care Tradition in Animal Ethics* (Columbia University Press, 2007), 3.
19. Steven Fesmire, *John Dewey and Moral Imagination* (Bloomington: Indiana University Press, 2003), 3.
20. Ibid., 37.
21. Ibid., 66.
22. Tom Alexander, quoted in Fesmire, *John Dewey and Moral Imagination*, 78.
23. Ibid., 128.
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25. María Lugones, "Playfulness, 'World'-Traveling, and Loving Perfection," *Hypatia* 2, no. 2 (1987): 4.
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Rationing in the ICU: First-Come, First-Served?

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Note: This essay is intended as an introduction to a panel session planned for the Philosophy and Medicine session at the Eastern Division APA meeting in January of 2016. The session will address a broader range of ethics issues related to rationing in the ICU than does this essay, but this essay should serve as a provocative introduction.

I. A HISTORICAL INTRODUCTION

The modern intensive care unit (ICU) is only a little over fifty years old. Its primary purpose has been to save lives that require prompt and complex medical or surgical care. To a large extent the ICU has been quite successful in achieving that objective. Roughly 83 percent of patients who are admitted to an ICU will emerge alive from that ICU, which means 17 percent of patients will die while receiving care in an ICU. ICU beds make up about 8 percent of hospital beds in the United States but account for about 20 percent of total hospital costs.¹ Given the intensity of care provided, few will be surprised by this cost discrepancy. However, there is intense pressure to control health care costs in the United States.² In 2014 the United States spent \$3 trillion on health care, roughly 17.5 percent of GDP.³ Roughly \$50 billion was spent by Medicare on patients in the last two months of life. The vast majority of that money would have been for ICU care. Hospitals typically have occupancy rates of 65 percent to 85 percent, but ICUs are typically at 100 percent on any given day. This is why hospital ICU physicians are faced on a daily basis with the problem of health care rationing. The obvious solution to this ethical issue would seem to be building more ICU beds. However, from the perspective of cost-conscious health policy analysts that would be exactly the wrong solution. This would only encourage filling those beds with patients who were likely to benefit no more than marginally from having

access to that bed. That is, the cost of health care would be driven further skyward with very little objective benefit to justify those costs. The practical conclusion would seem to be that ICU physicians must continue to struggle with health care rationing in the ICU.

This situation precipitated the need for more explicit guidance regarding how to make such rationing decisions justly, especially when the public perception was that life itself could be at stake for a patient denied admission to the ICU. More specifically, the concern was that such decisions should not be left to the prejudices and other decisional vagaries of physicians controlling admission to the ICU. Consequently, a Bioethics Task Force of the American Thoracic Society was charged with articulating the needed ethical guidelines. The result was a report published in 1997 under the title "Fair Allocation of Intensive Care Unit Resources."⁴ The authors started that report by saying that the primary goal of ICU was to preserve "meaningful human life," by which they meant "a quality of life personally valued and appreciated by the patient."⁵ The practical implication of this statement is that it would not be unjust to deny ICU admission to patients in a persistent vegetative state or to patients in the late stages of various dementias. (Some may find this position ethically troubling, but for purposes of this essay I will pass over that in silence.)

II. ICU RATIONING GUIDELINES: AMERICAN THORACIC SOCIETY

Near the beginning of their essay the Thoracic Society authors stated five principles which they jointly affirmed as underlying their recommendations regarding ICU care rationing. Very briefly, they affirmed that every individual is of equal value, that patient autonomy ought to be respected, that the goal of ICU care is to enhance a patient's welfare, that medically appropriate ICU care should be regarded as an essential component of a basic benefit package available to all, and that the duty of physicians to benefit their patients "has limits when doing so unfairly compromises the availability of resources needed by others."⁶ So, when exactly is it that providing access to the ICU, or technology in the ICU (such as ECMO), represents an unfair compromise of resources to which others presumably have a stronger just claim?

