RESPECT AND HEALTH CARE ETHICS: RESPECT, SOCIAL POWER AND
HEALTH POLICY

by

Meredith Celene Schwartz

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DEDICATION PAGE

Dedicated to Sue Campbell and Iris Marion Young who continue to inspire my philosophical perspectives.

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ABSTRACT

In this dissertation I argue in favour of a communicative view of respect for human dignity. This view of respect builds on recent interpretations of Kantian respect as second-personal, but adds an analysis of the ways in which contexts of pervasive structural social inequalities impoverish the epistemic and expressive resources within a society. I argue that, under conditions of structural social inequalities, respecting one another requires more than merely adopting a particular attitude or stance toward one another; it also requires achieving an understanding of the other across difference. Respect, on a communicative view is not an attitude adopted by one individual, but is instead a relation between two individuals as they attempt to interpret and understand one another across differences.

My view of communicative respect situates the respecting agents in their social contexts and examines the ways in which these contexts might create barriers to mutual understanding among members of differentially situated groups. When such barriers exist, a communicative view of respect demands that, at minimum, the individuals attempting to respect one another engage in this interaction with great care, for the dangers of misunderstanding are likely to be great. In many cases, in order to respect one another as moral equals, we must work to dismantle systems of oppression.

LIST OF ABBREVIATIONS USED

AIDS   Acquired Immune Deficiency Syndrome
AMA   American Medical Association
DHHR   Department of Health and Human Resources
HIV   Human Immunodeficiency Virus
WHO   World Health Organization

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I also want to recognize the patience and support of my partner, Joel Swedburg. He helped me in innumerable ways throughout the development of this project. He is always unwavering and warm in his support for me and this project.

Finally, I acknowledge the contribution of my parents, Mary Ann and Paul Schwartz. As a child in grade school I looked forward to professional development days

when I could sometimes accompany my father to his work as a medical photographer. I enjoyed using processors like the enlarger and developer and "helping" my dad as he arranged his subjects. I think being around the medical department at the University of Toronto and in my father's studio profoundly shaped me because by high school, biology was my favourite subject and an interest in human biology, health and disease has been an important focus of my academic career.

From both of my parents, I gained an interest in social justice, fairness, and equality. The story of how my parents met during the race riots in Detroit was part of the lore of my family repeated throughout my childhood. My parents told me about how their experiences with injustice partly motivated their emigration to Canada, which they saw as a fairer society. My mother, in particular, was concerned about classism, racism and sexism. She devoted her working life as an early childhood educator to a place called The Children's Storefront that sought to create a stronger community and lessen the isolation sometimes felt by the primary caregivers of small children, which she understood as a feminist act. She often told me that she thought abolishing slavery was a major task for social justice in the 19th century. She saw civil rights as a major task for social justice in the 20th century. She predicted that a major task for social justice in the 21st century would be to better understand the demands of equal moral respect.

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CHAPTER 1   INTRODUCTION

Bioethics has a problem with respect. The problem is not that bioethicists are disrespectful, or that they don't talk about the importance of respecting persons. Instead, the problem is that bioethicists talk a lot about respect: the concept of respect shows up everywhere from human research ethics documents,[1] ethical principles for clinical care,[2] health care professionals' codes of ethics,[3] to statements about the ethics of human embryo and stem cell research,[4] and health policies.[5] The problem with including the concept of respect in all of these disparate places is that the concept is often left unexamined. Policies often mention the importance of respect, but they seldom explore the concept and instead treat as obvious what respect entails and requires. Further, it can sometimes be difficult to see how the concept of respect has been put to work within

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[1] For example, World Medical Association (2008), National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) *The Belmont Report*, Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada (1998) *The Tri-Council Policy Statement*, Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada (2010) *The Tri-Council Policy Statement: Second Edition*. I discuss these research policies in greater detail in Chapter 2.

[2] See Beauchamp and Childress (1983; 2001; 2009). I discuss Beauchamp and Childress' *Principles of Biomedical Ethics* in greater detail in Chapter 2.

[3] For example, Canadian Medical Association (2004), Canadian Nurses Association (2008), American Medical Association (2001), Australian Medical Association (2004), World Medical Association (1948), International Council of Nurses (2000).

[4] For example, National Bioethics Advisory Commission (1999) *Ethical Issues in Human Stem Cell Research*, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1975) *Report and Recommendations: Research on the Fetus*, National Institutes of Health (1994) *Report of the Human Embryo Research Panel*, and U.S. Department of Health, Education and Welfare, Ethics Advisory Board (1979) *HEW Support of Research involving In Vitro Fertilization and Embryo Transfer*. For a discussion of the use of 'respect' in these various policies, see Lysaught (2004).

[5] For example, The World Health Organization (WHO) (2007a; 2007b; 2008a), West Virginia Department of Health and Human Services (2005).

health policies or how the policy is meant to promote respect among those subject to the policy. Invoking the concept of respect risks becoming a mere rhetorical device intended to set us at ease about the way medicine is practiced, the way medical research is conducted, or the requirements of health policies.

The concept of respect has significant rhetorical power because respect is important in our everyday lives and respect has a central place in many different moral and legal traditions from a variety of cultures. Children are taught to respect their parents, elders, religious leaders and cultural traditions (Dillon 2007b). Some patriots emphasize their respect for their country, flag and military troops. Musicians and rappers have written songs about the importance of respect.[6] Philosophers stress the importance of recognizing the respect that is owed to all persons in virtue of their inherent equal moral worth, or dignity (Kant 1995, 1996). The Preamble to the *Universal Declaration of Human Rights* affirms the importance of respect for the inalienable human rights and inherent dignity of all persons as the "foundation of freedom, justice and peace in the world" (United Nations 1948). Respect has been important in movements that struggle for social justice. Movements for social justice often identify practices and institutions that fail to respect members of social groups because of racism, sexism, heterosexism or classism (among other forms of prejudice). Securing greater respect and self-respect for members of oppressed social groups is both a goal and an effect of social justice movements (Thomas 1995). Many philosophers argue that the moral goodness or justice of a society depends in part on whether it supports the respect or self-respect of its

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[6] The examples here are too numerous to name, but a particularly well-known example is Aretha Franklin's cover of Otis Redding's "Respect," in which she changed the tone of Redding's more pleading version to a demand for the respect she deserves and is owed. Rap artists have also written about the significance of being disrespected or "dissed."

members (Rawls 1971; Meyers 1995; Thomas 1995; Anderson 1999). When we invoke the concept of respect it carries an array of rich, thick and weighty connotations. The importance of the concept of respect gives it rhetorical power and so bioethicists and policy makers should be careful when they invoke the concept to ensure that they are actually using the concept in their work. In some cases, as I read health policies aimed at reducing health inequalities, I got an uneasy sense that the policy was not being respectful of those subject to the policy.

1.1 RESPECT AND HEALTH POLICY

Policies can create environments that are conducive to respecting one another, that are neutral regarding interpersonal respect, or they can create barriers to this respect. That is, interpersonal respect is conditioned by the policies implemented within a given society. Take homecare for example; many policies promote homecare as a means of enhancing patient autonomy and dignity precisely because they allow patients to remain at home, and in North American contexts the home is closely tied to ideas of independence, privacy, personal control, dignity and freedom.[7] The greater sense of control that patients have when they are in their own home, rather than an institutional setting, allows patients to relate to their friends, family, and caregivers as equals in a way that is not available to institutional residents (Parks 2003, 61). One reason provided for preferring homecare to hospitalization is that homecare helps patients maintain a sense of dignity that helps them resist the depersonalization that often occurs in institutional settings (Romanow 2002, Chapter 8; Twigg 1999).

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[7] I am well aware that the home often falls short of these idealizations, and the home can also be a site of abuse. The dominant trope in North America, however, is that the home is one's castle.

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Although the positive effects on patient autonomy and dignity are sometimes cited in policy documents that recommend homecare over the hospital, many homecare policies fail to consider what a home health care provider needs in order to show respect for the patient. In order to respect their patients, homecare providers must treat them as persons, rather than viewing the interaction merely as a set of tasks to be completed on a body as quickly as possible and thereby dehumanizing or objectifying the patient. This is often made difficult for the homecare provider because they are under pressure to help their clients get out of bed, bathe and perform other toiletries, dress and eat; however, their employer often allows about an hour for each visit (Parks 2003, 45). When only a very short time is allotted for performing these complex and intimate tasks, many homecare providers have little choice but to see their work as performing a series of tasks as quickly as possible. In this case, the economic imperative for homecare providers to be efficient can undermine their ability to treat their patients as persons, rather than seeing the interaction as a series of tasks to complete. Jennifer Parks, who was a homecare nurse, believes that many homecare providers acutely experience the tension between engaging with their patients respectfully and the pressure to do their jobs efficiently. She believes this pressure contributes to caregiver burnout and the high turnover of homecare workers (Parks 2003, 41). The institutional structures and rules created by health policies create the conditions under which interpersonal respect is enacted and sometimes these policies can make interpersonal respect more difficult.

It is important to examine all kinds of health policies for the role that respect is playing within the policy and to assess whether the policy facilitates interpersonal respect. What I understand from the discussion of relational autonomy might suggest that

it will be especially important to consider the role of respect when policies target social groups that are vulnerable to illness because of their group memberships. For example, in liberal democracies the poor and those who are dependent on social assistance often face several stereotypes that undermine their status as respect-worthy. To the extent that autonomy is equated with independence, self-sufficiency and self-reliance, their very status as depending on state aid can impair their autonomy and respect standing.[8] The poor are often assumed to be undereducated and to lack the skills to understand the complexities of medical risks and advice, making them vulnerable to paternalistic interventions.

A recent overhaul of the West Virginia Medicaid plan illustrates this point.[9] West Virginia's Department of Health and Human Resources (DHHR) was concerned because Medicaid benefits had not been expanded in decades. The DHHR undertook a massive redesign of the Medicaid system that would allow beneficiaries access to enhanced benefits[10] on the condition that they sign a member agreement which includes the responsibility to "follow the rules and requirements of the West Virginia Medicaid program and [the] health plan" (West Virginia Department of Health and Human Services 2005, Attachment D). Beneficiaries must keep their doctor's appointments, take

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[8] See Young (1995) for an interesting discussion of how ideas of self-sufficiency began in liberal theory as ways to enhance equality among (white male) citizens, and gradually was transformed into a means of undermining our equality as citizens.

[9] West Virginia is not alone in proposing greater personal responsibility in health care. Florida, Idaho, Kentucky, and Germany have all proposed plans that offer incentives or disincentives to encourage patients to take steps to preserve their health. See Goldstein (2006), Schmidt (2007) and Schmidt (2008) for a discussion of these other plans. See Schwartz (2009) for a discussion of how the West Virginia Medicaid plan might also affect climates of trust and distrust between doctors and patients.

[10] The expanded benefits include nutritional counseling, ophthalmic and dental care.

their prescribed medications, eat well, not smoke, not drink alcohol in excess, and follow other health-related advice from their health care practitioners (West Virginia Department of Health and Human Services 2005, Attachment D). Beneficiaries who do not meet the requirements will lose any of the expanded benefits for which they may have previously qualified.[11] Health care providers are expected to monitor and report on the patient's compliance with the requirements, but "the plan does not specify standards for the successful adherence to these criteria" (Bishop and Brodkey 2006, 756). Enrolling in the expanded benefits plan is voluntary: Medicaid beneficiaries can decide whether to sign up for the extended benefits or remain with the system of Medicaid benefits that had previously been available in West Virginia.

The West Virginia Medicaid redesign intends to improve the quality of life for the beneficiaries it serves, but it increases the constraints on their choices. For example, although the plan allows beneficiaries to exercise their autonomy, it limits this exercise to giving blanket consent to the requirements of the expanded Medicaid plan. The beneficiaries are allowed to decide whether to sign up for the benefits or refuse them, but if they do opt to sign up for the plan they are required to comply with their doctor's orders. This requirement impedes their ability to refuse the individual prescriptions or recommendations of their health care provider. The plan requires patients to promise to take care of their health by making "lifestyle" choices (eating well, not smoking, and drinking only in moderation) that are currently fashionable among affluent members of North American societies, but these "lifestyle choices" may ignore the realities of living

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[11] For example, if the Medicaid beneficiaries fail to meet their responsibilities, they will be limited to four prescriptions per month, regardless of need or ability to pay out-of-pocket.

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on little income in poor neighbourhoods. Many people who are working low-wage jobs or are receiving social assistance have difficulty meeting dietary recommendations on their meagre incomes (Ehrenreich 2001, 196-197), or because poor neighbourhoods have plenty of convenience stores that sell junk food, but lack grocery stores that sell fresh produce (Latham and Moffat 2007; Grenon, Butler and Adams 2007; Larsen and Gilliand 2008). The plan requires patients to keep their medical appointments, but it can be very difficult to meet this requirement. Many patients who work low-wage, insecure jobs, complain that they cannot always make their appointments because they cannot get time off work and lack benefits such as sick leave. Many patients cannot find childcare or reliable transportation to the health care facility.

Under the revised West Virginia Medicaid plan the doctor and the patient are positioned in ways that exaggerate already existing inequalities between them. The doctor is charged with monitoring the patient's compliance and is given wide latitude to decide what this amounts to because no standards for compliance are specified. In contrast, the Medicaid beneficiary is put in a highly unequal position relative to the provider and is given little latitude when negotiating with their provider who might read the negotiation as non-compliance. Finally, the policy itself can reinforce the view that those who are dependent on social assistance only have a right to that assistance if they meet certain conditions. This policy seems suspicious of the Medicaid beneficiaries, and when I first read the plan I could not shake the feeling that this policy is disrespectful toward those who might be subject to it. But I had no way of analysing this uneasy sense that would fit with the mainstream bioethical interpretation of respect as "respect for autonomy" and I was not sure what a feminist "respect for relational autonomy" might entail.

In this dissertation I am interested in four related elements of respect: First, I am interested in interpersonal respect and how our political and philosophical ideals of equal moral respect are (or fail to be) enacted in the often highly-unequal relationships that characterize health care encounters. Second, I am interested in how interpersonal respect is conditioned by the kinds of health policies that are implemented. Third, I am interested in how respect is related to social group membership in ways that can undermine or create barriers to interpersonal respect. Finally, I am interested in how unequal social contexts can affect health policies which in turn can serve to undermine respect for individuals who come from oppressed groups. I do not consider these elements in separate chapters, instead these concerns are woven throughout all of the chapters arising as thematic issues concerning respect that need to be examined. By examining these four elements, I hope to be able to clarify how we could move toward creating more respectful health policies in the face of the numerous social inequalities that characterize modern societies.

1.2 STRUCTURE OF THE DISSERTATION

I argue for a communicative view of respect for persons that builds on Darwall's (2006) second-personal interpretation of Kantian respect for human dignity. Kantian discussions of second-personal respect add an important relational element to respect, but pay insufficient attention to the barriers to understanding one another that can be erected in contexts of structural social inequalities. On my view, respect is not an attitude that one person adopts toward another; it is a feature of the communicative relation between persons. Under oppressive social structures the expressive resources available within a given society are often deficient. Deficient epistemic and expressive resources will

undermine our ability to understand one another and will create barriers to the equal

moral respect that we owe one another. Respect for persons is, therefore, not something

that is under individual control but instead involves shared responsibilities to resist forces

of oppression and domination within a given social context.

In the second and third chapters I begin my analysis of the concept of respect in

bioethics by selectively surveying some of the important ways the concept of respect has

been used in bioethics to date. I begin in Chapter 2 by examining the introduction of the

concept of respect into the bioethical discussion in *The Belmont Report* and the canonical

work of Beauchamp and Childress (1979). Early in the development of bioethics,

theorists tended to focus on interpersonal respect in doctor-patient encounters and in

human research. In clinical contexts, they were particularly concerned with the dangers of

paternalism as one way that we can fail to respect one another by violating the other's

autonomy (e.g. Beauchamp and Childress, 2009). In research contexts, the worry focused

on the potential for researchers to neglect the well-being of subjects in pursuit of greater

medical knowledge. To counter the possibilities of paternalism and research abuses, early

bioethics stressed the importance of respecting either 'persons' or their 'autonomy.'

In both research and clinical contexts, the concept of respect was put into practice

by obtaining informed consent before performing any medical procedures or enrolling a

subject in a research protocol. The focus of the discussion in early bioethics was on

practical rather than theoretical issues: bioethicists described in detail how to determine

whether an individual is competent (and hence able to make autonomous decisions) and

they debated the requirements of a fully informed consent. There was less attention paid

to the nature of *respect* or the requirements that follow from an obligation to respect persons or their autonomy.

In Chapter 3 I examine some more recent criticisms of and reactions to the concept of respect that I described from the early bioethics literature. Beginning in the 1990s, feminist bioethicists focused on the 'autonomy' element of "respect for autonomy." They objected to the atomistic and self-interested view of moral agents and their autonomy. In their place, they described relational views of autonomy that have broadened the discussion by examining a number of ways in which our autonomy is constrained under unequal social contexts (Sherwin 1992; Sherwin 1998; Meyers 1995; Meyers 2004; Walker 2007). Feminist bioethicists described the ways in which research and clinical practice fail to provide members of disadvantaged groups the resources required to support their autonomy (for example, they have failed to conduct research on disadvantaged social groups that would be required in order for members of these groups to make an informed decision). According to these views, competence, coercion and misinformation are not the only constraints on individual autonomy; an individual's autonomy can also be constrained by the social relations that exist in an individual's social context. Mainstream bioethicists responded to the feminist criticisms by suggesting that we should work against oppressive forces that undermine autonomy, but they did not believe that feminist accounts of relational autonomy would require significant revisions to their view of autonomy. I argue that this underestimates the power of the feminist criticisms. If we accept a relational view of autonomy we are required to revise the view of respect prevalent within bioethics because it is no longer sufficient to merely accept the voluntary decisions made by individuals. Some of the more recent discussions in

research ethics (*The Tri-Council Policy* 1998, 2010) and the ethics of public health policy (Powers and Faden 2006) seem to be implicitly drawing on a changed view of respect, but it is not yet clear how these authors understand respect.

In Chapter 4 I turn to a closer examination of Kant's ethics and his description of autonomy. One feature of Kantian ethics that lends it philosophical elegance is Kant's systematic understanding of different concepts and how each is connected to the others. His view of rational beings as autonomous is based on our ability to reason about the moral law and thereby give ourselves an understanding of our moral duty. Autonomy, on his view, is not the mere ability to make decisions or set our own ends; instead, it is the ability to prescribe a consistent and universal law according to which we should act. The autonomous will elicits our respect because of its relation to the "holiness and strictness" of the moral law (*The Metaphysics of Morals* 1996, 187; AK 6:435-436).[12] I discover that the discussion of autonomy in Kantian ethics is quite different than that found in canonical bioethical texts. It is not clear that a Kantian interpretation of autonomy would support current practices of obtaining informed consent. Instead, we find stronger support for the importance of respecting patients and obtaining their informed consent in the passages within Kant where he discusses dignity, which is the absolute worth of persons that puts them beyond any "price" or system of values-of-exchange. It is in these passages that we find Kant's second formulation of the categorical imperative: "Act so

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[12] I have been working with translations of Kant's work. The date and the first page reference refer to the translated edition that I have used. Following the reference to the translated edition I have included a reference to the Standard German edition of Kant's writing issued by the German Academy as it was reported in the translated volume. The reference appears as AK followed by the volume and pages where the original passage was found. I include the AK references in order to make it easier for the reader to verify the citations across different translations of Kant's work.

that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only" (*Foundations of the Metaphysics of Morals* 1995, 46, AK 4:429). This formulation of the categorical imperative forbids deceptive, coercive and violent means of convincing others to participate in your ends.

Some recent interpretations of Kantian ethics have stressed the distinction that Kant places on the different perspectives we can take when relating to and contemplating other persons. From one perspective we can consider people as things, as objects of scientific study, bodies to be acted on, or the subject of social policy (Strawson 1974); from the other perspective we consider persons as agents, as persons who have experiences, reasons for their actions, and with whom we can engage interactively. These discussions of Kantian ethics suggest that respecting another involves taking a second-personal relation toward the other (Darwall 2004; 2006). In Chapter 4 I argue that these discussions shed light on the importance of respect in bioethics: we might expect that any practice that encourages us to adopt an objective stance toward one another will be a practice where reminding ourselves we should also take an interactive stance (the stance taken when we respect persons) will be of particular importance. Because medical research and medical treatment encourage the physician or scientist to adopt an objective stance toward the body as an object of scientific study or medical treatment we should expect that principles of respect ought to be prominent to help mitigate the objective stance. When we think of respect in this way, we might be able to discover other practices where respect should also be prominent. In the domain of bioethics, one such practice might involve setting medical and public health policy, since setting policy

involves taking an objective stance on persons: that is, viewing them as a social or medical problem to be solved.

Although the second personal view of respect has significant advantages over earlier (third personal) views of Kantian respect, in Chapter 5 I argue that there are, nevertheless, limitations to the second-personal view when it is applied in contexts of structural inequalities like those that feminist theorists have exposed. Both Kant and Darwall claim that equal moral respect is compatible with social inequalities. Although it is true that individuals are still owed equal moral respect even if they occupy a lower position in the social hierarchy, both Kant and Darwall pay insufficient attention to the multiple ways in which social inequalities can undermine the equal moral respect that we all deserve. I argue that pervasive structural inequalities often undermine our ability to understand one another as moral equals because these inequalities affect our authority, autonomy, responsibility and whether we will be forgiven for our transgressions. Kant's view of respect does not focus sufficient attention on these aspects of a relational view of respect and so his view remains incomplete. When features of the social structure operate in ways that create unequal expressive resources, epistemic lacunae and epistemologies of ignorance, it is not sufficient to merely accept the reasons of others when we consider these reasons to be minimally rational. Instead we must work against the forces of oppression and domination, that might distort our ability to respect one another as equals.

In Chapter 6 I argue that a relational understanding of autonomy demands a communicative view of respect in which respect is not merely an attitude adopted by one individual toward another but is instead a second-personal relation that demands an understanding of the other from the other's perspective. This kind of communicative

respect will involve the exchange of reasons between two individuals, but from the perspective of respect it is not sufficient to focus on the two interlocutors. Instead, we need to focus directly on the forces of oppression and domination that contribute to our misunderstandings of one another. We cannot eliminate these complex forces in a single interaction, however. Working to resist oppression and domination requires a collective effort and shared responsibilities. Under social conditions that involve pervasive systems of oppression and domination, often the best that two individuals can do when attempting to respect one another as moral equals is to be careful about how they attempt to demonstrate respect toward one another within systems of structured inequality.

CHAPTER 2   **RESPECT IN EARLY BIOETHICS (1940s-1980s)**

In Chapter 1 I described the prominence of respect as a concept in bioethics, but I claimed that despite the frequent mention of respect, bioethicists have not sufficiently explained the concept. In this chapter I describe the uses of respect within early bioethics contexts in order to begin to motivate my claim that this concept requires greater bioethical attention (a task I continue in Chapter 3). Medical ethics has been around in some incarnation since at least the ancient Greek physicians,[13] but the current discipline of bioethics arose in the late 1940s largely as a response to Nazi atrocities and later scandals in medical research and, in the 1960s and 1970s, as part of a patients' rights movement that stressed the important role of value differences in clinical decision-making (Wolf 1999, 65-66). In section 2.1 I describe the research and clinical contexts that formed the backdrop to the emergence of bioethics as a discipline. My aim in this section is to identify and describe the concerns that motivated the introduction of the concept of respect in bioethics. In section 2.2 I examine the concept of respect that developed as part of the bioethical response to these problems in research and clinical medicine. In general this concept of respect has been attributed to Kantian ethics, although the connections are not always explained in much detail. I note some of the differences in the object and scope of the concept of respect developed by *The Belmont Report*[14] in response to research abuse and *The Principles of Biomedical Ethics*

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[13] The Hippocratic Oath is one example of ancient bioethics that continues to have influence today. Another example comes from the model of physicians as having Aesculapian authority, a view that refers to Aesculapius a healer at Troy.

[14] *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* is authored by the National Commission for the Protection of

(Beauchamp and Childress 1979) in response to problems in clinical medicine. Despite the differences in the concept of respect developed in research and clinical ethics, both concepts of respect have the same practical application in the practice of obtaining informed consent from research subjects or patients, as I describe in section 2.3. Respect is put into practice by protecting the rights of individuals to refuse or accept whatever research protocols or treatment options they are offered by physicians or researchers.

My aim in this chapter is to highlight the subtle differences, as well as the similarities in the concepts of respect that were developed at the beginning of bioethics as a formal discipline. These early discussions of respect are useful because they add a more substantial ethical grounding to the codes of ethics, such as the *Nuremberg Code* and the *Hippocratic Oath*, which came before them. But they are also limited because they pay insufficient attention to the important role that difference played in the scandals I describe in section 2.1. In Chapter 3 I explore how some more recent uses of the concept of respect pay more attention to difference and so represent a significant departure from the concepts of respect described in this chapter. A second issue with the discussion of respect in early bioethics is that the theoretical grounding of the concept is often invoked quite loosely. The concepts of respect described in bioethics literatures are often attributed to Kant, but the concepts differ in many ways from his discussion. I explore these issues further in Chapter 4.

2.1 HISTORICAL CONTEXT: RESEARCH ABUSES AND CLINICAL PATERNALISM

Human Subjects of Biomedical and Behavioral Research (1979). For simplicity I refer to the document as "*The Belmont Report*" throughout this chapter.

The context in which bioethics developed was characterized by situations in which there were unchallenged and unchecked differences in power and knowledge between medical researchers and research subjects and between physicians and their patients. In some cases this resulted in abuses or scandals and bioethics was born in response to the outrage caused by the public attention to these indignities (Wolf 1999). In this section I look at some of these cases in order to situate the concept of "respect" in the historical context that inspired its introduction into bioethical discussions.

2.1.1 Abuses in Medical Research

Probably the most widely known instances of abuse of research subjects were the experiments carried out on prisoners in Nazi concentration camps. The Nazi doctors conducted their experiments as part of an explicitly racist attempt to exterminate the Jewish people (Wolf 1999, 65).[15] These experiments were often painful and cruel, and many of the research subjects were killed, disfigured, or disabled in the course of these experiments. The experiments included studies to examine "the limits of human endurance and existence at extremely high altitudes," (*Nuremburg Medical Case Transcript* 1946, 11).[16] Subjects were put into chambers that mimicked the low-pressure that occurs at altitudes of up to 68,000 feet (about 21,000 meters). Approximately 200 subjects were involved in the high altitude experiments and about 80 subjects died in the process. Nazi doctors also conducted experiments to study, prevent and treat

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[15] Jews were not the only subjects of the Nazi experiments. Any concentration camp inmate was at risk, including inmates who were homosexual, gypsies and enemies of the state. The most explicit racism was against the Jews, however.

[16] All quotes come from the Harvard Law School Library's *Nuremberg Trials Project: A Digital Document Collection* http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/1_01.html accessed March 4, 2010. The page numbers refer to the pages of the original document, not to the document provided on that website.

hypothermia. Prisoners were frozen in tanks of ice water, or kept naked outdoors in freezing temperatures; then researchers tried various means of rewarming them. About 100 people died in the course of these experiments. Thousands of healthy concentration-camp inmates were deliberately infected with malaria, epidemic jaundice, spotted fever, yellow fever, small pox, cholera, diphtheria, typhoid, or paratyphoid so that the efficacy of various drugs and vaccines could be tested. The death toll from these experiments was enormous. More than half of the subjects in the malaria experiments died, while 90 percent of the participants in the spotted fever experiments died. Doctors also used various tests to investigate sulphanilamide, an antimicrobial agent. Researchers deliberately infected wounds with streptococcus, gas gangrene, and tetanus. They interrupted the flow of blood with tourniquets to simulate battlefield injuries, and aggravated these injuries by "forcing wood shavings and ground glass into the wounds" causing intense agony and injury to the research subjects (*Nuremburg Medical Case Transcript* 1946, 12). Researchers inflicted chemical burns on subjects in order to test the efficacy of various treatments for incendiary bombs. During the Nuremburg trials, the cruelties of Nazi medical experimentation were revealed.

The revelations from these trials prompted the development of the *Nuremberg Code* (1947) which outlined 10 principles for ethical human experimentation. The first of these principles is that research subjects must give voluntary consent. The *Nuremberg Code* specifies the requirements of valid, voluntary consent: the subjects must have the legal capacity to consent, they must be informed about the research, they must comprehend the information required in order to make an enlightened decision, and they must have "free power of choice, without the intervention of any element of force, fraud,

deceit, duress, overreaching or other ulterior form of constraint or coercion" (*Nuremberg Code* 1947). The members of the Nuremberg tribunal believed they were articulating principles of research that were already widely accepted by the research community. However, the defence lawyers could point to many similarities between Nazi experiments and experiments that were occurring in the United States (Steinbock, Arras, and London 2009, 729). The principles of the *Nuremberg Code* do not seem to have been as widely accepted by researchers as the members of the tribunal believed.

The *Nuremberg Code* was meant to have international application, and it was adopted by the American Medical Association (AMA) in 1947, the same year it was drafted (Phillips 2001, 240). The *Code* did not appear to have much effect on research practices in the United States, however. Bonnie Steinbock, John Arras and Alex John London postulate that the context in which the *Nuremberg Code* was developed (as part of Nazi war crimes trials) might have given American researchers the perception that it did not apply to what they were doing. The Nazi doctors were characterized as "monsters" and their research was condemned for being of little scientific value. Medical researchers in America might not have believed that the research in which they engaged had much in common with the Nazi experiments. Researchers might have thought that the rules of the *Nuremberg Code* did not apply to the legitimate research in which they engaged (Steinbock, Arras, and London 2009, 729).

Although the Nazi medical experiments are the most widely known set of cases of medical abuse in research, they are by no means an isolated instance. The Tuskegee syphilis study began well before the *Nuremberg Code*, but continued long after. Like the Nazi experiments, the Tuskegee study is said to have little scientific value and the

researchers expressed racist views about the experimental subjects. This study, conducted

by the U.S. Public Health Service in Tuskegee, Alabama between 1932 and 1973,

enrolled approximately 400 African American men with late-stage syphilis and 200

uninfected African American men as controls in a trial to study the natural course of

syphilis (Jones 1981, 1). Although similar studies of the natural course of syphilis had

already been conducted on Norwegian whites, the Tuskegee researchers reasoned that the

natural course of syphilis was likely different in blacks and whites (King 2001, 243-244).

Dr. Taliaferro Clark headed what he called a "study in nature" rather than an experiment.

Dr. Clark believed that syphilis was extremely prevalent among blacks in the area and

that most of the blacks (he believed about 99%) would not seek treatment for the disease.

This created what he called a "ready-made situation" to study syphilis, where the perfect

conditions for the study were occurring "naturally" (Clark quoted in Brandt 2009, 755-

756). The physicians did not think they were increasing the risk of spreading syphilis in

the population because they believed that the conditions were already occurring, and they

could merely passively observe as the disease ran its natural course.

Finding a sample for the Tuskegee study proved difficult. The prevalence of

syphilis in the area was well below what the researchers expected (Jones 1981, 116).

Further, many of those who did test positive for syphilis had already sought treatment,

and so had to be excluded from the study according to the study's inclusion criteria.[17]

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[17] Another difficulty was that when Dr. Vonderlehr (appointed to the study by Dr. Clark) explicitly stated the inclusion criteria for the study (men over 25) none of the men in the area would show up because they feared the exams were draft physicals. The doctor had to test many women and men who did not fit the trial criteria to deceive the actual research subjects about the purpose of the physical exams. This added cost to the study because the researchers promised to treat all those whom they discovered were positive for syphilis but who did not meet the trial's inclusion criteria. The researchers were very

The physicians involved in the research attracted poor share-croppers to the study by deceptively offering free medical examinations and treatments. Many of the medical procedures were not for the general health of the patients; they were actually used to test for the presence of and to study syphilis (Pence 1999, 467). All of the research subjects in the Tuskegee study were denied access to penicillin long after it was proved an effective treatment for syphilis and had become widely available in 1953 (Jones 1981, 178). Local physicians were given the names of the research subjects and instructed not to treat their syphilis, even though failing to treat communicable illnesses was illegal under Alabama law (Jones 1981, 144-45; 178).

When the actions of these researchers were uncovered in the 1970s, the Public Health Service offered the excuse that penicillin would have been harmful because of the advanced stage of the participants' syphilis (Jones 1981, 195; Brandt 2009, 760, 761). To explain their actions, the researchers again cited the importance of the research for advancing medical knowledge, coupled with the belief that they were not creating an increased risk for the study participants because, as one researcher stated, African Americans are a "notoriously syphilis-soaked race" (quoted in Pence 1999, 465). Again, the researchers cited the alleged lack of treatment-seeking in this population as an established fact that was not created by the researchers, but existed "naturally" in the area (Dr. Charles Barnett quoted in Brandt 2009, 761).

There were a number of problems with the Tuskegee study. First, the researchers were deceptive about the study. The researchers misled the subjects who believed they were receiving medical treatments when in fact they were being tested for the presence

eager to control these costs, which they believed were difficult to justify (Brandt 2009, 757).

and progression of syphilis. Second, the researchers failed to inform many of the research subjects that they had been diagnosed with syphilis. The subjects were not informed that the disease was contagious nor that it was transmitted through sexual intercourse. Without the diagnosis, the research subjects could not take any steps to reduce the spread of the disease, for example by remaining abstinent (Jones 1981, 74). Third, once penicillin was widely available and known to treat syphilis, the researchers actively withheld treatment from the research subjects in order to preserve the integrity of the study (Jones 1981, 178; Brand 2009, 757). Finally, the researchers were unable (or perhaps unwilling) to notice that facts about the study population contradicted their beliefs about the conditions that justified the study. The researchers believed that they were conducting "a study in nature," and could be "passive" observers of conditions that were "naturally" occurring. But the facts of the situation contradicted these beliefs. Many potential research subjects had to be excluded because they had already sought treatment and many of the subjects who were included in the research were willing to participate only when they believed they were receiving therapy (Brandt 2009, 757). Both of these facts should have raised questions about the presumption that the study population would not seek treatment. Instead of being "passive" observers of a "study in nature" the deceptive practices of the researchers combined with their withholding information about the syphilis diagnosis and treatment (once it became available) contributed to creating the conditions the researchers believed were "naturally" occurring. The Tuskegee study is now believed to have contributed to the deaths of many of its research subjects and contributed to the spread of syphilis among African American women and men in the area.

Like the researchers in the Tuskegee study, the researchers involved in the Willowbrook State School study of hepatitis justified their actions by appealing to the questionable claim that they were conducting "studies in nature" that did not put their research subjects at additional risk because the condition studied was already so prevalent in the population (Rothman and Rothman 2009, 752). Unlike the Nazi experiments and the Tuskegee trials, the importance of the research and the quality of the data in the Willowbrook study has not been questioned. Further, the researchers in the Willowbrook study received permission from the parents of the children involved in the research (Steinbock, Arras, and London 2009, 730). Nevertheless, the Willowbrook study is widely considered to exemplify exploitive practices because the researchers demonstrated a lack of concern for the research subjects by purposely exposing them to a dangerous disease and by creating misleading and coercive letters to obtain permission from the subjects' parents.

From 1956 to 1972, physicians in New York State led by Dr. Saul Krugman infected about 800 mentally impaired children with the hepatitis virus in order to study the course of the disease from its earliest stages and develop a vaccine. The Willowbrook State School had high rates of hepatitis infection among both the staff and the resident children. Because the rates of hepatitis infection were so high, Dr. Krugman believed that treatment would be inefficient and it would be more effective to develop preventative measures such as vaccines (Rothman and Rothman 2009, 749). Further, the researchers believed they were also directly benefitting the research population because their study used a mild form of the hepatitis virus, which could protect the children from the more virulent strains found on the ward.

Krugman's experiments were intended to determine whether injections of gamma globulin (the part of blood plasma that is rich in antibodies) would protect children from hepatitis. Krugman opened a special unit in the school to admit children between the ages of three and eleven to the study. He and his researchers injected some of the children with gamma globulin, while others who served as controls were not given the injections. Both groups were fed live hepatitis virus. Krugman compared the number of hepatitis infections among the controls with the number among those who had received the gamma globulin. He found that gamma globulin did provide protection against hepatitis infection. Six to twelve months later, Krugman fed both groups another dose of virus to determine whether the gamma globulin had any lasting protection against the virus or whether the protection was only short-term. Krugman discovered that the gamma globulin did indeed provide lasting protection to those who had received the injections. These experiments yielded another set of important results. Dr. Krugman closely tracked the rate of infections in the school and was able to determine that two different virus strains cause hepatitis, strains that we now call hepatitis A and hepatitis B. Krugman's results were met with acclaim and he was praised for both his results and his research methods (Rothman and Rothman 2009, 750-751).

Although Krugman's trials did yield scientifically and medically valuable knowledge, they are nevertheless ethically questionable, and Krugman's justifications are dubious. Krugman claimed that he was conducting a "study in nature" because he did not create the conditions that contributed to the spread of hepatitis in the school, but it is difficult to square this claim with the fact that he fed live virus to children who were not yet infected with the virus. According to Krugman's rationalizations, these infections did

not add to the subjects' risk because of the high prevalence of hepatitis on the wards in which the experiments were conducted. But enough was known about the spread of hepatitis at the time that this high prevalence could have been addressed by improving hygienic measures (Rothman and Rothman 2009, 752). Krugman received permission from the parents of the research subjects, but he phrased the permission letters in positive and misleading ways. He mentioned the gamma globulin injections and their possible benefits, but omitted the facts that some control-group subjects would not receive the injections and that all subjects would be deliberately fed live hepatitis virus.

The experiment became increasingly coercive because of the link between admission to the school and enrolment in the experiment. At the beginning of the experiment, parents were told their children would be approved for admission to the Willowbrook State School more quickly if they agreed to the research. Admission could otherwise take several years. As time went on, the school became increasingly crowded because there were few educational options for children with cognitive disabilities. By the end of the experiment, overcrowding at the school meant that admissions were closed. The only option for parents who wanted their children admitted to the school was to agree that their children would participate in the research (Rothman and Rothman 2009, 752). Tying admission to the school to permission to take part in the research was unduly coercive.

These are by no means the only cases of abuse in medical research. Throughout the cold war, the U.S. Department of Defence, the Atomic Energy Commission (which later became the Department of Energy), and the Manhattan Project funded research into radiation exposure (Phillips 2001). At the time the experiments took place, the dangers of

exposure to radiation were already well known. The researchers usually selected research subjects who "had little understanding of radiation and were highly vulnerable" including "prisoners, the mentally retarded, newborn babies, the terminally ill, members of minority groups, and the indigent" (Phillips 2001, 239). Many of the research subjects were not informed that they were taking part in a trial.

In 1963 researchers in New York injected live cancer cells into 22 chronically ill patients at the Jewish Chronic Disease Hospital who did not have cancer and over 300 postoperative gynaecology patients at Memorial Hospital (Katz et. al. 1972). Dr. Chester Southam, who headed the Jewish Chronic Disease Hospital trail, had noticed during his experiments on patients at Memorial Hospital and the Ohio State Penitentiary that cancer patients have a slower immunological response and reject injected foreign cancer cells more slowly compared to healthy patients (Arras 2009, 741). The purpose of the Jewish Chronic Disease Hospital research was to establish whether the cancer caused the immune deficiency in cancer patients or whether the immune deficiency was caused by their debilitated condition (Arras 2009, 740). Based on his previous experiments, Dr. Southam believed that the risk from injecting live cancer cells would be minimal. The research subjects were never told they were in a trial or that they were being injected with live cancer cells because the researchers feared this information could create "unnecessary" fears among the patients who were "ignorant" about cancer and would not appreciate the minimal risk involved. Instead, researchers told the patients that they were testing their immune capacity.

Between 1985 and 1986, researchers funded by North American companies carried out trials of Norplant contraceptives in 600 urban slums in Bangladesh, Indonesia,

Haiti and Brazil (Cadbury 1995). Although Norplant is supposed to be removed and can cause health problems when it is left implanted under the skin, the researchers lost track of many research subjects before removing the implant (Hartmann 1995, 210). Women who were enrolled in the trials were discouraged from removing the implants before the end of the trial: some were told that they would have to pay for the removal surgery if they wanted to withdraw before the end of the trial. The cost of removal surgery was often priced beyond their means. Several women were given money to participate in the trial and were discouraged from reporting any health problems (Roberts 1997, 12). UBING, a Bangladeshi monitoring group, found that many of the women enrolled in the trial were not given a proper exam before their involvement, were not informed of the potential side effects of the drugs, and were not aware that the drug was still in the experimental phase (Cadbury 1995).

The cases of abuse in medical research highlight that the researcher's interest in advancing scientific knowledge can sometimes blind them to the humanity and well-being of their research subjects. The resulting research abuses were sometimes quite shocking and cruel. In many cases the researchers exploited the social prejudices of their day that had created groups of patients who were easy to coerce into a study because they were in prison (the Nazi trials), had little access to health care (the Tuskegee study) or schooling (the Willowbrook study) outside of the study. Sometimes the researchers held views about their subjects that were explicitly racist. As Susan Wolf puts it, "Differences of race, ethnicity, and gender all too often seem to occasion unethical behaviour in health care and research" (2005, 66). Many of the researchers in these cases justified their methods by suggesting the benefits and medical advances from their experiments

outweighed the risks of harm to the research subjects. A number of the researchers were

unable or unwilling to recognize how their actions, deception, or withholding information

and treatment contributed to creating and perpetuating the risks faced by their study

subjects; instead the researchers characterized their role as one of passive observation

(conducting a "study in nature"). Some researchers even suggested their research had

direct benefits for the research subjects who gained access to medical treatments or

received 'protective' effects from the research protocol. But as Dr. David Egilman said in

criticizing the radiation experiments, "For some reason, rich white people were deprived

of all this wonderful research" (quoted in Phillips 2001, 239). The history of medical

research involves a number of cases in which the pursuit of scientific knowledge

combined with social prejudices and coercive situations to create scandalous situations in

which researchers exploited and abused research subjects.

2.1.2 Paternalism in the Clinic

The context that gave rise to problems in clinical medicine was somewhat

different from the research context, although here, too, differences between the doctor

and the patient played a prominent role. Unlike research contexts where even the

idealized researcher has "divided loyalties" to both the subjects and the research results,

in clinical contexts the idealized physician's main objective is to treat the patient and look

after the patient's well-being. Under paternalistic models of the doctor-patient

relationship that were dominant in the early twentieth century, the physicians' medical

knowledge was believed to make them experts in determining what was best for the

patient. The paternalistic model assumes there are shared objective criteria for making

medical decisions, but this assumption began to give way as patients asserted the

importance of their values in determining which treatments are in their own interests. In this context many of the problems in the practice of medicine arose around questions of who has the authority to decide what is in the patient's best interests.

A number of different models of the doctor-patient relationship have long been a part of medicine. For example, writing in 1956, Thomas Szasz and Marc Hollender identified three models of the doctor-patient relationship in the medical practice of that time, which they characterize according to the activity or passivity of the doctor and the patient. The first model sees the physician as active and the patient as passive, someone who is acted upon but is considered "inanimate" or unable to contribute (Szasz and Hollender 1956, 586). They liken this model to the interaction between a parent and an infant. The second model of guidance-cooperation still sees the physician as active, but gives more agency to the patient. The physician has more knowledge and power than the patient, and speaks from a position of guidance or leadership. The physician expects the patient to "cooperate," "look-up to" and "obey" the doctor (1956, 587). Szasz and Hollender think this relationship bears similarities to the relationship between a parent and an adolescent child. The final model they identify is the model of mutual participation, which is predicated on the desirability of equality among human beings. This model sees the doctor and patient as having approximately equal power, as being interdependent and engaging in an activity that is meant to satisfy them both (Szasz and Hollender 1956, 587). Although more egalitarian models of the doctor-patient relationship could be identified as early as the 1950s, paternalistic models of doctor-patient relations that reflected the first two forms identified by Szasz and Hollender

remained the norm well into the 1970s (Buchanan 1978),[18] and paternalistic values were enshrined in professional codes of ethics.[19]

Medical paternalism can roughly be understood as "interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation, where the alleged justification of interfering or misinforming is that it is for the good of the person who is interfered with or misinformed" (Buchanan 1978, 372). Paternalistic actions on the part of physicians can occur on a spectrum ranging from physicians who provide selected information that will encourage patients to choose the medical therapy the physician prefers, to physicians who authoritatively make decisions on behalf of the patient and simply inform the patient when treatment will commence. Paternalistic models of the doctor-patient relationship assume that there are "shared objective criteria for determining what is best" (Emanuel and Emanuel 1992, 2221) and that physicians' medical knowledge makes them experts in determining which treatment meets these criteria and is therefore best for their patients.

Beginning in the 1970s and continuing today, the paternalistic practice of medicine fell out of favour for a number of reasons. On the paternalistic model doctors were believed to act in the best interests of their patients, but beginning in the 1960s, people became increasingly aware that doctors might have conflicting interests to those of their patients. Physicians might have an interest in controlling the costs of medical care when they are paid on a per-capita basis or given other financial incentives (from

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[18] Szasz and Hollender remark that the mutual-participation model is "essentially foreign to medicine" (1956, 588).

[19] For example, the *Hippocratic Oath* states, "I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice" (in Steinbock, Arras, and London 2009, 61), but it does not require the physician to consult patients about their values or perception of their own interests.

government or insurance companies) in order to avoid medical interventions (Hillman

1990; Angell 1993; Callahan 1998; Morreim 1998). Conversely, physicians can have an

incentive to recommend too much medical care when they are paid on a fee-per-service

basis (Burney et. al. 1979, Gabel and Redisch 1979). Physicians often have close

relationships with representatives from large pharmaceutical companies, and these

relationships have been shown to affect the prescribing practices of doctors even when

(especially when) doctors believe they are not influenced by their relationships with

pharmaceutical companies (Chren, Landefeld and Murray 1989; American College of

Physicians 1990; Lexchin 1993; Coyle et. al. 2002a and 2002b; Moynihan 2003).