The authors respond to this last question with twelve propositions that are intended to express ethically appropriate reasons for offering or denying a patient access to the ICU. I will not try to critically assess all these propositions, but I will focus only on proposition number six, which endorses a first-come first-served principle. But to appreciate the point of that proposition we need to review the preceding propositions. The first proposition states that only patients with "sufficient medical need" have a *prima facie* just claim to ICU resources. In other words, a patient with a high anxiety level about a very ordinary surgery may not have her anxiety relieved by a physician responding positively to her demand for an ICU bed. The second proposition states that ICU care "should provide the patient a certain degree of potential benefit."⁷ Again, the authors add that patients with advanced dementia or in a persistent vegetative state would not meet this criterion. Likewise, a

patient might need hospital care for that routine surgery, but the ICU might not be able to provide more than a very minor benefit over and above what can be competently provided in an ordinary hospital unit. Such a patient would not have a just claim to an ICU bed. The same will be true (often) for patients who are certain to die of their current illness very shortly; there may be very little of substantial benefit that the ICU can offer that could not be provided by an excellent palliative care service (and it will often enough be the case that aggressive, family-demanded ICU care yields a net harm for such patients, which would not appear to be something that patients would demand for themselves as a matter of justice).

The third proposition is that patients (when possible) ought to give informed consent for both the initiation and continuation of ICU care, a point that would be most ethically salient when such care is likely to represent a net harm to the patient. The fourth proposition is that patients ought to have equal access to ICU care “regardless of their personal and behavioral characteristics.”⁸ In other words, nothing about the patient’s age, or social status, or religious or political beliefs, or sexual orientation, or general lack of compliance to social norms ought to result in him or her having less than equal access to the ICU compared to other patients with comparable medical need and likelihood to benefit. The fifth proposition adds to the fourth that ability to pay should be irrelevant to determining access to the ICU, given sufficient medical need and ability to benefit from that care.

The sixth proposition is the one that will receive the bulk of our critical attention. The authors write: “When demand for ICU beds exceeds supply, medically appropriate patients should be admitted on a first-come, first-served basis.”⁹ The authors reject a utilitarian approach to ICU bed rationing, i.e., giving preferred admission status to a patient with a better prognosis over another equally needy patient with a somewhat worse prognosis. We might imagine this situation. An 85-year old with a severe heart attack and emergency bypass surgery has just been admitted to the last bed in the ICU, when two hours later a 50-year old accident victim needs that same bed after having emergency surgery. Both are expected to be discharged alive, but the 85-year old has a cancer that is very likely to kill him within two years. The authors would clearly not endorse removing the 85-year old from the ICU in order to make room for the 50-year old, though “obviously” many more high-quality life-years would likely be saved if such a switch were made. This conclusion will strike many as something ethically problematic. But, to be fair, we should examine the reasons and reasoning of the authors in support of this conclusion.

III. FIRST-COME, FIRST-SERVED: THE ETHICAL JUSTIFICATION

The Thoracic Society authors start by affirming again that every individual’s life is equally valuable. Further, they contend that there must be thresholds for both medical need and medical benefit that must be met before invoking the first-come first-served rule. In other words, as mentioned earlier, individuals must have sufficiently urgent and

complex medical need that requires ICU care that cannot be adequately and effectively addressed outside the ICU by other hospital services. Further, there must be sufficient likelihood of substantial benefit. If there is a 90 percent or greater chance that an individual is going to die within a week in spite of anything the ICU might offer, then that lack of sufficient benefit means the necessary threshold will not be crossed that would justify admission on a first-come first-served basis. In the example above, both patients would satisfy this threshold criterion, though the older patient arrived first. Still, what is ethically troubling is that so many life-years would be put “at-risk” by not providing that younger patient with immediate access to an ICU bed. In one article I read the authors looked at a year’s worth of delayed admissions to an ICU bed. What they found was that each hour of delayed admission represented a 1.5 percent increased risk of ICU mortality.¹⁰ As noted, it seems neither rational nor just that so many life-years would be put at risk. But that *seeming* might be ethically misleading.