During the 1960s and 1970s it emerged that doctors had also been involved in

protecting social interests that were counter to the interests of their individual patients;

for example, doctors were involved in coercively sterilizing people with disabilities and

the poor (Black 2003). Physicians can have a number of competing interests, so the ideal

of paternalism seemed increasingly unrealistic. Not only did doctors have interests that

might influence their medical decisions in ways that are counter to the patients' interests;

during this time it was also recognized that non-medical values play a role in medical

decision-making. The doctor and the patient might not share the same values, and so

might make treatment decisions in different ways.[20] The cumulative effect of these social

changes was a push for greater patient autonomy within clinical medicine.

One important source of the movement to limit physician paternalism and

increase respect for the decision-making authority of patients has come from patient

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[20] For a discussion of the problems with a paternalistic model of doctor-patient relationships see Buchanan (1978) and Goldman (1980). For a discussion of different potential models of physician-patient relationships and their limitations see Szasz and Hollender (1956), Childress and Siegler (1984), Emanuel and Emanuel (1992).

advocacy groups and religious groups. In Canada, Jehovah's Witnesses' right to refuse blood transfusions was enshrined in law in the 1987 legal case involving Mrs. Georgette Malette and her physician, Dr. D.L. Shulman. Mrs. Malette arrived at the hospital after suffering multiple injuries in a car accident and was unable to consent at the time she arrived. Mrs. Malette was a Jehovah's Witness and did not want any blood or blood products because of her religious beliefs. She had a card in her purse that stated her refusal of any blood or blood products that might be administered to her. Dr. Shulman did not adhere to the directives on the card because he believed that Mrs. Malette would die without the transfusion and although the card was signed, it did not indicate the date of the signature nor was the card witnessed. The Supreme Court of Ontario and the Appeal Court both ruled that the card represented a legitimate refusal of treatment and that Dr. Shulman should have respected the limits that this refusal placed on his liberty to treat Mrs. Malette. The court found that administering medical treatment to Mrs. Malette without her consent constituted a tort of battery. The court affirmed that all medical treatment requires informed consent from the patient or their surrogate decision-maker (Roy et al. 1994, 120-121; Shields 2004, 501).

In 1989, Nancy B. became ill with Guillian-Barré syndrome, which causes ascending paralysis. The hospital staff intubated her and placed her on a respirator. Nancy B. could not breathe without the respirator, but decided she wanted the respirator removed to allow her disease to take its course. She was judged to be competent and withdrew her consent for the use of the respirator. She sought an injunction from the Court to require the hospital to remove the respirator because her motor function had deteriorated to the point where she could not remove the respirator on her own. The judge

in the case ruled that keeping her on the respirator would violate her person and because her decision was made competently with an awareness that she would die without the respirator's support, she was entitled to have her personal autonomy respected and the respirator removed. The judged ruled that removing the respirator was not a criminal act because the person who removed the respirator at the patient's request is not assisting the patient to commit suicide or intentionally killing the patient, but is instead allowing her disease to take its natural course (McDonald 2004, 504).

A second source of criticism of practices common in clinical medicine came from the women's movement. During the 1960s through the 1980s members of the women's movement, and in particular the women's self-help health movement, offered a range of criticisms of medical practice. Some of these criticisms can be characterized as objecting to physician paternalism, but other complaints went beyond complaints of physician paternalism and addressed the disrespect women faced in the medical system more generally. In 1969, women formed The Doctor's Group to discuss their dissatisfaction with clinical encounters with health care personnel and the medical care they were receiving (Dresser 1996, 145). The Boston Women's Health Book Collective collected and documented women's complaints about the care they received. According to the Collective, women complained that physicians and other medical personnel frequently withheld knowledge, misled or lied to women, and treated them without consent. Women charged that physicians failed to listen to or believe their complaints, and women were often offered moral advice instead of medical care or referrals to community services (such as battered women's shelters). When women did receive treatment they thought many of the procedures were unnecessary, sometimes mutilating or otherwise too

extreme for the problem. Women were vulnerable to sexual abuse and harassment from their physicians and were sometimes used as "teaching material" without their consent (the Boston Women's Health Book Collective 1998, 681). The members of the women's health movement challenged the assumption that doctors in clinical setting always acted in accordance with the best interests of their women patients.

The women's health movement was critical of medical care and medical providers, noting that physicians "frequently are patronizing, detached, disrespectful, racist, homophobic, and unwilling to trust the reports of their women patients" (Dresser 1996, 147). The women's health movement attended to the myriad ways that individual clinical encounters were shaped and influenced by the context of medical practice, noting that medical education encouraged physicians to adopt an authoritative posture, including a tendency to view medical decision-making as infallible (Dresser 1996, 148). The Collective recognized that men experience some of these problems as well, but believed that men in general are treated with more respect than women in health care contexts. The movement attended to the inherent power imbalance involved in all doctor-patient relationships, but they also noted that this imbalance is often worse for female patients because it is exacerbated by the typical male-female power imbalances when doctors were predominantly male. The women's health movement objected to the disrespect and sexism they experienced from doctors.

In summary, the perception of the doctor-patient relationship has changed from one that valued medical paternalism to one that focused on patient rights. The high-profile cases I described above highlighted patients' rights to self-determination in the context of medical decision-making. As these cases unfolded, people were also becoming

aware of iatrogenic disease (illnesses caused by medical interventions), and the conflicts of interest that exist when doctors have a financial stake in the treatments they recommend. Moreover, because of increased specialization, the medical relationship was becoming increasingly impersonal. Whereas patients once had one doctor and limited contact with specialists, it was becoming increasingly common to be attended by a medical "team" of diverse experts each charged with a different aspect of the patient's care. This makes it less likely that doctors will know their patients' values and be able to take these values into account when making medical decisions. An increasing awareness of cultural diversity and the rights of members of non-dominant groups makes it impossible to maintain the fiction that doctor and patient are invariably likely to share the same values (Mappes and DeGrazia 2001, 56-57; Steinbock et al. 2009, 5). These developments have combined with an increasingly consumerist medical culture to create dissatisfaction with authoritarian medical practices.

2.2 RESPECT AND BIOETHICS

The historical and cultural backdrop that elicited bioethical response was slightly different in the research and clinical contexts. In the cases of research abuses, researchers exploited vulnerabilities created by inadequate social services to recruit subjects into research protocols that were sometimes abusive or scientifically questionable and often involved deception of the research subjects. In the clinic, the old idea that 'doctor knows best' became suspect as it became apparent that doctors do not always share the values of their patients and that values can be important to decisions about which course of treatment is best. In each of these different contexts bioethicists invoked a concept of

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respect that draws heavily from enlightenment concepts of respect, especially those found in Kant's theory. I examine these early bioethical discussions of respect in this section.

2.2.1 Respect for Persons and Research Ethics

Since the development of the *Nuremberg Code*, over thirty sets of guidelines and codes of research ethics have been developed. Common to all of the codes is the principle that research may not be conducted without the express informed consent of the research subjects (Mappes and DeGrazia 2001, 228). Although a number of codes of research ethics had been developed, there had been little discussion of the ethical foundations for these codes and so, in the 1970s, a National Commission was formed in the United States to investigate these foundations. According to Albert Jonsen, one of the members of the National Commission, the commissioners "judged that they were being asked to explore the ethical foundations for human research more deeply than had any extant statements" (Jonsen 2005, 4). This discussion resulted in *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (1979), which explicitly connects respect for persons to the provisions requiring informed consent. Tom Beauchamp, another member of the National Commission, suggests that this connection represents a significant departure from previous codes of research ethics. He writes that with the *Belmont Report*,

> a general strategy emerged for handling problems of research ethics, namely, that each principle made moral demands in a specific domain of responsibility for research. For example, the principle of respect for persons demands informed and voluntary consent. Under this conception, the *purpose* of consent provisions is not the protection from risk, as many earlier federal policies seemed to imply, but the protection of autonomy and personal dignity, including the personal dignity of incompetent persons incapable of acting autonomously, for whose involvement a duly authorized third party must consent. (Beauchamp 2005, 18).

The authors of *The Belmont Report* (1979) state that the principle of respect for persons

gives rise to two moral imperatives: to "acknowledge autonomy" when subjects are

capable of self-determination, and to "protect" subjects with diminished autonomy, such

as children, prisoners and patients with dementia or other mental impairments. According

to *The Belmont Report*'s authors, respecting the autonomy of those who are fully-capable

of self-determination involves giving weight to the considered judgements of subjects

and refraining from interfering with their actions unless these actions will harm others.

For those with diminished capacity for self-determination, *The Belmont Report*

recommends protection, which admits of degrees according to the particular situation of

the potential research subject and the relative risk of harm or potential benefit from the

study protocol. The concept of respect for persons discussed by the authors of *The*

Belmont Report is inclusive because it covers both those with uncompromised autonomy,

and those whose autonomy has been compromised to one degree or another. The

suggestion is that both groups are owed respect, though the behaviour required by this

respect may differ depending on the degree to which the subject is autonomous and the

particularities of the situation. In each case, the intention is to honour that person's

wishes (when they are known) or interests in the absence of detectable wishes.

Although *The Belmont Report* did not specifically credit Kant with the view of

respect that they invoke, the standard bioethical interpretation reads these documents as

employing a Kantian concept of respect.[21] Kant's second formulation of the categorical

imperative, The Formula of Humanity, directs agents to: "Act so that you treat humanity,

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[21] Some of the commissioners recognize this heritage in reflections about their work on
the *Belmont Report*. For example, see the discussion in Beauchamp (2005) and Jonsen
(2005).

whether in your own person or in that of another, always as an end and never as a means only" (*Foundations of the Metaphysics of Morals* 1995 46; AK 4:429). *The Belmont Report* recognizes that the purpose of research is primarily to "test an hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships)." Research will always use subjects as a means to the end of advancing medical knowledge. Kantian respect allows researchers to treat subjects as a means so long as they are not used as a *mere* means, but are also treated as ends in themselves. The practical application of the Kantian prohibition on treating persons as mere means occurs by obtaining the informed consent of autonomous research participants or by protecting the "best interests" of incompetent participants by consulting third parties who are close to the participant. The connection between Kantian ethics and the concept of respect used in bioethics was strengthened with the publication of Tom Beauchamp and James Childress's *Principles of Biomedical Ethics* (1979). Beauchamp and Childress developed the principlist approach to deal with a variety of bioethical issues, including the problems in clinical medicine that I described in section 2.1.2. As I describe in the next section, Beauchamp and Childress narrow the principle of respect for persons to a principle of respect for their autonomy but they continue to see this principle as requiring the practice of obtaining informed consent.

2.2.2 Respect for Autonomy and Clinical Ethics

In their canonical work, the *Principles of Biomedical Ethics*, [22] Tom Beauchamp and James Childress developed the principlist approach to bioethics to provide a principled foundation that would add coherence to the discussions and judgements in bioethics (1979,vii, 5-12).[23] Earlier editions of *The Principles of Biomedical Ethics* did not highlight the discussion of "respect" in the name given to the principle, which they

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[22] There have been six editions of the *Principles of Biomedical Ethics*. The first edition was published in 1979, the second in 1983, the third in 1989, the fourth in 1994, the fifth in 2001 and the sixth in 2009. I do not intend to provide an extensive analysis of the changes from one edition to the next, although I will note in some places how the concept and terminology surrounding 'respect' and 'autonomy' have shifted.

[23] It might be considered inappropriate to suggest that the principlist approach is a response to problems in clinical medicine, given this broad description of the project. Beauchamp and Childress are not entirely clear about the scope of their discussion from one edition to the next and whether their four principles apply to research, clinical medicine, health policy or all three. In the first edition they state they understand the scope of 'biomedical ethics' to apply to "problems of therapeutic practice, health care delivery, and medical and biological research" (1979, vii-viii) and that their intended audience includes "health care professionals such as physicians and nurses, research investigators, policy makers in biomedicine, and students preparing for such roles" (1979, ix). I infer from this discussion that they intend their theory to have broad application. By the sixth edition the preface no longer discusses the intended scope or audience for their discussion. They open the first chapter with a focus on medical ethics and professional ethics (2009, 1-9). They note that "Policy formation and criticism involve more complex forms of moral judgement than ethical theories, principles, and rules can handle on their own" (2009, 9) and they specify that their theory derives "from considered judgements in the common morality and professional traditions in health care, particularly medicine and nursing" (2009, 25). I am not sure whether this is meant to restrict the scope of their discussion to clinical medicine, or whether it is intended to recognize that principlism's approach has always emphasized clinical medicine. In a paper about his involvement with *The Belmont Report*, Beauchamp describes that he and Childress had already drafted large sections of *The Principles of Biomedical Ethics* before he began work on *The Belmont Report*, but that he and Childress had not focused on research ethics (2005, 13). Beauchamp suggests that much of the work on research ethics present in *The Principles of Biomedical Ethics* came from his rejected sections for *The Belmont Report* (2005, 17). Although the principlist approach is not restricted to clinical ethics, I think it is fair to discuss this work as a particularly important response to the problems in clinical contexts because it has had considerable influence in the context of clinical medicine and the clinical context seems to have been influential to Beauchamp and Childress when they were writing the early drafts.

call "the Principle of Autonomy" (1979).[24] The name of this principle accurately reflects

the emphasis in their discussion, which highlights the importance of autonomy in medical

contexts. Through all of the editions of *The Principles of Biomedical Ethics*, Beauchamp

and Childress are clear that the object of respect is the autonomy of the person and

respectful relations are restricted to those that occur between autonomous persons.[25] The

focus of the discussion thus narrows this principle from the one described in *The Belmont*

Report in both the scope of the principle and its object, though Beauchamp and

Childress's principle shares with *The Belmont Report* the view that this principle has a

practical application in the practice of obtaining informed consent from autonomous

patients (or research subjects). In this section I describe the understanding of autonomy

and respect provided by Beauchamp and Childress, and in the next section I compare

their view to the view described in *The Belmont Report*. Beauchamp and Childress'

discussion is valuable because they add considerably more theoretical discussion and

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[24] The discussion of and terminology around this principle has shifted from one edition to the next. The second edition retains "The Principle of Autonomy" as a description (1983, Chapter 3), but by the third edition the principle was called "The Principle of Respect for Autonomy" (1989, Chapter 3) and by the fourth edition Beauchamp and Childress dropped "The Principle" from each of their chapters (not just the chapter on respect for autonomy) to get the modern incarnation: "Respect for Autonomy" (Beauchamp and Childress 1994, Chapter 3). Both the fifth and sixth editions refer simply to "Respect for Autonomy" (Beauchamp and Childress 2001, Chapter 3 and 2009, Chapter 4).

[25] Beauchamp and Childress do recognize duties that are owed to non-competent patients or research subjects. For example, those who are now incompetent but were once autonomous (for example an elderly patient with dementia, or a patient who has been rendered unconscious) and expressed their wishes regarding treatment or research participation while competent (for example through a living will or advance directive) should have those wishes respected. For patients who were never competent (for example children or those with certain kinds of developmental problems) Beauchamp and Childress argue that we should still treat them according to the principles of beneficence, non-maleficence and justice. Beauchamp and Childress consider non-competent patients to be valuable and morally important, but non-competent patients are not respected on Beauchamp and Childress' account precisely because the object of respect is autonomy on their view.

depth to our understanding of the concept of respect compared to the discussion of the concept in *The Belmont Report*.

Beauchamp and Childress focus on autonomy in very localized situations as something that occurs in specific instances of choice and decision-making, rather than as an over-all property, ability or trait of the person (2009, 100). They see this version of autonomy as a harmonizing of the views of John Stuart Mill and Kant. According to Beauchamp and Childress, Kant focuses on morally correct autonomous choices, while Mill focuses on the individuality of autonomous agents. For Mill the importance of autonomy is that it permits people to live and develop according to their own convictions. Individuals require the right to self-determination (or liberty) in order to protect themselves both from the tyranny of the State and from the "tyranny of the majority" or "the tendency of society to impose, by other means than civil penalties, its own ideas and practices as rules of conduct on those who dissent from them" (Mill 1998, 237). Respecting the liberty of individuals to decide how they will live their lives is the best way to ensure that we act in ways that actually do benefit the other. Mill recognizes that there are limits to liberty that arise from the needs of living together in a society, but he takes the right to liberty to be quite broad. For Mill this gives rise to what is known as the harm principle: "the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection… to prevent harm to others" (Mill 1998, 241). Mill allows some intervention when the person holds false or ill-considered views, so Mill's version of autonomy requires a presumption toward non-interference, but is compatible with some actions required for strengthening autonomous expression, such as providing further information

or correcting mistaken beliefs. Mill's emphasis on liberty is quite strong. He says that individuals are amenable to society only in that part of their conduct which concerns others, but that individuals' right to independence is absolute in the part of their conduct that concerns themselves. "Over himself, over his own body and mind, the individual is sovereign" according to Mill (1998 241-242).

From Kant they draw an emphasis on self-legislation, which they describe as the view that "the reasons for actions for autonomous persons are their own reasons, and they are principled rather than arbitrary reasons" (Beauchamp and Childress 1979, 58). The essential element of autonomy is the idea of self-directed action based on a rational principle the agent accepts.[26] Taking the views of Mill and Kant together, Beauchamp and Childress characterise autonomy as "a form of personal liberty of action where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself" (1979, 56). Autonomous persons are capable both of deliberating about their plans and of acting in accordance with that plan. In contrast, a person of diminished autonomy "is highly dependent on others and in at least some respect incapable of deliberating or acting on the basis of such deliberations" (Beauchamp and Childress 1979, 57). [27] A person's autonomy can be compromised by individual

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[26] I leave aside a more detailed description of Kant's view of both respect and autonomy for Chapter 4. In that Chapter I look in depth at his view of respect and offer some comparisons to the view of respect described by Beauchamp and Childress. Although Beauchamp and Childress draw inspiration from Kant, the view they offer is significantly different than the Kantian view of respect.

[27] Their definition is further refined by the fifth and sixth editions where they characterize autonomy as "at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice" (2001, 58; 2009, 99). "The autonomous individual," they write, "acts freely in accordance with a self-chosen plan… A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or acting on the basis of

limitations that impede deliberation (such as immaturity or mental handicaps) and by social environments that infringe on one's ability to act (as is the case for those who are imprisoned). The central element of this principle is autonomy, and autonomy is the object of respect in their discussion.

It is not enough to be autonomous, according to Beauchamp and Childress. One must also be *respected* as autonomous and one must respect the autonomy of others (1979, 58). According to Beauchamp and Childress, "To respect autonomous agents is to recognize with due appreciation their own considered value judgements and outlooks even when it is believed that their judgements are mistaken. To respect them in this way is to acknowledge their right to their own views and the permissibility of their actions based on such beliefs" (1979, 58).[28] Granting persons the right to their own views requires that one recognizes they are entitled to their own judgements and that one refrain from interfering with their liberty. Beauchamp and Childress recognize that this is tied closely to Mill's harm principle, and they also believe that it is supported by Kant's Formula of Humanity that recognizes the unconditional worth of persons as ends in

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his or her desires and plans" (2009, 99). This shift from "dependence" to "control" might be in part a response to some of the discussion of relational autonomy and the numerous ways in which people are dependent on one another that I will survey in Chapter 3.

[28] By the sixth edition this account characterizes respect as "acknowledging the value and decision-making rights of persons and enabling them to act autonomously" (2009, 103). This second element requires both respectful action and attitude, and involves more than non-interference with persons' decisions, but also positive actions such as providing information, building up the capacity for autonomous choice, and dealing with emotions, such as fear, or other conditions that might distort autonomous actions. In contrast, disrespect involves actions and attitudes that "ignore, demean, or are inattentive to others' rights of autonomous action" (2009, 103). Again, I think this is a response to some criticisms that have pointed out the numerous ways in which autonomy can be compromised other than those considered by Beauchamp and Childress in this early edition. I look at the criticisms of Beauchamp and Childress' view of autonomy in more detail in Chapter 3.

themselves, never to be used as mere means. Beauchamp and Childress interpret treating another as a means as a violation of autonomy "because the person is then being treated in accordance with rules not of his own choosing" (1979, 59). Disrespecting autonomous agents involves either rejecting the considered judgements of persons or denying persons the freedom to act on their considered judgements. They believe that their discussion of respect as part of the principle of autonomy is able to reflect Kantian insights: "For Kant a moral relation between persons is always one where there is mutual respect for autonomy—where both are autonomous, of course. It is hard to find fault with this point in his argument" (Beauchamp and Childress 1979, 59). The scope of respect on their view includes only those persons who are autonomous, since it is incoherent to respect the autonomy of those who are not autonomous. Beauchamp and Childress recognize that there are differences between the views of Mill and Kant, though they think that both views are similar in terms of the requirements on our actions regarding others. Mill makes a moral demand of non-interference, while Kant requires both non-interference and that one adopt an attitude of respect "about the personhood and beliefs of others" (1979, 59). Both theories require similar actions regarding others, and so Beauchamp and Childress conclude the views are compatible with the principle they have outlined.

In clinical contexts the emphasis has been on respecting a patient's autonomous decisions. This emphasis arose in part as a response to the paternalism that once characterized medical encounters. In the clinic, the requirement to seek informed consent from patients helps to remind doctors that the decision making authority rests with the patients. Bioethicists have usually assumed that doctors have their patients' best interests in mind when treating their patients, but also recognize that because doctors and patients

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may have different values and beliefs about what makes a life go well, they may not always make the same decisions. For this reason, doctors should seek informed consent from their competent patients in order to protect their right to autonomous self-determination.

2.2.3 Comparison of the view of Respect in Research and the Clinic

The concept of respect has been important to bioethics. In research, subjects are used as a means to further the advancement of knowledge. Kant's famous injunction that persons must always be treated as ends and never as mere means articulates one important tool for countering some of the ethical problems that occur in research contexts. Kantian respect reminds us that although using subjects as a means to advance knowledge is unavoidable, researchers must also remember that these subjects are persons and must never be treated as *mere* means to medical ends. In clinical contexts, bioethicists found the importance that Kant and Mill placed on the value of individuals' autonomy is useful for transferring decision-making authority to the patients themselves in order to avoid medical paternalism. There are, however, important differences in the discussion of both the object and the scope of respect in each context.

First, the two concepts of respect differ on what we should respect. *The Belmont Report* says that we should respect *persons*, while Beauchamp and Childress say that we should respect *autonomy*, which they think means respecting the particular decisions that a patient makes about medical treatments or research participation. The first edition of *Principles of Biomedical Ethics* does not explain the emphasis on autonomy rather than personhood, but in the sixth edition Beauchamp and Childress explain that they eschew the language of "respect for dignity" and "respect for persons" because they believe the

terms "dignity" and "persons" are unclear and "inherently contestable" (2009, 66; 70).

Their goal "is to be as precise as possible about what is and must be respected" (2009,

70). In order to be precise about what must be respected, Beauchamp and Childress talk

about "respect for autonomy." Although they draw inspiration from Kantian ethics and

the importance that Kant places on autonomy, the view of autonomy that they offer

differs significantly from Kant's view (as Beauchamp and Childress themselves

recognize in later editions 2009, 346). For Kant, persons decide autonomously when they

conform their wills to the requirements of moral obligation: to be autonomous requires

that one choose universally valid principles that accord with the three formulations of the

categorical imperative (as I describe in more detail in Chapter 4). In contrast, Beauchamp

and Childress understand autonomy more generally as involving self-determination.

Although they say this view results from harmonizing the views of Mill and Kant, it has

more in common with Mill's principle of autonomy than it does with the Kantian version

because Kant's version requires examining the decision-making procedure, whereas

Mill's does not. For Kant, acting solely on one's desires would not count as an

autonomous act, since the only acts that are autonomous in Kant's sense are those that are

motivated by duty to the moral law.[29]

Second, the scope of the concept of 'respect' that is invoked by Beauchamp and

Childress involves a significant departure from *The Belmont Report*. *The Belmont Report*

which invokes a concept of respect that applies to all persons, whether autonomous or

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[29] For a thorough discussion of the Millian, rather than Kantian, roots of this kind of
autonomy, see Onora O'Neil (2002) *Trust and Autonomy in Bioethics*, especially
Chapters 2 and 3.

not.[30] Beauchamp and Childress invoke a substantially different concept of respect that applies only to those persons whose decisions can be considered autonomous, or those who have expressed their autonomous wishes through advance directives.[31] Beauchamp and Childress' focus on respect as a concept that requires "respect for autonomy" in some ways shifts their analysis onto the particular patient and away from the health care professional. Much of Beauchamp and Childress' discussion of "respect for autonomy" focuses on when a person's actions or decisions should be considered autonomous and hence worthy of respect.[32] From the perspective of the health care provider, this principle divides the requirements of "respect for autonomy" in two. First, the health care professional must assess whether the particular decision is made autonomously. If so, then the second requirement of the principle is that health care professionals respect their autonomous patients. Interactions with those who are not autonomous won't involve "respect" in Beauchamp and Childress' sense, but these interactions are covered by the

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[30] As I describe in the next chapter, more recent codes of research ethics take an even broader view of the scope of respect. For example, the *Tri-Council Policy* extends the concept to the selection of research projects or the interests of groups *The Belmont Report* includes a consideration of groups in the discussion of justice: researchers are required to consider who should receive the benefits of research and who should bear its burdens. This consideration is similar to the way that the *Tri-Council Policy* discusses respect in the selection of research projects and group interests, but in *The Belmont Report* it is considered to be based in concerns of justice rather than concerns of respect for human dignity.

[31] Beauchamp and Childress are not explicit on this point in the first edition, but by the sixth edition they are quite explicit: "Our obligations to respect autonomy do not extend to persons who cannot act in a sufficiently autonomous manner (and who cannot be rendered autonomous) because they are immature, incapacitated, ignorant, coerced, or exploited. Infants, irrationally suicidal individuals, and drug-dependent patients are examples" (2009, 105). Across editions this distinction between those whose autonomy we are obliged to respect and those we are not seems to have strengthened.

[32] This focus is especially acute after the third edition as the section on competence expanded.

remaining three principles of beneficence, non-maleficence, and justice. Again, the

narrower discussion of the scope of respect found in Beauchamp and Childress involves a

significant departure from Kantian ethics. The element of respect that Kant introduced to

Western philosophy, the part that is considered unique and revolutionary, was precisely

his view that respect was owed equally to all members of the moral community rather

than to a restricted class based on some social status they held or feature they

possessed.[33] Kant's view is closer to the view of respect described in *The Belmont*

Report, which requires researchers to respect all potential and current research subjects,

without first requiring an assessment of their competence. The behaviour that is required

of researchers in order to demonstrate respect will be different in different circumstances,

depending on the extent to which the research subject is autonomous and the extent of the

risks involved in the research protocol.

The differences in the object and scope of 'respect' between the research context

(which emphasizes respecting persons and includes both those who are autonomous and

those who are not) and the clinical context (which emphasizes respecting autonomy and

focuses only on those who are competent to make their own decisions) might be

explained by the different perceived dangers in these contexts. As discussed above, in

research contexts, there is a danger that persons will be used merely as a means to

advance scientific and medical knowledge. Although the researcher might be interested in

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[33] It is quite complicated to try to work out how to interpret Kant's assertion that respect is owed equally to all whether they were rational or not and despite whether they exercised or were able to exercise their autonomy when he at the same time grounds his moral view on the absolute and fundamental moral value of rational nature. A discussion and explanation of this point is fairly technical and I leave it until Chapter 4. Alan Wood's description of strict persons and extended persons is useful for understanding how Kant's view of respect is grounded in rational nature, and yet owed even to people who are not rational (2008, 95-101).

treating the patient, the main purpose of research is not to treat the patient, but rather to discover whether a proposed intervention is effective. Because research is perceived to carry greater risks than treatment does due to the uncertainty surrounding experimental procedures, and because research subjects might mistakenly believe they will receive benefits from the "latest" treatments when in fact the actual benefits (and risks) are still indeterminate, some amount of paternalism is tolerated and perhaps even required in research contexts. Researchers must protect the subjects' well-being, and they must end the trial if they suspect the subjects' well-being is at risk, even if the subjects would prefer to continue with the experimental treatment. This could account for the broader scope in the object of respect *for persons* in research contexts. In contrast, in the clinic, the presumption is that the well-being of the patient will be the main goal of the physician. In clinical encounters, the perceived danger is that the physician will act paternalistically, according to their own beliefs about what is in the patient's interests rather than considering what the patient believes to be in his or her interests. In these cases a strong emphasis on respecting autonomy to protect against possible paternalism makes sense.

Despite these differences in the concept of respect that is used in bioethics, in practice in both clinical and research settings, respect is understood as requiring informed consent. The physician or researcher has a duty to provide all relevant information to the patient or research subject, and the patient or research subject has a right (although not an obligation: they can designate decision-making to someone else if they wish) to make their own decisions about whether to accept a particular treatment or participate in a particular research protocol. Through this process, the practice of informed consent is

supposed to respect patients by recognizing the decision-making authority of the patient or research subject. The assumption is that with adequate information, the patient or the research subject will look out for their own best interests as they understand them in the context of their values.

In both research and clinical ethics the discussion of informed consent focuses on the elements of: 1) information, 2) comprehension, and 3) voluntariness. To these three, Beauchamp and Childress add a fourth: competence to consent, which they see more as a presupposition of informed consent rather than one of its elements (1979, 67). In later editions, Beauchamp and Childress specify that the criteria for assessing competence vary from one decision to the next according to the complexity, difficulty, or risk associated with the decision. The competence requirement plays a "gatekeeping" role to distinguish between "persons whose decisions should be solicited or accepted from persons whose decisions need not or should not be solicited or accepted" (Beauchamp and Childress 2009, 111). This element of informed consent is highlighted in *The Principles of Biomedical Ethics* because of the focus on respect for autonomy. It is not explicitly part of *The Belmont Report*, which construes respect for persons more broadly, although elements of competence are implicit in the comprehension requirement outlined in *The Belmont Report*.

When the research subject or patient is not able to comprehend the information due to immaturity or illness, then the researcher or physician must rely on previously expressed wishes, if these are known. When the research subject or patient has not made their wishes know, then a surrogate (or proxy) decision maker, such as a family member can decide on behalf of the research subject or patient. Surrogate decision makers should

attempt to determine what the subject or patient would want under the circumstances (Beauchamp and Childress 2009, 137), or they should decide based on the best interests of the subject or patient if the relevant preferences cannot be known (e.g. for young children or those who have never been competent). In the case of research, when a surrogate decision-maker decides on behalf of the research subject, they should be allowed to observe the study and they may withdraw the subject from the study at any time. Someone must still provide informed consent.

2.3 CONCLUSION

The history of scandals in research and medicine gave rise to bioethics in its modern form. This history is one in which differences between researchers and their subjects or physicians and their patients played a large role. One of the ways that early bioethics responded to these abuses was by stressing the importance of respect for persons or for their autonomy and insisting that researchers and physicians must obtain informed consent before enrolling a subject in a research trial or initiating a course of medical therapy. The practice of obtaining informed consent helps ensure that research subjects and patients are able to make their own decisions about whether to participate in research or therapy with full information about the purpose of the research and what participation will entail. Further, the requirement that consent be given voluntarily is meant to protect against coercive practices in medicine and research.

Informed consent is one important way to help protect patients, but it also has some limitations. Respecting persons by obtaining informed consent works well for some kinds of medical situations but it pays insufficient attention to the contexts that can contribute to making some groups of people more vulnerable to medical abuse and

disrespect. Although both *The Belmont Report* and *The Principles of Biomedical Ethics* pay some attention to the ways that particular social arrangements can limit autonomy, they both focus this discussion on prisoners, and pay insufficient attention to more subtle ways in which social arrangements can be coercive. In the cases of research abuse that I described in the first section of this chapter there was usually some feature of the social arrangements present at the time that contributed to the abuse of that particular patient group. In the Tuskegee study the promise of free medical treatments which would otherwise not be available has been considered unduly coercive. At least part of what made the offer of free medical treatments coercive in the Tuskegee study was the existing context in which the black subjects could not afford the high cost of medical care (Jones 1981, 65). This context made the black subjects vulnerable to coercive (and deceptive) offers of free treatments in a way that wealthier patients were not vulnerable. Similarly, in the Willowbrook school study tying participation in the study to school admission has been considered a coercive feature of the study. But again part of what made this offer coercive was the context in which there were few educational options for cognitively impaired children. If other options had been available, then the offer of admission tied to agreeing to participate in the study would have had less coercive effect. The groups that turn up in these stories of medical abuse are not random. Instead, we see a similar pattern of particular kinds of groups that are the subjects of this abuse. Often the particular social arrangements of the time facilitated the exploitation of a particular group. Informed consent does not address these kinds of vulnerabilities, and these vulnerabilities continue to contribute to problematic research practices today. For example, structural disadvantages present in our current "global marketplace" create vulnerabilities for

groups from poor countries, and we are currently seeing some questionable research being conducted on members of these groups. Although the concept of respect was introduced in a context in which prejudices played a large role in creating the conditions that led to the exploitation of research subjects, early bioethics focused on generic patients and generic researchers or physicians and paid little attention to the role of difference in these contexts. More recent discussions in bioethics pay more attention to difference; I examine these discussions in the next chapter.

CHAPTER 3   **RESPECT IN LATER BIOETHICS (1990-2011)**

The focus of early bioethics was on individual rights and ethical standards that were clear and specific enough to serve as legally binding requirements. In this context, respect was used to ground the practice of obtaining informed consent. Grounding informed consent in the moral principle of respect strengthened the requirements by creating a rationale that was not easily overridden in situations of low-risk or socially useful research or therapy. This use of respect represents an important achievement in bioethics, but it also elides some aspects of the problems in research and clinical medicine that elicited the bioethical response. In particular, the individual-focused response pays insufficient attention to the role that difference played in creating these problems. The research subjects and patients who were likely to be exploited and disrespected by researchers and physicians were not the privileged but instead those with less power in their social contexts.[34]

In the research abuses I described in section 2.1.1 a prejudiced views about particular social groups combined with social institutions that offered inadequate services to some groups to create a situation in which specific groups were more vulnerable to exploitation by researchers than were other groups. In clinical medicine differences between the values held by patients and those held by physicians contributed to the arguments against a paternalistic model of the doctor-patient relationship that assumed shared and objective criteria for medical decision-making. The women's self-help health

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[34] I do not mean to imply that there was no attention to difference in early bioethics. Both *The Belmont Report* and the *Principles of Biomedical Ethics* pay some attention to differences and the "vulnerability" of particular social groups. The role of difference was given some attention, but it was not the focus. For a discussion of some of the unrealized feminist potential of *The Belmont Report* see Sherwin (2005).

movement complained that sexist, racist and homophobic beliefs and values meant that

members of some social groups experienced lower-quality clinical care. The concept of

respect that stresses respecting the individual's right to make decisions related to research

participation and clinical treatments does little to address these systemic concerns about

how pervasive social inequalities affect medical research and practice.

More recent work in bioethics has engaged directly with the roles social

differences have played in medical contexts. These more recently emerging voices

discuss issues around respect, such as the nature of autonomy, respect for cultural (and

other) groups, and the effects of social inequality on respect for individuals, but they do

not provide a specific examination of the concept of respect itself. This recent work

comes from three different sources. First, feminist bioethics emerged with the founding

of the International Network on Feminist Approaches to Bioethics (FAB) in 1992 and the

publication of Susan Sherwin's *No Longer Patient* and Helen Holmes and Laura Purdy's

Feminist Perspectives in Medical Ethics that same year.[35] Feminist bioethicists consider

oppression to be an ineliminable analytic lens for understanding the ethical issues within

medicine. Many feminist bioethicists have been critical of Beauchamp and Childress'

concept of autonomy because of its narrow focus on individuals and particular isolated

instances of decision-making.[36] The narrow focus on individuals fails to consider how

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[35] Although feminists wrote and worked in bioethics during the early period described in Chapter 2, the emergence of FAB as a supportive network for feminist bioethics was important for promoting and recognizing feminist work in bioethics. There had been feminist papers published in bioethics journals before 1992, but Sherwin's book was the first monograph in the area, and, together with the anthology edited by Holmes and Purdy, named and offered a specifically feminist approach to bioethics.

[36] For some criticisms of individualistic concepts of autonomy see Susan Sherwin (1992) *No Longer Patient* and (1998) "A Relational Approach to Autonomy in Health Care," Carolyn McLeod and Susan Sherwin (2000) "Relational Autonomy, Self-Trust, and

persons are embedded within social contexts that can constrain the choices of some social groups more than others (Sherwin 1992). Feminists note that some of the norms that we pick up from the societies in which we live might exercise a pernicious controlling influence that cannot be directly attributed to particular others. Further, the free choice within a set of options does not justify the set of options itself (Anderson 1999, 309) and in some cases the medical options available (e.g. elective cosmetic surgery) are troubling from a feminist perspective. From this discussion a relational concept of autonomy emerged, as I describe in section 3.2.1. Discussions of relational autonomy challenged the view of autonomy described by Beauchamp and Childress' "principle of respect for autonomy," but less feminist attention was paid to the concept of respect and whether changes in the concept of autonomy would entail changes in the related view of respect.

Second, in the Canadian context, movements to recognize the rights of First Nations peoples grew and strengthened, especially during the stand-off in July of 1990 between Kanehsatake and the village of Oka in Québec. Members of First Nations communities complained that the Canadian government did not honour its treaties with First Nations communities (Obomsawin 1993). They charged the Canadian government with failing to provide decent health care to First Nations communities. Further, the health care the government did provide was sometimes inappropriate and failed to respect First Nations cultural and epistemic traditions. First Nations groups exposed the racist assumptions about and interpretations of First Nations peoples, cultures, traditions and

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Health Care for Patients who are Oppressed," and Diana Meyers (2004) *Being Yourself: Essays on Identity, Action, and Social Life*.

knowledges perpetuated by many white researchers. The *Tri-Council Policy*[37] that

governs research in Canada was developed in this context and first published in 1998. In

section 3.2.2 I describe how the authors of the *Tri-Council Policy* recognize the

importance of respect not only for the individual research subjects, but also in framing

research questions and considering the effects that research will have on certain social

groups. The *Tri-Council Policy* gives a central role to respect, but they do not describe

how they understand the concept of respect or whether their understanding is the same as

or different from other ways the concept has been articulated by bioethicists or

philosophers.

Third, although a few bioethicists have discussed public health ethics since the

beginning of bioethics as an academic discipline in the 1970s (e.g. Beauchamp 1976),

interest in public health ethics has increased over the last ten years.[38] Public Health has a

broad agenda with diverse responsibilities that include many clinical activities (e.g.

immunization), but it can roughly be distinguished from clinical medicine by its emphasis

on the health of populations and subpopulations. One area of concern within public health

ethics is the trenchant persistence of health inequalities. Madison Powers and Ruth Faden

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[37] *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (1998)
is authored by Canadian Institutes of Health Research, Natural Sciences and Engineering
Research Council of Canada, Social Sciences and Humanities Research Council of
Canada. The first Tri-Council Policy statement was published in 1998, and was amended
in 2000, 2002, 2005. A second edition was released in 2010. In this chapter I will refer to
these documents as the "*Tri-Council Policy* (1998)" and the "*Tri-Council Policy* (2010)"
for simplicity.

[38] For example, the Journal *Public Health Ethics* published its first volume in 2008. A
number of books were recently published to address issues specific to public health ethics
(e.g. Beauchamp and Steinbock 1999; Anand et al. 2004; Powers and Faden 2006; Asada
2007; Daniels 2008). Part of the reason for the recent interest in public health ethics
might be the result of high-profile global virus outbreaks (e.g. SARS in 2002, H5N1 in
2004, and H1N1 in 2009) (Baylis et al. 2008, 196).

(2006) argue that health inequalities result from densely woven patterns of multiple systemic disadvantages. These systematic disadvantages are interlocking and their interaction creates a multiplicative, cascading effect; inequalities along one dimension will often reinforce inequalities along another dimension. As a result, addressing health inequalities requires seeing social justice as the foundation for public health. Powers and Faden understand social justice as requiring a sufficiency of well-being along six dimensions, one of which is respect. They say that public health policy should aim to create a sufficiency of respect, as I describe in section 3.2.3. They do not, however, describe their understanding of respect in much detail. Instead, they gesture to Darwall's interpretation of Kantian respect as "recognition."[39] Powers and Faden assert that the kind of respect they have in mind is recognition respect and that it is this form that is under assault in oppressive social contexts. The do not, however, spend any time considering whether the views they put forward cohere with the version of Kantian respect provided by Darwall.

Although the majority of bioethicists continued to focus on respect for individuals, a growing community of feminist and other theorists interested in social justice (disability, sexuality, anti-racist, and aboriginal) attended to questions of social differences and the role that structural inequalities and oppression played in medical contexts. The concepts of respect and autonomy continue to play an important role in these discussions, but the concept of respect itself has rarely been examined. But it seems to me that when the discussion changes important elements related to respect, such as changing the concept of autonomy, then the concept of respect will also require

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[39] I examine both Darwall's and Kant's view of respect in detail in Chapter 4.

rethinking and revision. Without this rethinking we risk a worse conceptual confusion than that found in early bioethics. The trend in early bioethics was to become increasingly specific about what was to be respected and how respect was to be put into practice in medical contexts; the problem there was that while we came to know about the object of respect, we knew little about the concept of respect itself. In contrast, the trend in some approaches to later bioethics was to broaden the concept so that the object of respect (autonomy) changes (to relational autonomy), the behaviour required by respect expands (from merely obtaining informed consent to engaging in consultations with communities) and respect takes on roles it did not have before (as a part of the health policy making process). But, once again, bioethicists offer scant discussion of the concept of respect itself. While, the practice of obtaining informed consent is necessary but not sufficient for respecting the patient or research subject in some more recent works, we are left uncertain about what else is required or how these requirements relate to respecting persons. Though the concept of respect is invoked in these works, it remains under examined.

The concept of respect in the three bioethical uses I described above is slightly different from those found in early bioethics as described in Chapter 2 because respecting relations are set in the context of unequal societies and attention to these inequalities is considered important for respecting individuals. Before I begin to describe the discussions around the concept of respect in section 3.2, I think it is important to describe my understanding of oppression as a structural concept, since contexts of inequality are central to later views of respect in the feminist and other progressive approaches to bioethics to which I refer. In section 3.1.1 I describe social structures and structural

inequalities. Central to the idea that oppression is a structural phenomenon is the idea that no one need intend to perpetuate oppression for systemic inequality to continue. Oppression can be the result of coordinated and uncoordinated actions and decisions made by individuals as they respond to the social structures (norms, values, institutions) in which they find themselves, as I describe in section 3.1.2.

The cumulative effect of these individual decisions and actions can sometimes result in a situation where one social group experiences greater social power relative to another. The concept of a social group is therefore important to an analysis that looks at the oppressive effects of social structures. As Powers and Faden write, even if we are interested in the well-being or rights of individuals, "in the real, historically situated world, how individuals fare is generally a function of the status, standing, and position within densely woven patterns of systemic disadvantage of the groups of which they are a part" (2006, 61). In section 3.1.3 I provide a relational understanding of social groups that does not posit some essential attribute shared by all group members, but instead sees social groups as emerging relationally through their interactions with one another. These patterns of systemic inequalities have measurable effects on the health and longevity of various social groups. Although causal mechanisms are not yet worked out, substantial empirical evidence demonstrates the existence of health inequalities that relate to social group membership as I describe in section 3.1.4.

3.1 OPPRESSION AS A STRUCTURAL CONCEPT

Traditional understandings tend to conceptualize oppression as a dyadic relationship that involves both an oppressed group and an oppressor group, where the oppressor group exercises tyranny over the oppressed (Tomsons 2006, Chapter 2). A

structural understanding of oppression differs from traditional understandings because it

focuses on how both intentional and unintentional elements of societies (e.g. institutions,

traditions, practices and values) interact to create social positions that constitute some

groups as unequal to others. On structural views, oppression is not always the result of

intentional tyranny, such as that exercised by the Nazis against the Jews, but can also

result from "the everyday practices of a well-intentioned liberal society" (Young 1990,

41). On structural understandings of oppression there need not be an oppressing group

that is explicitly trying to keep the oppressed group down, although some groups will be

relatively privileged within the social structure.[40] Structural views of oppression are

relational: when some group suffers a disadvantage it is in relation to the advantages

experienced by another group. If we fail to attend to the relational[41] nature of the

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[40] Although some group will be privileged relative to the oppressed group this does not
mean they benefit from oppression, since all groups might be worse-off under conditions
of structural inequality than they would be under more equal conditions. For example, in
North American societies women are oppressed relative to men because women as a
group have less social power than men as a group. Even though men are privileged
relative to women, men are also harmed by the sexist institutions that support patriarchal
relations. Men often find it more difficult to make certain choices, such as becoming a
full-time caregiver to their small children, that they might prefer to make under more
equal circumstances.

[41] When I use the word "relational" here I am intentionally referencing the work that
feminist philosophers have done in describing the relational nature of autonomy (which I
describe in more detail in section 3.2.1). Relational autonomy describes the idea that
whether we have autonomy and the extent of our autonomy is not merely an individual
matter. Instead, the extent to which we can exercise our autonomous capacities depends
on the arrangements present in our societies. Structural positioning is relational because it
is not merely a matter of the absolute status of an individual within that society (e.g. their
material well being or some other measure of their social position); instead structural
positioning involves the status of one individual relative to other individuals within that
society. The same level of material well-being (e.g. income) will lead to very different
structural positioning according to the level of material well-being of others in that
society. We cannot isolate those who are worst-off and still have an accurate picture of
the situation. Instead, we need to look at the worst off, those who fare best and the

structural positioning, then we risk conceptualizing the disadvantage as a problem only for the worst-off. In contrast, structural views understand oppression to result from the social institutions, traditions, practices and values, which interact to create determinant positions that constitute some groups as unequal to others and this creates structural positions of advantage and disadvantaged that internally constitute one another.