We might imagine that this is a fifteen-bed ICU, that if it feels unseemly to discharge our 85-year old patient, who is expected to recover, that surely there must be another patient in that ICU who could be justly discharged in order to make room for our 50-year old patient. Our Thoracic Society authors would consider such an option. They agree that no one has a right to that ICU bed for the indefinite future, especially if in the course of their stay they no longer meet the threshold requirements that justified their admission in the first place. They might fail to meet those threshold requirements in one of two ways. They might have gotten “better enough” that additional days in the ICU would make no more than a marginal difference in benefit for them. That is, those patients are most likely to survive with a few extra days in a regular hospital bed, though there might still be a very small risk of a sudden medical reversal that could prove fatal. Still, those patients may be justly removed from the ICU. Alternatively, if patients now occupying a bed have failed to benefit from ICU care, have gotten worse so that their prognosis is more than 90 percent likely that they will die within the next few days, then they too may be justly removed in order to make room for our 50-year old patient. However, we need to consider yet another scenario in order to test the ethical reliability of that first-come first-served rule.

Imagine that all the other patients currently in the ICU continue to meet those threshold criteria that justified their admission in the first place. Physicians might have their suspicions and intuitions about which patients are likely to survive that ICU stay and which ones will not. And, as many ICU physicians know, there are a number of prognostic tools in general use that can generate a more objective picture of prognosis for each of these patients. (For the curious reader these tools will have acronyms such as APACHE IV, SOFA, and TISS.¹¹) These tools are informative but not consistently reliable in the prognostic information that they generate. Consequently, the Thoracic Society authors conclude that it would be ethically problematic to make what in some cases would be life and death decisions on the basis of the prognostic information generated by these tools. And it would be even more problematic to rely upon “clinician judgment”

of prognosis in comparing patients since such judgments would be too greatly vulnerable to bias, ambiguity, and subjectivity. Their conclusion is that we must stick with the first-come first-served rule. They see this as being justified by a commitment to a fundamentally egalitarian principle. All these lives are of equal value. This approach has the moral virtues of a lottery; it is impartial and impersonal. It might not be ethically perfect because at times “smart patients” and “rich patients” might be able to get to the ICU door first, but the utilitarian alternative is seen by the authors as being more ethically flawed.

IV. FIRST-COME, FIRST-SERVED: A CRITICAL ANALYSIS

In the remainder of this essay I want to test the ethical robustness of the first-come first-served rule with respect to ICU rationing. I will argue that it is largely reliable in yielding “just enough” rationing decisions with regard to ICU access, but that it is in need of some limitations and constraints in specific clinical situations. I want to start my analysis by trying to better understand the rule itself.

We might imagine this situation. A lifeguard is in a boat, no other lifeguards around, when he notices two men drowning. They are roughly equidistant from his boat but in roughly opposite directions. He knows he can only save one of them. He arbitrarily picks one of them and rushes to get close enough that he can throw the man a lifeline. As the man is drawn closer to the boat the lifeguard realizes that this is a real estate agent who cheated him out of \$10,000 several years ago. He jerks the lifeline out of the individual’s hands because there is still time to get to the other individual and save his life. How should we judge from a moral point of view the action of the lifeguard? It seems we would judge him harshly. Suppose the lifeguard tried to justify his behavior by saying that he knew he had an obligation to save someone, because that was his social role, but neither drowning individual had any more of a just claim to his services than the other, and he was entirely free to save one or the other. He did make one choice at first, but he changed his mind about who to save, and this was his prerogative. I assume that all my readers would conclude that this was just the worst sort of rationalization of clearly bad behavior. That real estate agent (no doubt despicable) turned out to be “first-come” by virtue of the choice that the lifeguard made, and, hence, he had the moral right to be the first-saved.