Oppression and domination are paradigm cases of structural injustices. Iris Marion Young defines oppression as consisting in systematic institutional processes that prevent some people from learning, developing and using an expansive set of skills and also inhibit their ability to express their feelings and perspectives on social life (1990, 38). Domination, according to Young, consists in "institutional conditions which inhibit or prevent people from participating in determining their actions or the conditions of their actions" (1990, 38). The concept of 'structural inequalities' is broader than both oppression and domination. There are multiple different oppressions and each form of oppression might have unique expressions and create unique challenges for the social group that is oppressed. These multiple oppressions share in common that they create real differences in power between social groups. In the first part of this chapter I examine structural inequalities, using oppression as my example. I shall then discuss the importance of taking this understanding of structural inequality into account in discussions of respect.

3.1.1 Social Structures and Oppression

The spatial nature of the structural metaphor highlights that the various positions within social structures create possibilities for acting: the norms and expectations

spectrum of individuals in-between the two extreme positions along a number of intersectional axes.

associated with these positions present agents with options that both constrain and enable

their action. As individuals interact within social structures they recreate these same

structures; social structures are perpetuated through the coordinated and uncoordinated

activities of a number of individuals. Social structures create determinant positions for

social groups, but the relations of inequality can be quite complex at the individual level

because a single individual might belong to many different social groups that are

positioned differently, and the experience of oppression can be different as the result of

belonging to multiple social groups. As Kimberle Crenchaw explains,

> Black women can experience discrimination in ways that are both
> similar to and different from those experienced by white women and
> black men. Black women sometimes experience discrimination in
> ways similar to white women's experiences; sometimes they share
> very similar experiences with Black men. Yet often they experience
> double-discrimination—the combined effects of practices which
> discriminate on the basis of race, and on the basis of sex. And
> sometimes, they experience discrimination as Black women—not the
> sum of race and sex discrimination, but as Black women (1994, 44).

Conversely, individuals can experience some degree of protection from discrimination

because of their intersectional identities. For example, although an individual might be

disadvantaged because of her gender, she might experience some advantages because of

her class or race. Structural injustice results when a number of structural inequalities

interact to create densely woven patters of systematic disadvantage.[42]

Oppression might involve intentional action, but oppression can also be

perpetuated by unjust social structures and social institutions that do not require

intentional actions. Many recent feminist discussions understand oppression as a

structural concept and have argued that the perpetuation of oppression often involves

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[42] I owe the description of structural injustice as consisting in densely woven patterns of
systematic disadvantage to the work of Madison Powers and Ruth Faden (2006).

subtle and complex interactions. Many cases of structural injustice result not from

explicit judgements about the worth of claims, but rather from inattention to the needs, or

existence, of certain groups. In this case there is no judgement that the claim is less

worthy, the claim is simply not considered as part of the options on the table for

discussion. In other cases, the claims might not be judged unworthy of consideration, but

might fail to receive a fair hearing because the claims of marginalized groups are

positioned in ways that make the concerns seem like "special interests" (Young 1990).

Feminist theorists agree that oppression *might* involve the intentional exercise of

authority by one person, or a state, over another individual or social group, but they do

not consider this a necessary feature of oppression because oppression can also be

perpetuated by unjust social structures. The oppressed can sometimes act to perpetuate

their own oppression because of the existence or structure of particular social institutions

(Cudd 1994; Young 1990; Young 2000).

In order to understand oppression as a structural concept, we need to have an

understanding of social structures and how social structures can operate to create

situations in which some social groups are disadvantaged relative to others. [43] According

to Young, social structures involve social institutions, interactive routines, cultural

traditions, social practices and values that may be formal or informal and the physical

structures in which these routines and interactions take place. [44]

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[43] In describing oppression as a structural injustice, I draw on Iris Marion Young's
description of social structures in her book *Inclusion and Democracy* (2000, Chapter 3),
and her articles "Equality of Whom? Social Groups and Judgements of Injustice" (2001a)
and "Responsibility and Global Justice: A Social Connection Model" (2006).

[44] It is important to note that I am not claiming that the existence of social structures is
bad in *itself*. Social structures are necessary to any kind of cooperative living
arrangements. Indeed, I believe that social structures would persist even in the absence of

Young describes social structures by highlighting the spatial nature of the structural metaphor. Social structures have a special element because they create various particular positions that individuals occupy. These positions stand in determinant relations to other positions and these relationships internally constitute each other. They are relationally constituted because each particular position in the social space could not exist apart from other positions and the larger organizational structure of the activity to which it is related. For example, to be a patient someone else needs a medical doctor and the features of these two positions relationally constitute one another. Both of these positions, doctor and patient, owe their existence to the larger institutions of allopathic (or other) medicine and the norms and values attached to these positions within a particular society.

Although social structures involve positions occupied by individuals, these positions are the results of interactions among individuals and should not be understood as reified or static. Young cites Anthony Giddens' notion of the duality of social structures as "rules and resources, recursively implicated in the reproduction of social systems" (Giddens 1984, 25 cited in Young 2001a, 13). People act on the basis of rules, resources and expectations that their various social positions make available. In acting according to these norms, they reproduce those structures. As Young says, these

formal arrangements, for example, under anarchy. In their recent book, *The Rebel Sell: Why the Culture Can't be Jammed*, Joseph Heath and Andrew Potter argue that the problem with countercultural movements is they want to do away with social structures altogether. This is a view that they attribute, in passing, to feminists (2004, 66-67; although in other places they seem to contradict this position). This is not how I understand feminist criticisms. On my understanding, the criticism is not of the existence of social structures, but of *particular elements* (although sometimes quite a large number of elements) of particular social structures that contain oppressive practices that serve to disadvantage some groups relative to others. The analysis does not aim to abolish social structures, but instead to improve them.

structures "constitute the historical givens in relation to which individuals act, and which are relatively stable over time. Social structures serve as background conditions for individual actions by presenting actors with options; they provide 'channels' that both enable action and constrain it" (2006, 112). Young worries that thinking of social structures as both the rules for and products of individual actions may make the development and perpetuation of social structures sound intentional. The existence of social structures, however, is the result of many coordinated and uncoordinated activities that often produce effects no one foresaw or intended. The interactions among individual actors also have future effects which may not be intended, and may be counter to the best intentions of the actors (Young 2001a, 13-14).

Sidewalks, for example, were built to create a separated walking space for pedestrians where they would be safe from vehicles. No one deliberately set out to hamper the ability of people in wheelchairs to move about the city when sidewalks were introduced; they simply did not consider that people other than pedestrians might have a legitimate claim to use the sidewalk. Many of the oppressive consequences of collective actions are as much the result of inattention as of intention.[45] When people who used wheelchairs complained about the way that sidewalks without sloped corners impeded their mobility, policies were implemented to build slopes into sidewalk corners. This created a new set of rules and resources that construction workers and city planners are expected to follow. Sloped corners also benefited people pushing carriages or shopping carts and elderly people with mobility difficulties. This example demonstrates that the

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[45] I do not intend to convey that this inattention is always blameless. Different cases of inattention might be more or less blameworthy depending on the particular circumstances. In some cases the inattention itself is disrespectful, as I describe in section 3.2.3.

barriers that are created by social institutions can be unintentional. It also shows that social structures are subject to change. Finally, the example shows that the collective actions themselves have implications for the rules and resources that will be available for future actors within that social space.

Structural inequality results when social institutions and practices create barriers for some social groups while enabling others. In the example of wheelchair users and sloped sidewalk curbs, the physical environment creates barriers to the mobility of wheelchair users but facilitates safe mobility for ambulatory persons. The disadvantages created by these physical structures are not limited to mobility. People in wheelchairs would also have difficulty participating in the political process, since they would not be able to enter the buildings where voting and decision-making take place. Their ability to access jobs and positions of authority would be similarly disadvantaged if they could not enter the buildings or operate the equipment once inside. When a number of structural inequalities exist that reinforce one another the result is structural oppression. Although it may be less obvious, these disadvantages for people in wheelchairs also create comparative advantages for ambulatory persons because these persons will be competing for jobs, positions of authority, and housing with a smaller pool than they would be if people in wheelchairs were not so limited. If we consider the numerous ways in which the built environment creates disadvantages for people in wheelchairs who are seeking housing or employment, then we can see that addressing the barriers for people in wheelchairs would lower the privileges of ambulatory persons because the competitive pool would increase, thereby decreasing chances of unearned advantage that leads to greater success experienced by privileged groups. This can help us understand why the

privileged often express resistance to these kinds of changes which are perceived as giving "special" consideration to people who use wheelchairs.

Structural injustice does not fully determine outcomes for individuals. Some of those from privileged groups may squander their opportunities, whereas others from oppressed groups may overcome these barriers by being hardworking, lucky, or both. Even though some people are able to overcome the obstacles faced by members of their social group, we should not think this means that they had the same opportunities as members of privileged groups or that they did not face any barriers (2001a, 15). Although there might be a number of individual differences among members of the same social group because of luck or effort, it is still important to look at the average differences that exist between social groups in order to identify structural injustices. For feminist analyses of social structures, the various differences between social groups are important moral data that should not be abstracted away in examinations of justice. If we fail to take seriously the position of different social groups, we will not be able to examine how individual "free choice" can result in oppressive inequalities that no one would freely choose.

3.1.2 Free Choice and Structural Inequalities

One of the central features of a structural understanding of oppression is that no person or group needs to intentionally set out to oppress another group in order for oppression to be perpetuated. Further, oppressed groups can often contribute to their own oppression through the cumulative effects of individual choices within oppressive social structures. There are many choices that might seem "free" when considered in isolation, but that become morally problematic when we consider that the cumulative results of

these interactions can involve oppressive disadvantages for some groups that would not be freely chosen, even if each choice that led to the cumulative result was freely chosen by a rational agent. When we are concerned about structural inequalities, which involve group-based harms, then we should be concerned with the cumulative effects that decisions have on the situations of members of different social groups. However, we should also attend to individual rights and liberties. When we understand persons as embedded in their social contexts which shape the conditions of their decisions and actions, we can work to improve the social structures so that they provide better conditions and contexts in which to make decisions.

The history of women's oppression in North America, for example, involves the sexual division of labour in which women took care of children and the domestic, or 'private,' sphere and men worked in the 'public' sphere (Okin 1989). [46] The structure of employment institutions developed in this context and assumed that labourers had full-time wives in the home. The family wage system that arose at the end of the 19th century during industrialization allowed men to earn enough through their labour to support their families (Hartmann 1999). In Canada, the system ensured that women would receive only half as much money as men for the same work if they did enter the workforce (Status of Women Canada 1999, Chapter 1). This system perpetuated men's financial advantages and women's economic dependence, allowed men to control women's labour for their

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[46] Of course, it was never the case that all women stayed home and tended to the private sphere. Many women have always worked outside the home, especially poor women whose salaries were needed to support the family, although even women who work outside the home usually shoulder the majority of childcare and other caregiving responsibilities within their homes. Nevertheless, the history in which women were considered to be full-time caregivers affected the development of the working world, which has been structured around the needs of married, middle-class, heterosexual white men.

own benefit, and encouraged women to stay home rather than choose a career. Women's caretaking responsibilities at home reinforced their inferior market position by making them seem like unreliable and undedicated workers. This combination buttressed the division between the public and private spheres creating different "appropriate" spheres for women and men (Okin 1989; Hartmann 1999).

Today, women are no longer excluded from productive resources and most women work outside the home in the labour market. Women, however, continue to earn less on average than men do, even when they are employed in similar jobs. A 2006 report by Statistics Canada found that women working full-time earned on average only 71% of what men earn when working full-time, a figure which has not changed much in the past decade (139). The gap between men's earnings and women's earnings widens over the course of their lives. Women employed full-time aged 16-24 earn 81% of what their male counterparts do, whereas women employed full-time aged 45-54 and 55 and older earn less than 70% of what men in the same age categories do (Statistics Canada 2006, 140). Looked at in isolation from the historical data, this may seem unproblematic. Wage differences are sometimes explained by women's reluctance to negotiate for higher salaries when accepting a job offer and to push for raises once employed (Katz and Andronici 2006). Michael Levin argues that this situation arises because men and women innately prefer to take up different jobs and roles, thus the situation of different wages is unproblematic and merely reflects difference in individual choice (1987, cited in Cudd 1998, 387).

When the current gender wage gap is examined in the context of women's historical oppression, however, we begin to understand why it constitutes current

evidence of women's oppression.[47] Although formal barriers to women's participation

have now vanished, the assumptions and values that developed the institutions linger on.

The institutions of the labour market developed with the assumption that labourers had

wives at home. It was assumed that men were free to work long hours with someone else

to care for the children and attend to daily needs of cleaning, shopping and preparing

meals. Although women were allowed into the workforce, the structure of employment

institutions has been slow to change. *Someone* needs to attend to the home, mundane

subsistence needs, and needs of children (if there are any).[48] Women still do most of this

work even when they also work outside the home (Veltman 2004).

　　Ann Cudd (1998) argues that the very existence of the gender wage gap sets up a

vicious cycle: it creates a certain set of choices that are rational for a woman to make in

her individual interest, but that are against the interests of women as a group, and which

tend to perpetuate the wage gap itself. Cudd begins with an example based on a rational

choice model involving a man and a woman (let's call them Davida and Rani

respectively), both of whom begin with equal talents, education and work experience and

equal power. These two may also be committed to equal marriage and equal sharing of

the housework and waged work. The two then have a baby they name Sam. We can

imagine that they believe that one parent *ought* to be the primary caregiver for Sam, or

we can imagine that they live in a social context that lacks adequate and affordable

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[47] For an extended discussion of the importance of examining oppression in the historical
context in which it occurs, see Tomsons 2006, Chapter 3.

[48] The need to stay home and attend to the daily needs of children will be particularly
acute in societies where childcare is considered the "private" individual responsibility of
the child's parents (usually the mother) rather than a collective or social responsibility.

socialized childcare which *requires* that one parent be the primary caregiver.[49] If there is

a wage gap that follows the statistical norm, then Rani and Davida would have different

rational expectations about their earning potential. If they make the decision of who

should care for Sam on this basis, and they want to maximize the well-being of the family

unit, they will decide that Rani should act as the primary caregiver.

This decision will have individual consequences for Davida and Rani. Davida will

gain "human capital" as he gains work experience. Rani, in contrast, will lose work

experience, and since she already faces a wage gap, she will now be doubly

disadvantaged if she returns to the workforce. If the situation faced by Rani and Davida is

typical of the situation faced by men and women in their society, then there are collective

consequences from these individual decisions that accrue to the social groups to which

they respectively belong. Women in general will seem like poor employment risks, not

likely to take their job seriously or to be as reliable on the job. Since the jobs that

command higher salaries require dedication, mobility, independence and devotion, men

will be more likely to seem like good candidates for these positions. Women, then, will

on average earn less than men do as a group, perpetuating the wage gap that lead Rani

and Davida to make the decisions they did in the first place. Thus, the maintenance of

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[49] Here my example differs a little from that offered by Cudd. She only examines the case
in which the decision for one parent to stay home is a matter of values. I would add,
however, that the decision for one parent to stay home to care for children can also be a
part of the limitations imposed by the social structure. Children need care. In the absence
of high-quality, affordable (or socialized) childcare that is adequately staffed and has
sufficient facilities for each child, the decision to stay home and care for children is more
than just the result of particular preferences. It is a constrained decision. *Someone* must
do this work, and if parenting is privatized so that it is the sole responsibility of the
parents, or the responsibility of those they can afford to pay for the service, then the
decision *to* stay home, like the decision of *who* should stay home, is also constrained by
existing social structures.

social inequality can be "the rational result of the choices made by individuals, given initial social inequality" (Cudd 1998, 397). Cudd calls this "the invisible foot" of the market.

Is there any reason to think that Cudd's model has explanatory force? Perhaps we would not think it had explanatory force if we examine the existence of the wage gap in isolation from the historical context of women's oppression. Perhaps then, Levin's explanation of differential preferences would be sufficient. However, the historical existence of the family wage sets up the initial situation that Cudd's model presupposes: differential wages based on gender. Further, Cudd's model predicts the increase in the wage gap that occurs as men and women age, whereas Levin's explanation does not.

Men as a group benefit from the situation: they have higher earning power and someone at home to take care of their needs and the needs of their children (if any).[50] Their greater earning power will also give men more bargaining power in the relationship, since they would fare better than women were the relationship to dissolve. However, these men do not need to be "oppressors" as this term is commonly understood as someone acting with malice toward the oppressed. The men and their female partners need only act in the best interests of the family considered as a unit. We now begin to see

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[50] This is not to imply that there are no costs to individual men from the existence of the social structures of the working world. Men's choices are also constrained by the existence of the wage gap. Namely, the wage gap makes it more difficult for men to decide to be full-time caregivers to their children, and this is certainly a limitation on their choices. Further, men who decide to stay home often experience derogatory attitudes from others, especially from other men who work full-time (Belkin 2008). The choice, however, results in a power differential in which men's greater earning power gives them a better bargaining position in the relationship than their female partners have because their female partners are economically dependent on the men (Okin 1989). Further, men benefit as a group because they are positioned as the "typical" full-time worker; as such, they are seen as better employment candidates and can command better wages.

how historical injustice can create social structures that perpetuate injustice, even once most members of society repudiate that very same injustice. The manner in which social structures constrain different social groups will itself be different because of the different social histories of the groups. The experience of systemic disadvantage is, however, a necessary feature of oppression.

None of the features that structure the working world are necessarily oppressive on their own. It is not necessarily oppressive to stay home and care for children rather than to seek employment outside the home. If care-giving work was valued as a way of developing important marketable skills, for example if it was considered to make one a better manager, the incentive for women to stay home would be less damaging to their employment and income prospects. The wage gap could be unproblematic if it were best described as the result of different unconstrained preferences between men and women, as Levin believes (although even this is debatable).[51] It would also be unproblematic if individuals were not judged according to their group membership, but rather according to their life-plans. Women and men may face different rationally self-interested choice structures if there were adequate socialized childcare that was affordable. It is only once these features of the social and historical context are examined and seen as systematically related to one another that we can see the operation of oppression.

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[51] I do not agree with Levin that such a situation would be unproblematic. These preferences are often encouraged by differing socialization for male and female children. Further, even if the preferences were "purely innate" we might have questions about a society that is organized so that one of its essential responsibilities (raising the next generations) leads systematically to the political disempowerment and relative economic vulnerability of its members who fulfill that responsibility. Society is probably not obligated to accommodate just any old preference (for example the preference to be a full-time surfer), but it ought to accommodate at least those responsibilities that are essential to its own perpetuation (such as raising children).

We are now in a position to understand Marilyn Frye's birdcage metaphor for oppression. Frye describes the birdcage as capable of restricting a bird's flight, but this cannot be seen by looking at a single wire at a time. Each individual wire seems harmless on its own. It is not until one steps back and examines the cage as a whole that one can see how the barriers are systematically related so that they serve to prohibit the bird's movement (Frye 1983, 4-5). Oppression can be difficult to detect: if one studies the elements of a social system one at a time, the barriers may seem accidental, occasional, or the result of individual choices, and hence avoidable. It is only when one examines how these barriers are systematically related to each other that one can see the ways that these forces and barriers constrain certain groups relative to others. Frye's metaphor of the birdcage is helpful for pointing out how seemingly innocent barriers can combine systematically to create severe constraints on individual choices and actions. The metaphor is also useful for explaining how systemic oppression can be passed off as accidental or occasional aberrations when one focuses narrowly on only one bar of the cage in isolation.

3.1.3 Relational Social Groups and Structural Inequality

Ordinary discourse differentiates people according to their social group. We speak of Kim Campbell as a woman and Jean Chrétien as a man. We identify Barack Obama as Black and John McCain as white. The census bureau asks us to identify ourselves according to social groups in the data it collects. Yet, the concept of a social group is contested, both in philosophy generally and within feminist philosophy specifically. In philosophy questions arise about the status of groups and whether groups are simply aggregates of individuals or legal fictions. Questions include whether groups can be

agents and whether the notion of group responsibility is coherent. Feminist debates about social groups usually understand these groups to be more than mere aggregates of persons (Young 1990, 44). For feminist philosophers a problem of social groups has centred on how to understand these groups without positing an essence that unites group members. In this section, I argue that social groups should be understood relationally.

In understanding groups relationally, groups are "collections of individuals who stand in determinate relations with one another because of the actions and interactions of both those associated with the group and those outside or at the margins of the group" (Young 2000, 89). Part of the problem of oppressive social structures is that the determinant positions they create among members of different socially structured groups are not positions of equality. A relational view of social groups understands social groups not as sharing essential attributes, but as emerging through interactions among individuals within particular historical social contexts. This happens, as Tomsons argues, because of historical processes that have selected certain features of persons as significant for structuring social norms, institutions and practices (2006, 93). Often the selection of features is contingent, in some sense, because other features could have been chosen or could have emerged as significant had different historical encounters occurred. The features that are selected as significant may vary from one society or historical period to the next, although some features such as gender, seem to be significant in most societies.[52] It is the particular and contingent encounters between social groups in

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[52] It is important to note that although gender is a significant feature for social organization in most societies, this does not mean gender is "the same" across societies. Gender is conceived of and enumerated differently across societies. For example, some societies recognize more than two genders whereas Europeans have historically recognized only two.

particular social and historical contexts that produce the perceptions of similarity and difference among the social groups. The attributes that classify individuals as members of the 'same' social group are perceived as similar only by comparison with others whose attributes appear more different in that respect (Young 2000, 90).

Before Europeans arrived in North America, for example, no group existed that anyone thought of as 'Indians,' 'First Nations,' 'autochthones,' or 'Inuit.'[53] Instead, there were a number of different bands (councils or tribes) living on Turtle Island who saw each other as quite different, based on other attributes that seemed salient before colonization by Europeans. These bands had different ways of life, some living in nomadic societies while others lived in settlements. They had different languages that set them apart from one another. There were different kinds of cultural products: some bands made small, portable carvings whereas others made huge totem poles that could not easily be transported. There were different forms of government, economy and law. Even before European colonization, however, the differences among these groups were relational and the differences that seemed salient for distinguishing different bands depended on the point of comparison. For example, the bands often identified their own distinctness differently from the way other bands identified them.

The group 'Indians' (and later 'First Nations') emerged through the encounter with colonizers from Europe who saw the inhabitants of Turtle Island as more similar to one another relative to the differences they perceived between these first inhabitants and their European compatriots. In Canada, these differences were codified into law in 1876 with "An Act for the gradual Civilization of Indians," known as the "Indian Act"

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[53] My example here is inspired by Young's discussion of the Maori in New Zealand (2000, 90).

(Steinhauer 2006). These laws structured Canadian society and continue to structure

Canadian society based on these differences and singled out 'Indians' for different forms

of treatment and different legal status than other inhabitants of Canada. The restructuring

of society that took place during the encounter between the peoples of Turtle Island and

European settlers meant that some differences that were previously salient were

suppressed,[54] while others were highlighted creating new emergent groups.

The 'differences' between 'Indians' and 'Europeans' that emerged as salient for

the structuring of Canadian society according to the newly imposed European laws are in

some sense contingent. Things could have gone differently had a different group, for

example the Chinese, colonized Turtle Island. If Europeans had not had colonial desires

to claim these territories as their own, other differences may have emerged as salient. On

relational understandings of social groups, groups are distinguished by their relations to

others, so that "social difference may be stronger or weaker, it may be more or less

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[54] For example, Paula Gunn Allen (1986) notes that many of the attributes that current
North Americans of European descent think of as belonging to themselves, actually have
their roots in the cultural forms of First Nations peoples. Allen traces the roots of
constitutional systems of government to the forms of government that were common
among some Native bands such as the Iroquois. Ideas of liberty and equality similarly
have their roots in the encounter between the peoples of Turtle Island and Europeans
whose stark hierarchies could finally be exposed as not part of the natural order, but
rather one choice of social organization among other possibilities. There was mutual
influence between the European's discontent with feudalism, and their encounter with
these other forms of social organization. But these encounters get twisted, so Europeans
write the history as though they came to North America already searching for liberty,
equality and freedom from tyranny, rather than encountering these values once they
arrived. Many European-Americans think of their cleanliness as something that
distinguishes them from those in Europe whom they see as less hygienic, but this too
comes from First nations groups who engaged in frequent bathing. What is now
considered an "enlightened" position against corporal punishment of children also had its
roots in these encounters, since many Native groups saw child abuse as abhorrent. Some
of the differences that emerged through the encounter were appropriated from one group
by the other. Their roots were then denied, often through fictitious stereotypes, for
example that Native peoples were "dirty, violent, savages."

salient, depending on the point of view of comparison" (Young 2000, 90). Although these differences are contingent, they are not entirely arbitrary. They are not arbitrary because these differences, unlike the differences of aggregates or associations, become a part of the social structures. Furthermore, because these differences are implicated in social structures, they condition subjectivity in ways that arbitrary differences do not.

Social structures involve practices, values, institutions, cultural traditions and so forth that are used to organize society. These practices and norms create determinate positions that are constituted in relation to other positions. Features of the social structure create possibilities for expression, and both enable and constrain action by presenting various different kinds of options to agents. I also suggested that the inhabitants of these positions are not just arbitrary individuals, but instead contain individuals who are so positioned because of their membership in social groups. My discussion of Cudd's "invisible foot" of the market (1998) shows how the particular historically situated features of the labour market can serve to sort some kinds of people (heterosexual women with husbands and children) into particular positions (economic dependence) while sorting others (heterosexual men with wives and children) into other positions, both of which are defined in relation to one another. This account shows that gender difference is a structural difference because we did not need to postulate any essential attributes of women that caused them to be in this position. Instead, the initial conditions made it rational for women to choose to stay home and care for their children. It is the trait of bearing children within the context of current North American heterosexual economic

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relations that causes this sorting, rather than some essential characteristics of women.[55]

Certain traits that are used to sort people into social positions tend to clump together in

ways that we identify as social groups. But this does not require any of the traits to be

essential to the group nor does it require postulating inherent superiority or inferiority to

the trait itself. Although particular traits may sort people in particular ways in one social

context, they could sort people in quite different ways given a different social context.

Social groups involve collections of individuals who are similarly positioned on certain

measures within particular historical social structures.

3.1.4 Health Inequalities

In many places around the world, there have been significant improvements in life

expectancy and reductions in morbidity during the twentieth century. The increases in life

expectancy and decreases in morbidity have not been shared equally either among or

within countries; the differences result in what are known as 'health inequalities' (Anand

and Peter 2004, 1). 'Health inequalities' are differences in health outcomes between

social groups identified by variables such as socioeconomic class, racial, ethnic or

indigenous groups, gender, lesbian, gay, bisexual, and transgendered individuals, people

with disabilities, homeless people, and people living in different geographic locations.[56]

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[55] Notice that bearing children is not an essential characteristic of women, because not all women bear children. Nevertheless, the trait of bearing children 'clumps' around the social group we identify as women: Whereas not all women bear children, most of those who have born children are women. I say "most of those who have born children are women" because some trans men have born children (Tedmanson 2009). Whether one believes that only women have born children will depend on one's definition of 'woman.'

[56] It is important to note that some authors make a distinction between 'health disparities' and 'health inequalities.' For example, in the glossary for "Canada's Response to WHO Commission on Social Determinants of Health" (Public Health Agency of Canada 2007) they define 'health disparities' as "differences in health status that occur among population groups defined by specific characteristics" such as the ones I listed above.

Examples of health inequalities abound. In 2005, the average American could expect to live five years longer than Palestinians, but black American men could expect to die three years sooner than Palestinians (Gadson 2006).[57] Within the United States, disparities in life expectancies exist between racial groups. Men of colour in the United States in 2001 had a life expectancy (68.6 years) that was 6.4 years lower than the life expectancy of white men (75.0). Women of colour had a life expectancy (75.5) that was 4.7 years lower than white women (80.2) (Allen and Easley 2006, 53). In Canada, First Nations and Inuit people have mortality rates almost 1.5 times higher than the national average and infant mortality rates are up to 3.5 times higher than the Canadian national

'Health inequality' is "the generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and social groups… that need not imply moral judgement" (Public Health Agency of Canada 2007). This terminology is not consistent across authors, however, and different studies and theorists use the terms differently. In this dissertation, I will use 'health inequality' to mean those differences that are associated with group membership rather than individual health differences. I do so because group-based measurement allows us to see many kinds of unfair inequalities that measuring inequalities across individuals obscures. Asada and Hedemann (2002), and Asada (2007) have excellent discussions of the differences in measurement methods and argue in favour of group-based approaches. Amartya Sen also favours measuring group-based inequalities rather than individual inequalities. Sen realizes there are many kinds of diversity, and the focus on groups could lead to empirical confusion if we tried to take account of all diversities. Nevertheless, Sen thinks we can make sense of group-based measurements if we focus on the more important ones. According to Sen, the question we have to ask for each context in which we measure inequalities is: "What are the significant diversities in *this* context?" (1992, 117)). I reserve the term 'health inequity' to express the moral judgement that health inequalities are morally wrong.

[57] These statistics update the ground-breaking study by McCord and Freeman that identified this issue in 1990. McCord and Freeman found that although Americans in general had a longer life expectancy than those in Bangladesh, life expectancy for young black men in Harlem was lower than the life expectancy for young men in Bangladesh (McCord and Freeman 1990; Marmot 2001). Statistics from 2006 show similar disparities continue to exist, though this particular comparison may be outdated. Life expectancy for all groups together in America is 78 years (74.6 for males), whereas in Bangladesh it is 63 (62.5 for males) (WHO 2006), the average life expectancy for males in occupied Palestinian territories is 70.9 years whereas for American black males life expectancy is 68.8 (Gadson 2006).

infant mortality rates (Shah 2004, 274).[58] Aboriginal peoples in Canada are

overrepresented among those infected with HIV and are infected at an earlier age than

non-Aboriginal Canadians (Larkin et al. 2007, 179). Canadian Aboriginal people have

higher rates of chronic and infectious disease, diabetes, lung cancer and suicide (Frohlich

et al. 2006, 134).

   People with lower incomes experience impoverished health. Absolute deprivation

is very significant internationally. Internationally among poor and wealthy nations GDP

correlates with mortality of children under five, ranging drastically from 300 per 1,000

live births in Sierra Leone to about 4 per 1,000 live births in Sweden and Japan (Marmot

and Bell 2006, 27).[59] If we restrict our analysis to richer countries, GDP no longer

correlates with life expectancy among countries,[60] but within a single wealthy country

there remain strong inequalities in health related to socioeconomic measures. This

suggests, according to Marmot and Bell, "Once a country has solved its basic material

conditions for good health, there is evidence that more money does not buy better

health… in rich countries, where the problems of absolute material deprivation have been

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[58] The life expectancy for Aboriginal men on-reserve is 67.1 and off-reserve 72.1
compared to a national average of 76 years for Canadian men. For Aboriginal women life
expectancy is 73.1 on-reserve and 77.7 off-reserve, compared to a national average of
81.5 years for Canadian women (Frohlich et al. 2006, 134).

[59] Marmot and Bell do not provide GDP for these countries at the time of these statistics
(2003), but the CIA's *World Factbook* ranks Sierra Leone 163rd in GDP at
$4,307,000,000 in 2008 ($700 per capita GDP). Japan is ranked 4th in GDP
$4,348,000,000,000 in 2008 ($34,200 per capita GDP) and Sweden is ranked 33rd at
$348,600,000,000 in 2008 ($38,500 per capita GDP). These figures are in US$ and have
been adjusted for purchasing power.

[60] It is also interesting to note that some poor countries, such as Cuba (GDP $5,259) and
Costa Rica (GDP $9,460) have life expectancies close to or higher than the United States
(Costa Rica's life expectancy is 77.9 years, the United States comes in at 76.9 years, and
Cuba is 76.5 years). Some exceptional countries have been able to do remarkably well at
preserving health with little income.

solved, it is not absolute level of income or wealth that matters for health. What matters is a person's position within the social hierarchy" (2006, 28; 29-30). Absolute deprivations associated with poverty and unequal access to medical care are important factors in creating poor health outcomes, but increasing evidence shows that inequalities in health persist even in the absence of absolute deprivation, and in contexts that grant universal access to medical care.

Health inequalities based on gender group membership are complex,[61] and it is difficult to know how much of these differences can be accounted for by biological differences, how much to attribute to socialization and social norms of masculinity and femininity, or how much is a combination of these two factors (among other influences). In 2006, Canadian men had life expectancy of 78.3 years, whereas women had a life expectancy of 82.9 years (WHO 2006). Although women are often thought to have biological advantages over men, some of this difference might also be caused by social factors, such as violent deaths in societies where male violence is tolerated (or even encouraged)[62] and deaths related to risk taking behaviour, which is sometimes

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[61] This is not to deny that other health inequalities are complex. One of the things that complicates gender-based health inequalities is that many studies conflate disaggregation by sex with identifying gender differences in social roles (Philips 2008). But there is not a clear relationship between these two. Further, many people identify as transgender, transsexual or cisgender, and many people may identify as lying somewhere in between these possibilities which can create complicated relationships between sex and gender norms. 'Cisgender' is a term that is used to denote non-transgender identities. 'Cisgender' employs the Latin-derived prefix 'cis-' which means "on the same side" as a contrast with 'trans' which means "across," "beyond" or "though." Cisgender is variously defined as: 1) a person whose determination of her or his sex and gender are universally considered valid, 2) someone who identifies with the sex and gender he or she was assigned at birth, or 3) someone who conforms to gender norms (Green 2006, 247 fn1; Serano 2007, 33).

[62] Women's health can also be made vulnerable in societies that tolerate or celebrate male violence due to violence against women that takes many forms.

encouraged among men.[63] Worldwide, men are exposed to health hazards in the

workplace, and suffer work-related fatalities more often than women, partly because

exposing men to risk is more tolerated in many countries (WHO 2007a, 50). In a number

of other countries, however, female life expectancy is lower or equal to that of men

(WHO 2007a, 42).[64] Amartya Sen estimates that there were 30 million missing women in

India, and 40 million missing women in China in the mid 1980s due to unequal valuing

of and resource sharing with male and female children and foetuses (1992, 124 fn 19).

     Further complicating the case of gender, if we look at measures other than life

expectancy, women fare worse than men do. For example, women in both high- and low-

income countries experience greater morbidity than men (WHO 2007a, 42).[65] Women

and men may have different vulnerabilities and disease progression. For example, women

are more sensitive to chemical exposures than men are because of different absorption

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[63] Men are often encouraged to engage in risky behaviour as a sign of masculinity. For example, according to WHO, globally, 2.7 times more men die from traffic injuries than women and are more likely to be injured in all categories of road accidents (pedestrians, vehicle occupants, drivers and cyclists) (2007a, 49).

[64] These counties include Bangladesh, Tonga, Afghanistan, Nepal, Malawi, Benin, Botswana, Cameroon, Central African Republic, Kenya, Niger, Nigeria, Pakistan, Qatar, Tuvalu and Zambia (WHO 2007a, 442).

[65] For example, WHO indicates that 68 out of 126 health conditions and health risk factors have at least a 20% difference between men and women. Women also face increased risks due to their role in reproduction including HIV, reproductive infections and cancers. WHO reports that women lose 2.19 times more Disability Adjusted Life Years (DALYs) than men due to these reproductive risks combined with morbidity, disability and mortality related to maternity. Women lose more DALYs than men related to eyesight, migraine, mental health, muscle and bone strength, ageing, nutrition and burns. Men lose more DALYs than women in areas related to excess consumption, infectious disease or deaths or injuries caused by drowning, falls and road traffic accidents (WHO 2007a, 43).

rates, metabolism and excretion of fat-soluble chemicals (WHO 2007a, 45).[66] Disease

processes in women are understood less well than they are in men and many treatments

were only studied in male subjects and then dangerously extrapolated to women (Dresser

1992; Rees and Chavkin 2006). Women often face under-treatment for conditions such as

pain (Jackson 2003) and heart disease (Redberg 2005). Many of women's health needs go

unmet (Rees and Chavkin 2006; Bryant, Leaver and Dunn 2009). Gendered health

inequalities appear to exhibit a complex interaction between biological differences and

social norms and practices and these disadvantage men and women in different ways.

　　　These are just some examples of health inequalities among social groups and

there are many, many more examples in the literature.[67] The evidence suggests that many

kinds of inequalities have concrete consequences for the health status of individuals

(WHO 2008a). Many authors believe that health inequalities related to social group

membership are unjust because it seems unfair that accidents of birth would have a large

effect on one's quality of life and opportunities (e.g. Veatch 1981; Anand 2002; Powers

and Faden 2006; Whitehead and Dahlgren 2006; Hausman 2007; Daniels 2008).[68] We are

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[66] This can cause particular problems when chemical safety levels are tested on adult male populations (Warren 1997, 10).

[67] For example, Lombardi and Bettcher (2006) explore health inequalities that affect lesbian, gay, bisexual, transgender and transsexual individuals. Pappas (2006) discusses health inequalities by geographic region. Health inequalities affect groups such as forced migrants (Toole 2006), homeless people (Gelberg and Arangua 2006, Pauly 2008), incarcerated people (Drucker 2006), the elderly (Estes and Wallace 2006), and people with disabilities (Bethune-Davies et al. 2006; Groce 2006).

[68] There is, of course, debate over how to understand when and whether a health inequality is unjust. For example, Powers and Faden think that health inequalities are unjust when they are the result of "densely woven patterns of disadvantage" that do not allow for a sufficiency of well-being (2006, 3). Daniels thinks that health inequalities are unjust when they result from "an unjust distribution of the socially controllable determinants of population health" in Rawls' framework (2008, 140). Peter (2001) also uses a Rawlsian approach to argue that health inequalities are unjust in so far as they

able to affect health inequalities through both deliberate policy decisions and the unintended consequences of policy decisions (Marmot 2004, 41). Because we have ample evidence on health inequalities and they are considered unacceptable yet continue to persist, many of those who study health inequalities consider it important to close the gap between knowledge and action (WHO 2005; NCC 2006; Collins and Hayes 2007). Health inequalities pose an interesting problem because although they are a health issue, they are best addressed through broad social policies and political action, rather than through strictly medical approaches that treat individuals.[69]

3.2 THE ROLE OF DIFFERENCE IN LATER BIOETHICS

Discussions of respect in early bioethics did not focus on the role of social differences in creating or contributing to ethical issues within medicine. Instead, these discussions assumed a generic patient, generic researcher and generic physician; the people who populated bioethical imaginations in the early days were conceived of in the abstract, even when they were based on particular individuals in real-life cases. Although

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result from an unjust basic structure of society. Whitehead and Dahlgren think health inequalities are unjust when they involve *systematic* differences in health status between different socioeconomic groups; they are *socially produced* and are therefore unnecessary and avoidable because they are amenable to change, and they are the result of *unfair* and unjust social arrangements (2006, 2). Not all authors agree that it is possible to define criteria for deciding when health inequalities are unjust, however (e.g. Vallgårda 2006). Questions about what makes health inequalities unjust are important, but I do not have the space to get into this debate in the context of this dissertation.

[69] I do not intend the political and the medical to be exclusive. Political decisions (such as the design of health care systems) can be influenced by desired medical outcomes (access to needed care in order to improve or maintain biological functioning). Further, some medical decisions (perhaps which conditions to study) are influenced by political elements (for example, who is making the decisions about funding and on what basis). I think these two domains are often mutually influential. All I mean to suggest here is that the political approaches to health inequalities go beyond what we normally think of as medical care.

the abstract approach to bioethics continues to this day, in the later period of bioethics there emerged a strong minority of ethicists dedicated to examining the role that social differences play in creating or exacerbating ethical issues in health care delivery and medical research.

3.2.1 Feminist Bioethics and Relational Autonomy in Clinical Medicine

Feminist approaches to bioethics are varied and have examined numerous areas of medical practice, research, medical systems and the cumulative effects of particular decisions within medical contexts. I will focus on some of the feminist criticisms of the concept of autonomy used in bioethics since these criticisms relate to the concept of respect in bioethics and they have been fairly influential. Susan Sherwin distinguishes 'feminine' and 'feminist' ethics. Feminine ethics developed out of the recognition that traditional approaches to ethics did not take women's experiences or styles of moral reasoning into account and often failed to fit with their intuitions (Sherwin 1992, 42). For example, Carol Gilligan's *In a Different Voice* (1982) criticized Lawrence Kohlberg's hierarchy of moral development. When women were tested using his methods they ranked on average as less morally developed than did men. Gilligan proposed that this ranking did not show women were in fact morally immature; instead she thought it showed there was a problem with the test that took male development as normative. Gilligan interviewed a number of women and identified a feminine style of moral reasoning, which she named an ethics of responsibility (a style that has now been developed theoretically as the ethics of care). Feminine ethics is characterized by its recognition and valuation of women's experiences and styles of moral reasoning.

Feminist ethics also recognizes the moral perspectives of women, but it is characterized by a political perspective that stresses the unacceptability of women's oppression and a critical approach that examines specific practices that constitute their oppression (Sherwin 1992, 49). Although feminist ethics recognizes the moral perspectives of women, feminist ethicists are also cautious about celebrating gendered traits that have developed in sexist social contexts. For example, Sherwin criticizes a depoliticized care ethics because women's caregiving role has contributed to their subordinate status and oppressed groups have particular reasons to be sensitive to the needs of others that stem from their oppression (1992, 50).[70] Feminist ethics takes oppression (especially the oppression of women, but also other forms of oppression) to be a central category for analysing particular features of a given society. Feminist bioethics expands the scope of bioethics to consider the effects that health care practices have not only on the patients who are directly involved but also to consider their effects on broader patterns of discrimination, domination, exploitation and oppression in the societies in which they are embedded (Sherwin 1992, 5).

Feminist bioethicists and philosophers have objected to the view of the self that is assumed in many traditional bioethical discussions. They charge that the view of the self that underlies Beauchamp and Childress' autonomous decision-maker is an atomistic, individualistic, isolated, rationalistic and abstract. These feminists argue that persons are not actually like that, and so the self that is assumed in these accounts is a fiction. Furthermore, it is a fiction that valorizes men's lives and devalues women's traditional

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[70] Not all versions of care ethics are depoliticized in this way, as Sherwin recognizes. Since the publication of *No Longer Patient*, several feminist care ethicists have developed specifically political approaches to care ethics. For example, see Joan Tronto's (1993) *Moral Boundaries: A Political Argument for an Ethic of Care*.

caregiving roles. These feminists note that humans are in a multitude of interconnected

relationships. Many feminists have taken the relational nature of selves to be fundamental

to what it is to be a person.[71] Annette Baier (1985) puts this point by saying that all

persons are "second persons" who develop in relation and interconnection with others. It

is only through our relation to others who nurture us, educate us and socialize us that we

develop as persons at all. Susan Sherwin notes that if persons don't receive education,

socialization and nurturance from others, then they can be damaged, sometimes so

seriously that they are not effective moral or political agents (2009, 151). As Sherwin

writes, "To identify someone as a person is to recognize her place within a moral

community and to appreciate her relational connections to other members of that

community who have been integral in generating that status for and with her. It is also to

place moral demands on others in their relations with those designated as persons"

(Sherwin 2009, 152). Labelling someone a person, on this view, is not just a matter of

determining whether they have a physical or psychological characteristic, but instead

requires determining the moral understandings of a culture (Sherwin 2009, 153).[72]

     Not all humans are able to engage in active reciprocal relationships: some will

have cognitive limitations or physical embodiments that make active reciprocal relations

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[71] See for example, Annette Baier (1985), Robin Dillon (1992c), Margaret Farley (1993), Susan Sherwin (2009).

[72] Sherwin notes that different human communities have been more or less generous with determining who counts as a member of their moral community. Some cultures include animals, living entities, or all of creation in this status. Other cultures have been less generous, restricting personhood only to their most privileged members. Although Sherwin believes there is some room for debate and deliberation about marginal cases of humans who cannot engage in social relationships (PVS patients, fetuses, etc.) she is also careful to note that this does not mean that all personhood is up for debate. For example, when colonizers treated First Nations people in North America as nonpersons this was a mistake because they were agents who were able to participate in moral communities and had moral sensibilities and cross-cultural moral conversations (2009, 153-154 fn 8).

impossible (e.g. people in persistent vegetative states (PVS), persons with severe disabilities, fetuses). Through our relational practises we sometimes hold these humans in personhood, to use Hilde Lindemann's term (2002, 30).[73] For example, when a family welcomes a fetus and begins to prepare for its birth they might already begin to form relationships with the fetus, though this relationship is mediated through the body of the pregnant woman. To the extent that the preparations put them in relationships with the fetus, then they are treating that fetus as a person -- that is, holding the fetus in personhood.[74] In the case of PVS patients or people with severe disabilities, their families might hold them in personhood by providing for their needs, keeping their memories alive, and so forth.

From this very different view of selves feminist theorists developed a different view of autonomy. They have argued that the autonomy of individuals is both constrained and made possible in various ways by the relational structures within their societies. When societies are characterized by pervasive structural inequalities, these constraints and possibilities are different for different social groups. Relational theory looks at how the autonomy of individuals is constituted under oppressive circumstances in ways that allow greater freedom of choice to some while constraining the free choices of others. For example, Sherwin notes that individuals from oppressed groups often internalize their

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[73] As Lindemann describes it, 'holding in personhood' is the "practice of holding the individual in personhood by constructing or maintaining a personal identity for her when she cannot, or can no longer, do it for herself" (2002, 30). Lindemann's example is her sister Carla who had severe hydrocephaly that prevented her from lifting her head. Although Carla had serious disabilities, her family loved her and cared for her. Through their caregiving practices the family came to know her as an individual, though each member of the family knew her somewhat differently because their relationship to her contributed to who she was as an individual.

[74] When a relationship with the fetus is not wanted by the pregnant woman, however, the fetus would not have the status of personhood on this relational account (Sherwin 2009).

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oppression; this can impair someone's autonomous abilities by undermining her sense of herself as a competent agent (1998, 35). Even if an agent were able to retain a robust sense of her agency under oppressive circumstances, her autonomy might still be constrained if information pertinent to her is lacking. For example, women were long excluded from medical research, in part because their fluctuating hormones were thought to confound the clean results obtained by studying men (Dresser 1992). Although this might produce neater results for the clinical trials, it made the clinical application of these results to women questionable. When women were faced with a clinical option, they would have less information than men about the risks and benefits of that treatment for persons with bodies and physiologies like their own. No matter how well the doctor informed these women about the results from clinical trials, and no matter how intelligent or competent the women were, their autonomy would nevertheless be compromised relative to men because of the inadequacy of the information.

Relational views of autonomy ask us to consider how the agent is situated within her social context and analyse how the oppressive social forces operating in her social context might constrain or facilitate her choices in a variety of ways. Where these constraints operate to keep some groups oppressed relative to others, relational theorists argue that we must work to remove these oppressive forces.

The reaction from mainstream bioethics has not sufficiently recognized the depth of the criticism of autonomy made by feminist bioethicists. For example, Beauchamp and Childress characterize feminist complaints as follows,

> Some feminists have sought to affirm autonomy but to interpret it
> through relationships. These conceptions of 'relational autonomy'
> derive from the conviction that persons' identities are shaped through
> social relationships and complex intersection social determinants,

such as race, class gender, ethnicity, and authority structures. These
accounts see persons as interdependent, but they also caution that
"oppressive socialization and oppressive social relationships" can
impair autonomy, for instance through forming an agent's desires,
beliefs, emotions and attitudes and through thwarting the development
of the capacities and competencies essential for autonomy
(Beauchamp and Childress 2009, 103).

This is an interestingly individualist interpretation of the view that I described above.

Beauchamp and Childress focus on the individual effects of oppressive socialization but

they neglect the parts that describe the different relational positioning of social groups

that give some groups greater social power and greater ability to shape research activities

to suit their needs. Beauchamp and Childress agree that it is important to overturn

oppressive socialization and relationships (2001, 61), but they do not seem to think that

this will require major revisions in their theory and they pay little attention to the role that

medical research or practice might play in perpetuating oppressive socialization and

oppressive social relationships. They believe that the conception of autonomy as

relational is "illuminating and defensible" but only as long as it "does not neglect or

obscure the main features of autonomy" as they have described them (2009, 103).

Beauchamp and Childress are not hostile to relational views of autonomy, but they also

do not believe that they require any major revisions to the view they have already

expressed, and if relational views of autonomy were to require such revisions, they

believe the view of individual autonomy they express should take priority.

I don't think Beauchamp and Childress have correctly interpreted the feminist

complaint, nor have they correctly located the revisions that feminists suggest should be

made to their view. When feminists have objected to the standard view of autonomy and

then argued that autonomy is relational and one's autonomy is constrained in various

ways by oppressive social relationships and social structures, it is not clear that the goal

of these feminists was then to have this relational autonomy respected according to traditional bioethical interpretations of what that means. On traditional bioethical interpretations to respect someone's autonomy *just is* to accept the particular decisions made by competent persons (patients or research subjects) when these decisions are made with full information and understanding of the risks and benefits. Feminists certainly don't want physicians (or researchers) to override the competent decisions made by oppressed persons, but neither have they been content with accepting the decisions as being the only or the main way of addressing relational autonomy. Feminists want us to respect relational autonomy by looking at the broader social context.

Feminists have not spelled out how they would understand obligations of respect under oppressive circumstances, but it seems they have something more in mind than the simple acceptance of particular decisions. I believe what the feminist relational view of autonomy requires is a revision in the associated view of respect. Beauchamp and Childress locate the main force of the argument in the *view of autonomy* that is offered; They believe that they can keep their view of respect constant so long as they include a brief mention of the importance of removing oppressive forces. I think this is a mistake. I believe that feminist arguments for a relational view of autonomy entail a revision in the *view of respect* and the *requirements of respect*. Without such a revision, the obligations to remove oppressive forces becomes disconnected from the relational view of autonomy that feminist have provided. To my knowledge, however, feminist theorists have not offered an account of respect that is connected to a relational view of autonomy. In Chapter 4 I return to Kantian discussions of respect to see whether there are resources for revising the view of respect in light of relational arguments about autonomy. In Chapter 6

I provide a revised view of respect that might be able to accommodate feminist relational accounts of autonomy.

3.2.2 Respect as the Foundation of Research Ethics

The *Tri-Council Policy* has a broad mandate, since it covers all human subjects research conducted in Canada, including research in the social sciences, humanities, natural sciences, engineering and medicine. Perhaps as a result of the breadth in the kinds of research they consider, *The Tri-Council Policy* (1998) provides a very broad account of respect. For the authors of the *Tri-Council Policy*, the concept of "respecting human dignity" not only applies to all persons, whether autonomous or not, but also the selection of which research projects to pursue, and the interests of groups that might be affected by the results of the research.[75] This concept is significantly broader than the concept described by both *The Belmont Report* and Beauchamp and Childress, which I described in Chapter 2. *The Belmont Report* invoked a concept of "respect for persons" that also applied to all persons whether autonomous or not, but it did not extend this concept to the selection of research projects or to a consideration of the effects that research might have on groups. Further, the *Tri-Council Policy* gives a more central role to respect than either the *Belmont Report* or Beauchamp and Childress (1979). Both of the earlier documents that I described in Chapter 2 position respect as one principle among several others. Beauchamp and Childress are clear that these principles are to be balanced against one another (2009, 19-24), and that the principle of respect for autonomy does not have moral priority over the other principles (2009, 99). The *Tri-Council Policy* provides a different

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[75] Although the *Tri-Council Policy* includes a brief discussion of using the concept of "respect for human dignity" in the selection of research projects and in thinking about the interests of groups, the document does not provide much guidance on what this would entail.

understanding of the role of respect in research ethics. In both the first (1998) and second (2010) editions of the *Tri-Council Policy*, respect for human dignity is considered fundamental and it is in some way related to all of the other requirements of the policy (though the relation changes from one edition to the next).

Given that respect for human dignity plays such a fundamental and central role in the *Tri-Council Policy*'s discussion of research ethics, it is surprising that this concept is not given a clear definition. The first edition of the *Tri-Council Policy* does not define "dignity" at all, and the second edition states that the concept of 'dignity' "lends itself to a variety of definitions and interpretations," although they do not further clarify these possible interpretations or take a position on its meaning for the purposes of the document. The first edition of the *Tri-Council Policy* invokes the concept of "respect for human dignity" not only as a specific principle governing the use of human subjects in research, but also as part of an overarching framework in which all of the more specific principles are to be understood (2005, i4-i6). The authors of the *Tri-Council Policy* also include "respect for human dignity" as one of the specific principles that govern research. Here they state that the principle is meant "to protect the multiple and interdependent interests of the person—from bodily to psychological to cultural integrity" (2005, i5). The authors don't say much more than this about the specific principle of respect for human dignity, unfortunately. And, unlike some other specific principles (respect for free and informed consent, respect for privacy and confidentiality, and respect for justice and inclusiveness), the specific principle of respect for human dignity is not given an extended treatment in its own section of the *Tri-Council Policy*. In the second edition of the *Tri-Council Policy* respect for human dignity is still recognized as "an underlying

value" but it is no longer discussed as part of an overarching framework that directs the understanding of the more specific principles. Instead, the second edition states that "respect for human dignity is expressed through three core principles—Respect for Persons, Concern for Welfare, and Justice" (2010, 8). In both cases, however, respect for dignity requires more from the researchers than obtaining informed consent from research subjects (although it requires this, too). One aspect of respect that is unique to *The Tri-Council Policy* that is not found in the earlier versions described in Chapter 2 is the attention that is paid to social groups. Both versions of the policy think that in order to conduct respectful research, we must attend to the effects this research might have on social groups.

When discussing respect for human dignity as an overarching framework to situate research projects involving humans, the authors of the first edition of the *Tri-Council Policy* claim that respect requires both the selection of morally acceptable ends for research and the selection of morally acceptable means to reach those ends. In order to choose morally acceptable ends, researchers are to think about the benefits to individual patients and associated groups, and also epistemic ends such as the advancement of knowledge. This requires a concern for individuals: to ensure that research proceeds by morally acceptable means, the *Tri-Council* authors invoke the Kantian idea that research subjects should never be treated as mere means, no matter how morally valuable the ends of research might be. But it also includes group concerns: researchers must think about the effects that research might have on particular social groups. This requirement remains rather sketchy in the first edition of the *Tri-Council Policy*, but it is strengthened and described in more detail in the second edition. Rather

than merely requiring researchers to "consider" the effects that research might have on social groups, the second edition of the *Tri-Council Policy* now requires, "[e]ngagement during the design process with groups whose welfare may be affected by the research" to help "clarify the potential impact of the research and indicate where any negative impact on welfare can be minimized" (2010, 10). The authors of the second edition of the *Tri-Council Policy* expand on these requirements in the 9th chapter where they focus their discussion around research on First Nations groups. The authors of the *Tri-Council Policy* (2010) say that First Nations people have a special status and are important in Canadian contexts because the colonialist history of the country inflicted particularly harsh and severe forms of oppression and domination on First Nations populations.

The *Tri-Council Policy Statement* (2010, Chapter 9) begins by recognizing the history of colonization in Canadian society and the detrimental effects this colonization has had on our epistemologies of First Nations cultures. First Nations ways of living were often devalued and described in stereotyped ways. Medical research on First Nations populations often did not benefit Native populations, but was instead used against them to describe them as deficient or in need of the 'civilizing' influence of white-Canadian society. Because of this there exists apprehension and mistrust among Aboriginal peoples toward researchers who seek to 'understand' or 'benefit' their communities. These historical and ongoing injustices lead the authors of the *Tri-Council Policy Statement* to conclude that research with Aboriginal peoples should only be conducted in partnership that respects Aboriginal knowledge systems and seeks the participation of First Nations peoples "in planning and decision making, from the earliest stages of conception and design of projects through to the analysis and dissemination of results" (2010, 106). The

policy seeks to create a better balance in the relationship between researchers and the community: one that ensures "mutual benefit in researcher-community relations" (2010, 106).

The *Tri-Council Policy Statement* developed its recommendations for the ethical conduct of research among First Nations peoples in consultation with First Nations groups. First they require community engagement (2006, Article 9.1, 110) which includes community input about whether including 'Aboriginal' identities as part of the selection requirements is justified, whether Aboriginal identity should be used as a variable for the purpose of analysis of the research data and input about the interpretation of any research results that refer to Aboriginal peoples, language, history or culture (2006, 110). The particular form of community engagement will vary with the particular type of research, but the *Policy* states that the extent of engagement should be decided in participation with Aboriginal communities and not by non-Aboriginal researchers alone (2006, 111). Further, researchers should recognize the complex authority structures involved in research with Aboriginal communities. For example, the prospective "participants may not necessarily recognize organizational communities or communities of interest as representing their interests" (2006, 115). In these cases individual participants should be informed of the nature and extent of the collaboration between researchers and Aboriginal organizational communities.

Researchers should also take care not to characterize First Nations communities as monolithic. They need to recognize the diverse interests of all relevant sectors, including those individuals and subgroups who might not have a voice in formal leadership (2006, 116). When research applies a sub-group analysis on their findings (for

example by considering the effects on First Nations women in particular), then they should also seek the input from members of these sub-groups (2006, 117). Researchers should also respect the community codes of ethics and standards of practice. Notwithstanding the respect for local customs, however, researchers are still required to seek REB review and approval, though in some cases the REB membership might need to be modified to include persons with expertise in Aboriginal cultures (2006, 120). Finally, researchers should engage in collaborative and participatory research practices that engage the active involvement of those who are subject to the research. Not only should the research participants be involved in the design of the research question, protocol and the assurance of mutual benefits to both research and participant communities, but the research protocol itself should also strengthen the research capacity among the community personnel from First Nations groups that are involved in the research (2006, 123-125)

Although the *Tri-Council Policy* explains how researchers should engage and consult groups in order to engage in respectful research, many of these considerations have applications beyond First Nations groups. I certainly would not want to deny the unique features of First Nations oppression in the Canadian context. Historically, the Canadian government treated First Nations people with an especially heinous set of policies that were genocidal, attempted to eradicate their culture and the means of passing that culture on to future generations, and denigrated their systems of knowledge. No other group in the Canadian context has experienced oppression to the same extent as First Nations populations. Although First Nations populations have experienced a particularly brutal form of oppression within Canadian contexts, I think that the attempts to repair

research relations with First Nations populations offer important lessons for other contexts as well. Some of the recommendations made by the *Tri-Council Policy Statement* are specific to First Nations groups, and would not have wider application (for example, those that recommend attention to the importance of elders as the guardians and disseminators of knowledge). Others, however, have broader application. For example, those that require community engagement in setting the direction of research, determining the expected benefits of research, and evaluating and participating in the results of research, all have application to research on other oppressed groups that have historically been excluded from the processes of determining the conditions of their own actions.

The *Tri-Council Policy* gives a very important role to respect for human dignity, but they do not adequately analyse the concept. As a result some of the specific recommendations in the *Policy* are not clear. In particular, the requirement to consult with community groups when engaging in human subjects research is quite different than the recommendations that are found in *The Belmont Report* or the *Nuremberg Code*. If this requirement is justified by respect for persons, the notion of respect implicitly invoked seems somewhat different that the traditional bioethical view of respect as acceptance of a fully informed choice.

3.2.3 Respect and Public Health

Public Health encompasses a wide variety of concerns, methods, policies and interventions. Public health is sometimes defined very broadly as "an organized activity of society to promote, protect, improve, and, when necessary, restore the health of individuals, specified groups, or the entire population" (Last 2007, 306). Public health

has broad and diverse responsibilities including preventing, discovering and responding to outbreaks of infectious disease," responding to disasters or bioterrorism, preventing and managing chronic diseases and mental illnesses, and promoting good health including by contributing to government policies that affect our health (housing, poverty, the environment, etc.) (Public Health Agency of Canada 2004). Public health ethics is a relatively new addition to the bioethics landscape. As Baylis, Kenney and Sherwin note, the newness of the focus on ethical issues specific to public health means that for many, the frame of reference remains the acute care model found in allopathic medicine and many of the concepts, methods, and boundaries of public health ethics remain largely undefined (2008, 200). It is unclear whether moral frameworks developed in the context of allopathic medicine, which focuses narrowly on individuals, translate easily into public health contexts, since the focus of public health involves considering the "needs of communities and populations through actions that are taken at a social or political level" (Baylis et al. 2008, 201). Public Health differs significantly from allopathic contexts because the focus of public health is on populations, or subpopulations and how social contexts affect health, disease transmission, and disease aetiology.

Although the concept of respect has played a central role in clinical and research contexts, respect has been less prominent in public health ethics to date. There have been two distinct ways the concept of respect has been used in public health ethics. First, respect has been invoked as an external constraint on public health policies that would otherwise seek to maximize population health outcomes according to utilitarian

principles.[76] The first use of respect reminds us that public health works to promote the needs of communities, and there is a danger that public health interventions could involve violations of individual autonomy, rights, or dignity. In these cases, there is a need to consider the individual and each person's inherent equal moral worth. One of the dangers of public health policies is that because they aim at the common good, it is easy to forget about the rights and interests of specific individuals (Baylis et al. 2008, 201). Some public health measures, such as ordering quarantines in times of pandemic outbreaks, do directly violate individual autonomy. In these cases there is certainly a very heavy burden on public health policy makers and public health officers to prove that the intervention is necessary and that there is no less burdensome way to achieve the same end.

The second use of respect in public health ethics is exemplified by Madison Powers and Ruth Faden's discussion in *Social Justice* (2006) where they treat respect as internal to the ethics of public health as part of the aims of public health policies. They reject the view that respect functions solely as an external constraint on public health's otherwise "utilitarian commitments to bring about as much health as possible" justified by concerns of beneficence (2006, 9). Instead, they believe one cannot speak about justice in public health policy without considering how other public policies and social environments are structured and how people are "fairing with regard to the rest of their lives" (2006, 10). According to Powers and Faden, one of the central elements of well-being that should be promoted by public health policy is respect and self respect. On their view, an understanding of respect requires looking at the social context and the numerous

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[76] The view that the concept of respect should function as an external constraint on public health is articulated by Dan Brock (2004) among others.

barriers to equal respect that result from structural inequalities. Respect, they argue, is internal to public health and should be part of the aims of health policies.

Respect is internal to the ethics of public health, on this view, because a sufficiency of respect is one of the essential dimensions of well-being with which public health should be concerned. Powers and Faden say that at minimum, "respect for others involves treatment of others as dignified moral beings deserving of equal moral concern. Respect for others requires an ability to see others as independent sources of moral worth and dignity and to view others as appropriate objects of sympathetic identification" (2006, 22). Even though respect plays a central role in Powers and Faden's view, they do not provide much conceptual clarity when they discuss respect. Instead, Powers and Faden briefly mention that the kind of disrespect they are interested in is a failure of what Darwall (1977) called Kantian recognition respect. Recognition respect, they assert, is the form of respect that is lacking when people are judged to be inferior based on their group membership, for example in phenomena such as racism and sexism. Powers and Faden do not say much more than this about their understanding of respect, and they do not give a detailed analysis of how recognition respect fits within their view (in Chapter 6 I will provide this discussion and analysis). Instead, they discuss how group-based social inequalities undermine respect for members of oppressed social groups.

Powers and Faden have a complex view regarding the relationship between respect for individuals and respect for the social groups with which they are identified. They write, "Lack of respect is a dimension of well-being characteristically under assault when an individual is the object of discrimination based on judgements of intrinsic inferior social status, often linked to properties of group membership, such as ethnicity,

gender, or social class, or to ability or appearance" (Powers and Faden 2006, 23). Powers and Faden note that even though it is possible to maintain one's self-respect under discriminatory and oppressive social conditions in which negative and disrespectful views about one's social group are pervasive, retaining one's self-respect in these conditions requires "heroic efforts or good fortune" (2006, 23). They believe that both respect and self-respect are vital for human flourishing. Pervasive disrespect for social groups creates an awareness that one is excluded from the "reciprocal system of mutual respect that others in one's society enjoy" (2006, 23). This is a serious injustice, according to Powers and Faden.

The kind of disrespect that concerns Powers and Faden is structural and systematic. This disrespect is not "simply the consequence of unrelated instances of bad luck," they write; it is "the predictable consequences of some forms of social organization that are within the power of human agency to alter" (2006, 71). The forms of social organization that concern Powers and Faden create densely woven patterns of systematic disadvantage that are often "multicausal in origin and multidimensional in effect" (2006, 71). These disadvantages often clump together and have a cascading effect so that an inequality in one aspect will beget further inequalities in other aspects, compounding the problem, so that the number of inequalities "mutually reinforce and perpetuate one another" (2006, 72). When Powers and Faden discuss how this oppressive system of compounded disadvantage works along the dimension of respect, they draw on the examples of racism, sexism, and ethnic conflict. Powers and Faden follow Iris Marion Young and Ann Cudd in characterizing these phenomena as typically involving

> (*a*) lesser respect accorded to some persons because they are members of an identifiable group; (*b*) which often translates into lower respect for self

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and a reduced sense of personal efficacy and capacity for self-determination among members of the lower status group; and (*c*) members of higher status groups benefit (or believe they benefit) from a social arrangement in which members of subordinated groups are held in lower regard (Powers and Faden 2006, 73).

Powers and Faden believe that there are often multiple sources of this disrespect and multiple means through which the disrespect is demonstrated. For example, racial groups may differ in their material resources which is both compounded and preceded by a lack of respect accorded to the social groups with fewer resources. After the abolition of slavery, former slaves had very few material resources relative to the whites who were once their masters. One cause of the lack of resources was the disrespect shown to slaves who were not considered persons. This lack of respect was also related to maintaining the unequal resources because former slaves were not considered worthy of the same kinds of jobs, property or legal rights as the white former slave owners. The lack of respect afforded to blacks in the post-abolitionist South both caused and perpetuated the unequal material resources between the two groups. When one group is not given respect, then this group's concerns are ignored because their claims are not considered worthy of attention. The situation of reduced respect often results from initial power disparities and serves to reinforce these disparities.

In addition to the adverse effects on respect, Powers and Faden say oppressive contexts of multiple, interwoven disadvantage are often accompanied and compounded by fewer opportunities for self-determination, attachment and other dimensions of well-being. They write,

> The central moral evil of reduced respect, accompanied by the overlapping
> and mutually reinforcing nature of effects on dimensions of well-being of
> all kinds, justifies a heightened level of moral scrutiny and a commitment
> to the eradication of the self-perpetuating constellations of disadvantages
> that result. For these reasons, the job of justice is not one in which it is

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enough to focus on some factors, such as disparities in wealth and income, and hope that as a contingent matter, all else of moral significance will come in its wake. Our theory does not ignore the prominent causal role that resource inequality may have in group domination, or minimize the profound effects of the overlapping social determinants on self-determination. However, because it takes the capacity for respect for self and others and capacities for attachment as morally important concerns in their own right our theory comprehends a full range of distributive and nondistributive concerns as equally important elements of systematic patterns of disadvantage, for which it is the job of justice to remedy (Powers and Faden 2006, 74-75).

Because this kind of failure of "recognition" respect is widespread and is related to the ways in which society is structured, the response that is required must also be attentive to the social context.

Powers and Faden provide a rich description of the kinds of social inequalities that affect respect for different social groups, but it is not entirely clear how they understand the concept of respect, and as I will show in Chapter 6, there is an uneasy fit between the way they use 'recognition respect' and the theoretical underpinning from Darwall that they invoke. I believe their attention to the interlocking and cascading nature of structural inequalities is important. They are right, I think, to note the ways in which inequalities in one aspect of well-being are often caused by and reinforce inequalities in another aspect. They note that when the social structures under which we live fail to provide for or respond to our important needs, this can cause a loss of respect. One characteristic of domination, they say, is that the claims of some social groups are not considered worthy (2006, 74). Powers and Faden recommend a concept of respect that focuses attention on these social contexts and how they influence the health and well-being of members of different social groups. Because unequal social contexts undermine the respect of some groups, while exaggerating the respect accorded to other groups, there is reason to attempt to change these unequal elements of the social structure since

we have an obligation to recognize the equal moral dignity of all people. These aspects of their discussion seem to be invoking a relational view of respect that sees respect for one group as related to (and relative to) the respect given to other groups. But this description is at odds with the view provided by Darwall that understands recognition respect as absolute rather than relative, as I describe in Chapter 4. Without a clear understanding the concept of respect Powers and Faden are using it becomes difficult to understand how public health policy is supposed to promote respect. In order to have a clear idea of how public health policy could promote respect, we need a better understanding of the concept of respect under discussion. In the next chapter I turn to a Kantian discussion of respect to develop a clearer view of the concept of respect.

3.3. CONCLUSION

In later bioethics we see the development of a politically sensitive view that attends to the relations of inequality that are pervasive in modern liberal societies. There is a complex understanding of structural inequalities and the way that subtle aspects of the social structure can constrain choices, actions, and interactions among individuals so as to result in oppressive inequalities that position some groups at a disadvantage relative to others. These views have been critical of some elements of the discussion of respect found in early bioethics. Feminist bioethicists have been particularly critical of the concept of autonomy and personhood that appears in canonical texts, such as Beauchamp and Childress' *Principles of Biomedical Ethics*. Some feminist critics charged that the view of persons presupposed in much of early bioethics is overly atomistic and individualistic. This view fails to account for the deeply embedded and relational nature of persons, who develop as "second persons" situated in social contexts. These feminist

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critics have also challenged the atomistic view of autonomy that develops out of this view of persons. They suggest that the mere selection from among a set of options does not justify the set of options itself. Often the options available are problematic and contribute to the perpetuation of oppression for some social groups. Feminist bioethicists developed a relational view of autonomy that attends to the ways that autonomy is conditioned by the structures of the society in which the individual is embedded. The relational nature of autonomy means that the quality of the options available differs according to the social location of the individual. This criticism of the concept of individual autonomy in early bioethics also constitutes an oblique criticism of the concept of respect at work in early bioethics, since in that work the object of respect is autonomy: physicians are instructed to respect the autonomy of their patients. The criticism of respect implicit in the criticism of the object of respect has not been fully developed, however. It does not seem that feminists should be satisfied with merely switching the object of respect to relational autonomy and it is unclear to me what it would mean to respect relational autonomy.

The codes of research ethics that were developed in Canada during the later period pay greater attention to social inequalities and the harm that can be done when outside researchers interpret cultures with which they are unfamiliar. The *Tri-Council Policy* pays particular attention to the harm that has been done to First Nations communities by Canadian researchers who have misinterpreted and misrepresented these cultures. Further, medical research that has focused on genetic or biological bases for some of the social problems faced by First Nations communities (such as alcoholism, illness, and suicide) has contributed to negative stereotypes about members of these communities. The *Tri-Council Policy* recommends that research should be conducted in

consultation with communities and this collaboration should include an identification of the possible harm that could result from the research. The first edition of the *Tri-Council Policy* explicitly states that respect is the foundation for research ethics and that all of the requirements of the policy should be interpreted through an understanding of respect for human dignity. The second edition of the *Tri-Council Policy* backs away from the strength of the early statement to some extent, and seems to accept the view that the concept of human dignity is vague and open to a number of interpretations. The second edition retains the central value of respect, however, and now says that the more specific requirements are expressions of this principle. Given the centrality of the concept of respect within the *Tri-Council Policy*, it is surprising that the authors do not give an extensive explanation of the concept. Whereas some of the other ethical principles and requirements have a chapter dedicated to an explanation and elucidation of the concept and connected requirements, the concept of respect receives but a few paragraphs in the introduction. The reader is left to infer the connections among the more specific requirements as expressions of respect.

Finally, Powers and Faden have argued that public health policy should promote respect and that pervasive social inequalities undermine the respect and self-respect of members of disadvantaged social groups. They reference Darwall's Kantian account of recognition respect, but then say little more about how they understand the concept and they do not provide an analysis that examines whether their discussion accords with Darwall's recognition respect. Powers and Faden provide a detailed account of the effects of reduced respect, and they suggest that structures of interlocking disadvantages contribute to reduced respect, but it not clear from their discussion how the systematic

structures they have in mind contribute to reduced respect. Without an understanding of these relations we are left unsure how public health policy could redress the situation.

In the next chapter I return to a Kantian discussion of respect, since this discussion is referenced by both early and later bioethicists who draw on a concept of respect. I will argue that there are resources within the Kantian account that could be used to support the broader concept of respect that we find in later bioethical accounts, but that the Kantian account has underestimated the power of social hierarchy and so needs to be politicized according to some of the insights described in this chapter.

CHAPTER 4   **KANTIAN RESPECT**

In Chapters two and three I briefly surveyed the concept of respect as it has been

used in bioethics. In early bioethics the concept of respect focused narrowly on individual

rights and specified the particular requirements of informed consent. One historical

reason for this focus is that the bioethicists of the time were interested in responding to

serious abuses of research subjects to ensure such abuses would not happen again. The

standards they created were specific enough that they could also serve as legal standards,

enforceable through the court system. These standards are important and I would

certainly not argue that we should give up the requirements of informed consent. But the

narrow standards have a limited focus, and we should not think that duties of respect are

exhausted once the researcher or physician has obtained informed consent. In later

bioethics the concept of respect expanded to include an examination of group rights and

structural injustices. These discussions examine how structural injustices affect Kantian

concepts of equal respect, or suggest revisions to Kantian elements (such as the concept

of autonomy) in the discussion of respect, but the relationship between respect and

structural injustice is not clearly spelled out. There is a sense that racism and sexism are

incompatible with respect, but it is not clear why. In this chapter I examine Kant's

discussion of respect, autonomy, and dignity[77] in order to compare Kantian respect to the

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[77] In the section of *The Metaphysics of Morals* where Kant describes our duties to others,
he includes duties of love (or beneficence) alongside duties of respect. He sees these two
duties as creating a balance, which he describes in a beautiful passage: "The principle of
mutual love admonishes them [rational beings] to *come closer* to one another; that of the
respect they owe one another, to keep themselves *at a distance* from one another; and
should one of these great moral forces fail, 'then nothingness (immorality), with gaping
throat would drink up the whole kingdom of (moral) beings like a drop of water' (if I
may use Haller's words, but in a different reference)" (*The Metaphysics of Morals* 1996,
198-199; AK 6:449; emphasis in original). A complete exploration of Kantian respect or

concepts of respect used by bioethicists.[78] I argue that Kant's discussion of respect and recent second-personal interpretations (e.g. Darwall 2006) of this concept could be useful in bioethics.

Most bioethicists equate Kantian concern for respect with respect for autonomy, so I begin in section 4.1 with a description of Kant's view of autonomy. I argue that there are a number of important differences between the way that Kant describes autonomy and the way that bioethicists have tended to understand the term. Kant's definition of autonomy is very precise: autonomy is the capacity by which we regulate our deliberations to bring them into accord with the categorical imperative. To determine whether someone is acting autonomously on Kant's view requires determining whether the reasons she provides for her action or decision (her maxims) accord with the demands of the moral law. Sometimes acting autonomously will require the agent to override her particular interests, wants or desires in order to meet the demands of the moral law. In contrast, bioethicists use "autonomy" to describe a general capacity to make decisions in one's own best-interests based on one's own values, desires, and beliefs. Bioethicists have generally not required that a patient subject his reasoning process to the categorical

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Kantian ethics should include his discussion of love, but in this dissertation my focus is on the concept of respect and its use in bioethics, so I will forgo an examination of the connections between these two duties. For more on the relations between Kantian duties of love and respect see Baron (1998), Velleman (1999), Bagnoli (2003), and La Caze (2005).

[78] In addition to discussing respect for autonomy and respect for dignity, Kant discusses "respect" in a third way as respect for the moral law. In some passages it seems that the moral law is more fundamental to Kant's view of respect than is respect for autonomy. Respect for autonomy is justified, according to Kant, because autonomy is the capacity through which we can discern the moral law. I will not discuss respect for the moral law here, however, because this sense of respect is rarely invoked in discussions in bioethics. For more on the three ways Kant discusses respect for persons see Dennis Klimchuk (2004) "Three Accounts of Respect for Persons in Kant's Ethics."

imperative nor do they require the patient to examine his reasons in relation to the demands of the moral law. Although Kant values autonomy very highly, he does not restrict our obligations of respect to only autonomous persons or their autonomous decisions. Kant's version of respect is meant to apply to everyone whether autonomous or not. There is a disconnect between the way "autonomy" is used by early bioethicists and the way Kant used the term. Kantian respect would require more in research and clinical contexts than merely obtaining informed consent—it also requires recognizing the dignity of persons.

In section 4.2 I describe Kant's understanding of human dignity as an absolute value. My purpose in this section is to show that Kant's discussion of dignity is at least as clear as his discussion of autonomy and so the fears about the contestability and lack of clarity in the concept of dignity expressed by some bioethicists (namely Beauchamp and Childress and the second edition of the *Tri-Council Policy*) are less troubling than these bioethicists suppose. Kant says there are two perspectives we can take when we consider persons. We can view persons from the objective (or phenomenal) perspective and we can view them from the interactive (or noumenal) perspective. When we respect persons we recognize the other as a subject with absolute moral worth, or dignity: as an end in itself. These two perspectives are not mutually exclusive. It is possible to consider another from both the interactive and objective perspectives. But on Kant's account, we must always adopt the interactive perspective towards other persons; we must treat them as ends and never only as mere means.

Stephen Darwall (2006) provides an interpretation of Kantian respect that stresses the distinction between the objective and interactive perspectives in Kant's writing. In

section 4.3 I examine Darwall's interpretation of respect as second-personal. Darwall's view of respect, which stresses the interactive stance, understands respect as a particular practical relation that one takes toward other persons when one recognizes each one's authority as a moral agent. In adopting a second-personal stance toward another, moral agents must view the other as the source of at least some of their moral duties. The second-personal view of respect is relational because its focus is on the kinds of relationships that occur between persons. I think the second-personal interpretation of respect has many things in its favour. In particular it stresses the importance of understanding the perspectives and reasons of other moral agents. I argue that the idea that Kantian respect is interactive, or second-personal in Darwall's terms, is an important insight that should be adopted in bioethics.

The second-personal account of Kantian respect is consistent with the emphasis on informed consent in early bioethics. It will continue to require that medical professionals obtain informed consent from research subjects and patients. In section 4.4 I conclude the chapter by considering some advantages of the second-personal account of respect that are missing from early accounts of respect in bioethics. In particular, the discussion of respect in early bioethics highlights the vulnerability of patients or research subjects, but says little about the vulnerability of researchers or physicians. Early bioethicists described reasons why the autonomy of individuals might be at risk in research and medical encounters. But these early accounts are one-sided. They fail to describe why researchers or physicians might be at a heightened risk of disrespecting their research subjects or patients. The medical abuses and wide-spread paternalism that I described in Chapter 2 was not merely a situation in which research subjects and patients

were vulnerable, it is also a situation in which that vulnerability *was exploited by* researchers and the patient's wishes *were not considered* by physicians. If we do not wish to impute a crude or blanket condemnation of researchers or physicians (and we should not wish to do so because not every failure of respect reveals a bad moral character), then we need some explanation about why research and therapeutic contexts might put *researchers* and *physicians* at heightened risk of disrespecting their subjects or patients. The second-personal account of respect is able to do so. Not only can the second-personal account provide reasons that researchers and physicians might be at risk of disrespecting subjects and patients, this account also explain why respect should be an important consideration in public health policies, as Powers and Faden recommend. The fit between bioethical discussion and the second-personal account of respect described by Darwall is not perfect, however. In Chapter 5 I argue that the second-personal account of respect described by Darwall pays insufficient attention to the effects of the social inequalities I described in Chapter 3.

4.1 KANT ON AUTONOMY

Kant believes that there are two different perspectives from which we are able to consider ourselves. From one perspective we can think of ourselves as part of the "phenomenal" world. When we think of ourselves in this way we consider ourselves as animal selves (as a "human being," "*homo phaenomenon,*" or "*animal* rationale"). When we consider ourselves from the phenomenal perspective, we are part of "the system of nature" (*The Metaphysics of Morals* 1996, 186, AK 6:434). From the second perspective, the deliberative perspective, we consider ourselves as agents, as beings that are capable of making decisions (as persons, "*homo noumenon*," or rational being). It is only when

we consider ourselves from this second perspective that we understand the will as autonomous, which is the "property of it by which it is a law to itself independent of any property of the objects of its volition" (*Foundations of the Metaphysics of Morals* 1995, 57, AK 4:440). According to Kant, when we think of ourselves from the interactive (or noumenal) perspective, we are committed to the freedom (or autonomy) of the will because this freedom must be presupposed in intelligible deliberation. In order to think that we are agents, we must think of our will as free because if we use our reason to make judgements based on "bidding from the outside" then we are not in fact making judgements based on reason, but instead responding to impulse (*Foundations of the Metaphysics of Morals* 1995, 64-65, AK 4:447-448). When we think of ourselves as agents, as beings whose wills are causes of their actions, then we must presuppose that our wills are free.

The freedom of the will that we must presuppose from the deliberative perspective is not mere chaotic randomness, according to Kant, "Otherwise a free will would be an absurdity" (*Foundations of the Metaphysics of Morals* 1995, 63 AK 4:446). Instead, if we are to understand our wills as the cause of our actions, our wills must operate according to laws. But the laws according to which the will acts cannot be the physical laws that make up the phenomenal perspective. If the will was compelled by these physical laws, then the will would be determined by external forces and would not be a cause of our actions. The kind of freedom we must presuppose for our wills is autonomy, or "the property of the will to be law to itself" (*Foundations of the Metaphysics of Morals* 1995, 64, AK 4:447). Autonomy, for Kant, is the ability of our rational will to give itself laws that are not derived from external biddings or impulses. In

order for the will to be "a law to itself" we must act according to "no other maxim than that which can also have itself as a universal law for its object" (*Foundations of the Metaphysics of Morals* 1995, 64, AK 4447). This kind of freedom requires giving oneself principles that can be consistently universalized, and to act upon those principles. According to Kant, this means acting on the first formulation of the categorical imperative "Act only according to that maxim by which you can at the same time will that it should become a universal law" (*Foundations of the Metaphysics of Morals* 1995, 38, AK4 421). So the free will is the will that acts according to the moral law. "A free will and a will under moral laws are identical," as Kant writes (*Foundations of the Metaphysics of Morals* 1995, 64, AK 4:447).

For Kant, autonomy has a very precise meaning. The will that does not act according to the principle of morality by giving itself principles of action that can be universal laws is not an autonomous will, but is instead a heteronomous will that is impelled by forces external to the will such as desires, biological urges or psychological impulses. This feature of autonomous wills gives Kant's concept of autonomy a non-self-regarding element. The will that is free, according to Kant, gives itself the moral law which is formulated in terms of principles that could consistently be willed to be universal. When Kant discusses what it is to consistently will that a maxim become universal law, he does not have in mind that the agent should like the state of the world so imagined. Instead, Kant is interested in the logical implications of this willing; he wants to ensure that the principles of our actions are *consistent* when turned into universal laws.

In order to test whether a maxim could be consistently willed to be a universal law, we must first specify the subjective maxim (or statement of principle) on which we act. Then we should ask whether we can cast this maxim as a universal law that should govern all rational agents. Some maxims will fail at this stage. For example, Kant thinks that lying promises will fail at this stage. Let us imagine someone, whom I will call Arthur, wants to borrow money from Gunta. Arthur has no intention of paying Gunta back but he promises to do so anyway. Kant says this maxim will fail because the maxim behind Arthur's promise to repay a debt he cannot repay is "When I believe myself to be in need of money, I will borrow money and promise to repay it, although I know I shall never be able to do so" (*Foundations of the Metaphysics of Morals* 1995, 39, AK 4:422). This maxim could not be a universal law because if we were in a world where everyone made such promises whenever they were in need, then no one would believe any promises, and the whole enterprise of promise-making would collapse. When universalized, the maxim is contradictory because the very practice it presupposes could not exist in such a universe. Kant says these maxims "Cannot even be *thought* as a universal law of nature without contradiction" (*Foundations of the Metaphysics of Morals* 1995, 40, AK 4:424; emphasis in original). Maxims that fail at this stage generate "perfect duties" that admit of no exceptions and must be fulfilled to the fullest extent possible. The lying promise is internally self-contradictory, so it generates a duty not to make a promise with no intention of fulfilling that promise at any time, and this duty must be fulfilled to the fullest extent possible.[79]

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[79] An interesting aside: one common objection to Kantian ethics that is discussed in most Introductory Ethics classes is the case wherein Kant would allegedly suggest that we ought to tell the truth even if a Nazi appeared at our door and we were hiding Jews in our

Some maxims will pass this first test, but there is a further stage to deciding whether an act is morally permissible or whether it constitutes a moral duty. If we determine the maxim could consistently be universalized, we must then ask whether we could rationally *will* to act on the maxim in a world where it has been universalized. Kant's example here is a person, whom I will call Mona, who does not wish to aid others in their time of need. The maxim in this case is: "Let each one be as happy as heaven wills, or as he can make himself; I will not take anything from him or even envy him; but to his welfare or to his assistance in time of need I have no desire to contribute" (*Foundations of the Metaphysics of Morals* 1995, 40, AK 4:423). Kant thinks that such a world could be thought as a universal law, and the "human race could exist" under such conditions. This maxim therefore passes the first test according to Kant; it can be made

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attic who would surely be murdered when we revealed their hiding place. Kant might have uttered these sentiments in some places in *The Metaphysics of Morals* (1995, 184, AK 6:431) and in his reply to Benjamin Constant, but he appears to give a different position on such cases in his *Lectures on Ethics*. In Kant's discussion of truthfulness in *Lectures on Ethics*, Kant maintains a stance in favour of truthfulness, but he recognizes that there are different kinds of lying. In particular, he gives the example of lying to someone who has a knife to one's throat and is asking if one has any money. Kant says that we need not tell the truth to the robber because "he will abuse it and my untruth is not a lie (*mendacium*) because the thief knows full well that I will not, if I can help it, tell him the truth and that he has no right to demand it of me" (1963, 227). If we lie to the robber we have not done him an injustice, but Kant thinks we should nonetheless recognize that we have acted against "humanity" in telling a lie. This seems right to me. Often when we are put into a situation where we are "forced" to lie we regret that we had to lie (that is, we resent being put into that situation) but we don't feel that we did wrong to the individual to whom we told the lie (since they were the one to put us in that situation). Kant writes, "If force is used to extort a confession from me, if my confession is improperly used against me, and if I cannot save myself by maintaining silence, then my lie is a weapon of defence. The misuse of a declaration extorted by force justifies me in defending myself" (*Lecture on Ethics* 1963, 228). Presumably similar considerations would apply in the Nazi example even though the confession would not be used only against me but also against those hiding in my attic. For more on the misinterpretation of Kant's views on lying, see Allen Wood's discussion in *Kantian Ethics* (2008, 244-251).

into a universal law to govern all rational beings.[80] Nevertheless, Kant does not think

such a maxim could be consistently *willed*. This maxim cannot be consistently willed

because the universalized maxim would undermine its own self-interested end. It would

be counter to the end expressed because there are often instances in which Mona would

find herself in need of the "love and sympathy of others" but through universalizing this

law Mona would have robbed herself of "hope of the aid [she] desires" (*Foundations of

the Metaphysics of Morals* 1995, 40, AK 4:423). In this case the contradiction is not

found in the maxim itself, but is instead found in the will that would espouse it. When

maxims fail this second test, then they generate imperfect (or meritorious) duties.

"Imperfect duties" are duties that admit of some latitude; we ought to fulfill these duties,

but they can be fulfilled sometimes and to some extent, in contrast to perfect duties which

must always be fulfilled to the fullest extent. Because we could not consistently will a

maxim of unfettered self-interest, we have an obligation to aid others, but when we

provide aid and the extent to which we provide aid on a given occasion is left up to our

discretion.

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[80] I do not agree with Kant's assessment here. If everyone acted on a maxim of universal unhelpfulness and failed to assist others in their time of need it seems exceedingly unlikely that any person would ever make it out of their infancy, and therefore it is doubtful that the "human race could exist" under such conditions. Kant might object that my view describes a contingent fact about *human* rationality (that it requires time and the assistance of others to develop) rather than a necessary fact about rationality *as such* (what reason would be if housed in beings unlike humans). The crux of the argument depends on how one views rationality and its necessary features, but this discussion would take us too far from the topic of this dissertation. I think the very practice of universal unhelpfulness presupposed by the maxim would crumble in a similar way to the lying promise, because it would create conditions in which there were no rational beings to act in unhelpful ways. I doubt very much that the "human race could exist" under such conditions.

The examples that Kant gives could easily be misleading, making it seem as though Kant's version of autonomy is based on self-interest. In each example, the subjective maxim (the maxim in its non-universalized form) he imagines involves self-interested ends. But it is important to remember that for Kant autonomy does not solely involve giving ourselves subjective maxims. He says that our ability to set our own ends in this way has only the extrinsic value of usefulness (*The Metaphysics of Morals* 1996, 186; AK 6:434). Instead, autonomy is the process of determining the moral law for ourselves, which involves subjecting these maxims to the test suggested by the categorical imperative. This test is not a test of whether the resulting situation will be one the agent likes or finds to be in his self-interest. Instead, it is a test of the logical consistency of the universalized maxim, or the consistency of willing such a maxim to be universal. If we were purely rational beings the categorical imperative would function as a law of nature. But humans are limited beings and for us, the categorical imperative functions as a constraint on our inclinations (Klimchuk 2004, 41). Kant says that we should adopt a posture of respect toward the moral law, which requires setting the moral law as an arbiter over one's inclinations. Autonomy is the capacity by which we regulate our deliberations to bring them into accord with the categorical imperative, despite what our inclinations might be.

Kant's use of "autonomy" is significantly different from the use of "autonomy" that has become popular in bioethics (as I described in Chapter 2). In bioethics "autonomy" has been used to describe a general capacity to make decisions in one's own best-interests based on one's own values, desires, and beliefs. "Respect for autonomy" has generally been understood by bioethicists as respecting the rights of competent

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persons to make decisions about their treatment or research participation. Respect for

autonomy is usually invoked as the morally preferable alternative to coercion or

compulsion to participate in research or receive treatment. Beauchamp and Childress

state that they decided to focus on "respect for autonomy" rather than "respect for

persons" or "respect for human dignity" because they believe that "autonomy" is a

clearer concept that is less inherently contestable (2009, 66; 70). But just as there are a

number of ways to understand the concept of "human dignity" and a number of ways of

specifying what counts as a "person," so too, there are a number of ways to understand

the concept of autonomy.

Kant's use of "autonomy" is indeed clear, but it might not be very useful for

bioethics.[81] When Kant talks about "autonomy" he is describing a property of the will by

which it is able to give the moral law to itself. The autonomous will is the means by

which we assess our own actions in relation to our moral duty. Bioethicists have not

usually recommended that patients ought to morally evaluate their treatment decisions.

Nor have they recommended that physicians or researchers undertake a moral evaluation

of the decisions of patients or research subjects. In bioethics, the concept of patient

"autonomy" is meant to limit physician paternalism in clinical contexts and prevent

deceptive and abusive research practices. The concept of autonomy in bioethics conveys

the idea that a physician should accept the patient's decisions about treatment with no

stipulations about the content of the patient's decisions so long as the patient is deemed

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[81] There is disagreement on this point. For example, Onora O'Neill (2002a) argues that a
more Kantian version of autonomy would be useful in bioethics. In contrast, I believe that
the demands Kantian autonomy places on one's reason might be a little excessive when
one is facing a serious illness. A full discussion of this point would take me too far from
my argument, however.

competent. For Kant, autonomy is the faculty we use in order to determine what duty demands. In bioethics autonomy is not about discerning one's duty but is instead about the right to full information and the patient's right to make his or her own decisions about whether to accept particular medical treatments or participate in medical research.

A second difference between Kantian respect and the version of respect for autonomy found in the canonical bioethics textbook by Beauchamp and Childress involves the *scope* of our duties of respect. Although autonomy and the ability to reason clearly play an important role in Kantian ethics, Kant does not restrict our duties of respect to only those who are autonomous or are able to reason. The Kantian ideal of respect for persons is universal and egalitarian in the sense that respect is owed from all and it is equally owed to each. The goal of this kind of respect is to create "a kingdom of ends" where persons are regarded as moral equals: as beings whose dignity affords them a value that is beyond any price (as I describe in detail in Section 4.2). Kant does not restrict this obligation to only rational or autonomous beings, but instead says we must respect all persons or we fail to treat rational nature as an end in itself. Alan Wood argues that the best way to understand the universal and egalitarian nature of Kantian respect is to think of 'personhood' as having both a strict and an extended sense in Kantian ethics (Wood 2008, 96-98).