We can modify the scenario a bit. The drowning individuals are again roughly equidistant from the lifeguard. The lifeguard arbitrarily picks one to save and throws out the lifeline but then quickly realizes that this is a “really old” guy he is about to save while the other individual must be a lot younger with more life-years to lose. Having been profoundly influenced by a passionate utilitarian philosopher in an undergraduate philosophy course, he quickly gets his boat over to save the other individual. Would we be justified in judging any less harshly the lifeguard in this second scenario compared to our first scenario? Again, it seems the first-come first-served rule best explains the harsh judgment we would make of the lifeguard in either scenario. As nearly as I can judge, these

scenarios seem very analogous to the circumstances of the ICU physician charged with responsibility for determining who has the strongest just claim to the last bed in the ICU in the scenario I sketched above.

We can imagine a third version of our scenario, starting with our second scenario. The lifeguard tosses the lifeline to the older drowning individual who has grabbed hold. But the lifeguard doubts that he has made the right choice. A wave disrupts the grip of the old man on the lifeline, which allows the lifeguard to think, “Now I can make a different choice; it would have been wrong for me to jerk the lifeline from his hands but he is the one who let go.” And he hurries over to the other drowning individual. My judgment is that the lifeguard would be open to justified moral criticism for essentially the same reason as in our first two scenarios. If our 85-year old patient experienced some life-threatening emergency event within an hour of being admitted to the ICU, an event the ICU was well-prepared to reverse, we would judge as unjust an ICU physician who ordered the ICU staff to allow the patient to die so that a bed would then be available for the 50-year old emergency room patient. Again, this seems to strengthen the *prima facie* rightness of the first-come first-served rule endorsed by the Thoracic Society group. Having said that, I now want to consider an alternate scenario that might require that some limitations be attached to our first-come first-served rule.

The British refer to an ICU phenomenon known as “bed-blockers.” These are patients who have inordinately long ICU stays, measurable in weeks or months.¹² This is a very challenging ethical issue for them, since they have less than half the ICU beds we have in the United States on a population-adjusted basis. Most of the time, the fact that a patient will be a bed-blocker is not something that can be known with confidence at the time of admission. But at other times this might be something that is known with confidence. Should such knowledge sometimes generate an exception or limitation to the first-come first-served?

Scenario A: Imagine that the ICU director knows at admission that a patient will need a bed for at least two months with a 40/60 chance of surviving that ICU stay. We might further imagine that this patient is 40 or 60 or 80 years old. We might also imagine that this patient has some additional incurable disease such that he has a maximum life expectancy of four years under ideal conditions. At the moment this is the last bed in a fifteen-bed ICU. Turnover in the ICU has typically averaged two patients per day for the past two years. But there are three other patients in the ICU who have been there almost a month whose prognosis is very uncertain, meaning that no one would be surprised if they were to die in the ICU. Now one thing that is clear from this description is that this patient right now will satisfy the threshold criteria of the Thoracic Society. That is, this patient has a clearly medically justified need for ICU care and he is likely to derive sufficient benefit from ICU care. But the reader will recall that the Thoracic Society also endorsed the principle that the duty of providers to benefit patients “has limits when doing so unfairly compromises the availability of resources needed by others.” Might this be one of those situations where this latter point needs to be considered?

It might be the case that the description given so far is not ethically compelling enough such that we would consider overriding the first-come first served principle in this situation. But we could add other detail that would increase the ethical pressure on maintaining the first-come first-served rule. We could imagine that half the beds in the ICU were occupied by patients who had been there already for a month or longer. We could imagine that this reduced turnover to only about one patient per day, and that it was common that once per week three or four patients were going to need admission to the ICU whose prognosis was generally much more positive. Again, I want the reader to imagine that none of the patients in the variants of this scenario are violating the threshold constraints that either justified their admission to the ICU or their continued stay in the ICU. Some might be somewhat closer to violating a threshold constraint by virtue of the fact that they are more likely not to survive this ICU stay, though no one could confidently say that there was greater than 90 percent likelihood that this would be true.