Wood believes that Kant's conception of reasoning is much closer to everyday thinking about reasoning than Kant's discussion of the noumenal realm might make it seem. For Kant, reason is a faculty, or capacity, and it gains its status as the highest capacity because it is the only one capable of organizing, directing or criticizing other faculties (Wood 2008, 16). Because we have the capacity to reason, and regulate our

actions according to reasons, we also have an obligation to govern our own lives individually and in community with others. Kantian reasoning is closely connected to the ability to communicate, since in governing ourselves communally we must also come to an understanding with them. Reason is also flexible: it can be guided by techniques, methods, rules, procedures or calculi, but it is not reducible to these. Mechanical procedures or sets of rules cannot be the final arbiter of what is rational because these procedures could themselves be tested and criticized through our capacity to reason (Wood 2008, 17).

These features give rise to three maxims of reason. First, one should think for one's self and not allow one's thought to be guided by dogma or controlled by another. Thinking for one's self does not mean that we should ignore the views of others, however. To the contrary, thinking for one's self requires that one take the views and information provided by others into account. Thinking with others forms the basis of the second maxim: "Think from the standpoint of everyone else" (Wood 2008, 17). Thinking from the perspectives of others is supposed to limit self-interest and help to move reasoning beyond the first-person standpoint (as I explain in more detail in section 4.3). According to Wood, in order to think for one's self, one should take the views of others as a contribution to one's reasoning process but should not allow the thinking of others to substitute for one's own (2008, 18). In order to take the views of others into account, one needs to communicate with them to gain information and understand their perspectives. Communication between rational beings is a condition for the existence of reason, and acting rationally is acting on grounds that are intersubjective or shared by and valid for others as well. "What it is rational for me to do may not necessarily be what is rational

for others to do, because my situation may differ from theirs." Wood explains. "But if I have a valid, rational ground for what I do, then that ground is also comprehensible from the standpoint of others" (2008, 18). Finally, one should reason consistently with one's self. To be consistent one must not only avoid contradictions, one must also act on the basis of principles that constitute good reasons, though of course it can be quite difficult to sort genuinely good reasons from reasons that only seem good. Kantian reasoning requires communicating with others and exercising one's own rational capacities in order to develop a view of what counts as a good reason. Mechanical procedures cannot replace this difficult and interpersonal effort.

The aim of reasoning is to come to a consistent view about good reasons for acting, and this requires deliberation and communication with others. Kant's view of reasoning as deliberative and interpersonal provides a view that is more open to what Beauchamp and Childress call "inherently contestable" concepts like 'personhood' and 'dignity.' (I look at Kant's concept of 'dignity' in the next section). Personhood is a central concept in Kantian ethics because of its relation to moral obligation. We have certain duties to persons that are obligatory ends on Kant's view, namely duties of respect and duties of love or beneficence. Kant does not think these duties are only owed to those who are autonomous; Kant thinks that some individuals are too dependent on others to develop the independence of will required for autonomous decision-making, yet these persons are still owed duties of respect and love.

Alan Wood sheds light on this aspect of Kantian ethics by proposing that Kant understands personhood to have both a strict and an extended sense. According to Wood, those persons who are rational are persons in the strict sense but other beings might be

persons in an extended sense. Children, for example, have not yet developed their

capacities for reasoning to the extent where they would be considered persons in the strict

sense. Wood argues that we would nevertheless show disrespect for rational nature if we

did not help a child to develop these capacities to maturity (2008, 97). So respecting

rational nature requires us to respect some who are not persons in the strict sense. The

status of extended persons is not quite the same as strict persons, because they cannot

equally participate in deliberations with others, but it is not a lesser status. "Here we must

also face up to the fact," according to Wood, "that who counts as a person in the extended

sense is something that must be determined by those of us who are persons in the strict

sense" (2008, 97). Only persons in the strict sense are able to enter into the discussion

and deliberation about who should count as an extended person.[82] These deliberations are

constrained, however, by our respect for the dignity of rational nature.

Kantian respect, then, has a wider scope than the kind of respect described by

Beauchamp and Childress. A Kantian would agree with Beauchamp and Childress that

we have obligations of beneficence to non-autonomous persons, but he would disagree

that respect should be restricted to only those who are autonomous. On Wood's

interpretation of Kantian personhood, Kant would object to the gate-keeping role of a

mechanical procedure, such as determining competence, as a means of determining to

whom we owe duties of respect. Wood's description of Kantian approaches to

determining personhood has more in common with relational approaches to personhood

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[82] Wood takes a similar approach to discussing our obligations to non-rational animals. Since only rational beings can deliberate about how to treat animals, and only rational beings can hold one another accountable for that treatment, these obligations must be decided by persons in the strict sense. These deliberations must also be grounded, however, in a concern for the dignity of rational nature which would forbid certain kinds of behaviour (2008, 101), such as the cruel torture of animals for amusement.

(described in Chapter 3), although it has a different emphasis. The Kantian and relational approaches to determining personhood are similar because they both require discussion, communication and deliberation within a moral community. The approaches differ in emphasis, however, because Kant gives a central and directive importance to the dignity of rational nature, whereas relational approaches give importance to the relationships among persons. I now want to look at Kant's discussion of dignity in order to better understand why he gives a central role to the dignity of rational nature.

4.2 KANT ON DIGNITY AND RESPECT

It is important to note from the discussion of Kant's view of autonomy that he believes we are autonomous when we think of ourselves as agents, acting for reasons. Kant recognizes that humans are limited beings who are not pure rational agents, so rather than acting as a law of nature, the categorical imperative acts as a constraint on our actions under which we allow the moral law to be the arbiter over our inclinations. This dual-perspective that we can take on ourselves, thinking of ourselves either as rational beings whose wills are the cause of our actions, or as animal beings who are determined by our desires, needs, and emotions provides Kant's ethics with a dual way to value ourselves and others. When we consider ourselves from the phenomenal perspective we have little worth, and the price that different individuals can command (for example in labour markets) will vary according to the value of their talents. In contrast, when we consider ourselves from the noumenal perspective, we have an "absolute inner worth" that Kant calls dignity. The idea that our rational natures have an absolute worth is very important to Kant's ethics because it provides a non-contingent source of value that can ground the principles of morality as holding for all rational beings. Not only does our

dignity provide an absolute value that elicits respect, but it also puts us on a footing of equality with all other rational beings who share this inner worth.

To help us think of the proper way to value ourselves and each other from the moral perspective, Kant creates a kind of triangulation where we value ourselves highly from the noumenal perspective as rational beings who are capable of discerning the moral law, but at the same time we are to recognize our imperfection in the face of the moral law which should instil a humility in us; finally we are also to recognize that when considered from the phenomenal perspective we have little worth. Recognizing these different modes of valuing ourselves and all other rational beings is meant to help us look beyond the contingencies of social existence in the phenomenal realm where there are a number of inequalities. In this section I examine Kant's writing on the kind of respect that is owed to rational beings as legislators of the moral law.

4.2.1 Dignity as Absolute Worth

As I discussed in section 4.1, Kant understands the autonomous will as a will that gives the moral law to itself by testing its subjective maxims against the categorical imperative. He says that we must presuppose the will is autonomous any time that we consider ourselves as agents. A will that is free responds to reasons rather than being impelled by other factors such as natural laws or psychological proclivities. If the will were not autonomous, then we would not be basing our decisions on reasons, but would instead be impelled by causes that are external to the will. The way that Kant understands autonomous decision-making is not based in self-interest or self-regarding reasons. Instead, he understands autonomous decision-making to occur when we formulate

principles that are logically consistent when universalised and that can consistently be willed in their universalised form.

Kant asks whether there is "a necessary law for all rational beings that they should always judge their actions by such maxims as they themselves could will to serve as universal laws" (*Foundations of the Metaphysics of Morals* 1995, 43; AK 4:426). If there is such a law, Kant believes it must be connected *a priori* with "the concept of the will of a rational being as such" (*Foundations of the Metaphysics of Morals* 1995, 43; AK 4:426). Any consideration that is connected to the will through empirical considerations, or contingent considerations of taste or desire, would not afford any universal principles "valid and necessary for every volition" (*Foundations of the Metaphysics of Morals* 1995, 44; AK 4:427). The incentives provided by contingent principles could at best yield hypothetical imperatives. If the will operated only under these conditions, then the will would not be determining itself by reason alone. In order to be a legislator of universal laws, the will must set aside contingent incentives. Contingent incentives are relative, and so their worth is also relative to the particular faculty that desires them and the inclinations and needs that give rise to them. Since contingent incentives have only relative worth, they cannot form the basis of principles that would be necessary and valid for all rational beings.

In searching for something that has unconditional, or absolute, worth Kant settles on the rational nature of man (*Foundations of the Metaphysics of Morals* 1995, 45; AK 4:428).[83] Kant writes, "every rational being exists as an end in himself and not merely as

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[83] Earlier in *Foundations of the Metaphysics of Morals* Kant identifies the good will as the only thing that could be called good "without qualification" (1995, 9; AK 4:393). Any talent or "gift of fortune" that one might have can become bad or harmful if one has a bad

a means to be arbitrarily used by this or that will" (*Foundations of the Metaphysics of Morals* 1995, 45; AK 4:428). Non-rational beings, which we call "things," have only relative worth. We can use things as mere means. In contrast, rational beings are "persons" and have unconditional worth as "ends in themselves" that "restricts all [arbitrary] choice" (*Foundations of the Metaphysics of Morals* 1995, 45; AK 4:428). The principle that rational beings are ends in themselves is extremely important for Kant's moral theory. He says that when we understand something as "an end in itself" this means that as such an end, we cannot replace the "end in itself" with another end for which these beings would serve as a means. When we recognize something as an "end in itself," we recognize it as having a particular kind of value. This kind of value is independent of the interests and desires of the agent who recognizes that value. As a source of value that is independent of the contingent desires or interests of the agent, the value of rational beings as "ends in themselves" provides an objective end, or an unconditional and absolute worth (*Foundations of the Metaphysics of Morals* 1995, 45; AK 4:428). Kant says that each person "necessarily thinks of his own existence in this way, and thus far it is a subjective principle of human actions" (*Foundations of the Metaphysics of Morals* 1995, 46; AK 4:429). This kind of absolute worth recognized by each person is not only a subjective principle, however. We must also recognize that

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will. The good will is not good merely because of what it is able to accomplish, however. Instead the good will "would sparkle like a jewel all by itself, as something that had its full worth in itself" (*Foundations of the Metaphysics of Morals* 1995, 10; AK 4:394). But Kant does not make the good will the foundation for his view that rational beings are ends in themselves, which gives them an absolute worth that grounds respect. Kant believes that respect is owed to all rational beings, even those who have a bad will. We might think of this distinction along the lines of Darwall's distinction between appraisal and recognition respect. The good will deserves esteem, and individuals with a good will deserve appraisal respect. Recognition respect is owed to all, even those who lack a good will. Rational beings are ends in themselves even if they have a bad will.

every rational being must think of his existence as having unconditional worth, and so the absolute worth of rational beings is also an objective principle.[84] This connection between our capacity as a moral legislator and our unconditional, absolute worth is intimately related to the way that Kant understands dignity.

For Kant the difference between relative worth (which he calls 'price') and absolute worth (which he calls 'dignity') is connected to the dual way that we are able to consider ourselves or others from either the noumenal or the phenomenal perspective. When we consider other rational beings from the noumenal perspective we must recognize the third formulation of the categorical imperative, namely we recognize that "the Idea of the will of every rational being as a will giving universal law" (*Foundations of the Metaphysics of Morals* 1995, 49; AK 4:432). From this perspective we recognize that every rational will has a status as givers of the universal law. This binds us together as "a kingdom of ends" because each rational will is the source of its own law, but we will share this law in common since its source is not in contingent matters of taste, desire or emotion, but in principles that can be consistently willed as universal. Kant is quite explicit about the difference between price and dignity in the realm of ends. He writes:

> In the realm of ends everything has either a *price* or a *dignity*. Whatever has a price can be replaced by something else as its equivalent; on the other hand, whatever is above all price and therefore admits of no equivalent, has dignity.
> That which is related to general human inclinations and needs has a *market price*. That which, without presupposing any need,

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[84] I think these two claims that we must think of ourselves as ends with unconditional worth and that we must recognize that every rational being must think of his existence as having unconditional worth are normative claims for Kant. They are not descriptive claims about how people actually do value themselves and others, because descriptively they are false. Kant's example of someone who wishes to commit suicide shows that descriptively we might fail to value ourselves unconditionally. Kant thinks, however, that our moral duty demands that we think of ourselves in this way, as having intrinsic worth.

accords with a certain taste (i.e., with pleasure in the purposeless play of our faculties) has a *fancy price*. But that which constitutes the condition under which alone some thing can be an end in itself does not have mere relative worth (price) but an intrinsic worth (*dignity*).

Morality is the condition under which alone a rational being can be an end in himself, because only through it is it possible to be a lawgiving member in the realm of ends. Thus morality, and humanity so far as it is capable of morality, alone have dignity. Skill and diligence in work have a market value; with, lively imagination, and humour have a fancy price, but fidelity in promises and benevolence on principle (not benevolence from instinct) have intrinsic worth. (*Foundations of the Metaphysics of Morals* 1995, 51-52: AK 4:434-435; emphasis in original).

The distinction between the kinds of value that we have when considered either as "persons" or as "man in the system of nature" is quite sharp. In *The Doctrine of Virtue* Kant repeats the sentiment expressed in the passage above and he stresses that when we consider ourselves as animal or phenomenal beings, we are of slight importance. From this perspective we share a common value with other animals, and even our power to reason does not give us more than an *extrinsic* value of usefulness. Reason gives us the ability to set our own ends, and this power might give us a higher price than animals and might give one man a greater earning power than another, but this is only in terms of the values of exchange or "a *price* as of a commodity in exchange with these animals as things" (*The Metaphysics of Morals* 1996, 186; AK 6:434). Our ability to reason and the particular skills that we have might give us the ability to command a higher price than the labour of animals, or those with fewer (or less valuable) skills, but these things are valued only as commodities in systems of exchange. In fact, even though a person's price may differ from another's, Kant says that when valued from the phenomenal perspective "he still has a lower value than the universal medium of exchange, money, the value of which can therefore be called preeminent (*pretium eminens*)" (*The Metaphysics of Morals* 1996,

186; AK 6: 434). From the perspective of the phenomenal world our worth is slight, according to Kant.

In contrast, considering ourselves as persons, or noumenal beings, "as the subject of a morally practical reason" we are exalted above any price. Kant writes, "for as a person (*homo noumenon*) he is not to be valued merely as a means to the ends of others or even to his own ends, but as an end in himself, that is he possesses a *dignity* (an absolute inner worth) by which he exacts *respect* for himself from all other rational beings in the world. He can measure himself with every other being of this kind and value himself on a footing of equality with them" (*The Metaphysics of Morals* 1996, 186; AK 6:434-6:435). When Kant says that persons have dignity he assigns to them an infungibility, a worth that puts persons outside of the system of exchange that involves worth only in the sense of price.

4.2.2 Human Dignity, Treating Others as Ends and the Interactive Stance

One of the distinguishing features of persons on Kant's view is that the ways in which we can interact with persons differs from the ways that we interact with things. As Rae Langton notes, things in Kant's philosophy are "a resource, to be used as means for human ends" (Langton 1992, 486). We attempt to understand things so that we can make better use of them. Part of the reason we use science to gain a better understanding of how things work is so that they can be used more efficiently for our ends. The more we understand about things, the better we understand how we can use them as a resource. Things are fungible; we can exchange one unit of a thing for another unit of that same

thing and it will make little difference.[85] But we have a different kind of relationship to

persons. When we do things with persons and are treating them as persons in the activity,

then we share in the activity together in a way we cannot share activities with things

(Langton 1992, 487). We participate together in the activities we undertake with persons.

The reason that we can share our activities with other persons in this way is because they

also have free wills, can form their own ends and can reflect on those ends, whereas

things cannot. When we try to understand other persons we should not do so merely to

put them to use for our own ends, instead we must understand other persons so that we

can share our ends together. In order to share ends in this way we must also recognize the

rational nature of others and that the will of every rational being has intrinsic value.

When we understand that rational nature has an absolute and unconditional worth, then

we can understand the second formulation of the categorical imperative (also known as

the formula of humanity): "Act so that you treat humanity, whether in your own person or

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[85] This might be a flaw in Kant's thinking. Although Western science and technology
have tended to consider things as replaceable resources, the recent environmental crises
that we face might show that seeing things as replaceable resources involves a mistake.
Many discussion in ecological ethics and ecofeminism see treating things as replaceable
resources as a problem in Western philosophy (see for e.g. Val Plumwood's view that
environmental ethics has been hampered by its reliance on rationalist ethics 1991; Karen
Warren's discussion of her relationship to rocks 1996, 26-27; Catherine Roach's analysis
of the environmental slogan "Love your Mother [Earth]" as undermining environmental
activism because it might encourage the exploitation of both our mothers and the earth;
1996, 52-56). Some non-Western traditions with which I am not very familiar might take
a different stance toward things. Pantheistic traditions, for example, see the divine as
present in all things, not only in rational nature where Kant locates the divine. Respect in
these traditions might be owed to things and animals as well as to 'rational beings.'
Further, as Rae Langton points out, Kant's view that we regard things as replaceable is
just not true (even in Western cultures). Langton says "We often value particular items in
such a way that they *aren't* replaceable by a duplicate" (1992, 486 n. 9). Things have
sentimental and other kinds of value that make (at least some) things non-replaceable. I
won't discuss these issues further because in this dissertation I focus on respect for
persons rather than the kind of respect we might owe to all life and all things on this
planet.

in that of another, always as an end and never as a means only" (*Foundations of the Metaphysics of Morals* 1995, 46, AK 4:429). We use others as mere means when we make it impossible to share our ends together and when we fail to engage them from an interactive stance and instead only engage with them as an object.

When we treat others as mere means we use them and ignore the dignity of their humanity. Kant thinks that it is permissible to treat another as a means, since all cooperative interaction involves treating the other as a means. It is permissible to use another as a means so long as we do not treat them as *a mere means*. "We use others as *mere means*," as Onora O'Neill explains Kant, "if what we do reflects some maxim *to which they could not in principle consent*" (2002c, 286). Kant uses the example of a lying promise where Arthur (as I've named him) borrows money from Gunta and promises to repay the loan, but has no intention of fulfilling that promise. The reason that this lying promise uses Gunta as a mere means to the end of obtaining money is not just that Gunta *did not* consent to giving the money (rather than just lending money); the problem is that Gunta *could not* consent to the exchange of funds with Arthur because it is impossible to give consent when part of the fundamental principle (or maxim) of the action involves deception (Klimchuk 2004, 43). Arthur must ensure that Gunta is ignorant of the maxim behind his action. If he fails to ensure she is ignorant of the maxim, then it would no longer be a false promise because Gunta would know Arthur had no intention of paying her back; in other words, Gunta would not be loaning the money, she would instead be giving Arthur the money (O'Neill 2002c, 286).

The formula of humanity can be used to identify one problem with some of the abuses that occurred in medical research that I described in Chapter 2. One part of what

was troubling about the research abuses was that they involved deceptive manipulation of the research subjects and sometimes involved violence and coercion. The Tuskegee doctors did not inform the subjects that they were participating in a trial. The participants thought they were receiving treatment. This deception robbed the research participants of the ability to consent to the trial and therefore treated them as mere means to the ends set by the researchers. It is important to note that it was the deception involved that made this case one in which the subjects could not in principle consent to participation. It was not just that they did not consent to the study (because they were not asked), but also that the deceptive practice of calling the procedures involved "treatment" meant that they could not consent in principle in this instance. We might think the maxim behind the doctor's deception was something like the following: "I will deceive potential participants by calling research procedures 'treatment' if I think it will allow me to conduct a trial when otherwise the participants would refuse." In this case the participants would have to be kept ignorant of the doctors' underlying maxim or they would no longer be able to call 'research procedures' (such as diagnostic tests and spinal taps) 'treatments' and the participants would no longer be deceived.

Maxims that don't allow the possibility for other persons involved to consent use the other as a mere means. Actions that could only be based on deceptive maxims do not allow the consent of the other party and so are unjust on Kant's view. It is important to notice that Kant's formulation does not rule out the pursuit of research *per se*, because research like other cooperative endeavours can use the other as a means. What it does rule out is the use of *deceptive* research practices. Medical research itself is not ruled out because as long as the research protocol is described accurately then participants can

consent to it in principle. It is only when deceptive, violent, or coercive practices are used

that research becomes problematic on this analysis. Kant's formulation also describes

why the coercive nature of the Willowbrook trials was problematic: it did not allow

parents a genuine chance to dissent from participating in the research because agreeing to

research participation was the only way to have one's child accepted into the school. A

second way of using another as a mere means occurs when one uses violence or coercion

to persuade another to participate in one's project. Violence and coercion use the other as

a mere means because the other does not have the genuine choice between consenting or

dissenting (O'Neill 2002c, 286). The coercion and violence involved in the Nazi trials

would clearly be ruled out by the requirement to avoid treating others as mere means.

These two ways of treating others as a mere means are central in the discussions of

informed consent (e.g. in *The Belmont Report* 1979; Beauchamp and Childress 1979,

2009), which I described in Chapter 2. But there is a third way of failing to treat others as

ends which is to fail to recognize their subjectivity and engage with them second-

personally.

4.3 SECOND-PERSONAL RESPECT: STRESSING THE INTERACTIVE STANCE

The second-personal account of respect is useful because it helps us think about

how we ought to engage with others. The admonition to avoid treating persons as mere

means tell us what we ought *not to do* (lie or be deceptive in particular ways, violently

coerce others, and otherwise prevent others from adopting our ends as their own when we

need them to help meet our ends). The second-personal account fills out an understanding

of what we *should do* in order to treat others as ends. The second-personal nature of

respect has been developed most completely in the work of Stephen Darwall (2004,

2006).[86] Darwall introduced the second-personal views of respect to correct a flaw in the third-personal view of recognition respect he provided in the paper "Two Kinds of Respect" (1977).

In his early work on respect, Stephen Darwall (1977) introduced the distinction between 'recognition respect' and 'appraisal respect' to help us understand the kind of respect that Kant argues is owed equally to all when we also believe that some kinds of respect can be deserved or fail to be deserved (that is, some kinds of respect can be merited or not).[87] Darwall characterizes appraisal respect as involving the judgement that someone's behaviour or projects are worthy of praise. This kind of respect is not owed equally to all because not all projects and behaviours are equally respect-worthy. Appraisal respect can be deserved or not depending on our evaluation of the person as a person (their virtues, character or moral excellence) or our evaluation of the person as engaged in the pursuit (their skills or abilities relevant to the pursuit). Whether this is a moral form of respect will depend on the pursuit. Since appraisal respect is relative to some standard of merit, appraisal respect can be a matter of degree. In contrast, recognition respect is not a matter of degree; it is not a matter of evaluating a thing, but of recognizing something as the kind of thing that elicits our respect. Recognition respect

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[86] Darwall is not alone in adopting this perspective on Kantian respect. Darwall himself credits as inspiration Peter Strawson's (1974) discussion. Carla Bagnoli (2007) has developed a very similar view of Kantian respect as a "dialogical interpretation." I focus on Darwall here because he provides a monograph on the second-personal stance and its relation to Kantian ethics, and his account is the most extensive and detailed account of these aspects of Kantian respect.

[87] Darwall does not think that Kant makes an explicit distinction between appraisal and recognition respect (2006, 131). But I am not entirely sure that is true. I think Kant's discussion of the different ways of valuing persons, according to their price or according to their dignity is an acknowledgement of this difference, although it is put in different terms.

does not involve an evaluation. Instead, recognition respect involves recognizing the status or weight something ought to be accorded in our deliberations. Moral recognition respect involves the added element that a failure to account for this status or weight would be morally wrong. Recognition respect consists "in a disposition to weigh appropriately in one's deliberations some feature of the thing in question and to act accordingly," (Darwall 1977, 38).

In his later work, Darwall comes to believe he was mistaken to think that recognition respect merely involves registering a fact or feature about someone and according this fact or feature weight in one's deliberations (2006, 131). This view is mistaken, he believes, because it is open to Iris Murdoch's complaint that Kantian respect does not respect individuals, but the "universal reason in their breasts" (Murdoch 1999, 215 cited in Darwall 2006, 131). According to Murdoch's objection, Kantian respect does not require respect for *the person* at all. It merely requires that one register a fact or feature (such as personhood) and give weight to this fact or feature.[88] If one merely respects a fact about persons, then one is respecting the fact, but not the individual themselves. To correct this defect in his early view, Darwall introduces the idea that recognition respect is a second-personal concept.[89]

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[88] See Bagnoli (2003) for more on this point.

[89] Darwall's (2006) use of the concept of "second-personal" reasons is very different from Annette Baier's (1985) discussion of "second persons" that I described in Chapter 3. When Baier talks of "second persons" she is describing the way that we become persons who are members of the moral community in relation to others who are already persons. Baier emphasizes the role of others in our development of our subjectivity and sense of ourselves as responsible members of the moral community (1985, Chapter 5). Darwall's focus is not on the development of our moral agency, but instead on the perspective that we take toward other members of the moral community once we have become moral agents.

Darwall's idea that recognition respect is second-personal relies on a distinction between three different domains of value that can be discerned by considering the perspective of the person who is evaluating the situation or action. The first-person perspective involves the domain of goodness and concerns questions about what *I* should want and what is good for people. The first-person standpoint involves I-I relations. From this standpoint a moral agent might deliberate about what *I* should want now, considering what *I* wanted in the past and what *I* might want in the future. For example, I might have an immediate desire to skip class, but I might also have a more general first-person desire to obtain an education. Deliberating from the first-person perspective I might decide that my desire to skip class is incompatible with my desire to obtain an education and so I might decide to attend class in order to fulfill my more long-term goals of obtaining an education. Ideals of the good help moral agents to take-up the standpoint of a prudent person with foresight who might be concerned to harmonize her current desires with one another and with the needs and interests of her future-self (Anderson 2005). The first person perspective has not played an important role in discussions of respect for others, but this perspective might be significant when deliberating about the requirements of self-respect (such as the obligation not to feign humility in order to gain the favour of others) and our duties to ourselves (such as the requirement to know one's self and to seek one's moral perfection).

The second-person perspective involves the domain of right and wrong and of justice. The second-personal stance enables us to take-up the perspective of others who might make claims on us because of how our conduct affects their interests (Anderson 2005). From the second-personal perspective we consider the other (the grammatical

second person singular, or "you") to be the source of our obligations. From the second personal perspective I have obligations to you because you have the standing to make claims on me. This second-personal perspective differs from the third-personal perspective that relies on objective considerations as the source of our obligations. The third-person perspective is that of a detached observer who is not involved in the situation. This perspective is sometimes called the God's-eye view. It involves standards of virtue and vice. From the third-personal perspective we consider how a detached observer would judge, approve or disapprove of our conduct (Anderson 2005).

Both third-personal views and second-personal views of Kantian respect are supposed to consider persons as agents rather than as mere objects or animal selves. Both views of Kantian respect stress that respect is a form of recognition of the other as a person, that is, as a member of the moral community. The second-personal and third-personal views differ because the third-personal view of respect is characterized by giving the proper weight to some fact or principle in one's deliberations, whereas second-personal respect is characterized by a particular mode of engaging with others in one's interactions with them. This distinction is not meant to be too strict, since even the second-personal view will involve some deliberation and the third-personal view certainly does not prohibit engagement. Instead, the distinction is meant to mark the main perspective adopted by each form of moral deliberation. These three different perspectives are not mutually exclusive; we often move between the three different perspectives when assessing a single moral issue.

Taking up a second-personal perspective, according to Darwall, involves particular kinds of reasons that are unique to this perspective. Darwall says, "*A second-*

personal reason is one whose validity depends on presupposed authority and

accountability relations between persons, and, therefore, on the possibility of the

reason's being addressed person-to-person" (2006, 8; italics in original). Recognition

respect is an attitude toward individuals and not just toward a fact about them because of

the role that respect plays in mediating the second-personal relations between individuals.

Darwall's account of second-personal respect requires engaging with others in relations

of accountability, as he writes:

> To respect someone as a person is not just to regulate one's conduct by
> the fact that one is accountable to him, or even just to acknowledge the
> truth of this fact to him; it is also to make oneself accountable to him,
> and this is impossible outside of a second-personal relation. This, I
> believe, is what most deeply underlies the sense of 'respect''s root,
> '*respicĕre*' (to look back). To return someone's address and look back at
> him is to establish second-personal relationship and acknowledge the
> other's second-personal authority... making oneself vulnerable to his
> attitudes and responses by empathy (2006, 142; emphasis in original).

Respecting another, according to Darwall, requires taking a second-personal stance

toward that person. The second-personal stance is a relational stance because it

recognizes that persons have interests and make claims on one another and that the

validity of these claims depends on the other's relation to us as persons.

Darwall characterizes respect as taking a second-personal stance toward others

which involves recognizing a "distinctively second-personal kind of *practical authority*:

the authority to make a demand or claim" (2006, 11; emphasis in original). In sum, then,

when we adopt the second-personal stance that recognizes the authority of another to

make demands, then we also enter an interdefinable circle of concepts, each of which

implies the rest. This circle of concepts is comprised of second-personal authority, valid

claim or demand, second-personal reasons, and responsibility. Each of these second-

personal concepts implies the others: to make a valid claim or demand presupposes that

one has the authority to make it, and in making an authorized demand we create a second-personal reason for complying with the demand. The validity of second-personal reasons depends on the presupposed authority relations between persons, and so the reasons must be able to be addressed person-to-person. These reasons are agent-relative because the reasons derive from agents' relations to one another. The authority to make demands also implies accountability because it not only creates a reason to comply, but also implies that we are responsible for compliance (Darwall 2006, 8-12). Darwall believes this implication can also work in the other direction. He writes, "Conversely, accountability implies the authority to hold accountable, which implies the authority to claim or demand, which is the standing to address second-personal reasons" (2006, 12).

Second-personal address involves not only the relations of making claims and being accountable to those who make claims, it also involves a reciprocal awareness of one another. When I relate second-personally to you, then we have a mutual awareness that includes an awareness of our relating. When I relate second-personally to another agent I see her as "responding (more or less rationally) to my address, which she also regards as an intelligible response or address to her" (Darwall 2006, 44). This reciprocal awareness requires being able to take up each other's perspective, a capacity that Darwall calls empathy. Empathy, he says, involves "the capacity to put oneself in another's shoes," engage in "imaginative projection into another's standpoint" or "simulation" while "retaining a sense of one's own independent perspective" (Darwall 2006, 44-45b). The capacity for empathy is important for relating second-personally with others.

According to Darwall, the idea that humans have an absolute inviolable dignity also includes a second-personal element. Recognizing human dignity partly involves

recognizing that there are ways one should and should not treat others (that is, recognizing the first-order moral norms from a third-personal perspective), but it also involves the recognition that others have the standing to demand this treatment from us (2006, 13-14).[90] Darwall believes that moral reactive attitudes express demands and expectations of certain kinds of conduct. These attitudes are second-personal because they presuppose the authority to hold one another accountable and they also presuppose that those we hold accountable have the same standing to hold us accountable (2006, 17).

Darwall tells us that respect for persons requires recognizing the second-personal authority of another. "We accord authority within the second-personal relations that structure mutual accountability," according to Darwall, "by relating to one another in ways that acknowledge each other's standing to demand, remonstrate, resist, charge, blame, resent, feel indignant, excuse, forgive, and so on" (2006, 141). Not only does respect require recognizing the fact of this authority, but it also requires relating in a way that engages this authority. These two aspects can come apart. For example, one might recognize the fact that someone has second-personal authority, but not feel inclined to defer to the other's reasoning and instead feel inclined to act paternalistically.[91]

Darwall often uses epistemic authority as a way of illustrating second-personal authority as it relates to respectful interactions. In particular, Darwall considers the

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[90] A person could recognize first-order moral norms without accepting that anyone has the authority to demand that he comply with these norms. According to Darwall, even if a person scrupulously followed these first-order norms, he would still fail to acknowledge the dignity of persons and would not be respecting their dignity (2006, 14).

[91] Darwall's provides the example of a father with a college-age daughter as a case in which one person might recognize the fact that another has second-personal authority without relating to her in a way that respects that authority. The father might recognize that she is an adult, but he might still find it difficult to relate to her as an adult because "parental habits die hard" (2006, 141). He might still try to get her to do as he believes is in her best interests rather than deferring to her own perspective on what she wants to do.

epistemic authority that we grant to one another in testimony as similar to the second-personal authority that he thinks characterizes respect. The main difference between the second-personal authority involved in respect and that involved in testimony is that testimony is not "second-personal all the way down" (Darwall 2006, 57). Testimony can provide a second-personal reason when one takes the person's testimony as a reason to believe something. When we take another's testimony as a reason to believe something then we give them second-personal authority in our own reasoning about what to believe. At some point, however, the second-personal authority that we grant to someone who is providing testimony can be defeated by third-personal considerations, such as when we have reason to distrust her beliefs or judgements (Darwall 2006, 12). The second-personal authority involved in epistemic relations, like testimony, involves a third-person "relation to the facts as they are anyway," which earns the testifier the standing to provide reasons for us to believe (Darwall 2006, 57). In contrast, the case of the second-personal authority to address reasons for action involves the normative relations between persons rather than a third-personal form of authority (Darwall 2006, 125). Darwall draws on the example of a platoon commander giving orders to her troops to describe the second-personal authority of the kind he believes is relevant to respect (2006, 12; 125). The reason that the troops have for obeying this order is because of the standing that she has to make commands. "This is not a standing, like that of an advisor, that she can acquire simply because of her ability to discern non-second-personal reasons for her troops' conduct" (Darwall 2006, 12). Instead the standing is fundamentally second-personal

because it arises from her authority, and derives entirely from the normative relations

between the commander and the troops (Darwall 2006, 125).[92]

All second-personal address involves "presuppositions concerning the second-

personal authority, competence and responsibility of addresser and addressee alike,"

according to Darwall (2006, 20). When we enter into second-personal address with

another we are committed to seeing the other as "self-originating source[s] of valid

claims" (Rawls cited in Darwall 2006, 21). This recognition involves a number of

important presuppositions. Darwall argues that there is:

> …a form of reciprocal respect that is built into all second-personal reason-
> giving, even when the authority relations it explicitly presupposes are at
> odds with the full equality we now believe to characterize the moral point
> of view. Any pure case of claiming or demanding presupposes the
> standing necessary to enter into second-personal reasoning at all.
> Specifically, it presupposes a distinction between legitimate forms of
> address that, as Fichte puts, "summon" persons to determine themselves
> freely by second-personal reasons (however hierarchical), on the one
> hand, and coercion, that is, impermissible ways of simply causing wanted
> behaviour that "depriv[e the agent] of its ability to act freely," on the other
> (Fichte 2000: 41). This means that whenever second-personal address
> asserts or presupposes differential authority, it must also assume that this
> authority is acceptable to its addressee simply as a free and rational agent
> (Darwall 2006, 21-22).

The practice of entering into a second-personal exchange presupposes a moral standing of

equality because it recognizes the other as competent to regulate their behaviour

according to reasons, rather than forcing the person to comply by force or coercion. The

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[92] I find this example misleading as an analogy for equal moral respect since the relations
involved are relations of inequality rather than equality. Although the platoon commander
has the authority to make demands of her troops, the reverse is not true and the troops do
not usually have a reciprocal form of authority to command the platoon commander.
They are able to make some claims on the commander. For example they can demand
that she value and protect their lives and skills. Further (and more importantly) it is an
odd example because there is a huge amount of social infrastructure that goes into
establishing the respect the commander demands.

particular reasons given might require justification, and personal characteristics, such as knowledge or wisdom, might play a role in whether one's reasons are accepted (Darwall 2006, 13), but the structure of the practice of exchanging second-personal reasons presupposes a kind of moral equality. On Darwall's account, this moral equality is consistent with hierarchical reasons and unequal authority relations as long as these are acceptable to a free rational agent.[93]

Darwall maintains that the presuppositions of moral equality involved in second-personal interactions are present even if none of the parties to the interaction are aware of the presuppositions. The presuppositions persist even if all parties to the interaction would reject them if they did become aware of them. Darwall clearly states his position: "My thesis is that the assumptions I identify are presuppositions of second-personal address in the sense that (second-personal) reasons can be validly addressed only if these assumptions hold. They are 'normative felicity conditions' of the (pure) address of second-personal reasons in general" (2006, 24-25). On Darwall's view, in order for second-personal address to succeed as a valid form of interpersonal engagement, the interlocutors must presuppose that they each have equal moral standing, equal authority to make demands of one another and they are mutually accountable.

Darwall's account of respect as second-personal stresses the importance of viewing persons as a source of authority and a source of valid moral claims. Respectful relations involve a second-personal stance from which we account for ourselves and ask others to give account to us, making our reasons explicit to one another. On this view,

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[93] Although Darwall's account is consistent with Kant's view that equal moral respect is compatible with significant political and social inequalities, I think they both underestimate the effects of the kinds of structural inequalities that I described in Chapter 3. I return to this point in Chapter 5.

respect is an interactive relationship between individuals which is quite different than the objective stance we might take when deliberating from a third-person perspective or when considering another as a thing.

4.4 SECOND-PERSONAL RESPECT AND BIOETHICS

To this point I have identified a number of confusions in the descriptions of autonomy prevalent in canonical works in bioethics. I argued that Kant's account of autonomy is significantly different than the account of autonomy that has been provided in the canonical work of Beauchamp and Childress (1979) and other bioethicists. Beauchamp and Childress are right to think that obtaining informed consent from patients and research subjects is important for bioethics, but the basis for this requirement has an uneasy fit with Kant's discussion of autonomy, which emphasizes conforming one's reasons to the requirements of duty. A better basis for the practice of obtaining informed consent can be found in Kant's account of dignity and the importance of always treating others as ends and never as mere means (also known as the formula of humanity).

Standard discussions of the formula of humanity tell us what we *must not do* in order to respect others and recognize their dignity: we must not deceive them, or use other forms of violence or coercion to get them to comply with our ends because this would be to treat them as a mere means to our end. The formula of humanity tells us that if we want to participate with others to achieve an end, then we must allow them to make that end their own by seeking their informed, consensual participation. The second-personal account of respect adds to this a more developed account of what we *must do* in order to respect another: we must engage with others from a second-personal perspective that recognizes their subjectivity. The second-personal account continues to emphasize

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the importance of human dignity and the importance of respecting the reasons and perspectives provided by others, but it has an advantage over the earlier accounts offered in bioethics because it can also provide an explanation of why situations like research and clinical medicine might put researchers and physicians at risk of disrespecting research subjects or patients. In this section I describe some of the ways in which a second-personal account of respect could improve discussions of respect for human dignity in bioethics.

The early accounts of the importance of respect in bioethics describe reasons that research subjects or patients might be vulnerable in research and clinical contexts. The imbalance of power and knowledge between the researcher or physician and the research subject or patient is said to increase the vulnerability of the latter in each case. Further, research subjects in clinical trials and patients seeking medical advice are often ill and concerned for their well-being. This might make them more open to the suggestions of someone speaking with authority and medical training. These explanations seem reasonable, and I would not suggest they are unlikely sources of vulnerability. But they do not really explain why *researchers* or *physicians* are in danger of exploiting this vulnerability. The mere existence of a vulnerable individual does not necessary lead to temptations to exploit that vulnerability. Infants, for example, are vulnerable but this does not lead us to create elaborate codes of ethics to remind parents not to exploit the vulnerability of their infants. We also need an explanation of why it might be easy for the researcher or physician to ignore or overlook the desires of the patient. The formula of humanity and the second-personal account of respect can provide this explanation.

In the context of medical research, the idea that research subjects are used as a means to the end of advancing medical knowledge is fairly easy to see. The researcher has an end (advancing medical knowledge or testing a particular treatment) and requires the participation of research subjects in order to meet that end. In research contexts the formula of humanity reminds researchers that although they will use the research subjects as means to the end of advancing medical knowledge, they must not use them as mere means and must, at the same time, treat research subjects as ends in themselves. The means-end relationship is fairly clear in research contexts, but the means-end relationship is less clear in clinical contexts. In clinical contexts physicians often have the end of treating or curing the patient, but this end seems less amenable to using the patient as a mere means. The patient will usually share this end with the physician and it is in order to obtain this end that the patient seeks the physician's assistance. In clinical contexts the second-personal account of respect can help explain why physicians might be tempted to overlook the wishes of their patients. The reason that respect is imperilled in clinical contexts is not (only) that the physician will sometimes use the patient as a means to some end that the physician has but the patient does not share;[94] another danger is that the medical perspective involves taking an objective (third-personal), rather than interactive (second-personal), stance toward the patient.[95]

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[94] It can (and does), of course, happen that physicians have some end in mind that they do not share with the patient. For example, the physician might have a financial interest in prescribing a particular course of treatment rather than another. The physician might also be operating in a system where she is encouraged not to send patients for further specialist evaluation in order to save costs. These would not be ideal cases; in the ideal case both the physician would act with the patient's interests in mind.

[95] The danger of adopting an objective (third-personal) perspective is equally present in medical research. I focus here on physicians rather than researchers but this discussion applies equally to both researchers and physicians.

When a physician contemplates possible treatments for a given condition there is a pull toward thinking of the person primarily as a body or as locus of physiological processes. When we consider persons from this perspective we are less interested in the person as an agent who might share her reasons with us. We are instead looking at the person as a 'thing' that we might study as part of the natural order. Medical knowledge is primarily about the physiology, chemistry, and biology of persons and is less about their agency or understanding their reasons for action. Adopting the perspective of one who wants to treat another characterizes what Strawson calls the objective stance (Strawson 1974, 9 n. 10).[96] Taking a medical perspective often involves (at least in part) seeing the patient's body and the patient's symptoms as an interchangeable instance of other similar symptoms that have already been studied by medical science, and can therefore be treated or managed. From the medical perspective there is a sense in which one body is interchangeable for another body; the body is treated as a thing.[97]

One significant effect of discussing the importance of respect in doctor-patient relationships is to remind physicians that they should counter, or balance, the objective (third-personal) medical perspective with a respectful (second-personal) perspective toward the patient. The problem of respect in clinical encounters has generally been understood by bioethicists as a problem of paternalism. When doctors act paternalistically they do what they consider to be in the patient's interest, perhaps without consulting the

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[96] I am indebted to Langton's (1992) discussion in her paper "Duty and Desolation" for pointing out the importance of this passage in Strawson.

[97] This point might be contentious, since some doctors try to treat the "whole patient" and would resist the description that they are treating only the patient's body. We are able to move between perspectives that we take on one another, however. My point here is merely that some of the scientific methods involved in medicine encourage a focus on the body.

patient. The second-personal account suggests that another way that physicians can disrespect their patients is by seeing them primarily as a body to be treated or cured. The objective (third-personal) perspective is inherently tied to the medical perspective which focuses on treating and curing ailing bodies. Although the practice of obtaining a patient's informed consent before performing any particular medical procedure might go some way toward preventing patients from being used as mere means, it might not go far enough toward ensuring that the objective medical stance doctors are encouraged to take by the very nature of their work is balanced by the second-personal perspective that relations of moral respect require.

The practice of obtaining informed consent from a patient is meant to ensure that no treatment or procedure is performed on a patient unless the patient has first been informed of her options and informed about the risks and benefits of the various potential options (including the option of doing nothing), the patient has considered these options and has made a decision about which option she would like to pursue. Since the process of informing the patient is supposed to be honest and non-coercive, informed consent does go some way toward ensuring that the patient can adopt the ends of treatment as her own. But the informed consent process is also highly procedural, and the process of discussing treatment options and obtaining informed consent occurs for only a very small fraction of the interaction between the doctor and patient. Most of the patient's care occurs before and after the informed consent discussions. In some cases the informed consent discussion might be conducted by someone other than the physician.[98] Although

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[98] The informed consent process might be conducted by someone other than the doctor for a number of reasons. In Germany the informed consent discussion for abortion procedures is not conducted by the doctor but instead by someone who is not affiliated

informed consent is certainly important, it is also important not to think that obtaining

informed consent discharges *all* of the physician's duties of respect toward the patient.

The maintenance of a second-personal stance toward the patient will be important

throughout the clinical encounter.

The description of clinical encounters as focusing on the physiology of the patient

can also be applied in research contexts. In research contexts, as in clinical contexts, the

researcher is often interested in the physiological reactions that research subjects have to

a particular form of treatment. Again this endeavour encourages an objective or third-

personal relation between researcher and research subject. We would expect that in both

research and clinical contexts there would be good reason to stress the importance of

respecting persons (that is, interacting with them from a second-personal perspective) as

a means of countering the objective perspective inherent in the practice of medicine and

research.

4.5 CONCLUSION

In this chapter I argued that the account of "respect for autonomy" found in

Beauchamp and Childress' (1979; 2009) account differs significantly from the discussion

of autonomy found in Kant. I argued that Kant's discussion of respect for human dignity

provides a better foundation for the practice of obtaining informed consent because of its

stress on treating others as ends in themselves. Further, I argued that recent

interpretations of Kantian respect as requiring us to adopt a second-personal stance

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with the doctor in order to minimize any role the doctor's financial interest might play in
the discussion. Some informed consent discussions, such as those related to genetic
testing are extremely complex and so the discussion might be led by a specialized genetic
counsellor where one is available. In Canada, medical students are often deployed to get
consent forms signed before surgeries in order to save time.

toward others provides important insights that help flesh out the positive obligations imposed by respect for persons. Second-personal views of respect forcefully remind us that respect for persons will be important in contexts that encourage us to adopt an objective perspective. An additional benefit of the second-personal account of respect is that unlike the autonomy account of respect, the second-personal account of respect can help us understand why respect might be important in policy-making contexts, as Powers and Faden (2006) have argued. If the objective stance puts us at risk of disrespecting others, then we might think respect would be especially important in policy contexts as well as in research and clinical contexts. When policy makers are deliberating about which policy to implement objective (third-personal) considerations are often prominent. Policy makers are asked to consider measures of efficiency, such as cost-benefit ratios. These considerations involve adopting third-personal relations toward the population that is subject to the policy. So, again we might think that reminders about the importance of respecting the particular population under consideration would be important. In Chapter 6 I consider how second-personal accounts of respect would apply in policy contexts and some of the additional requirements such an account would suggest in clinical medicine and medical research. Before turning to the practical application of these elements of Kantian respect, however, I will consider some of the limitations of the discussion of respect in Kant and Darwall. Both Darwall and Kant believe that equal moral respect is compatible with social inequalities. In Chapter 5 I argue that this underestimates the pervasive effects of the inequalities that I described in Chapter 3. If we take the importance of equal moral respect seriously, then we should endeavour to eliminate structural inequalities.

CHAPTER 5   RESPECT AND STRUCTURAL INEQUALITIES

In Chapter 4 I argued that the discussion of autonomy in bioethics is significantly different than the discussion found in its Kantian roots. I suggested that Kant's discussion of dignity and the importance of always treating others as ends and never as mere means is still able to explain the importance of obtaining informed consent, but has added advantages because this account is able to fill in some further details about what respect requires of us, especially when it is given a second-personal interpretation. In particular, the second-personal account of respect can help explain why we might be in danger of disrespecting others in particular situations; whenever we undertake an endeavour that encourages seeing the other as an object to be acted upon the risk that we will disrespect the other will increase. In such situations it will be particularly important to remind ourselves of the importance of respect for persons. But these are not the only situations that create a danger of disrespecting others. We are also in danger of disrespecting others when they are vulnerable because of their position in unequal social structures - as was discussed by the ethicists and bioethicists I surveyed in Chapter 3. In this chapter I examine the ways in which social inequalities can interfere with the exchange of reasons that are central to Kantian respect. I argue that an adequate account of respect should examine not only the exchange of reasons, but also aspects of the social structure that can undermine communication and understanding among individuals, especially when they come from different social groups.

Although all patients and research subjects risk being considered from the third-personal perspective or used as mere means to an end, particular patient groups appear among those who have suffered research abuses and been subject to paternalism,

exploitation, neglect and inappropriate health care more frequently than other groups. As

I noted in Chapter 2, although researchers sometimes described their trials as beneficial,

white wealthy patients were deprived of these benefits (Dr. Egilman quoted in Phillips

2001, 239). Similarly, in the clinic of the 1950s Szasz and Hollender identified

paternalism as one model of the doctor-patient relationship, but there were always other

models that coexisted alongside this model including models that saw the doctor and

patient as equal participants (1956, 587). Although Szasz and Hollender note that the

paternalistic models they identified (both the active-passive and the guidance-cooperation

models)[99] require that the physician "disidentify with the patient as a person" to some

extent, they do not suggest that the model of mutual participation should be applied to all

patients. Instead they write, "the greater the intellectual, educational, and general

experiential similarity between physician and patient the more appropriate and necessary

this model [the more egalitarian model of mutual participation] of therapy becomes"

(Szasz and Hollender 1956, 588). Presumably, the greater the experiential differences, the

less appropriate the egalitarian model would be. Szasz and Hollender are describing the

models of the doctor-patient relationship are present rather than suggesting what model of

this relationship should be adopted, but as they report social differences seem to influence

whether doctors will adopt paternalistic relationships with their patients. To the extent

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[99] As I described in Chapter 2, the active-passive model sees the physician as active and the patient as passive, someone who is acted upon but is considered "inanimate" or unable to contribute (Szasz and Hollender 1956, 586). They liken this model to the interaction between a parent and an infant. The guidance-cooperation model still sees the physician as active, but gives more agency to the patient. The physician has more knowledge and power than the patient, and speaks from a position of guidance or leadership. The physician expects the patient to "cooperate," "look-up to" and "obey" the doctor (1956, 587). Szasz and Hollender think this relationship bears similarities to the relationship between a parent and an adolescent child.

that paternalism is a form of disrespect that overlooks the importance of individual decision-making, these patients will be more likely to be disrespected. Social inequalities appear to contribute to creating situations that put some patients at risk of being disrespected in medical contexts. In this chapter I examine the relationship between social inequalities and relations of respect.

Both Kant and Darwall think that equal moral respect is compatible with social inequalities. I find this part of the Kantian discussion of respect ambiguous. There is a sense in which it is true that equal moral respect is compatible with social inequalities: no matter the position one occupies within a social hierarchy one still deserves (and is still owed) equal moral respect. But their discussion seems to pay insufficient attention to the power of social hierarchies; in particular, pervasive structural inequalities have subtle but wide-spread effects on the relations among persons in ways that undermine relations of moral equality. Kant is aware of the humbling effects that some types of social inequalities (which he calls "dependence") can have on those who require assistance. His discussion of dependence seems to express some discomfort with the effects of social inequalities on self-respect, but he does not examine these problems in much detail, and the detail he does provide focuses only on economic inequalities and ignores other forms of social inequality (such as racial or gender inequalities). If Kant does provide an argument against social inequalities, as Allen Wood (2008) has suggested, it is not an argument that is taken up in Darwall's account (nor has this suggestion been taken up by many bioethicists who invoke Kantian respect). I shall argue that social inequalities pose a problem for relations of respect that is more significant than Darwall recognizes. The effects of social inequalities are particularly significant for a relational account, like the

one offered by Darwall, because structural inequalities affect the elements that Darwall takes to be central to respect: the exchange of reasons, reactive attitudes, and empathetic engagement.

One of the features of societies that are structured by inequality that I described in Chapter 3 is that the voices and experiences of some social groups will have less historic representation. Including members of excluded groups as equal members of that moral community will require more than simply recognizing them as an antecedently equal member of the society. It will also require conceptual labour to include their perspectives and experiences in ways that are available to moral reflection. We cannot skip over this difficult step if we are to meet the demands of respect. Darwall misses the importance of this requirement since he works from an idealized account of Kantian respect that considers only the "pure" cases in which there are no non-rational influences (2006, 20). But this account creates a limited view of respect because it fails to consider how social inequalities affect relations among persons. These effects include epistemic effects, so relying on reason alone is a less certain path to respect than Kantians often suppose. We must also attend to the non-rational ways in which we express ourselves and the extra-rational effects that structural inequalities have on the available epistemic resources.

My argument in this chapter builds on the arguments about relational autonomy that I described in Chapter 3 and considers the importance of concerns raised there for the concept of respect. In that chapter I described the views of feminist theorists who exposed some of the ways in which social structures constrain the autonomy of individuals in ways that affect different groups in different ways. In this chapter I review ways in which unjust social structures constrain relations of respect in ways that reflect

differences of power among different social groups. The purpose of this examination is to argue that achieving a respectful second-personal engagement with another requires situating that relation within a social context and recognizing that our social contexts include numerous differences in power and authority. These differences will have effects on the relational engagement of the parties and one's success at being respectful will depend in part on how these differences are taken into account.

I begin in section 5.1 by describing Darwall and Kant's discussion of equal moral respect under unequal social circumstances. Kant's discussion of social inequalities is more detailed than Darwall's and Kant seems more troubled by the humbling effects of dependence. I believe that Kant was right to be worried about these inequalities, but he doesn't pay enough attention to their effects and he was not sufficiently inclusive in his discussion of which inequalities create worries. The remainder of this chapter describes some of these effects and I pay particular attention to the effects on the exchange of reasons that are central to Kantian accounts, such as the second-personal account provided by Darwall.

In section 5.2 I argue that the effects of social inequalities are wide-spread. I focus on epistemic lacunae created by pervasive structural inequalities because these most directly challenge the idea that second-personal respecting relations are best understood by examining only the pure cases devoid of nonrational influences (as Darwall does). A number of nonrational influences have important effects on our relations. I begin the section by describing work on epistemologies of ignorance and epistemic injustice. When the experiences of members of some social groups are marginalized then it can be difficult for members of these groups to offer such experiences as reasons for action, just

as it can be difficult for members of those groups who lack such experiences to understand them as providing a reason for action. Next I look at relations of accountability and reactive attitudes as a particular realm where responses to reasons play an especially important role. When we express reactive attitudes we hold others accountable for their actions, but when the expressive and interpretive resources within a society ignore or devalue the experiences of some social groups, it can be difficult to hold one another equally accountable because it can be difficult to express or understand some reasons held by those who are oppressed. When reason-giving breaks down in this way, we might have different attitudes about the accountability of some. We are not all equally accountable for the same things, and we don't all have equal power to negotiate our responsibilities (Walker 2007) or demand forgiveness for our transgressions.

In section 5.3 I examine how these epistemic effects of structural inequalities affect the relations among individuals whose psychological make-up has developed differently according to the differences of the social positions of their structural groups. Darwall thinks that a second-personal interaction involves an empathetic projection into the position of the other. Structural inequalities can make empathy more difficult because members of differently situated social groups are likely to have dissimilar experiences and emotional configurations that differ significantly from one another. This can increase misunderstandings between differently situated social groups and can make empathizing across difference more difficult. Further, if one is a member of a despised or marginalized social group, then suggesting that members of this group empathize with those who harbour prejudices against them might be bad moral advice that could undermine their

self-respect. The relationship between empathetic projection and relations of respect is complicated in contexts of structural social inequalities.

My argument in this chapter is that structural inequalities affect authority, accountability, recognition, and empathy in ways that often do not involve explicit reasons but instead involve aspects of the interaction that form the background of the communicative engagement. Since respecting one another takes place within a social context and draws upon shared social understandings that are often infected with prejudiced and biased views and riddled with epistemic lacunae, then relating respectfully to one another should not focus only on the exchange of reasons, but should also consider broader issues associated with communicating and understanding one another.

5.1 KANT AND DARWALL ON RESPECT AND SOCIAL INEQUALITIES

Kant's view of the relations among moral agents is egalitarian in the sense that he thinks that we all have an absolute, incommensurable moral worth. His view is not egalitarian in a social sense, however. He does not think that our equal moral worth entails that we should eliminate social inequalities. But he also seems somewhat troubled by unequal social relations and their effects on individuals. Kant is aware that social dependence puts individuals at risk of being humbled when they seek assistance, but his discussion of social inequality seems incomplete and he does not offer a satisfying way to resolve the tensions between moral equality and social inequality.

Kant is aware that certain forms of social inequalities might have effects on self-respect by putting some at greater risk of being humbled because of their social position. For example, when Kant discusses the ways that rich benefactors should behave toward the poor who receive their aid in *The Doctrine of Virtue* he seems uncomfortable with the

threat this situation poses to the dignity of the poor. He suggests that rich benefactors "should hardly even regard beneficence as a meritorious duty on his part" and that benefactors "must also avoid any appearance of intending to bind the other by it" (*Metaphysics of Morals* 1996, 202; AK 6:453). This is because although we have an obligation to help the poor, "our favour humbles him making his welfare depend on our generosity" (*Metaphysics of Morals* 1996, 198; AK 6: 449). In these passages Kant directs his attention to the wealthy and suggests that they should take great care when giving to the poor so that the poor are not humbled by this charity. But Kant has little to offer the poor in this situation. If receiving aid from a wealthy benefactor is likely to humble the recipient and make him dependent on this generosity in ways that are an affront to his equal moral dignity then how are the poor to resist this effect? Kant does not offer adequate advice to those who receive aid; his suggestion to those who require aid is merely to avoid being in such a situation if it is possible.

Kant recognizes that the sources of wealth often have roots in injustice: "Having the resources to practice such beneficence as depends on the goods of fortune is for the most part, a result of certain human beings being favoured through the injustice of government which introduces an inequality of wealth that makes others need their beneficence" (*Metaphysics of Morals* 1996, 203; AK 6:454). In these passages Kant seems to recognize that social arrangements are often unjust and the injustice of these social arrangements might put some individuals at greater risk of being humbled in a way that is an affront to their equal dignity. This seems like an important insight, but he does not develop it very far, nor does he suggest that the risks that such unjust arrangements pose to the self-respect of some might provide a reason to undo these unjust relations.

Further, when Kant discusses the citizenship of those who depend for their welfare on the generosity of others in *The Doctrine of Right*, he tells us this dependence prevents them from developing the independence of will required to make one fit to vote (*The Metaphysics of Morals* 1996, 91; AK 6:314). Not only does the economic dependence of the poor put them at risk of being morally humbled, it also disqualifies them from participating in the organization of their society. We might wonder whether this social exclusion would also have humbling effects on the poor, although Kant does not consider this possibility. According to Kantian politics, those who have been favoured by the injustice of the government are able to develop the independence of will required to be active citizens who participate in the organization of their society. We are meant to trust that the strength of their moral character will be enough to convince active citizens to vote in ways that will protect the passive citizens and allow these passive citizens to (somehow) work their way up to active citizenship while (somehow) struggling against the humbling effects of their dependence. While Kant notices the corrupting effects of dependence on the development of an independent will, he seems to underestimate the corrupting effects of power. But there are few examples in history where those in power listened to the complaints of those over whom they had dominion and willingly gave up their power to create a more just constitution. Historically the creation of a more just constitution was the result of struggle and revolt by those oppressed under the social structures in which they lived. For example, the civil rights movement required considerable and extensive revolt on the part of African Americans, which included breaking unjust segregationist laws.

Kantian politics is hostile to this form of revolt, however. Kant thinks that active

citizens have the right to vote for a sovereign who "has only rights against his subjects

and no duties (that he can be coerced to fulfill)" (*Metaphysics of Morals* 1996, 95; AK

6:319). If the sovereign makes a law that goes against "the law of equality" active

citizens have the right to oppose this injustice but they do not have the right to oppose by

resistance or revolt (*Perpetual Peace*, 1983, 136: AK 8:382). There is no right to sedition

or rebellion, according to Kant, even if the sovereign abuses his power. The people have

"a duty to put up with even what is held to be an unbearable abuse of supreme authority"

(*Metaphysics of Morals* 1996, 96; AK 6:320).[100] Even active citizens do not have the

right to rebel against their sovereign.[101] Under this political arrangement we might see

why active citizens would vote against a sovereign whose rule impinged on their

freedom, equality, or dignity, but it is difficult to understand how they could be motivated

to vote in the interests of the passive citizens who have little voice and are under threat of

humiliations to their dignity.

Not only does Kant allow even unjust inequalities that affect both the political and

moral domains, as Allen Wood notes, Kant also condones certain kinds of hierarchies of

power and authority that modern readers would reject as an affront to human dignity

(2008, 313 fn 5). For example, Kant thinks that a woman requires the protection and

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[100] The reason that there is no right to revolt is that such a law would be self-contradictory, according to Kant. To be authorized to resist, there would have to be a public law that gives this authorization so the law would give the highest authority to the people and not to the law itself. Further, the law authorizing revolt could not be made public because if one publicly declared one's intention to rebel, one would render one's own intention impossible since the sovereign would then prepare for the rebellion. In contrast, sovereigns do not have to keep their intentions secret (*Perpetual Peace* 1983, 136; AK 8: 382-383; *The Metaphysics of Morals* 1996, 97; AK 6:320).

[101] For women this applies also to her relations with her husband: she has no right to revolt against his decisions.

representation of a man and so she can never be his civil equal. For other passive citizens,

although they are "mere associates in the state" or "mere underlings of the

commonwealth" (as Kant describes them) they must be considered equal as human

beings,[102] and society must be arranged so that they can work their way up to active

citizenship. Not all citizens will be able to work their way up to active citizenship,

however; slaves and "all women" are passive citizens who Kant does not believe will

ever become active (*The Metaphysics of Morals* 1996, 92; AK 6:314). Wood thinks that

our modern rejection of these views does not demonstrate a flaw in Kant's view of

human dignity; instead it is the result of the two hundred years that we have had to reflect

on the implications of Kant's idea of dignity (Wood 2008, 313-314 fn 5). This reflection

has allowed us to come to a more complete and consistent understanding of what an

appreciation of human dignity entails, according to Wood.

 To an extent, I agree with Wood that Kant's idea of equal human dignity should

lead us to find sexist laws of coverture (and his other example of the family right over

their servants) to be repugnant. But I think Wood is mistaken when he absolves Kant's

theory of any culpability for Kant's inability to appreciate the problems with sexist and

racist practices. Recognizing the wrongs of sexism, racism and classism (among other

forms of oppression) was not merely the result of a more consistent application of

Kantian views of human dignity.[103] The realization that the systemic social institutions of

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[102] See Hannelore Schröder's (1997) discussion of Kant's view of the relations between husband and wife. Schröder claims that Kant's view of women as beings (or person-things) creates significant tensions in his argument about the alleged equal status of all moral beings with dignity.

[103] My discussion here is indebted to Annette Baier's (1993b) discussion of individualism and shared responsibility and Charles Mills' (2005) discussion of ideals and ideology. Baier (1993b) argues that one common way of understanding the historical struggle for

sexism and racism are wrong also required a softening of the sharp distinction that Kant

drew between "right" and "ethics."[104] When feminists and critical race theorists say that

sexism and racism are wrong, we are saying that certain political and social arrangements

are not acceptable (at least in part) because of the effects that these arrangements have on

moral equality and human dignity. We are saying that there is a relationship between the

right and the ethical. Furthermore, recognizing these wrongs required conceptual labour

on the part of the women's movement and the civil rights movement that provided us

with a better understanding of the experience of living under sexist and racist social

structures.[105]

One of the things that feminist and critical race theorists added to philosophical

discussions was an analysis of something between the coercive powers of the state and

the individuals who act "freely" as citizens of the state; namely they added the concept of

equal rights is to see it as an ever more consistent application of the principles of
individual liberty and equality that were already present in important philosophical and
political documents (such as in Kantian ethics or the American Constitution). She resists
this interpretation because it erases the work done by those who struggled for social
justice. Baier argues instead that those who fought and struggled for equal rights tend to
see "the discontinuity more than the continuity in amendments like the Fifteenth and
Nineteenth" (Baier 1993b, 242). Mills (2005) argues that the ability to perceive injustices
requires conceptual labour to make injustices visible and available to rational criticism or
discussion.

[104] See Alan Wood for a discussion of this distinction (2008, Chapter 10) and a
sympathetic treatment of Kantian views. For a more critical discussion of this distinction
see Victor Seidler (1986).

[105] The description of the conceptual labour involved with exposing sexism and racism
comes from Charles Mills (2005). Mills writes of the introduction of the concept of
sexual harassment "These realizations, these recognitions, did not spontaneously
crystallize out of nowhere; they required conceptual labor, a different map of social
reality, a valorization of the distinctive experience of women. As a result of having these
concepts as visual aids, we can now see better: our perceptions are no longer blinded to
the realities to which we were previously obtuse. In some sense, an ideal observer should
have been able to see them—yet they did not, as shown by the non appearance of these
realities in male-dominated philosophical literature" (2005, 176).

structural inequality and oppression that I described in Chapter 3. The kinds of structural inequalities that make up relations of oppression have a differential and coercive effect on the individual members of different social groups and so they affect the individuals that Kant thinks should remain "externally uncoerced and wholly free of legal or state power and interference," as Wood puts it (2008, 193), but these coercive effects do not always involve explicit laws, state power or interference. Individuals living in social structures that are characterized by oppressive inequalities are subject to coercive influences even when these do not come from the power or interference of the state. One cannot really begin to understand the coercive effects of oppression without this analysis of structural inequality, which is not already contained in Kantian ethics or a Kantian discussion of the right, but instead required the conceptual and political work of movements for social justice. For example, it required the women's rights movement's with its insistence that the personal is political. It also required the work done by members of the civil rights movement who exposed racism in our social and political institutions and continue to expose how some seemingly race-neutral policies have differential effects on racial groups.

Alan Wood suggests that Kant's account of general injustice might recognize a requirement that the state redistribute wealth in order to protect the external freedom of the poor (2008, 198). But I do not think that the epistemic labour done by members of movements for social justice is properly captured by Wood's interpretation of Kantian views about inequalities in wealth. Wood writes that in some of Kant's early lectures and notes, "there are suggestions that poverty itself represents a form of social injustice, even when it results from a distribution of property and from transactions that are none of them

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in themselves unjust" (2008, 199). Wood interprets this as recognizing a general injustice

that is not the result of individual acts, but is instead "the unintended results of free

human actions that are not unjust considered separately and singly" (2008, 199). The

effects that Wood considers are all material effects. Wood discusses how the state takes

from the poor to provide to the wealthy and then ask the poor to beg for a living that is

theirs by right (Wood 2008, 200). Wood thinks that a consistent way of reading Kant

would notice a responsibility on the part of government to either prevent or remedy

general injustices through redistributive practices.[106] The redistributive metaphors that

Wood uses to describe a possible amendment to interpretations of Kant have an uneasy

relation to the descriptions of sexism and racism, however. To be sure, sexism and racism

often result in some groups having fewer material resources than others. But there are

additional effects that are more not best understood by analogy to material goods. As Iris

Marion Young has noted, metaphors of redistribution are stretched to their breaking point

when they are extended to cover nonmaterial goods, such as respect, self-respect,

opportunity and (I would add) social exclusion and epistemic ignorance. Young argues

that extending the metaphor in this way misrepresents these social processes and relations

among persons as if they were static things that could be taken from one person and given

to another (1990, 15-16). Although the state might be able to lead by example in an

attempt to eliminate sexism and racism, this is not a process that is accomplished through

redistribution. Many of the problems of sexism and racism (as well as the non-material

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[106] Wood has a really nice turn of phrase to describe the absurdity of describing this
redistribution as charity: "These conditions are *theirs by right*. To represent them as a
degrading form of charity would be natural only to the sort of mindset that might
consider it demeaning to you if the police protected you from being assaulted by muggers
on the street instead of leaving you to fight it out with them" (2008, 200).

effects of poverty) are relational problems. As relational problems they are particularly significant for a view that understands respect as a practical relation among persons, such as the one provided by Darwall.

I find Kant's discussion of the effects of social inequalities on our moral equality as human beings to be unclear at best. He seems to be uncomfortable about these effects, but he never offers a satisfactory discussion of how those raised in unequal social circumstances should come to develop the independence of will or the sure sense of their moral equality that characterizes autonomous individuals and that is required of those who are civil equals. Darwall's view of respect as second-personal is even less attentive to the effects that social inequalities might have on relations of respect, and Darwall cannot make use of Wood's excuse for Kant that he did not have the luxury of time to reflect on a consistent application of the insights of Kantian concepts of equal human dignity. According to Darwall, as long as we have recognized the other as someone who is capable of responding to reasons, then we have respected them as a moral equal and the social inequalities that might affect both parties to this interaction have little importance. For Darwall, the validity of second-personal reasons presupposes the moral equality of the each interlocutor, and this presupposition holds even if neither party in the exchange would agree that they are moral equals.

For example, Darwall tells us that self-conceit (or arrogance) is self-defeating because once we enter the second-personal perspective we are committed to viewing the other as having an equal authority. Since self-conceit involves believing that one has an authority no one else has, addressing second-personal reasons denies the very premise of self-conceit (Darwall 2006, 139). On Darwall's account, self-conceit turns out to be very

rare, at least in its pure form. The example Darwall gives to demonstrate this point is

Joseph Stalin. Darwall thinks it is natural to think of Stalin as being self-conceited if

anyone is, since he was cruel and vicious toward his citizens. But, Darwall tells us, this

self-conceit was not pure because he was also motivated by reactive attitudes that

implicitly recognize the second-person standpoint. "Even when someone addresses

reasons he takes to derive from an unreciprocated authority over his addressee, he can

blame his addressee for not complying only from the very same standpoint from which

his addressee can blame himself, a standpoint they share in common as free and rational

persons" (Darwall 2006, 138). But if we have an account of respect that allows Stalin to

count as recognizing the equal respect of those he terrorizes, it seems to me something

has gone wrong with our view.[107] So, while Kant seems troubled by social inequalities,

Darwall seems willing to accept these inequalities and take reactive attitudes as evidence

that even when such inequalities are present, they do not entail a lack of recognition of

moral equality because in order to even express a reactive attitude, we must see the other

as a moral equal who is able to respond to reasons. I do not find this account satisfying.

Kantian accounts cannot merely rely on the ability to respond to reasons as an indication

of whether the moral equality of another is recognized because the existence of

inequalities affects what reasons are available for discussion between moral agents, as I

describe in the next section.

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[107] Darwall anticipates an objection to his argument here. He says that a natural response
to the view that people like Stalin are committed to recognizing the free and equal dignity
of rational persons by their reactive attitudes might cause someone to "deny that the
second-personal address, so understood, is anything we need have much of a stake in"
(2006, 38). This is not quite my objection, however. I think we do have a stake in second-
personal address, but if respect involves second-personal address yet allows Stalin to
count as recognizing the dignity of those he terrorized then we need more than this
minimal recognition for respect to have moral value. I return to this point in Chapter 6.

5.2 RESPECT AND THE EPISTEMIC EFFECTS OF STRUCTURAL INEQUALITIES

Darwall's account of respect as second-personal is an account that contains problematic idealizations.[108] His arguments that second-personal reason-giving presupposes moral equality in the "pure" case is abstracted from "manipulation, cajoling, or any other form of nonrational influence" (2006, 20). There is, however, a lot packed into that mention of "nonrational influence." In actual contexts there are pervasive nonrational influences on the interactions among individuals. In what follows I examine the ways in which impurities like racial, sexual and other prejudices systematically infect these relations. When there is a systematic failure to respect the moral equality of members of particular social groups then we have a situation that cannot adequately be analysed by looking only at the "pure" cases that occupy Darwall. Some forms of nonrational influence should not be abstracted out of a consideration of what it means to respect another because these kinds of influence lie in the background of our attempts to communicate with one another and they infect many of the concepts available for use in moral deliberation. My aim in this section is to demonstrate that focusing narrowly on the exchange and criticism of reasons misses some important features that lie in the background of communication. These background elements are not a part of the reasons themselves, but they will affect how moral agents interpret and respond to the reasons offered by others.

5.2.1 Epistemologies of Ignorance, Epistemic Injustice and Respect

When Darwall describes second-personal interactions, he says that in order to engage second-personally with another we must be able to "see the other's response to

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[108] See Mills (2005) for a discussion of the different ways that ideals and idealizations can enter into moral theories.

my address as more or less rational from her point of view" (2006, 44). One of the features that characterizes oppressive societies is an inability of dominant groups to see many of the responses of members of marginalized groups as rational. At least part of this difficulty is the result of the historic exclusion of these groups from the social interpretation of the meaning of various different experiences and the continued marginalization of differing perspectives. In these kinds of contexts what seems (or fails to seem) like a rational response to a given experience depends not only on the individuals involved in the interaction, but also on the expressive and interpretive resources that are generally available within a society, which I will call hegemonic discourses. There are two ways that this can create problems for relations of respect. The first involves cases in which the experiences of some groups have been ignored and the second involves cases in which the experiences of some groups are devalued or the value these groups attach to these experiences is discounted. A socially situated evaluation of hegemonic discourses is just as important to recognition respect as the individual engagement.

When Young (1990) describes the "five faces" of oppression, she identifies an expressive injustice she calls cultural imperialism and cultural domination. According to Young, cultural imperialism involves control of interpretation and communication in society by dominant groups, which results in the universalization of this group's experiences, values and culture. The experiences and perspective of the dominant become the norm, although this often goes unrecognized. When the meanings and interpretations of one group become normalized, the perspectives of other groups may become invisible: these perspectives are either ignored or mentioned only in stereotyped or marginalized

ways. Because these latter groups differ from the unremarkable universalized norm, they are paradoxically also made more visible as an 'Other' and branded with a stereotyped essence. The dominant group, in contrast, escapes group marking: their perspectives are believed to be neutral and group members are free to be individuals. The invisibility of the dominated group results from the failure to notice that the experiences of the dominant group are not universal, but in fact constitute a perspective (Young 1990, 59). When expressive resources distort the expression of the experiences of marginalized groups this can affect whether their interpretations of situations seem reasonable to members of groups who do not share these experiences.

Historically, in Western philosophy, most of the moral discussion and development of moral concepts has been done by white men with both educational and class privilege. As Miranda Fricker notes, "Our interpretive efforts are naturally geared to interests, as we try hardest to understand those things it serves us to understand" (2006, 98). When dominant social groups have contributed most of the discussion to a given domain, then it is common for their interests to be reflected in the resources we have for describing and expressing that domain. When marginalized groups have been excluded from developing expressive and interpretive resources, then they might find that large parts of their experience are not a part of the hegemonic discourses within their societies. Fricker (2006) characterizes this situation as one of hermeneutical injustice: "*the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural prejudice in the collective hermeneutical resource*"

(Fricker 2006, 100, italics in original).[109] Hermeneutical injustice is related to systemic

structural injustices, but can be very difficult to detect precisely because it involves a lack

of interpretive or expressive resources.[110]

Although hermeneutical injustice will usually place some group at an expressive

disadvantage relative to another group, it is not always (and perhaps only rarely) the

result of malice. In some cases, the neglect of some aspect of experience is not intended

to create an injustice and instead involves a mere overlooking of some features or facts.

In other cases, however, there will be aspects of "social life where the powerful have no

interest in achieving a proper interpretation, perhaps indeed where they have a positive

interest in sustaining the extant misinterpretation" (Fricker 2006, 98).[111] In some cases

the dominant group might create understandings that actively obscure the interpretations

that marginalized groups might prefer. The dominant group might have already created

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[109] Fricker uses 'collective understanding' to describe something similar to what I, following Young (2001b), am calling 'hegemonic discourse'. Common discourse, Young says, is influenced by structural inequality in ways that create hegemonic discourses. I prefer Young's concept of hegemonic discourse to Fricker's concept of 'collective understanding' because Young's concept makes room for non-dominant understandings that occur within a single society (see Mason 2011 for a discussion of these issues and their problematic discussion in Fricker). I describe this issue further in the section 5.2.2 when I discuss framing, accountability and forgiveness.

[110] Not all hermeneutical failings will be the result of differential social power. Fricker says that some failings will be localized and incidental: "By contrast, there can be cases of hermeneutical injustice that are not part of the general pattern of social power, and are more of a one-off. They are not systematic but *incidental*. Whereas systematic cases will tend to involve persistent and wide-ranging hermeneutical marginalization, incidental cases will tend to involve hermeneutical marginalization only fleetingly and/or in respect of a highly localized patch of the subject's experience. Incidental hermeneutical injustices, then, stem not from any structural inequality of power but rather from a more one-off moment of powerlessness" (Fricker 2006, 100).

[111] For a discussion of how some areas of ignorance are actively introduced or maintained see the discussion in Nancy Tuana (2004 and 2006) and José Medina (2011). When ignorance is actively maintained in order to protect abusive power relations this ignorance should be considered blameworthy.

descriptions of the behaviour or social institutions that serve their interests and obscure alternative possible explanation, which makes the hermeneutical injustice difficult to detect.[112]

Some of the ways in which our categories are constructed or described can show a lack of respect to certain groups. Jackie Leach Scully (2008) identifies how the ways that categories are described can interfere with respecting relations. When a category of persons (for example the disabled) has few neutral words to use to describe themselves or their experience, this can build disrespect into the communication without that disrespect being a matter of the reasons offered. For some categories, like gender, there is an internal hierarchy where men are accorded higher value than women. This need not be made explicit because it is part of our tacit knowledge about social arrangements "that everyone just has" (Scully 2008, 34). But for other categories, for example, disability, the language available forces us to make "a preemptive judgement about disability just in order to talk about it" (Scully 2008, 35). The preemptive judgement results from the words used to name the category, which are about negation and wrongness (disability, disorder, malfunction, invalid, deformed, disfigured, etc.). From the outset the discussion will be about a disvalued manifestation of the body. The connotations with deficit and dependence are so stigmatized in Western culture that they form a "subliminal background" to how we think about being disabled, the social role of disabled people, their moral agency and moral competence. In cases like these where the categorization itself is marked, "then *from the outset* our discussions are morally as well as biologically,

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[112] The classic example here is the case of sexual harassment, which I describe in greater detail in the next section.

socially, and discursively marked, and this needs to be taken into account in a bioethical engagement with disability" (Scully 2008, 35).

The words used to describe different social groups are important not only because they can cause offense, but also because their unchallenged use can engender "alienation, contempt, or hatred in those who use them" (Scully 2008, 33). Using loaded words reinforces cognate attitudes. But changing vocabulary alone won't solve the problem when the negative underlying attitude remains. Scully calls this "creeping stigmatization" where new terms invented as neutral ways to refer to downwardly-constituted social groups take on negative cognates (e.g. the numerous ways to refer to people with Downs Syndrome: mongoloid, retarded, mentally challenged, etc.). In such cases working to overcome these cognate attitudes requires deeper social change.

Cultural injustices have important consequences for societies. They affect how different social groups are recognized or misrecognized. Cultural injustice affects what we know and what we don't know and which resources we have available to express and describe our experiences. When the expressive resources that are available within a society are skewed in favour of dominant groups then the expressions of marginalized groups might seem less rational, or more difficult to understand. Cultural injustice shapes our sense of fairness, restricts the interpretive resources on which we can draw, and can distort our moral theorizing. These injustices affect how moral and political debates take place because some ways of framing issues will seem more 'natural,' or 'reasonable' due to the pervasive nature of these cultural norms. These injustices can affect the ways in which individuals communicate, but they are not usually part of the explicit reasons or explanations offered by individuals. Identifying hermeneutic injustices cannot be done by

looking at individuals alone, but instead requires an examination of wider social

institutions.

5.2.2 Responsibility and Forgiveness: Structural Inequalities, Respect and Reactive Attitudes

Darwall believes that reactive attitudes such as blame are centrally involved in

relations of respect. The pure cases that Darwall considers are ones in which individuals

are mutually accountable. In impure cases, however, we are not all equally accountable

for the same things. Instead there are "geographies of responsibility," in Margaret Urban

Walker's terms, and we don't all have the same power to negotiate or deflect these

responsibilities (2007, Chapter 3). One of the consequences of hermeneutic injustices is

that in some cases it is actually quite difficult to hold another accountable for the harms

or wrongs that one suffers. When the society in which one finds oneself lacks a

description of some harmful experience, then expressing that experience as outrage that

demands redress becomes more difficult. For example, before the concept of 'sexual

harassment' was described by feminist activists, women had a difficult time expressing

their experience of unwanted attention at work.[113] There was an existing interpretation of

the behaviour that saw it as harmless flirting. Women did not experience this as harmless;

however, there were no expressive resources for describing the way the behaviour

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[113] 'Sexual Harassment' is one well-known concept to emerge from feminists who developed different understandings of social phenomena and new vocabulary to describe that phenomena, but it is not the only new term developed by feminists. Alison Jaggar also attributes 'sexism,' 'womanism,' 'sexual objectification,' 'date rape,' 'othermother,' 'the double day,' 'the male gaze,' and 'emotional labour' to feminist conceptual work (2004, 238). It is also important to note that just because one has a difficult time expressing and receiving uptake for one's experience of harm, this does not mean one lacks an understanding of the experience as harmful. Rebecca Mason (2011) discusses the difference between collective understandings, dominant understandings and the ways in which dominant understandings can function to silence alternative understandings that are offered by non-dominant groups.

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seemed from the point of view of many women. When feminist consciousness raising groups got together and discussed their experiences they had to introduce a new conceptual resource (sexual harassment) to be able to name and explain their experience. Once the concept became widely-known expressing this wrong became more possible. However, it remains difficult to fully express the wrong of sexual harassment because old interpretations of the behaviour as 'harmless flirting' continue to circulate in hegemonic discourses. Achieving equal accountability under conditions of inequality requires collective exercises of moral imagination to imagine how things could be otherwise. It also takes conceptual work to name and explain various wrongs that previously went unnoticed. Furthermore, responsibility and accountability can be framed in a number of different ways and some of these undermine agency.

Sometimes the way an issue is framed can put one party in the discussion at a disadvantage, although the framing is not part of the explicit reasons offered in the discussion. For example, some discussions of the educational capacity of African Americans and Caucasian Americans frame the question as whether blacks are as intelligent as whites, or whether blacks are intellectually inferior to whites. This way of framing the issue puts African Americans at a disadvantage because the only options for compromise lie within a continuum that is already skewed in favour of Caucasian Americans. In this case the skewing of the framework is fairly easy to identify because we are already quite familiar with the discussion and a good deal of conceptual work has already been done to indentify the problems with this particular frame. In some cases, when a problem is being framed according to a discourse that reflects the influences of structural inequality it can be quite difficult to detect the framing.

Young (2001b) describes a 'discourse' as a system of stories and expert knowledge that are commonly accepted in society to explain how society operates. Many of the social norms and cultural values to which we appeal will reflect these understandings. When we attempt to explain our moral, social and political problems as well as when we propose solutions, we often draw on these norms, values, stories and expert knowledge. A discourse is hegemonic, according to Young, when "most of the people in the society think about their social relations in these terms, whatever their location in the structural inequalities" (2001b, 685). In societies that are characterized by structural inequalities, many of the conceptual and normative frameworks will be influenced by terms and discourse that make it difficult to think critically about aspects of one's social relations or to imagine alternative institutional arrangements. When deliberating about who is responsible, what they are responsible for, and ways to repair any moral transgression, the deliberation influenced by a hegemonic discourse might lead to an agreement that is conditioned by unjust power relations.[114] In cases where agreement is affected by hegemonic discourses, the frames used to describe the problem

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[114] In Chapter 3 I described one example of this when I discussed how Rani and Davida came to decide about which of them would stay home to raise their new baby, Sam. Because of the structural injustice in their society, there was a wage gap that meant women earn less than men on average. So rational individuals choosing in the best interests of the family would decide the woman would stay home, just as Rani and Davida decided. But we could also look at the role of other aspects of the social discourse that might contribute to their decision. For example, part of the hegemonic discourse in our society involves the belief that salary is related to effort or talent and that women are more nurturing than men. These social stories and norms could also have affected their reasoning. Furthermore, another hegemonic discourse often used to explain the wage gap postulates that women choose lower-paying jobs in order to increase their flexibility and ability to meet family responsibilities. Yet, it is difficult to square this view with the fact that most low-paying jobs are among the least flexible, while higher-paying jobs often offer more flexibility.

or decide on appropriate forms of punishment, praise, reward or repair can also be distorted.

A second way that framing can affect the discussion and negotiation of responsibility is through the extent to which the action is considered deviant and unforgivable or amenable to forgiveness. Lisa Wade (2010) describes two separate news reports that interviewed two different seven-year-old boys who had taken their families' cars on a joyride and were caught by police. One of the stories, which ran on *The Today Show* (Vieira 2009), reported on a white boy, Preston Scarbrough, and framed the joyride as "funny." The host, Meredith Vieira asks Preston about why he took the family car and then hid from the police once they were pursuing him.[115] He says he took the car because he wanted to know what it was like to drive and then he hid from police because he was frightened. Vieira seems understanding of his reasons, she replies, "I don't blame you actually," when he describes his fear. His punishment for the joyride is being grounded from videogames and TV for four days. During the interview Preston sometimes does not know how to respond to Vieira. The reasons she offers him as an explanation of his behaviour presume that he made an innocent mistake. Vieira ends the segment by describing her concern for Preston's safety and how this could happen to anybody.

In contrast, CNN ran a story about a black boy, Latarian Milton, who also took his family car on a joyride. When Ted White asks Latarian why he took the car, like Preston, Latarian says that he thought it would be fun. When asked what his punishment should

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[115] Preston's "joyride" is described in several ways throughout the video. Vieira and Preston's father, Mr. Scarbrough, describe the event as a "joyride," a suspect "driving erratically" a "high speed chase, they [the police] said… but it was high-speed for a seven-year old I suppose." When Vieira asks Preston about why he did this she says she doesn't blame him for wanting to hide "after taking the care for a joyride." Neither Vieira nor Mr. Scarbrough describe the event as "stealing" the car.

be, Latarian suggests something similar to Preston's punishment: no videogames for a week. But White explains that the police are going to charge Latarian with grand theft and while "he's too young to go into any type of juvenile facility... police say they do want to get him into the system, so that they can get him some type of help" (cited in Wade 2010). The difference in the framing of a similar act is quite different in the two descriptions. Preston is presented as a kid whose curiosity got the best of him. Latarian, in contrast is considered a "hoodrat," someone who is dangerous and "needs help" from "the system." The descriptions of the deviant acts are different and offer very different possibilities for forgiveness.

Once again, the ways in which transgressions are framed as either forgivable or a sign of unforgivable character defects is often related to the social injustices present within a society. Some groups, for example African Americans, are figured as more criminal and their transgressions receive less social forgiveness. Kelly Oliver (2004) argues that revolt and forgiveness are necessary components of developing subjectivity. By 'revolt' Oliver means small and mundane transgressions that test authority (2004, Chapters 9 and 10).[116] In its mundane forms revolt involves such things as the constant questioning of children who repeatedly ask why certain things are as they are. This questioning tests authority and "enables, renews, and restructures both the singularity of the subjectivity and the social" (Oliver 2004, 186). By questioning and revolting against authority we can displace authority and become subjects. We test the boundaries, as the two boys did when they took their family car to see what it is like to act as adults do.

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[116] Oliver does not include criminal transgressions within the scope of 'revolt.' Instead, she has in mind more mundane forms of testing authority. This constitutes a difference from the kind of revolt that Kant had in mind, I believe.

Revolt, however, also requires forgiveness that welcomes the transgressor back into the community as one who belongs. Revolt against social codes allows one to assert one's singularity and to assimilate these codes. Forgiveness "allows the subject to trespass the social order and yet be accepted back into that order as one who belongs" (Oliver 2004, 189). Oliver suggests that forgiveness plays a role "in constituting the subject as both individual and as belonging to the social" (2004, 180). Oliver understands forgiveness as a social dynamic that supports individual agency. Revolt allows us to assert our individuality, or separation from the social order, while forgiveness allows us to heal the separation and return to the social order. Oliver imagines this as an ongoing process, but she notes that it is not equally available to all individuals under oppressive social circumstances.

Under oppressive social circumstances, revolt can be particularly important because it allows the oppressed to resist harmful social norms, stereotypes and the downward constitution of oppressed social groups.[117] Oliver notes that through resisting oppression one can regain one's sense of oneself as an agent (2004, 73). One of the

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[117] Revolt, resisting and attempting to change oppressive social norms has been considered important by many philosophers who write about maintaining or repairing one's self-respect under oppressive societies. Dillon notes that under oppressive conditions self-respect can be damaged but that "damage is not destruction and individuals are not wholly constituted by their subordination or damaged self-respect" and so there are possibilities for remediation (1997, 248). One of the ways that Dillon believes that basal self-understandings can be remediated in the face of the damage done by oppression is by improving the socio-political contexts which helped form these understandings. She writes, "Active political engagement with others to eliminate or transform social forces responsible for deforming self-respect can bring about situations in which more adequate normative identities and self-understandings are possible" (1997, 249). Laurence Thomas (1995) has described how the revolts involved in civil rights movements against injustice often have the goal of enhancing the self-respect of groups subject to injustice, and also at the same time one of the effects of the existence of these movements is to increase the self-respect of its members.

double-binds created by oppressive circumstances, however, is that the possibility for

social forgiveness is often circumscribed or foreclosed. In the example of the two boys,

Preston is figured as forgivable. His transgressions are not taken to show a developing

criminal character, but instead a harmless transgression based on curiosity. In contrast,

Latarian's transgression is coded as more dangerous, less forgivable, and reason to place

him under the "helpful" supervision of the system.[118] In other cases when the revolt is

more serious and seeks social change rather than a fuller integration into existing social

environments, in order for an individual to be forgiven, the social environment itself must

be transformed. Dr. Martin Luther King's role in the civil rights movement provides an

example. King's transgressions were more serious than taking cars for joyrides. His

transgressions revolted against unjust laws that contributed to the oppression of Black

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[118] Devah Pager (2003) describes a sociological study that could be interpreted as supporting the idea that forgiveness applies unequally to members of different social groups. She conducted a study in which she created fake credentials for black and white matched-pairs of job applicants. The audit included some applicants who reported having a criminal record for non-violent drug possession and some who reported no record. She found that blacks with a criminal record were significantly less likely to get called back for the job than were whites (5% for blacks with a criminal record vs. 17% for whites with a criminal record) (Pager 2004, 958). Pager writes, the "ratio of callbacks for nonoffenders relative to ex-offenders for whites is 2:1, this same ratio for blacks is nearly 3:1. The effect of a criminal record is thus 40% larger for blacks than for whites" (Pager 2004, 959). This could be taken to show that black men with a criminal record seem less 'forgivable' to employers than do white applicants with a criminal record. Further, even black applicants with no criminal record were called back at a rate lower than white applicants *with* a criminal record (17% for whites with a criminal record vs. 14% for blacks with no criminal record) (Pager 2004, 958). Pager suggests that employers might be associating race with crime even when there is no evidence of a criminal record. For example, she reports that on three occasions, the black applicants were asked about their criminal involvement whereas none of the white applicants were asked about their criminal involvement (2004, 960). Pager's findings are particularly troubling given a recent report by the NAACP and the Drug Policy Alliance that found that although the rate of marijuana use among whites between the ages to 18 and 25 is higher than among blacks, the rates of arrest for marijuana possession is higher among blacks in California (Levine, Gettman and Siegel 2010).

people in America. King was not seeking forgiveness for these transgressions but was instead seeking to change the social order. King was considered criminal during his lifetime and spent time in prison. Nevertheless, forgiveness plays a role here. As the social order did begin to change King's transgressions ceased to be transgressions. Whereas Blacks were once segregated and using the social resources (schools, water fountains, washrooms etc.) reserved for whites was a transgression, it no longer is (well, at least not by law). In this case the forgiveness follows on transforming the social order. Whereas King was once regarded as a criminal, he is now widely regarded as a visionary. However, had the social order not been changed then King would not have been forgiven and would have remained a criminal outside society. There are no guarantees that transgressions will be forgiven.