Scenario B: Imagine that as in scenario A a patient is about to be admitted to the ICU. That is, they have a 40/60 chance of surviving this ICU stay, though it is anticipated that by Day 5 it will be very clear that they either will or will not survive this stay. But then there is a reversal of medical fortune for this patient, and it is clear that they will need that ICU bed for at least two months with still a 40/60 chance of survival. Does it matter, ethically speaking, that this patient was already admitted to the ICU when it became clear that he was going to become a bed-blocker for two months? Does the fact that there is this initial clear commitment to the patient (admitting him to the ICU) mean there is now a clear moral obligation to give him a right to that bed for two months, at least as long as he does not violate the threshold conditions for continuing to have a right to that bed? This is the sort of argument that is often made in re-transplantation cases.¹³

To illustrate, a patient is given a liver transplant that is saving his life, but the liver is a little less than perfect (and the patient knew that when he accepted the liver), and it is now failing after only six months. Does this patient then have a just claim to be at the top of the transplant list (first-come first-served), even though the clear implication of providing a second liver to this patient is that some other patient will be condemned to death who otherwise would have gotten that organ? I have argued that such a patient does not have a right to go to the top of the transplant list. Part of the reason for that conclusion is that someone else is being denied any chance for additional survival while this patient will have had two chances. Also, second transplants generally do not do so well in terms of overall survival as first transplants. The mere fact that the transplant surgeon has obligations of fidelity to the best interests of that patient is not sufficient to justify claiming a second liver for him.

Likewise, as with re-transplantation, if we tighten up the empirical constraints in our Scenario B so that patients now outside the ICU are denied admission because of accumulating bed-blockers at some potential risk to their lives, then it might be the case that our first-come first-

served rule ought to be overridden. More specifically, we might imagine that all the bed-blockers in the ICU were clustered relatively closely to one another in terms of their prospects for survival. Their prospects might still be in the 40/60 or 30/70 range. In other words we would have no good enough reason for dismissing any of them from the ICU in order to admit others who might have a more urgent need and better prospects. On the other hand, if there were a couple of these patients who were close to one of the thresholds (but not in clear violation of one of the thresholds), and if we did have the less-than-perfect prognostic tools mentioned above as a basis for confirming "closeness" to a threshold, then maybe that would provide a "just enough" basis for removing such individuals from the ICU in order to allow the admission of other patients with clearly superior prospects of benefit from the ICU. The reader will notice that I am not asserting this conclusion with a high degree of moral confidence. This is reasonable because it is far from clear that a high degree of confidence is warranted. It might be the case that we could have an ICU policy that would tilt in either direction and be "just enough." What might be necessary and morally appropriate would be to engage the broader community in a process of rational democratic deliberation. What policy would they (as mostly perfectly healthy individuals at present) want to see adopted when they or their loved ones would have future ICU needs and they might either be one of the bed-blockers or a patient on the outside urgently needing access to that ICU bed and having better prospects than some patients already in the ICU? Such choices could be made legitimately and justly by our healthy deliberators because they would in fact be behind a practical (real) veil of ignorance and they would be making these choices for their future possible selves. They would not be imposing these choices on undefended others.¹⁴

Scenario C: Patient is admitted to the ICU with a 40/60 chance of survival, and an anticipated stay of two months. But after two months have elapsed, the condition of the patient has deteriorated to some degree. What is believed now is that this patient is likely to need an additional two months in the ICU with a predicted 20/80 chance of survival. Again, the patient remains within the threshold limits that the Thoracic Society has in mind for continuation in the ICU, though, if we increase the ethical pressure again so that the availability of life-saving resources for others might be significantly compromised, it seems that more consideration ought to be given to dismissing this patient from the ICU despite a commitment to the first-come first-served rule. We might add one other twist to this scenario, which must be a common enough circumstance in an ICU. Specifically, what is the ethically right thing to do if a patient does violate one of the threshold limits? That is, a patient takes a turn for the worse such that a skillful clinician would judge *at that point in time* that this patient had less than a 10 percent chance of surviving this ICU stay. For how many days should a patient be allowed to remain in the ICU having violated this threshold for remaining there, given that he *might* improve a bit and once again be within the threshold? The main conclusion I would draw at this point is that it is not ethically obvious that the first-come first-served rule is the right rule to affirm in these more complex circumstances, all things considered.