As I have argued, oppressive social circumstances can undermine the equality of our accountability in at least two ways. The first way that oppressive social circumstances can affect accountability is when hegemonic discourse creates an epistemology of ignorance that leaves some aspects of experience unanalyzed or analyzed in only incomplete and partial ways that serve the interests of some groups while disadvantaging others. This can make it difficult to have one's claims taken seriously even as one might try to express the wrong. Correcting this problem requires attention to inequality and the social differences that might affect the interpretation of some experience. The second way that inequality affects accountability is through negative figurations that conceive of some groups as more dangerous or morally suspect than others. Margaret Urban Walker suggests that in order to adjust these kinds of inequalities, we need rich detailed geographies that examine "patterns of ascribing and deflecting responsibility" that look at

how these are socially shaped and imagine how they could be shaped in other ways (2007, 106). I would add to Walker's geography not just the assignment or deflection of responsibility, but also the possibilities for forgiveness once one has transgressed. As Walker writes, "We are not all responsible for the same things, in the same ways, at the same costs, or with similar exposure to demand or blame by the same judges" (2007, 106). Nor do we face the same possibility for forgiveness after transgression; we are not all welcomed back into the moral community to the same extent or with the same ease. Walker urges these descriptive geographies not merely for the sake of a better understanding, but as a way of examining "what is gained and what is lost" by particular practices of responsibility. She notes that some divisions of social and moral labour are harmless or useful, while others are more unsavoury (2007, 106).

When moral agents from different social groups meet each other under conditions of structural inequality they are likely to have different interpretive resources available and these have effects on their second-personal engagements. The experiences of some groups are more well represented than others within hegemonic discourses. The hegemonic discourses will obscure some reasons while bringing others to light. This will affect the ability of agents to hold one another accountable in ways that affect what is available to rational deliberation. If we want to succeed in respectful deliberations we cannot merely abstract these effects away, instead they require a difficult and laborious form of examination.

5.3 RESPECT, EMPATHY AND STRUCTURAL INEQUALITY

Darwall takes empathy to be important for respectful relations from the second-person standpoint, but the way that he describes empathy presupposes a strong similarity

in the perspectives of moral agents. It is important not to forget the limits of this kind of moral imagination when it is enacted by actual human agents who have only partial perspectives and inadequate understandings of others whose social situation and emotional configuration is quite different than their own. In such cases "imaginative projection" into another's shoes is just as likely to cause moral misunderstanding as it is to illuminate the other's situation as she understands it. "One of the commonest and most severe impediments of human moral understanding," as Margaret Urban Walker observes, "is the limitation of sympathy or even of recognition that arises from simple lack of experience of what others endure" (1991, 766). When empathy fails we are then faced with a question about how we should respond to the failure: should we take this as our own limitation or as a failing in the one with whom we are attempting to empathize?

Darwall understands empathy as distinct from sympathy because he says that empathy is an emotional experience from which I take up the position of another, whereas sympathy is an experience in which I appreciate your perspective from my own perspective. Sympathy takes a third-person perspective on the situation and focuses attention on "the other and the relevance of her situation *for her*" (Darwall 1998, 270). In contrast, empathy is a way of occupying the other's perspective that involves imagining her situation from her perspective. Darwall proposes that our empathetic capacities mature as we develop increasing emotional maturity. Empathy moves from being a kind of primitive and direct "emotional contagion" (Darwall 1998, 264) through a more sophisticated form that involves simulation and projection. Projective empathy gives us the ability to assess the propriety of the other's feelings. We evaluate whether we think the feeling is appropriate to the situation, and when we find it appropriate we "second"

that feeling. When we do not think the feelings another is expressing are appropriate to the situation, then it is difficult to empathize with them and "the inability to empathize will itself be an expression of thinking the other's feelings to be unwarranted" (Darwall 1998, 269). As we mature further, we develop a proto-sympathetic empathy, which is informed by projective empathy but goes beyond it because it is not entirely felt from the other's standpoint. This form of empathy is not entirely from the other's standpoint because it includes attention to the other's relation to the situation. The difference between the last two forms of empathy (projective and proto-sympathetic) involves the target of the emotion. In the case of projective sympathy we take on the other's feelings and so our emotional response has the same target as theirs. For example, if I have a projective sympathetic response to a friend whose father has died, then I share her grief and the target of the grief is the death of the father. In contrast, proto-sympathetic empathy includes the other as the target of the emotion. In proto-sympathetic empathy we imagine "what another person's grief is like for him, we are focused on the other person and his grief" (Darwall 1998, 272). From this perspective we take the other person and their emotional experience as the target for our own reaction.

Darwall sees empathy as a capacity that develops over time and gradually comes to bring the perspective of the other into clearer focus. But it is crucial to notice that our ability to empathize with another relies on a similarity in histories, emotional configuration and experience. As Darwall tells us, the ability to empathize with another depends on seeing their feelings as warranted in the situation, but when two people have emotional configurations that differ from one another then they might be more likely to see the emotional reaction as unwarranted, as overly sensitive or otherwise inappropriate

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to the situation. There are two things that I want to highlight in Darwall's discussion. First, I worry about the suggestion that empathy, understood as inhabiting the perspective of the other, should be characteristic of respect. In particular, for members of oppressed groups who are imagined within their societies as lesser (in a number of ways) than dominant groups, the suggestion that they should inhabit the perspective of the other risks damaging (or further damaging) their self-respect. My second concern is that Darwall's account of empathy is insufficiently attentive to the various ways that imaginative projection can fail when the two subjects in the empathetic relation have different histories, emotional configurations, experiences and moral understandings.[119] When hegemonic discourses are defective in the ways that I described in section 5.2, then our empathetic imaginative resources will likewise be limited and skewed toward dominant descriptions of the social and moral terrain.

My first concern with the suggestion that respect requires an imaginative projection into the perspective of another involves the damage that such a projection could do in social contexts of pervasive structural inequality and oppression. In oppressive social contexts hegemonic discourses are often characterized by a number of interpretive injustices that fail to include the conceptual resources required to describe the experiences of members of marginalized groups and thereby tend to misrepresent marginalized groups. In contexts where oppression is common, when members of marginalized social groups imaginatively project into the perspectives of their oppressors, this could have damaging effects on their self-respect and it can also have negative

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[119] This point has been widely discussed in the philosophical literature, especially by feminists (e.g. Young 1997a), critical race theorists (e.g. Thomas 1992-1993) and disability theorists (e.g. Scully 2008).

effects on the status of the group more generally.[120] When the other with whom we are

engaged views us as less than a full person, then taking up their perspective on us and

those who share our group membership is bad moral advice.[121]

Several philosophers who are interested in self-respect have been troubled by

persons they name "Uncle Tom:" a black person who lacks self-respect.[122] Laurence

Thomas (1995) notes that despite his numerous accomplishments, Booker T. Washington

has often been accused of acting like an Uncle Tom. Washington managed to accomplish

much more than most blacks at that time could reasonably hope for, including the

founding of the Tuskegee Institute for advancing the education of blacks. He was highly

esteemed in his time and had many successes. Washington had a strong moral character,

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[120] Some recent work in psychology might be interpreted as supporting the view that imaginative projection into the perspective of the oppressor can be damaging to marginalized groups. Claude Steele (2010) describes how groups that are stigmatized or stereotyped as poor performers in a given area will actually perform worse on tasks when the stereotype is evoked, for example by calling attention to their group membership. Steele postulates that situations where group members are reminded of the negative stereotype about their group in a particular domain causes members of those groups to become preoccupied with fears of conforming to the stereotypes and this preoccupation negatively affects their performance (Steele 2010, 119-120; 149; 170).

[121] See also Robin Dillon's discussions (1992a; 1992b; 1997) of the development of self-respect in oppressive societies. Her discussion is slightly different than mine because rather than focusing on taking up the perspectives of other individuals who hold biased beliefs about members of one's social group, she focuses on the ways in which negative messages about members of one's social group commonly circulated with in oppressive societies might affect one's self-respect. Nevertheless, many of the same concerns she raises about the effects of these messages would also apply to my discussion here.

[122] See for example Thomas E. Hill Jr.'s discussion of Uncle Tom and the Deferential Wife in "Servility and Self-Respect" (1995a), Bernard Boxill's discussion of the disagreement between W.E.B. Du Bois and Booker T. Washington in "Self-Respect and Protest" (1995), and for a somewhat different take on the issue see Laurence Thomas' discussion of Booker T. Washington in "Self-Respect: Theory and Practice" (1995) where he considers that Washington might have been strategic in his stance toward white society as well as the possibility that this stance showed he lacked self-respect. As I read her, Robin Dillon's (1997) "Self-Respect: Moral, Emotional, Political" is also a reaction against some of the standard interpretations of characters like the Deferential Wife.

but nevertheless, Washington's behaviour is sometimes described as morally

problematic. Thomas believes that the charge of being an "Uncle Tom" seems an apt

description of Washington because he was too accepting of the status quo:[123]

> It was the prevailing view of whites back then that blacks were not socially prepared for full-fledged citizenship and, therefore, that social intercourse between blacks and whites, political participation on the part of the blacks, and rights given to them should be kept to a minimum. It has seemed to a great many that, in his "Atlanta Exposition Address," it is precisely this view that Washington, himself, endorsed (Thomas 1995, 257).

Thomas maintains his ignorance of the extent to which Washington actually did endorse

these views. He believes it is possible that Washington was merely very strategic and was

using a calculated manipulation of pervasive social beliefs in order to ensure continued

financial support from whites at a time when interest in the education of blacks was

waning. Like Thomas, I don't think it is possible to discern whether Washington

endorsed negative views of blacks or whether he was acting according to a strategy; what

I want to focus on here, however, is the effects that an imaginative empathetic projection

into the perspectives of whites at the time might have on Washington.

One way to interpret W.E.B. Du Bois' criticisms of Washington is that Du Bois

believed Washington reflected the image of blacks that was lodged in the view of whites

at the time. Du Bois recognized the achievements of Washington, but seems to think that

his success came more from white communities than from black communities.[124] Not

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[123] In particular, Washington's metaphor for social segregation while maintaining economic integration has been often criticized: "In all things that are purely social we can be as separate as the fingers, yet one as the hand in all things essential to mutual progress" (Washington 1901, 221-222).

[124] Du Bois recognizes the fine line that Washington must walk in order to "so largely retain the respect of all" but he also seems to think that much of Washington's success comes from the outside: "If the best of the American Negroes receive by outer pressure a

only does Du Bois have reservations about Washington's leadership because he was first recognized by whites and then took on the role of a leader of two races when he was later accepted by Blacks,[125] Du Bois is also concerned that the views that Washington offers of black communities reflect the values and perspectives of whites to the detriment of the interests of blacks.[126] Du Bois identifies three attitudes that an "imprisoned group" might take regarding their captors: "a feeling of revolt and revenge; an attempt to adjust all thought and action to the will of the greater group; or, finally, a determined effort at self-realization and self-development despite environing opinion" (Du Bois 1973, 46). Du Bois does not offer an absolute evaluation of these attitudes, condemning some as bad and praising others as good; instead he seems to think that each might be appropriate at different times. His criticism of Washington rests in part on his reinstating "the old attitude of adjustment and submission" at a time when this was inappropriate because the race had already advanced and the racial tensions of the time called for an effort at self-

leader whom they had not recognized before, manifestly there is here a certain palpable gain. Yet there is also irreparable loss,—a loss of that peculiarly valuable education which a group receives when by search and criticism it finds and commissions its own leaders" (Du Bois 1973, 45-46).

[125] He also suggests that Washington primarily played a role of compromise between the white North and South: "But Booker T. Washington arose as essentially the leader not of one race but of two,—a compromiser between the South, the North and the Negro. Naturally the Negroes resented, at first bitterly, signs of compromise which surrendered their civil and political rights, even though this was to be exchanged for larger chances of economic development. The rich and dominating North, however, was not only weary of the race problem, but was investing largely in Southern enterprises, and welcomed any method of peaceful cooperation. Thus, by national opinion, the Negroes began to recognize Mr. Washington's leadership; and the voice of criticism was hushed" (Du Bois 1973, 49-50).

[126] Du Bois writes of Washington, "And so thoroughly did he learn the speech and thought of triumphant commercialism, and the ideals of material prosperity, that the picture of a lone black boy poring over a French grammar amid the weeds and dirt of a neglected home soon seemed to him the Acme of Absurdities" (Du Bois 1973, 43).

realization. Du Bois criticizes Washington's programme because it "practically accepts the alleged inferiority of the Negro races" (Du Bois 1973, 50). One of the problems with Washington's approach is that he empathizes too much with the perspectives of the dominant white society and does a disservice to others of his race in the process.

Thomas Hill Jr.'s interpretation of "Uncle Tom" characters is that their behaviour is problematic when Uncle Tom gives up his rights for too small a profit and thereby does not recognize the importance of his rights (1995a, 84),[127] but I think that the criticism offered by Du Bois is slightly different than Hill's. Du Bois does not criticize Washington because of Washington's desire to advance the economic situation of blacks, nor does he think that the economic advancement of blacks is an unworthy or "too small" a goal. Instead, Du Bois criticizes Washington because his identification with white perspectives on the problems that face blacks (or perhaps more accurately, "the Negro problem" which is ambiguous about whether Blacks face problems or are themselves cast as the problem) creates a "dangerous half-truth" that is likely to work against the goal of

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[127] Hill says this interpretation comes from Kantian descriptions of why a person might engage in false humility. Kant frequently describes servility or false humility as flattering another in an attempt to gain something else in place of one's self-respect. For example, when Kant describes the reasons that he believes that a person might humble himself, these are usually described as an attempt to gain some other kind of worth through the forfeit. Kant tells us that people are ambitious because they believe that they "will get an even greater inner worth" as a result of their ambition (*Metaphysics of Morals* 1996, 187; AK 6:436). Kant admits that some people might have a tendency to value themselves too highly. Nevertheless, he does not think that we should bow and scrape before others to counter the propensity to self-conceit because this is unworthy of human dignity (*Metaphysics of Morals* 1996, 188; AK 6:435). When he describes lying-humility he describes it as an attempt to flatter others. Again this seems like an attempt to gain favour by debasing oneself. Kant tells us that we must also avoid any propensity to servility, because "one who makes himself a worm cannot complain afterwards if people step on him" (*Metaphysics of Morals* 1996, 188; AK 6:437). In his *Lectures on Ethics*, Kant goes as far as to claim that "flattering oneself" into believing that humility is a virtue is "in fact a form of pride" (1963, 127).

advancing the economic situation of black communities, which is itself an important and

worthy goal.[128] Du Bois' criticisms seem to rest in part on the way that Washington's

empathy for white perspectives undermines the goals of black emancipation, even as

Washington undoubtedly holds to these same goals. Du Bois' own strategy for retaining

his self-respect is one of resisting an empathetic imaginative projection into the

perspectives of his oppressors. When Du Bois describes the "double-consciousness" of

blacks he advocates resisting the pull of an empathetic engagement with the perspectives

of the oppressor, which he sees as all-too-common:

> Between me and the other world there is ever an unasked question:
> unasked by some through feelings of delicacy; by others through the
> difficulty of rightly framing it. All, nevertheless, flutter round it. They
> approach me in a half-hesitant sort of way, eye me curiously or
> compassionately, and then, instead of saying directly, How does it feel to
> be a problem? they say, I know an excellent colored man in my town; or, I
> fought at Mechanicsville; or, Do not these Southern outrages make your
> blood boil? At these I smile, or am interested, or reduce the boiling to a
> simmer, as the occasion may require. To the real question, How does it
> feel to be a problem? I answer seldom a word.
> And yet, being a problem is a strange experience …the Negro is a
> sort of seventh son, born with a veil, and gifted with second sight in this
> American world,—a world which yields him no true self-consciousness,

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[128] Du Bois recognizes that Washington has sometimes opposed injustices committed against blacks, and has spoken out against lynching, "Notwithstanding this," writes Du Bois, "it is equally true to assert that on the whole the distinct impression left by Mr. Washington's propaganda is, first, that the South is justified in its present attitude toward the Negro because of the Negro's degradation; secondly, that the prime cause of the negro's failure to rise more quickly is his wrong education in the past; and, thirdly, that his future rise depends primarily on his own efforts. Each of these propositions is a dangerous half-truth. The supplementary truths must never be lost sight of: first, slavery and race prejudice are potent if not sufficient causes of the Negro's position; second, industrial and common-school training were necessarily slow in planting because they had to await the black teachers trained by higher institutions,—it being extremely doubtful if any essentially different development was possible, and certainly a Tuskegee was unthinkable before 1880; and, third, while it is a great truth to say that the Negro must strive and strive mightily to help himself, it is equally true that unless his striving be not simply seconded, but rather aroused and encouraged, by the initiative of the richer and wiser environing group, he cannot hope for great success" (Du Bois 1973, 57-58).

but only lets him see himself through the revelation of the other world. It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity. One ever feels his two-ness,—an American, a Negro; two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder.

  The history of the American Negro is the history of this strife,—this longing to attain self-conscious manhood, to merge his double self into a better and truer self (Du Bois 1973, 1-4).

For Du Bois part of the experience of being perceived as "a problem" is the constant struggle to *resist empathetic projection* into the perspective of an oppressive society (and those individuals who accept this socially dominant view) that creates a constant sense of "always looking at one's self through the eyes of others." Because assessing one's self from this perspective, through the eyes of *these* others, means one will perceive oneself through standards that guarantee one will not measure up.

In contexts that include structural injustice and negative figurations of particular groups it can be problematic to suggest that members of those groups empathize with others in their interactions. This kind of empathetic engagement could damage one's self-esteem and lead to the internalization of oppressive explanations of the social structure that work against the interests of those who are oppressed under such structures. The suggestion that respect requires an empathetic engagement with the other can be damaging to those who are oppressed, and it can also be misleading when attempted by those who are privileged by structural injustices.

My second concern with Darwall's suggestion that respect requires an empathetic engagement is that I am doubtful of the extent to which privileged members of unequal societies can imagine the experiences of others. Respecting another certainly involves taking their perspective into account. Because of this importance it might seem natural to

talk about "imagining one's self in the other's shoes," but it is equally important to remember that this imagining will never be complete because we are never able to escape our own perspectives and the imaginative projection can never take the place of difficult attempts at communication, as Young has stressed. Whenever we engage in communicative exchanges we bring with us "particular experiences, assumptions, meanings, symbolic associations, and so on, that emerge from a particular history, most of which lies as background to the communicating situation" (Young 1997a, 352). We can articulate parts of our histories to enhance understanding, but we can never tell all of our histories because they are inexhaustible and it is always possible to retell our history in a new context. Our positions are not interchangeable in part because we cannot live the history of another. Elizabeth Spelman argues that when we think we can put ourselves in the position of another we are not treating that individual as the person they are (1978, 159). Imaginatively projecting into the position of another involves seeing the other as an instantiation of a regularity rather than engaging with their particularity.

When we try to imagine the perspective of another we are always imagining what it would be like for us to be them rather than imagining what it is like for them to be them. Whether our imaginative projection will be successful depends to a great extent on how well we understand the other and the similarity between our own experiences, histories and emotional configurations. Laurence Thomas (1992-3) describes the dangers of attempting to imaginatively put oneself in the shoes of another when we have different memories, experiences, emotional responses and vulnerabilities. For example, Thomas argues, it is "moral hubris" to assume we can imaginatively project into the position of a holocaust survivor or a woman who has been raped (1992-3, 234). In such cases

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suggesting that you can imagine how the other feels can be dismissive or insensitive to her experience. According to Thomas this does not mean that we should give up on our attempts to empathize with others. Instead it means that we should be particularly careful when empathizing with those whose experiences we do not share. In these cases we owe the other "moral deference." Moral deference is an attitude that we owe to those whose emotional category configurations are different than ours because of unjust social structures. It is an attitude that is a "prelude to bearing witness to another's pain" (Thomas 1992-1993, 234). Thomas sees the adoption of moral deference as an opposition to the idea that there is a perspective from which "any and every person can rationally grasp whatever morally significant experiences a person might have" (1992-1993, 233). The deference Thomas envisions is meant to provide a bridge between individuals when one person is recounting their experiences of oppression to another who has not shared such experiences.

Thomas draws a distinction between general misfortunes that are independent of social categories, such as losing a loved one, being robbed and so forth, and misfortunes that are "hostile misfortunes," which attach to group membership, such as the experience of racism, sexual harassment or rape. Thomas thinks that we can, to some extent, imaginatively project into the position of another who has suffered a general misfortune. "Hostile misfortunes" that come about because of morally objectionable attitudes regarding the diminished social categories, however are not as easy to imagine. Those who do not belong to the diminished social category have practically no chance of experiencing the hostile misfortune. Although Thomas thinks that when two members of the same social group experience a hostile misfortune, they will have insight into the

other's experience, for individuals outside the group it can be very difficult to imagine what it would be like to experience hostile misfortunes. In oppressive societies people with different group memberships are likely to develop different emotional category configurations that result in a radically different experience of pain and suffering from different sources (Thomas 1992-3, 243). These differences create real difficulties when we try to imagine the perspective or experience of another.

According to Thomas, in cases where we have very different experiences and emotional category configurations than the other we owe them moral deference. Unlike Darwall who says that to empathize with another we need to see her as "responding (more or less rationally) to my address," for Thomas cases in which we cannot see the other's response as rational might signal a case in which our emotional category configurations are different. Referencing Nagel's paper "What Is It Like To Be a Bat?" Thomas suggests that if we were able to communicate with a bat the bat might tell us that "Hanging upside down is extraordinarily like experiencing death through colours" (1992-3, 233). A human hearing this description would have a difficult time understanding what the bat was expressing. But rather than taking this as an instance in which we would be justified to dismiss the claim as "so much nonsense" Thomas believes this is precisely a case in which we should recognize that we owe the bat deference since we have little understanding of bat experiences. One of the difficulties with understanding respect as involving an empathetic projection that requires seeing the other's response as minimally rational is that the failure to see the other's response as rational could be mine as much as it is hers. When we cannot empathize with the other or understand the other's emotion as warranted by the situation this could equally point to my own limitations in the context of

the structures of my society rather than being a limitation of the other. Darwall's account of empathy does not take enough account of the differences between individuals and how oppressive societies might result in different emotional category configurations that make empathizing across differences difficult. Rationality and the exchange of reasons is certainly important within respectful relations but there is more that goes into understanding the reasons of another than a mere rational assessment of those reasons. We need also to consider the way the exchange of reasons is situated in an unequal social context that might affect the interpretation and acceptance of this reason.

5.4 CONCLUSION

In this chapter I have argued that relational accounts of respect should attend to social hierarchies and the ways in which moral agents are embedded in these unequal social relations because social hierarchies affect how we interpret, accept or reject reasons offered for actions, our judgements of the accountability of others and whether we believe their transgressions are amenable to forgiveness, the ease or difficulty with which we empathize with others and whether an empathetic projection into the perspective of the other might have negative effects on our own self-respect.

The discussion of Kantian respect in Chapter 4 focused on the normative elements of respect, which tells us something about the way people ought to be valued and how they ought to value themselves. My concern in this chapter has not been with how people ought to be valued, instead it has been to describe how relations of inequality can affect the ability to enact the normative claims made by Kantian theorists who (rightly) stress the normative importance of recognizing that each person has a dignity that gives them an absolute moral value beyond any price. Alan Wood (2008) argues that a more consistent

Kantianism would require greater distributive justice. In this chapter I have attempted to show how there are also non-material elements of the social structure that affect our standing as moral equals. Although normatively we are moral equals, descriptively we are not equally situated with respect to our moral agency, moral authority, moral accountability and the moral recognition we receive from others. My argument has been that if we behave as though the normative conditions of moral equality obtain, when descriptively they do not, then we risk exacerbating the inequality rather than ameliorating it. What is required is the conceptual labour involved with developing concepts to describe oppressive practices and their effects as well as sociological data about how these practices operate in particular societies.

The disconnection between normative claims of moral equality and descriptive claims of moral inequality is not idle. If we do not examine the gap between what is and what should be, we risk creating moral theories and moral advice that involve problematic idealizations. These idealizations are troubling because they serve to mystify relations of inequality and to make inexplicable the perpetuation of oppression in societies that explicitly proclaim the equality of all while implicitly tolerating (or sometimes even promoting) the inequality of some. Idealizations can perpetuate oppression by creating moral ideals that are not appropriate in particular contexts that differ in important ways from the idealized model of how things ought to be. There is a place for thinking about how things ought to be, but we must also think about how things are and how best to move from actual states to better states that more closely approximate the ideal. In many cases, acting or thinking about problems as though the situation were ideal will not help us obtain more just situations. My purpose in these last two chapters

has been to return in Chapter 4 to Kantian discussions of respect to better understand how he described the concept and, in this chapter, to describe some problems that arise when we attempt to apply this concept under conditions of structural inequality in order to better understand the requirements of respect in bioethics contexts given the social reality of structural inequalities. In Chapter 6 I argue that a concept of respect that would be useful for bioethics should incorporate the second-personal elements of Kantian respect for human dignity, but it should also attend to structural inequality and ways in which social contexts can create barriers to communication.

CHAPTER 6 **COMMUNICATIVE RESPECT IN HEALTH CARE**

In Chapter 4 I argued that the second-personal view of respect provides a more accurate interpretation of Kantian respect than the discussion of respect for autonomy found in the early bioethics literature that I surveyed in Chapter 2. The second-personal view can explain why research and clinical contexts might create risks of disrespecting research subjects and patients. In Chapter 5 I argued that the relational elements of the second-personal view of respect are important and we should retain these aspects in bioethics contexts but that the abstracted descriptions of moral relations omit a consideration of the problems that occur when we apply this view of respect in unequal social contexts such as those described by the bioethicists I surveyed in Chapter 3.

My argument in Chapter 5 highlighted the ways in which societies that are characterized by epistemic injustices and epistemologies of ignorance create unequal responsibilities and inequalities in our ability to negotiate responsibilities or ask for forgiveness. Individuals who grow up in societies that are characterized by structural inequalities have differences in their emotional configuration depending on their social group and these emotional configurations are significant for the ease and wisdom of empathetic engagements with others. I argued that it is important to consider moral agents as embedded in their social contexts, and the importance of this consideration will be especially significant for relational accounts of respect, such as the second-personal account of Kantian respect that understands respect to be a practical relation between persons. The purpose of my argument in Chapter 5 was to demonstrate that many non-rational aspects of our communicative engagements will have significant effects on whether we are able to achieve an understanding of the moral perspectives of others.

Consequences matter for applied ethics and so I am not satisfied with an account of respect that focuses narrowly on the attitudes adopted by moral agents when they attempt to respect one another. On a second-personal account of respect we are able to respect one another as moral equals so long as the logical relations we are required to adopt in taking-up a second-personal perspective force a presupposition of that equality. These presuppositions are necessary, but not sufficient requirements of an account of respect that is to be applied in non-ideal contexts. We must be concerned to determine not only which logical relations must be presupposed in order for our second-personal claims to be valid, we must also consider the implications in terms of the effects (or consequences) of adopting such a view in non-ideal social contexts. As I argued in Chapter 5, if we presume moral equality in contexts of pervasive structural inequalities, we paradoxically end up perpetuating inequality rather than achieving equal moral relations. In this chapter I consider the implications of these arguments for the view of respect and its role in contexts of biomedical ethics.

The main flaw in Darwall's second-personal account of respect is that he makes the exchange of reasons central to relations of respect, but then pays insufficient attention to what is required to understand reasons. Darwall treats the exchange of reasons as though all that is required to understand a reason is for it to be articulated by another. In Chapter 5 I argued that this is not the case. Understanding one another takes place in social contexts that do not always have equal expressive resources. Often in order to understand the reasons articulated by another we must also understand a good deal about how they are situated and what their experiences have been. This understanding is not easy and it is not automatic. Darwall focuses his discussion on "pure" cases in which

there is no non-rational influence. This focus is useful because it helps to clarify the logical relations among concepts. The view is also limited because it focuses on relations that exist only in the abstract. When actual people encounter the reasons of others they do so against a whole backdrop of non-rational influences and these have effects that determine the success or failure of understanding between the two individuals.

On my view respect is a particular kind of moral communication that requires a particular attitude toward and understanding of the other. The view of respect that I am proposing places an emphasis on achieving moral understanding, unlike the second-personal account. It is not enough for a reason to be articulated, it must also be understood. The second-personal account provided by Darwall (2006) abstracts away issues of understanding the reasons articulated by others. It presumes instead that if a rational reason is offered, all rational agents will be equally situated to understand this reason and will therefore accept it as valid. In Chapter 5 I argued that this is not the case. Instead, many features of the contexts in which we live inhibit our understanding of the reasons or experiences of others. In section 6.1 I argue that this changes the concept of respect significantly. On Darwall's view respect is a "stance" one takes toward others in articulating reasons (2006, 5). To enter intelligibly into this stance one needs to make certain logical presuppositions about the moral equality of others and the presupposition will hold (he says) even if none of the parties in the exchange see themselves as moral equals. I do not think this is sufficient. If the parties in the exchange do not see each other as moral equals this will likely block their understanding of the reasons provided by the other.

Second, Darwall treats the exchange of reasons as though reasons could be given and accepted in the same way that I give might give you a material thing. It passes from me to you and all you need to do is reach out and pick it up. But exchanging reasons is not like that. In order for an exchange of reasons to be successful one party must be able to articulate the reason, and the other party must be able to understand (or take up) that reason.[129] When societies are organized in oppressive ways that disadvantage some social groups (e.g. women, Blacks, the disabled) relative to others, these groups will have different experiences and there might be greater opportunity for misunderstanding between the groups. This is not a symmetrical form of disadvantage in understanding, however. Groups that are oppressed have to operate under the norms developed for dominant groups and they have an interest in understanding the experiences of those who are more powerful than they. This means that it is often easier for members of oppressed groups to understand the reasons and experiences of (and therefore respect) members of dominant groups than it is for dominant groups to understand the reasons and experiences (and therefore respect) members of oppressed groups. For dominant groups there might be more work required of them for the understanding to be successful. The view of respect that I am offering has advantages over the second-personal account because it takes better account of the actual social contexts of pervasive inequality in which we find ourselves. I describe the communicative view of respect and outline some of its requirements in section 6.1. The communicative view of respect also has advantages when it is applied in health care contexts.

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[129] I am indebted to Sue Campbell's discussion in *Interpreting the Personal* (1997) for the importance of this aspect of expressive exchanges.

In section 6.2 I argue that a communicative view of respect would offer a different kind of analysis of several cases in clinical medicine, research ethics and health policy formation. Although I attend to all three contexts, I focus my discussion particularly on the policy context because respect in health policy has received less attention to date. Powers and Faden (2006) recommend a concept of respect for use in public health contexts that does not isolate policy decision-making from the possibly pernicious influence of unequal social contexts. Instead, their concept of respect is used to focus attention on these social contexts and how they influence the health and well-being of members of different social groups. They suggest that they are using Darwall's version of recognition respect; however, in section 6.2.3 I argue that their discussion does not fit well with Darwall's view. Powers and Faden argue that because unequal social contexts undermine the respect of some groups, while exaggerating the respect accorded to other groups, there is reason to attempt to change these unequal elements of the social structure: we have an obligation to recognize the equal moral dignity of all people. However, as I argue in section 6.2.3, Powers and Faden's discussion of policy decision-making leaves intact the structures that give some groups greater control over setting the conditions of their own actions and the actions of others. This is exactly the definition of domination that Young (1990) uses and that Powers and Faden endorse. Paradoxically, although Powers and Faden argue that we should eliminate oppression and domination, the methods of forming policy that they recommend risk perpetuating oppression and domination. In the next chapter, I propose an empowering-participatory method of setting health policy that meets the requirements of communicative respect, and so can create

health policy that promotes respect (when it is understood according to the communicative view).

6.1 COMMUNICATIVE RESPECT

I think both Darwall (2006) and Kant (1995, 1996) get a lot right in their discussion of respect. First, they are right to identify the intrinsic value of persons (which Kant calls 'dignity'). Second, I think Darwall is right when he says that respect requires engagement with the other from a second-personal standpoint. But Darwall focuses too narrowly on the exchange of reasons, which neglects the relational aspects of moral agents. In Chapter 5 I described the numerous ways that structures of social inequality can affect whether we are able to understand the reasons offered by others. In this section I argue that an adequate account of respect should examine these issues. If we fail to attend to whether a reason is understood then we will not know whether the exchange of reasons is successful. Focusing respect on understanding one another requires that we also take the social context into account when we are attempting to respect one another. In contexts of structured social inequalities we will have to be more cautious and more humble when respecting individuals from oppressed social groups. On many accounts of respect, respect is considered to be an attitude adopted by one person toward another (Dillon 1992; 2007b). The view of respect that I provide sees respect as a successful communication between persons from a second-personal stance. This means that respect is a relation that occurs between persons, not an attitude that can be located entirely within one person. Adopting a respectful attitude will be a part of this view, since this attitude should facilitate communication and understanding, but respect is fundamentally

a relation between persons on my view. Because my view of respect focuses on successful communication, I call it a communicative view of respect.[130]

In Chapter 4 I argued that Kant is right to identify persons as intrinsically valuable. Unlike commodities persons are not fungible. The view of persons as intrinsically valuable is a strength of Kantian moral theory and I believe an account of respect should continue to recognize this value. Kantians can allow some room for debating who should count as a person, and although all those with fully-developed reason must count as persons, the autonomous members of the moral community can engage in discussions with one another to determine to whom personhood should extend (Wood 2008). This view of personhood (and hence of those who have intrinsic value that Kant calls dignity), fits within a feminist paradigm of relational selves. Feminists have stressed the relational nature of persons over their rational nature (as I described in Chapter 3 and 4). I believe both aspects of our nature are important for our moral agency. Kant has provided an argument for why rational nature must respect rational nature: otherwise it would conflict with the value it must accord itself, he says. Feminists have provided arguments about the importance of our relational natures; without the

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[130] My communicative view of respect has many points of commonality with feminist discussions of relational ethics, particularly with discussions of relational autonomy (as I described in Chapter 3, and develop further in section 6.2). I decided not to call it a 'relational view of respect' because even common forms of respect (for example Darwall's early (1977) interpretation of Kantian respect) are relational in the sense that person *A* respects person *B* for (or as a result of) trait or feature *C*. In discussions of relational autonomy or relational integrity the term 'relational' is informative because it distinguishes these views from self-regarding, self-directed, self-protective, or atomistic versions of a concept with the same name (e.g. individual autonomy). I do not believe that 'relational' is informative for distinguishing the kind of respect I want to describe from other forms of respect. Further, I believe that using the term 'communicative' helps to illuminate the points of commonality my discussion has with Iris Marion Young's communicative ethics; I develop and explain this commonality in section 6.2.3.

relationships we have to one another we would not develop reason and we would not become moral agents. Further, without the relationships we have to one another there would be no moral community or moral activity. I think there is room to consider both aspects of persons as essential to our moral agency and membership in the moral community. We need not select only one of these aspects and elect it to be the most important or most fundamental aspect of our natures, or declare it to be the only aspect with which morality should be concerned. There is room for a plurality of aspects of the self, each of which is important to consider when deliberating morally.

Darwall (2006) neglects the importance of relationships and the relational aspects of the self. I have argued (in Chapters 3 and 5) that the feminist addition of relationships to the domain of moral concern is important. Darwall's view of respect also neglects the importance of the ways in which social relations can undermine our ability to understand the reasons of others. The communicative view of respect that I provide in this section recognizes both our rational and our relational nature. The exchange of reasons, deliberation and dialogue is important for moral discourse. But, as I argued in Chapter 5, if all we attend to is the exchange of reasons, and we treat the exchange as something that occurs in isolation from the social context, then we risk taking too simplistic a view on what is involved in understanding these reasons.

When Darwall describes 'the exchange of reasons' he provides only an account of an abstraction, and this abstraction does not reflect the actual practices of communication among persons. Actual situations of communication that occur among moral agents occur in a social context. This context will often affect whether something is recognized as a reason or fails to be recognized as a reason. Sometimes we need to check with one

another to ensure that we have correctly understood what the other has attempted to articulate through their reasons. It is quite easy to be mistaken when we believe that we have understood a reason, and as I argued in Chapter 5 social contexts of inequality increase the chances that we will misunderstand marginalized groups. The success of the relation requires not a mere articulation of reasons, but also an understanding among the participants. There are a number of ways that this understanding can be blocked, including the social power that exists between different groups. So a communicative view of respect will require moral agents to try to ensure their understanding of the other. The requirement to check one's understanding will be higher when one is attempting to respect an individual from a social group that differs from one's own since misunderstandings will be more likely when communicating across social group differences or when there are fewer shared experiences. The obligation to check one's understanding will increase still further if one is attempting to respect someone from a marginalized group one does not belong to because a structural form of misunderstanding might be operating to undermine the ease with which one can understand the member of a marginalized group.

As I argued in Chapter 5, Kant was right to argue for the normative requirements to give equal respect to each person. Kant is right that one's place in the social hierarchy does not affect the respect one is owed. If we discover that our social situation is such that social inequalities are causing greater difficulty to understanding the views of some groups, or difficulty for these groups to express their perspectives, then we cannot be satisfied with this situation. In Chapter 5 I argued that moral communities involve shared norms and understandings, expressive resources for describing (or failing to describe)

moral experiences and harms, and shared responsibilities. When the expressive resources within a society are inadequate as the result of oppressive social structures then the requirement that we respect persons equally will give us reason to work to eliminate these oppressive forces. In section 6.2 I describe some more practical ways that we can address forces of oppression and domination that cause misunderstandings in health care contexts.

Communicative respect focuses on understanding reasons rather than conceiving of the exchange of reasons in an abstract and decontextualized way that assumes any 'rational' reason is immediately available to all rational agents. One advantage of focusing on the understanding between the interlocutors is that we can provide a better description of respect for non-rational persons. Although the articulation of reasons is one important way in which we come to understand one another, it is not the only way. We can gain some degree of understanding (though not perfect understanding) through the emotional expressions of others, from their body language, and other means of expression. When parents give care to their pre-linguistic children they often rely on these kinds of cues to determine what the child needs. When Hilde Lindemann (2002) describes her relationship to her disabled sister, she describes the way the family constructed narratives that developed an identity for Carla based on their interpretations of her reactions. Although we won't achieve a complete or perfect understanding through these means, we might be able to achieve a partial understanding if we attend carefully in this way. On accounts that take an abstract consideration of the exchange of reasons as central to respect, it is difficult to understand how we could respect persons who do not have a rational nature either because it is not yet developed (e.g. infants and children),

because it will never develop (people with serious cognitive developmental delays), or because it was lost (elderly persons with dementia or Alzheimer's disease). On a communicative view we can respect these individuals so long as we attempt to understand them in our relationships to them. Of course, when we are attempting to respect those who cannot communicate with us through the exchange of reasons we will also have to be careful because the restricted mode of communicating will also increase the chance of misunderstanding what the other is expressing.

6.2 COMMUNICATIVE RESPECT IN BIOETHICS

My argument to this point has been that the second-personal interpretation of Kantian respect should be preferred over interpretations that only require respect for particular decisions (which is called 'respect for autonomy' in bioethics). I have also argued that when an idealized form of second-personal respect is put into practice in unequal societies, the consequences are likely to involve the perpetuation of social inequality because these contexts of injustice are often epistemically ill-equipped to deal with the experiences and reasons of oppressed persons. I argued that we should situate the interlocutors in their social contexts, attend to the dynamics of power between them and the epistemic lacunae present in their particular social milieu. In sum, we should consider elements of the communicative relation beyond the reasons that are articulated. We should be interested not only in the articulation of second-personal reasons and the interrelated second-personal attitudes, but also in the process required in coming to understand these reasons when they are articulated in unjust social contexts. In this section I describe how the communicative view of respect I advocate would be applied in medical contexts including clinical encounters, medical research, and health policy.

6.2.1 Communicative Respect in the Clinic

The communicative view of respect that I have proposed would require thinking about respect for persons differently in the context of clinical encounters. On the canonical view described by Beauchamp and Childress (2009) a health care provider would succeed in respecting her patients if she obtains their fully informed consent for each procedure that she performs. To see why this is an inadequate view, and to understand the difference that a communicative view would make I draw on an example from my own experience.

When my friend Tara and I were in our early twenties, Tara developed choriocarcinoma (placental cancer) after the birth of her first child.[131] Her condition went undiagnosed for nine months, though it should have been caught sooner. After her daughter was born Tara experienced a lot of bleeding. She brought her concerns to her doctor and explained that she was experiencing pain in her uterus, bleeding heavily and had been bleeding nearly constantly since the birth. The doctor was dismissive of her concerns and he told her that it was normal to experience bleeding after birth. Tara was sent home; although she was not reassured, she did not push the issue with her doctor.

When her daughter was about six months old Tara threw a party for her stepson's fifth birthday. During this party Tara began to have uncontrolled bleeding that soaked through numerous bath towels. She and her husband, TJ, decided to go to the hospital and left me and my partner, Joel, in charge of the rest of the party. At the hospital, Tara was

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[131] We wrote about this experience in Johnson and Schwartz (2007, 12-15; 162; 175-177). This example is drawn from that work, though some details have been changed from the actual course of events we described there. For example, the doctor in question was a woman but I have changed the pronoun to 'he' for the purposes of greater clarity. I have asked Tara's permission and the permission of her husband, TJ, to reproduce an account of these events in this dissertation. They gave permission and preferred that I use their real names rather than inventing names to conceal their identities.

told that she had experienced a miscarriage. Tara informed her doctor that she could not

possibly have been pregnant because she had not had sex since the birth of her daughter

due to the intensity of the bleeding and pain that she had been experiencing. Again the

doctor was dismissive; he suggested that perhaps Tara had become pregnant through

ejaculate near the opening to her vagina. Both Tara and her husband seemed offended by

this suggestion; when they returned home late that evening after the party had ended TJ

made some sarcastic comments to Joel and me about his super-human virility and his

ability to impregnate his wife without ever touching her. They stressed to us that when

they had said "no sexual contact" they meant it, as Tara had not been "in the mood" since

the baby was born. Neither Tara nor TJ had pushed the issue with the doctor, however.

Three months later Tara was hospitalized for uncontrollable blood loss and her

doctor had to perform an emergency hysterectomy. The doctor sought Tara's consent for

the hysterectomy. She was experiencing shock and was at the edge of unconsciousness

because she had lost over four liters of blood. Her doctor was not sure that she was in a

condition to fully understand the risks of the procedure, so he asked her permission to call

TJ and seek his more fully informed consent. TJ was terrified by her condition and he

was worried that he would not see his wife alive again. He agreed to the treatment the

doctor suggested. Soon after the surgery Tara received the diagnosis of stage-IV

choriocarcinoma. As Tara recovered in the hospital the doctor began to blame a number

of others for the late diagnosis, including Tara and her husband for their failure to inform

the doctor of Tara's pain and bleeding. Again Tara and her husband were offended by the

suggestion that they had not adequately informed the doctor about Tara's symptoms, only

this time they were also angry about the missed opportunities for diagnosing the cancer at one of the earlier visits.

Intuitively, this seems like a case in which the doctor did not respect Tara as his patient. His failure to take her symptoms seriously resulted in delayed diagnosis and treatment. The delay gave the cancer time to metastasize and spread to her lungs and brain, which made the required chemotherapy more complex. Further, Tara felt like she had not been respected. She felt like her experiences and her description of her symptoms had been "shrugged off" by the doctor (Johnson and Schwartz 2007, 13). She did not believe he had taken her seriously when he diagnosed her as having miscarried even with her report of the absence of sexual activity. The doctor did not listen and Tara felt like he was constantly "talking down" to her and treating her "like a child" (Johnson and Schwartz 2007, 75). "Feeling" disrespected is not proof of having been disrespected. It does, however, provide reasons for us to investigate further.

Beauchamp and Childress' account of respect for autonomy cannot capture the disrespect in this case. The doctor did seek Tara's consent for every procedure he performed. When he suspected she was unable to understand the information he was providing about the possible hysterectomy, he sought her permission to seek consent from TJ as a surrogate decision-maker. Furthermore, the doctor is not guilty of malpractice because he met the standards of practice required of physicians. Choriocarcinoma is extremely rare[132] and it is not common practice to screen for this cancer when women give birth. Furthermore, because of her young age a cancer

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[132] Choriocarcinoma occurs in only 1 in every 20,000 to 40,000 pregnancies (Johnson and Schwartz 2007, 35). Tara's doctor had never had a patient with this cancer before Tara's diagnosis.

diagnosis might not immediately occur to the doctor. Finally, even the diagnosis of miscarriage has a medical logic to it: because choriocarcinoma is a cancer that is made up of placental cells it produces human chorionic gonadotropin (hCG), which is the hormone that normally indicates pregnancy. The hCG hormone is detected by a pregnancy test, and Tara's hCG levels were elevated as a result of having choriocarcinoma. All of the measurable signs (short of biopsy) would indicate a pregnancy that ended in miscarriage. There was only one indication that Tara was not experiencing pregnancy: her subjective report that there was no sexual contact due to her experience of pain and bleeding.

The second-personal view of respect does a better (though still imperfect) job of capturing why the series of encounters between Tara and her doctor was disrespectful. Although the doctor sought her consent for the procedures, he did not really engage with her from a second-personal perspective. He did not listen to her reasons when she provided them, nor did he take these reasons seriously. During the early visits at the doctor's clinic, when Tara reported what she thought was an abnormal amount of pain and bleeding, the doctor did not accept her testimony of her experience as reason to investigate further. When Tara and TJ told the doctor why they did not believe she had been pregnant and was experiencing a miscarriage (the crucial information about lack of sexual contact) the doctor should have listened more carefully to this information. The second-personal view provides a framework for analysing the disrespect that occurred. In this case we might want to say that the doctor did not give adequate weight to the testimony of his patients.