V. CONCLUSION

What is ethically compelling about the first-come first-served rule is that patients in the ICU should have something more than a tentative commitment to that ICU bed and the necessary care that they require. That is, they should not have to wonder constantly whether some patient will come along who might have somewhat better prospects than them if they instead were given that ICU bed. Having said that, we need to add that the first-come first-served rule needs constraints or qualifications in at least some clinical circumstances (though I have made no effort in this essay to identify what all those circumstances might be). Patients do not have an unlimited right to an ICU bed merely because they arrived first, or because they have remained within the threshold considerations for admittance or maintenance in the ICU. The ICU is a social resource. Relevant considerations of justice should determine who has a sufficiently just claim to that resource. If individual use of an ICU bed threatens the equal just claims of others to an ICU bed, as with some bed-blockers in some situations, then considerations of justice other than first-come first-served may justify removing a patient from the ICU. If such considerations that would override the first-come first-served rule can be clearly articulated and legitimated through a fair and honest democratic deliberative process, then that would strengthen the justness of such a practice regarding ICU rationing.

NOTES

1. Robert Truog et al., "Rationing in the Intensive Care Unit," *Critical Care Medicine* 34 (2006): 958–63.
2. Nicholas Ward and Mitchell Levy, "Rationing and Critical Care Medicine," *Critical Care Medicine* 35, no. 2 (2007): Suppl., S102–05. "Critical care is characterized by very high expenditures on a relatively few number of patients, many of whom do not survive, and it is therefore a likely place where rationing could occur" (at S102).
3. A. Sisko et al., "National Health Expenditure Projections, 2013–23: Faster Growth Expected with Expanded Coverage and Improving Economy," *Health Affairs* 33 (2014): 1841–50.
4. American Thoracic Society Bioethics Task Force, "Fair Allocation of Intensive Care Resources," *American Journal of Respiratory and Critical Care Medicine* 156 (1997): 1282–1301.
5. *Ibid.*, 1283.
6. *Ibid.*
7. *Ibid.*, 1284.
8. *Ibid.*
9. *Ibid.*
10. Lucienne Cardoso et al., "Impact of Delayed Admission to Intensive Care Units on Mortality of Critically Ill Patients: A Cohort Study," *Critical Care* 15 (2011): BioMed Central, 8pp. <http://ccforum.com/content/15/1/R28>.
11. W. A. Knaus et al., "The APACHE III Prognostic System: Risk Prediction of Hospital Mortality for Critically Ill Hospitalized Adults," *Chest* 100 (1991): 1619–36.
12. One example of a bed blocker at the extreme end is reported in the *Wall Street Journal*. This was the case of Scott Crawford, 41 years old, with a failing heart. He did receive a heart transplant, but shortly thereafter he became septic. He suffered kidney failure, needed to have a leg amputated, and suffered respiratory failure as well as other medical complications. He was maintained in the ICU though his prospects after six months were described as "bleak." He died after 11 months in the ICU and bills of \$2.7 million. See Janet Adamy and Tom McGinty, "The Crushing Cost of Care," *Wall Street Journal* (July 6, 2012). <http://www.wsj.com/articles/SB10001424052702304441404577483050976766184>. Accessed March 31, 2015.
13. Peter Ubel, Robert Arnold, and Arthur Caplan, "Rationing Failure: The Ethical Lessons of the Re-transplantation of Scarce Vital Organs," *JAMA* 270 (1993): 2469–74. I wrote a paper in response to this essay (unpublished) under the title "Re-Transplantation of Major Organs: A Critical Assessment" (1994). Readers may request a copy.
14. I defend at length a certain version of rational democratic deliberation in my book, *Just Caring: Health Care Rationing and Democratic Deliberation* (New York: Oxford University Press, 2009), ch. five.