But it is not entirely clear what the second-personal view of respect would say about this case. In the example, questions about the diagnosis and the reasons Tara and

TJ provided for disbelieving the diagnosis are not moral questions or moral reasons; they are medical questions and medical reasons. The doctor does indeed have more epistemic authority on medical matters than do Tara and TJ. In fact, it was the doctor's medical authority (combined with his dismissive demeanor) that discouraged Tara and TJ from pressing the matter further. The doctor's medical explanation was reasonable. Although it is unlikely that someone will become pregnant without engaging in sexual intercourse, it is theoretically possible that ejaculate near one's vagina could cause pregnancy. Furthermore, tests indicated that Tara had elevated levels of hCG in her blood and urine, which would indicate pregnancy, so the doctor could make an argument that it was reasonable to discount their testimony in this case. Perhaps the doctor thought it would be more medically sound to base his judgement on the objective information provided by the hCG test than it would be to base his judgement on the subjective experience (and perhaps faulty memories) of his patients. Furthermore, he was not using Tara as a mere means to an end in this case. When he did want to operate on Tara, he sought informed consent so that Tara (or her representative in TJ as the surrogate decision-maker) could share these ends as her own.

Tara and TJ were offended by and angry about the treatment they experienced from the doctor, but they did not express this anger to the doctor in an attempt to hold him accountable. Instead, they kept their mouths shut until they returned home after the party at the end of the night. They only vented their frustrations to Joel and me. Perhaps the second-personal view would hold them accountable because they failed to respect themselves enough to keep insisting until the doctor listened. The approach taken by the second-personal view of respect does a better job of capturing some of what when wrong

in this case, but it would apportion more blame to Tara and TJ for failing to press the issue with their doctor than it would to the doctor's failure to listen, since his failure to listen could be justified as a reasonable response given his medical knowledge and the test results. Further, since this is not a case of exchanging moral reasons, it is not clear whether the second-personal account of respect would offer much advice about how to engage with one another in this instance.

I am not satisfied by the analysis suggested by the second-personal view of respect. As I described in Chapter 5, when people engage with one another in real-world contexts they engage in ways that involve a number of non-rational elements. The communicative view of respect would encourage us to look at this exchange in the social context in which it occurred, including relations of differential power, differences in the availability of reasons to explain one's situation (epistemic lacunae). We would be directed to examine the structural inequalities that affect authority, accountability, recognition, and empathy in ways that often do not involve explicit reasons but instead involve aspects of the interaction that form the background of the communicative engagement. In section 6.1 I argued that communicative respect asks us to adopt a respectful attitude toward one another, but it also asks us to situate ourselves with an understanding of the structural relations in our particular social context. Communicative respect analyses respectful relations not only according to the attitude adopted by each of the interlocutors, but also according to whether the communicative exchange was successful in creating an understanding among the interlocutors. When the understanding fails to obtain, communicative respect asks us to seek the reasons for this failure not only in the individual interlocutors, but also in the contextual features of the relation.

The exchanges that took place between Tara, TJ and the doctor involved many differences in power and knowledge that contributed to the lack of communication that occurred. For example, although Tara and TJ did not press their claim that they had not engaged in sexual intercourse with the doctor, his position as a medical authority with a great deal of social power and epistemic privilege combined with his individual dismissive demeanor to contribute to their reticence. Tara and TJ do not have shy characters and they are not ashamed to discuss their sex lives. Indeed, both Tara and TJ had openly discussed their distress at Tara's pain and bleeding and the effects this was having on their sex life with Joel and me. They offered this information openly to the doctor, and only became reluctant to press the point when they got the sense they were being treated dismissively.

It is not clear that their reluctance to press the point stems from a lack of self-respect in this case (as the second-personal analysis might suggest). It might instead indicate a sense of indignation that presupposes well-developed self-respect. Although the doctor did have some medical reasons for believing that Tara had been pregnant and was experiencing a miscarriage (the elevated levels of hCG), the testimony Tara and TJ were clearly providing contradicted this conclusion. Since elevated hCG is a sign that placental cells are present and these cells can be present for reasons other than pregnancy, the doctor should perhaps have investigated further. Tara had indeed provided a great deal of testimonial evidence that something was not right with her post-birth recovery. She had complained of pain and bleeding at a number of visits prior to the miscarriage diagnosis. Her account of the pain and bleeding corroborated the reasons she provided for the lack of sexual activity. Had the doctor taken her testimony seriously he might have

considered other possible diagnoses or elicited further information. At the very least, he should not have behaved in a way that made his patients reluctant to share information with him or to continue to explain the reasons they doubted his diagnosis.

Both Tara and I suspected the doctor's dismissive and condescending demeanor might be betraying that he held prejudiced views about teen mothers and their lack of understanding of how pregnancy occurs. Obviously one cannot know what is in the mind of another. But the doctor's dismissal of both Tara and TJ's reports of lack of sexual activity is cause for concern. It was as though he could not even hear their testimony about the lack of sexual contact. Our intuitive sense of the situation was that the doctor's dismissive attitude resulted from his assumption that Tara was a teenaged mother, although we do not have proof of his beliefs. We thought the doctor might believe Tara was a teenage mother because he had met TJ's son (Tara's stepson) who was five years old at the time. If the doctor assumed Tara had given birth to her stepson, that would have made her a teenager at the time of his birth. Prejudices about the educational levels of teenage mothers and their poor understanding of contraception, conception and pregnancy are widespread in the Canadian context. If the doctor was being influenced by biased assumptions he was making about teenaged mothers, a communicative view of respect would hold him accountable for his failure to examine these prejudices and attempt to counter them in his relational engagement.

Tara had told the doctor that this was her first pregnancy, but he did not seem to retain any information Tara provided. For example, after he performed her hysterectomy he later asked her whether she was regularly taking the birth control pill. When Tara said she was not, he gave her a lecture about the importance of avoiding pregnancy during

chemotherapy for choriocarcinoma, since they measure hCG levels to monitor the success of the treatment. He explained that hCG rises during pregnancy and this makes it impossible to tell whether the tumor is shrinking. Tara informed him about the hysterectomy he had performed and she was upset that something so significant in her life had not even registered for him. (He did not apologize for his memory lapse.) The doctor seemed to consistently dismiss or discount the information that Tara was giving him through testimony about her experience. If this dismissal or discounting of Tara's testimony turned out to be a systematic experience for women who are presumed to be teenage mothers, then a communicative view of respect would ask us to consider the elements of the social context and structural relations that contribute to these problems of communication. In this case it would not be a sufficient response to merely correct the doctor's mistaken beliefs about Tara's status as a teenage mother (holding the doctor's prejudices intact); we would also have to look at the sources of these prejudices in the social context.

We would have to ask whether there are epistemic lacunae so that a depressing number of people lack awareness or understanding of the experiences of teenaged mothers. We would ask whether hegemonic discourses about teen motherhood and the explanations of teen motherhood offered by these discourses contributed to their experiences of being dismissed or misunderstood. If it turned out that such effects were occurring then we would all, as a social community, bear some responsibility for changing these discourses or offering new explanations. This responsibility would not belong to Tara and the doctor alone; responsibilities for social changes are shared among the members of that community (Young 2006). Differently situated agents might bear

different kinds of responsibilities for changing the problematic discourses. If the doctor did indeed harbour implicit or explicit biases about teenaged mothers, then he would have an obligation to act with moral humility and refrain from speaking as an authority about the experiences of teenage mothers. The hospital could perhaps support these discussions by providing space or other resources for teen mothers to meet one another. The communicative view of respect suggests a different analysis of this clinical case than either the view of respect as accepting the decisions of a patient or the view of respect as second-personal. The communicative view can better illuminate problems in clinical medicine that involve implicit biases which might be affecting the interaction between doctors and their patients.

A second clinical issue that can be addressed by using a communicative view of respect involves the working conditions for health care professionals. In many cases health policies require health professionals to respect their patients, but they do not pay much attention to what the professional needs in order to respect the patients they serve. For example, in Chapter 1 I described Jennifer Parks' (2003) complaint that in her homecare practice, her employer demanded maximum efficiency from all the homecare nurses. Administrators calculated the time required to perform a variety of tasks (e.g. feeding, bathing, dressing, etc.) and then allotted a certain amount of time per patient based on the patient's needs on that particular day.

According to Parks these constraints prevented her from "making meaning" with her patients, lowered the sources of joy in the nurses' jobs, and contributed to caregiver burnout. We could also provide an analysis of this situation in terms of respect. On Beauchamp and Childress' view, Parks would succeed in respecting her patients if she

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received their consent before performing procedures. On Parks' account she did ask for consent when it was required and she even went beyond the requirements, for example, by asking permission before she entered 'special' rooms of the house such as the bathroom or bedroom. Nevertheless, she was uncomfortable with the mechanical way in which she had to interact with her patients if she was to succeed in meeting the demands for efficiency imposed by her employer.

The second-personal account of respect provides a better analysis of the situation. Remember from Chapter 4, Strawson characterizes respect as adopting an 'interactive' perspective, which he contrasts with the 'objective' perspective we take when we treat others as objects of social policy or subjects for treatment and management. Darwall's second-personal respect provides a fuller explanation of the difference between these two perspectives. One way to understand Parks' complaint is to say that the demands of her job put pressure on her to treat her clients "like bodies" on which a series of procedures must be performed. This does not allow her to engage interactively with them. A second-personal view of respect might say that to the extent she fails to engage with her homecare patients from the interactive perspective, she has failed to respect them. The second-personal account would suggest that Parks should resist the temptation to treat her clients as a mere means to a paycheque, or bodies upon which to perform procedures, and instead engage them second-personally. The second-personal analysis is useful and its recommendations are indeed ones Parks adopted. Parks reports that she handled her conflicting obligations by working overtime without pay, sometimes returning to a patient's house after her shift was over. Parks took the time required to treat her patients as persons with their own subjectivity, experiences and perspectives. Parks treated them

as persons because she did not "do things" to her patients, but instead shared the activity with them in ways that recognized they were participating in the activity as well.[133] But there also seems to be something unfair about that suggestion. On this view Parks is morally required to sacrifice personal (unpaid) time to meet the demands of her job and the demands of respecting her patients. This seems troubling, especially considering the inadequate compensation provided to many home care aids and home care nurses.

A communicative view of respect would provide a similar analysis to the one provided by the second-personal view, but it would take the working context into account and distribute the responsibilities more widely. The homecare agency (her employers) would also have obligations to respect its clients and its employees. Although the homecare agency should consider issues of efficiency in order to avoid wasting valuable resources, a communicative view would also require the employer to consider issues of respect when designing the job requirements for homecare nurses. The homecare administrators might not be in the best position to understand the relations of respect in these interactions, however. The demands on administrators encourage taking an objective or third-personal view of homecare delivery. The administrators are not directly involved in the interpersonal exchanges between homecare nurses and patients. The administrators are in many ways in the position of a third-person observing these exchanges,[134] although they are not disinterested and they are indirectly involved in the interactions between nurses and patients because they set the requirements under which

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[133] Here I am borrowing on Langton's (1992) way of explaining Kantian respect, which I described in more detail in section 4.2.

[134] I am using "observing these exchanges" in a metaphorical sense. In many cases administrators will not witness the caregiving done by nurses at all. Instead, they will receive data about this caregiving (e.g. how long it takes, what is successful, etc.) and they observe the data.

the nurses must act. For these reasons, the reflections of the administrators would likely be inadequate if they did not seek to consult with the nurses and patients. These are issues of respect in health policy, and I leave a more detailed discussion of these issues until section 6.2.3.

The analysis of respect in clinical contexts provided by a communicative view would still require informed consent because one part of recognizing the inherent dignity of persons involves asking their permission before doing something with them. If we were to fail to seek permission then we would be treating the person as an object rather than taking up an interactive stance toward them. Informed consent would remain an important and necessary requirement for respecting patients, but obtaining informed consent would not be sufficient for respecting patients. The second-personal view of respect would require homecare providers and their patients to take up a second-personal relation to one another. Unlike informed consent, which occurs at discrete moments in the relationship between the health care provider and the patient, the demands of second-personal respect spread over the entire encounter. The second-personal account would require nurses to participate in activities with their clients in ways that recognize and acknowledge that the patient is also participating in this activity. The communicative view of respect would also require mutual participation from nurses and patients, but it would situate this participation within a broader social context. The communicative view of respect would bring the home care agency into the analysis and would require all participants to engage in improving the structural conditions under which they live.

The requirements of a communicative view of respect are broader than merely obtaining informed consent. In this section I have used two specific examples to help

pick out these requirements, but I expect that adopting such a view of respect would help

solve a broader set of problems in medicine. For example, one of the complaints from the

women's health movement (that I left out of the description in Chapter 2) was that the

medical system is unresponsive to women's needs and the needs of other marginalized

groups. These problems continue and are not well dealt with through obtaining informed

consent. For example, gendered, racial and ethnic variations in prescription practices,

diagnostic referrals and medical knowledge are widespread and well-documented (e.g.

Jackson 2003; Anand et. al. 2005; Redberg 2005; Spertus et al. 2005; Rees and Chavkin

2006; WHO 2007a, 42-51). Women often face under-treatment for conditions such as

pain (Jackson 2003) and heart disease (Anand et. al. 2005; Redberg 2005). African

American patients are less likely to be referred for diagnostic tests for cardiac problems

and have worse outcomes after cardiac care (Spertus et al 2005). It is an empirical

question whether using a communicative view of respect would be successful in

addressing these issues. But to the extent that the communicative view requires

physicians to reflect on their implicit biases and on how implicit biases might affect their

ability to "hear" the reasons of others, this view of respect directs attention at these kinds

of disparities. When we have evidence that such disparities exist, a communicative view

of respect would require us to explore whether the kinds of difficulties in understanding

Tara's reasons that I described above might be operating in the physician's decision-

making and recommendation process in ways that contribute to these treatment

disparities.

A further issue that might contribute to the problems listed above involves not

treatment recommendations, but inadequate knowledge of treatment effects and

outcomes. As Rebecca Dresser argued, because women have historically been excluded from research protocols and currently still face barriers to participation in research, disease processes in women are understood less well than they are in men (Dresser 1992). This kind of lack of knowledge can be addressed by applying a communicative view of respect in contexts of medical research, as I describe in the next section.

6.2.2 Communicative Respect and Medical Research

In Chapter 4 I described some of the ways in which a second-personal view of respect would continue to require informed consent from research subjects. I argued that the second-personal view of respect is useful because it can explain why researchers might be at a heightened risk of disrespecting research subjects. A communicative view of respect demands more of researchers, however. Happily, we can find a model of some of these demands in the revised version of the *Tri-Council Policy*. The *Tri-Council Policy* provides an implicit appeal to a view of respect that is close to what I am describing as communicative respect but it does not make explicit the nature of their concept of respect. The communicative view of respect provides a justification for some of the requirements of the *Tri-Council Policy*, such as the requirement to consult with the communities one is researching. On the communicative view of respect we need to attend to what is known, what is unknown, and which groups are involved in creating knowledge and whether the knowledge they create reflects or ignores the experiences and epistemic practices of marginalized groups within their societies: When some groups are prevented from contributing to what is generally understood within their social contexts, this is likely to increase miscommunication between individuals. In Chapter 3 I described the importance that the *Tri-Council Policy* gives to research with First Nations groups.

The *Tri-Council* Policy authors assert that researchers have obligations to respect First

Nations communities (not just individuals), but they are rather vague about what that that

respect entails. The authors of the *Tri-Council Policy* are concerned about how

colonization combined with racist views about First Nations groups to create stereotyped

understandings of First Nations populations and ways of living that need correction in

future research.

A second-personal view of respect would not pick out these recommendations as

a requirement of respect for persons. On the second-personal view of respect, so long as

researchers respect the individual research subjects by treating them as ends in

themselves and engaging with them from the second-personal perspective, they will have

fulfilled their duties. It might be able to explain why the researchers should listen to the

reasons articulated by their research subjects, but it seems to have little to say about

recommendations aimed at communities of persons. The communicative view that I am

offering can explain how respect, and, in particular, this understanding of respect,

underlies some of the requirements of the *Tri-Council Policy*. The communicative view

of respect is interested not just in the articulation of reasons by the researchers and the

research subjects, but also in whether the exchanges between researcher and research

subjects result in understanding.

In Chapter 5 I described a number of ways in which inadequate social contexts

with epistemologies that are impoverished as the result of racism, sexism, classism, and

other structural forms of inequality can prevent one person from understanding another.

The *Tri-Council Policy*'s authors are correct when they identify Canadian contexts as

ones that make it difficult for non-First Nations[135] researchers to accurately understand

First Nations communities. In Canada, First Nations communities find themselves in the

position of having their understandings and experiences dismissed, ignored, misdescribed

and misrepresented by non-First Nations researchers who have not grown up learning

First Nation ways. This means researchers in this case are in a position in which the risk

that they will not understand is high. The *Tri-Council Policy* (2010) is right to

recommend caution here. This is precisely the kind of context that requires the humility I

described in section 5.3, only in this case it is epistemic humility as well as moral

humility that is required.

Although the *Tri-Council Policy* (2010) is quite clear that researchers must

consult with First Nations communities when they conduct research, the authors are

largely silent on the importance of a similar sort of respect when dealing with other

oppressed and marginalized communities. The second edition of the *Tri-Council Policy*

mentions in passing that researchers are required to engage "during the design process

with groups whose welfare may be affected by the research" to help "clarify the potential

impact of the research and indicate where any negative impact on welfare can be

minimized" (2010, 10). But, just as they do not explain how they understand 'respect' or

'dignity' in much detail, they also do not explain this requirement in detail except when

discussing First Nations groups. This positioning might make it seem like only First

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[135] By non-First Nations researchers I mean researchers who have grown up outside of First Nations communities. There are also many researchers who come from First Nations communities and might not experience these difficulties in understanding the non-First Nations communities they are researching. This is because the relationship of being an outsider is not symmetrical: First Nations researchers would not necessarily experience the same difficulties in understanding the communities of non-First Nations Canadians if they were to undertake research among these groups. This is because non-First Nations epistemologies are widely taught in schools.

Nations groups have been misrepresented or misunderstood by non-First Nations

Canadian researchers, but this is not so. The views and experiences of a number of

groups have been marginalized or misrepresented.

In Chapter 2 I described some of the complaints of the women's self-help health

movement. The women's health movement complained of further disrespect that I left

out of that chapter, however. For example, some of the women in these movements

described the views of women's bodies adopted by medicine as "stereotyped;" viewed

women's physiological processes as "less worthy" then men's; or adopted a

"disrespectful" view of women (e.g. Martin 1987; Martin 1991; Tavris 1992).[136] I left

these complaints out of the description in Chapter 2 because the account of respect I had

described to that time could not pick out these biased views of women's bodies and

physiological processes *as* disrespectful. In contrast, the communicative view of respect

can. On an account that understands respect as "respect for autonomy" the view of

women's bodies could not be interpreted as disrespectful because the autonomy (in the

bioethics sense of decision-making) of the women in the medical trials was not being

violated.

A second-personal view of respect would do a better job of describing this

problem, but it, too, would be unable to account for these complaints in a satisfactory

way. Whether the second-personal view would worry about these complaints from the

women's health movement would depend on whether the complaints were interpreted as

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[136] I believe that most of the papers in *The Politics of Women's Health: Exploring Agency
and Autonomy* by The Feminist Health Care Ethics Research Network with Susan
Sherwin as Coordinator could also be interpreted as offering an argument about the
biased and disrespectful account of women's bodies and physiological processes adopted
by medical researchers and physicians.

offering reasons to the researchers. The reasons offered to the researchers describe the view of women's bodies as biased and unreflective of women's own views of their bodies. The reasons call for the researchers to change their views about women's bodies so that the researchers' views better reflect women's own understandings. On the second-personal view the researcher would have to accept these reasons as providing a reason for him. But it is not clear what would then be required. The researcher would not be required to *actually* adopt these views of women's bodies offered by the women's health movement, because the researcher might believe that his own view of women's bodies is more accurate, more scientific, more objective, or the result of a more complete understanding of biology and physiology. He might decide, for example, that it was the women who were offering a biased or mistaken view. In fact, given the social context in which women's knowledge of their own bodies had been discounted the researcher might be *more likely* to make that determination. We are in a Catch-22 and the second-personal account of respect does not provide a way out because it does not require the researcher to examine the social context or other non-rational elements (such as biases, prejudices, etc.) that might be affecting his interpretations or understanding of the women's complaints. The second-personal account treats rational reasons as if they would be immediately available to the understanding of any rational agent. As I argued in Chapter 5, however, this is not an adequate description of how individuals understand (or fail to understand) one another's reasons. Social contexts of oppression can create difficulties in understanding the experiences or reasons offered by marginalized groups.

The communicative view of respect does a better job of explaining why medical research is disrespectful when it adopts a view of women's bodies that does not reflect

women's own understandings. This kind of research is disrespectful because it contributes to social contexts in which understanding women's descriptions of their experiences as reasons becomes more difficult (as I demonstrated above in describing the Catch-22 in the attempted communication between researchers and the women's health movement). The communicative view of respect would require researchers to reflect on the structures of oppression within their social context before deciding whether to accept or reject the interpretations from the women's health movement. This view of respect would not require researchers to automatically accept whatever views are offered by the members of the communities undergoing research; after all, many of the members from these communities might have internalized oppressive views about their own group. Instead, what is required is that when groups raise issues about the kinds of descriptions researchers have developed and these groups claim that these understandings are obscuring their own perspectives and experiences then researchers need to take these claims seriously. This requirement will be especially strong when the individuals whom researchers are studying come from groups that have historically been excluded from the production of knowledge either generally or in the researcher's discipline.

The *Tri-Council Policy*'s (2010) recommendations that researchers communicate with representatives from the groups who are being researched can now be understood as a requirement of respect on the communicative view, and it can be understood as a requirement that extends beyond the case of research with First Nations communities. The communicative view of respect that I am describing would not minimize the importance of consulting with First Nations communities. This would remain a vital requirement, given the racist Canadian context. The communicative view would,

however, help extend this consultative requirement to other marginalized groups and the view would explain why the requirement is important in oppressive social contexts.[137]

As I have argued in this section, the communicative view of respect can be used to justify the *Tri-Council Policy*'s (2010) requirement to consult with the communities one is researching. On the communicative view of respect we need to attend to what is known, what is unknown, and which groups are involved in creating knowledge and whether the knowledge they create reflects or ignores the experiences of marginalized groups within their societies. We need to attend to these things because when knowledge is created in ways that misunderstand or misrepresent the experiences or beliefs of some groups then this will make understanding their reasons more difficult. It will make communicating with one another harder. Consulting with the communities one is researching in situations where cultural or other differences are likely to increase misunderstanding is important because in these cases whether one has understood is more difficult to determine. It is important for the researcher to check back with the community to ask whether the interpretation is accurate as a way of determining whether one has understood what has been articulated. Researchers will have a responsibility to ensure that their research does not further or contribute to misunderstandings of marginalized communities.

One fortuitous advantage of using the requirements of research with Aboriginal populations as a model for research with other oppressed populations is that this could

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[137] Of course, we must also bear in mind that this requirement would not be restricted to complaints from the women's health movements. Some of the complaints from the disability rights movement that I described in Chapter 5 also fit this analysis. For example, see Jackie Leach Scully (2008). I have written about how including members of the disability rights movement in medical research might have an added benefit of increasing trust in medical systems in Schwartz (2007).

recognize the important and broadly applicable contributions made by First Nations

persons who developed the *Tri-Council Policy* in ways that can help undo systemic

oppression. Second, a broad application of the suggestions from the *Tri-Council Policy*

could help prevent a 'chilling' effect that these protections could have so as to result in a

view that Aboriginal research is particularly onerous, and so perhaps, not worth the

'extra' effort. It could help prevent this 'chilling' effect in two ways. First, our obligation

to respect the moral equality of persons is a strong obligation. This obligation is

described by Kant as a perfect duty, and requirements to respect human dignity are found

in most human rights codes (e.g. United Nations 1948). I have argued that a

communicative view of respect requires that we have an obligation to allow marginalized

groups to participate in research in order to improve our understanding of these groups.

Second, if the obligation to consult with communities extends beyond First Nations

groups to include other groups that have been marginalized within particular social

contexts then this requirement will not seem like a "special" requirement that only

applies to First Nations Groups. As I argued above, the requirement to include

marginalized groups as participants applies more broadly than First Nations groups. In

the Canadian context, however, the obligation to include First Nations groups will remain

strong because of the particular historical relations between First Nations groups and the

Canadian government.

6.2.3 Communicative Respect and Health Policy

In the area of health policy the communicative view of respect differs

significantly from both the view of respect for autonomy articulated by Beauchamp and

Childress (2009) and the second-personal view of respect described by Darwall (2006).

Neither of these views is able to capture the insight from Powers and Faden (2006) that public health should promote respect (among other dimensions of well-being). The view of respect as respect for autonomy is able to act as an external constraint on public health, as I described in Chapter 3, but respect for autonomy is an uneasy fit as something that could be internal to public health and promoted by public health. Remember, the 'respect' part of respect for autonomy just involves accepting the decisions of autonomous individuals (and being autonomous merely means having the competence and information to make decisions). It is not clear how public health policy could promote this acceptance in any meaningful way. Public health policy makers could include platitudes about the importance of respect and human dignity, and in Chapter 1 I identified a number of instances in which they are already doing this. But doing so would not do the work of lessening health inequalities that Powers and Faden hope it will do.

Powers and Faden think they are invoking Darwall's second-personal account of respect. In Chapter 3 I hinted that I thought there were some differences between the kind of respect that Powers and Faden were describing and the view that Darwall had provided. We are now in a position to explore these differences. Rather than providing us with an instance of Darwall's recognition respect, I think that Powers and Faden's account troubles some of the distinctions that Darwall invokes. First, Darwall (2006) characterizes respect as based on dignity. In contrast, he says, care is based on welfare. This creates a fundamental difference between care and respect on his view. Darwall sees care as third-personal, welfare-regarding and agent-neutral; in contrast, respect is a second-personal, dignity-regarding, agent-relative activity (2006, 126). Darwall comes to the view that care is third-personal because he believes that caring for another involves

promoting their objective welfare interests. The central concern of care-giving, according to Darwall, is whether it advances the cared-for's welfare, "the cared-for's own values are regulative only to the extent they are represented in his welfare" (2006, 127). For example, when a father refuses to give significant weight to his young daughter's protests about eating healthy food he is guided by concerns for her welfare and he takes her welfare to be the source of his obligations to provide healthy food. If the father considers his daughter's values this would only be to the extent that they affect her welfare; for example, he might be concerned that forcing his daughter to eat could result in issues with food later in her life, again a welfare concern. Darwall believes the father would be justified in pressuring his young daughter to eat healthy food since he is guided by concerns for her welfare. In contrast, if the father was now dealing with a daughter home from university, it would be disrespectful to force her to eat the healthy food he has provided because he would not be according her will the regulative weight it deserves (2006, 128). Darwall believes that this distinction places care and respect in different categories expressing different ways of treating people.

Powers and Faden place respect within the broader category of welfare, although it is not clear whether they would agree that welfare or care-giving is third-personal. Many feminist interpretations of care have resisted formulations that conceptualize care as purely universal or third-personal in Darwall's sense. Joan Tronto argues that conceptually care is both universal and particular (1993, 110). Tronto divides caring into four phases, one of these is care-receiving (1993, 107). The care-receiving phase requires attending to the cared-for's responses to the care-giving. According to Tronto, we cannot determine whether the caring need has been met unless we attend to the response from

those cared-for.[138] When we include the response to care as part of what it means to care well, then we can attend to certain dilemmas that arise in care-giving contexts. For example, the one providing care might prefer to do so in a different way than the care-receiver, but it is not immediately clear whose preference is more compelling (as it is on Darwall's view where the objective welfare interests take precedence when we are caring rather than respecting). Tronto argues that caring well requires attending to the response from the one cared-for, although the kinds of responses that we attend to will differ in different circumstances. Sometimes these responses will take the form of explicit reasons or expressed preferences, but other times we have to rely on other cues such as emotional expressions or perceived discomfort.[139]

I believe that Darwall is mistaken when he says that care-giving is third-personal. One of the problems in Darwall's account is that he takes care-giving to very young children as his paradigm, yet the vast majority of care-giving activities do not occur between one person with fully developed reasoning abilities and another who lacks reasoning abilities, as does a young infant. Instead much of the caring that we do involves individuals with differing degrees of dependence and reasoning (see the discussion of relational autonomy in section 3.2.1). The narrow account of care-giving provided by Darwall does not describe the care I give to my partner, for example. Although Darwall

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[138] Tronto is not alone in suggesting that care requires attending to the response from the cared-for. Sara Ruddick argues that care requires engaging with another's will. Ruddick describes mothering as a practice that requires mothers "to learn to relish reciprocity, to identify as a maternal virtue respect for the independent, uncontrollable will of the other" (1995, 73).

[139] Tronto's account of care is very general and includes caring for persons as well as caring for things like the environment or a musical instrument. She includes a variety of responses to care as those we need to attend to, including responses from inanimate objects. For example, she says that the sound of a piano can help us understand whether we have provided the required care (Tronto 1993, 107-108).

takes his account to be Kantian, I am not sure that Kant would agree with this view of

care-giving because Kant tells us that when we benefit another this has to be done

according to the other's perspective on what counts as a benefit; we are not supposed to

impose our own views of the other's good or we fail to act beneficently (*The Metaphysics*

of Morals 1996, 150, AK 6:385-386).[140] This objection is not fatal, however, because

either Darwall or Powers and Faden could easily revise their view of whether care and

welfare are best considered from the second- or third-personal perspective without doing

much damage to the rest of their argument.[141] I have argued that we should revise

Darwall's view of care so that care is understood as Tronto has articulated it. Tronto's

version of care has both second- and third- personal elements. The second tension in the

use of respect between Darwall and Powers and Faden is more serious.

Second, for Darwall (1977), recognition respect does not admit of degrees; we

either recognize someone as a member of the moral community or we do not. In contrast,

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[140] Kant says that there are certain ends that are also duties, and these are one's own
perfection and the happiness of others. We are not supposed to promote the other's
perfection because this would be a contradiction: "For the *perfection* of another human
being, as a person, consists just in this: that he *himself* is able to set his end in accordance
with his own concepts of duty; and it is self-contradictory to require that I do (make it my
duty to do) something that only the other himself can do" (*The Metaphysics of Morals*
1996, 150, AK 6:386, emphasis in original). Further, when it comes to promoting the
happiness of others as a duty, Kant writes, "this must therefore be the happiness of *other*
human beings, *whose* (permitted) *end I thus* make *my own end as well*" (*The Metaphysics*
of Morals 1996, 151, AK 6:388).

[141] The division of moral duties into first-, second-, and third-personal might require
further thought. I cannot enter into a full exploration of the implications of rethinking
these divisions in this dissertation, though it seems that at least some forms of care might
be second-personal in the sense that respect is second-personal. I believe that Margaret
Olivia Little and Coleen Macnamara are working on a view of deontic pluralism that
requires making assessments of our duties by adopting more than one of the perspectives
(that is, making the assessment from a first-, second-, and third-personal perspective). See
the description of their forthcoming book on Little's website at:
http://e105.org/maggie/topicDeon.php?m=ltbm

racism, sexism and other forms of prejudice don't usually have this characteristic; even in highly racist societies members of subordinated racial groups are usually considered moral agents (even if they are considered less trustworthy or less competent moral agents) and are blamed for their actions. In his later work, Darwall (2006) specifies that reactive attitudes, such as blame, are a form of recognition respect because they presuppose that the individual reacted to in this way is a moral agent capable of responding to reasons (2006, 138). Indeed, as we saw in Chapter 5, Darwall goes so far as to say that Stalin respected the moral equality of those he terrorized because he often felt reactive attitudes, such as resentment toward them. This description of recognizing moral equality seems much different than the one provided by Powers and Faden. When Powers and Faden describe prejudices and disrespect they use the language of being considered "less worthy," and they talk about having "less respect" rather than a complete absence of respect. These considerations draw on evaluations and so seem more akin to appraisal respect in Darwall's sense. At other times, Powers and Faden describe the kind of disrespect that troubles them as a concern about equal status; to that extent their discussion fits with Darwall's recognition respect. Again, the way Powers and Faden use the concept of respect troubles the distinctions made by Darwall, although in this instance it is the appraisal/recognition distinction that is troubled. Darwall's view is not concerned with status hierarchies or other social hierarchies, though these features are central to the account provided by Powers and Faden. Darwall believes that recognition respect is compatible with social hierarchies, so long as the individuals within those hierarchies are still treated as morally competent, able to respond to reasons and be accountable for their actions. These concerns are quite different than those expressed by Powers and Faden,

whose account is precisely one that examines the interrelationship between social hierarchies and respect for social groups. Powers and Faden argue that structural inequalities undermine the equal moral respect for social groups.

I think the view of respect as communicative could be more consistently applied within Powers and Faden's view. The communicative view continues to see respect as a second-personal engagement that involves moral recognition, but rather than focusing narrowly on the exchange of reasons, the communicative view of respect is interested in whether the individuals achieve an understanding of the reasons of others. As I argued in Chapter 5, whether such an understanding is achieved will depend upon the conditions of the social contexts within which the agents are situated. Understanding the reasons of another requires also having a good deal of information about the experiences of the other. The ease or difficulty of communicating these experiences will be affected by the kinds of social discourses the agents are able to draw upon. So, although recognition might be all-or-nothing in Darwall's sense, understanding admits of degrees. We can understand something more or less well, to a greater or lesser extent. We can have full understanding or incomplete understanding. Achieving this understanding can be made easier or more difficult to differing extents, as well. Some social contexts might make it a little more difficult to understand the experiences of one group while making it a lot more difficult to understand the experiences of another group. So the communicative view of respect can explain how structures of inequality could affect respect whereas Darwall's view cannot. Powers and Faden require a view of respect that can do this work, and so they should adopt a communicative view of respect.

Not only is the communicative view a better fit within Powers and Faden's account; it is also able to help us understand how public health policy could possibly promote respect. Powers and Faden are frustratingly unclear on this point. We know that they think structural inequality undermines respect, but it is not clear what they want health policy makers to do in order to address structural inequalities. Although Powers and Faden are concerned with changing the interlocking disadvantages faced by some groups, their suggestions for policy decision-making do not go very far to address the structures of institutional power. I suggest that the answer can be found by combining the concerns I described in my discussion of the clinical and research contexts above.

When Powers and Faden actually turn to policy-decision making, they offer very few positive suggestions regarding how Public Health Policy could promote respect or what Public Health Policy makers should do to ensure their policies promote respect. Instead, Powers and Faden survey a number of policy making procedures that are currently in place (e.g. cost-benefit analyses, cost-utility analyses) and show how these are insufficient for reducing social injustice (2006, Chapter 7). Powers and Faden do not reject the methods currently in use to ensure efficiency or engage public deliberation about health policy. Instead, they believe that these methods provide necessary but not sufficient data for decision-making. Powers and Faden argue that more is needed; specifically they argue that a "moral sensitivity analysis" should be applied to the use of efficiency-based methods (2006, 177). The moral sensitivity analysis tempers efficiency-based methods of policy-making by considering the effect that such methods would have on the goal of ensuring a sufficiency of well-being. Powers and Faden believe that taking non-health related aspects of welfare into account when creating health policies can help

explain some of the features that seem problematic in efficiency-based methods that make trade-offs within health (2006, 170). Fair enough, but it is difficult to understand how this is related to the more specific requirement that Public Health Policy should promote respect (as one of the aspects of welfare to be considered).

One of the few positive recommendations for promoting respect that Powers and Faden make to correct "insufficient respect" is to give priority to the health needs of those who are worst off. When we give priority to the health needs of the worst-off this can redress social neglect of their needs, and, according to Powers and Faden, "such policies are public expressions of respect. Specifically, they are public expressions that members of the disadvantaged group are entitled to equal regard as full moral persons" (2006, 89). Although I think it is true that responding to the needs of those who have previously received little social concern *can* express respect for that group, this result is not guaranteed. In many cases the ways in which the health needs of marginalized groups have been addressed can increase stigma and disrespect rather than removing this stigma or increasing respect. For example, when HIV/AIDS was first identified in the 1980s, efforts to raise awareness about the emerging disease often focused on homosexual men and drug users. The efforts to target the needs of these groups have since been criticized for increasing the stigma surrounding HIV/AIDS rather than having the effect of increasing the equal moral standing of people living with HIV/AIDS or the social groups to which they belong.[142] Powers and Faden recognize these dangers, which in part motivate their theory that in some cases non-health-related considerations, such as the possibility of social stigma, reinforcing stereotypes, and loss of other social goods, should

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[142] For a discussion of stigma in relation to HIV/AIDS see Van Vliet (1993) and Alonzon and Reynolds (1995).

count against targeted programs, even when such programs might be more efficient (2006, 169). The World Health Organization (WHO) has recommended against targeted programs in favour of universal programs because, the WHO believes, targeted programs are stigmatizing and can damage the self-respect of the targeted groups (2008a, 87). Targeted programs that are supposed to meet the needs of the disadvantaged do not guarantee that respect for the targeted group will be increased. I think we need to return to a more specific consideration of what puts an individual at risk of disrespect and what can put other individuals at risk of disrespecting them.

I think that the view offered by Powers and Faden gets many things right, such as their concern for the systemic effects of interlocking disadvantages. I agree that even if we are ultimately concerned with the well-being of individuals, we must attend to social groups because there are many forms of injustice that remain invisible at the individual level and become apparent when comparing social groups. I am somewhat concerned, however, by the decision-making structure that they leave in place in their discussion of health policy. They say that they are particularly concerned with domination and oppression, but their discussion of policy-making does not sufficiently take the dynamics of domination into account. They discuss policy-makers in the abstract, as though these policy-decision-makers would themselves be outside of these structures of domination and oppression rather than a part of these structures.

In Chapter 4 I argued that one reason that second-personal respect provides an improved account of respect is because it can account not only for the vulnerability of patients and research subjects, it can also explain why researchers and physicians might be at risk of disrespecting their research subjects or patients: they are at risk because the

activities of engaging in medical research and diagnosis encourage adopting a third-personal perspective. I said that we would not want to forbid researchers or physicians from adopting this perspective, because it helps with the medical endeavour (curing disease or treating disorders). What we want instead is to remind researchers and physicians that they should *also* adopt a second-personal perspective. There is a parallel to be drawn here with health policy contexts: The kinds of deliberations involved in setting health policies encourage the objective stance when persons are considered as "an object of social policy; as a subject for what, in a wide range of sense might be called treatment; [someone] to be managed or handled or cured or trained" (Strawson 1974, 9 n. 10). The very nature of the activity of policy decision-making can encourage decision-makers to adopt an objective stance toward those subject to the policy, and, thereby, might risk encoding some forms of disrespect into the policy if the decision-maker misunderstands or misrepresents the experiences of those subject to the policy. They could then perpetuate the misrepresentation of these experiences or interpretations as part of the hegemonic discourses within a society. A communicative view of respect requires that health policy decisions involve deliberations with those who will be subject to the policy. Thus, we need to focus more attention on the individuals who are asked to make health policy decisions, and not only on the particular decisions that they make (as Powers and Faden do).

Communicative respect requires moral agents to adopt a second-personal stance toward other moral agents, but it is also concerned with whether agents are able to understand one another's reasons and perspectives. As I argued in Chapter 5, contexts of oppression and domination make it difficult to achieve this understanding and so

communicative respect also requires that we attend to and attempt to remove the forces of oppression and domination at work within particular social structures. Health Policy makers will be attempting to make policy from within these contexts, and so we should look at how they are making their decisions. Just as it was important for researchers to engage with the communities they are researching in order to ensure they are understanding the experience from the perspective of that community (as I described in section 6.2.2 above), so too it will be important for health policy makers to check their understanding with the communities who will be subject to the policy.

Iris Marion Young describes oppression as systematic institutional processes which prevent some from learning, developing and using an expansive set of skills and inhibit their ability to express their feelings and perspectives on social life. Domination, according to Young, consists in "institutional conditions which inhibit or prevent people from participating in determining their actions or the conditions of their actions" (Young 1990, 38). Powers and Faden's policy discussion is concerned with some aspects of Young's definition of oppression: they are concerned to ensure that everyone has access to a sufficiency of well-being that would allow for the development of a number of skills, including reasoning, attachment, and self-determination. But their discussion pays insufficient attention to the ability of oppressed groups to participate in determining the conditions of their actions; that is they pay insufficient attention to domination. Powers and Faden endorse Young's description of oppression and domination, and they suggest that the view of social justice they offer seeks to eliminate both oppression and domination. However, all of the policy-making procedures Powers and Faden consider retain a decision-making structure that does not make enough room for those who suffer

under oppression to participate in determining the conditions of their actions by participating in creating health policies. Social policies, including health policies, are instrumental in setting the conditions under which individuals act. A communicative view of respect would require this participation because it is the only way to check whether a the policy-maker had achieved a correct interpretation and understanding of the experiences of groups that differ from the policy-maker.

One of the risks of allowing powerful groups to make decisions on behalf of less powerful groups is that the proposed solutions might involve developing 'treatments' or 'coping mechanisms' that allow oppressed groups to better thrive under oppressive conditions while retaining the oppressive and dominating features of these conditions intact.[143] The view provided by Powers and Faden goes some way to show why concern for the welfare of those who are oppressed is a matter of justice rather than just a matter of beneficence. But their view remains one in which the privileged, who now recognize that society is defined by hierarchical relations, have obligations to protect the vulnerable from the consequences of their vulnerability, which is one of the weaknesses I identified as a problem for Kantian respect in Chapter 5. I worry that Powers and Faden's theory-driven recommendations for policy-making contexts risks perpetuating the situation Strawson identifies wherein some are regarded as problems for social policy that should be cured or managed. In fact, if decision-makers consistently conceive of these groups as Powers and Faden do, as those who are "worst-off" in a society, this might risk neglecting the positive aspects of these groups.[144] Neglecting the positive features of

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[143] I return to this point in Chapter 7.

[144] See Diana Meyer's (2004) discussion in *Being Yourself* where she makes a similar point.

social groups is one way to perpetuate misunderstanding these groups who usually consider their members to be valuable and experience group membership as something beneficial.[145] Considering the importance of communicative respect in policy-making contexts requires a process of communicative participation that begins at the earliest stages when the problem addressed by the policy is identified. This can help guard against disrespectful policy because people usually do not consider their own social group as "the problem;" instead they are more likely to consider their group to have problems that need addressing. In contrast, when policy-makers deliberate about other social groups, they are more likely to characterize the group as *the problem* that needs to be managed.[146] On a communicative view of respect it will be important to consult with those members of the community that will be subject to the policy and the importance of this requirement will increase the greater the social distance between the group and the policy decision-maker.

It is important to note that it can be difficult to identify precisely who is "subject to the policy." In Chapter 2 I described how women involved with the women's health movement complained about interpersonal interactions with physicians and other health care providers, but they also made broader claims about disrespect. For example, women complained that their caring labour supports the medical system, but their labour is taken for granted and they are rarely consulted about medical practices and policies that might

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[145] Patricia Monture-Angus (1995) makes a similar point about the way anti-racist activists discuss the problems of First Nations groups and neglect the advantages of belonging to the First Nations.

[146] There is work in social psychology that identifies this phenomena as "defensive helping." For an example see the work of Nadler, Harpaz-Gorodeisky, and Ben-David (2009). This issue is also raised by Du Bois when he discusses "the Negro problem," as I described in Chapter 5.

significantly increase their care-giving burdens. The women's health movement objected to the institutionalization of disrespect for women as a group that occurs when medicine relies on women's labour without acknowledging this contribution and without consulting women about their roles. Other views of respect were not able to analyse these complaints as expressions of experiencing disrespect. But the communicative view of respect can explain why ignoring this labour is disrespectful: it is disrespectful because it treats women as a means to cheaper health care without consulting them about their views on the arrangement. Further, it neglects the importance of this labour to health outcomes and thereby devalues and fails to give recognition to women's contributions. On a communicative view of respect, those who are involved in informal caregiving within the home would also have to be included as participants in policy making decisions.

The doctors and nurses who take part in formal caregiving in medical institutions would also be considered part of those who are subject to the policy in many cases. In Chapter 1 and section 6.2.1 I described how homecare nurses often experience tension when they have to work under policies that both mandate they respect their patients, yet at the same time demand that the care they provide must be as efficient as possible. The constraints imposed by their employers allow little flexibility to the homecare nurses who find the efficiency demands require treating their clients as bodies to be managed, while the demands of respecting their patients require them to take more time and treat them as whole persons rather than things to be acted on.

In summary, then, the danger of disrespect in policy contexts occurs in one of two ways. First, it occurs when the policy relies on misunderstandings of the experiences of

some groups when identifying the problem or determining how to address the problem. In some cases policy-makers might ignore the group altogether. For example when the care-giving labour of women is assumed or taken for granted by the policy without recognizing or negotiating with those assumed to undertake the labour. Second, health policy is in danger of disrespecting groups of individuals when those subject to health policies are conceived of as a social problem to be subjected to treatment or management. Health policy does not always treat its subjects as "problems" for social policy or as objects to be controlled or managed. Sometimes health policies adopt a second-personal, or interactive stance that considers those subject to the policy as persons who have problems and the policy seeks to address these problems. The issue of regarding those subject to policy as problems seems to be particularly acute when the policy targets groups who are already disadvantaged by the structural inequalities present in society. The communicative view of respect suggests that this might indicate a case in which the likelihood that the policy-maker will misunderstand or misinterpret the circumstances of those subject to the policy will be high. If the possibility of misunderstanding is greater, then policy-makers should adopt methods that can help correct misunderstandings by checking with the communities subject to the policy. The risk of treating those subject to the policy as problems to be managed is likely to increase as the social distance between the decision-maker and the subjects of the policy increases.

6.3 CONCLUSION

In Chapter 5 I argued that rather than focusing on the exchange of reasons in the abstract we need to situate the communicative relation in the social context. When we situate the communicative relation we can see that the assumption that all rational reasons

are immediately available to all rational agents does not hold. Instead, social contexts of

structural inequality often include inadequate expressive resources that disadvantage

some groups relative to others. Rather than focusing only on the exchange of reasons I

argued in this chapter that we must also attend to whether the agents are able to achieve

an understanding of one another. This changes the concept of respect because respect is

no longer an attitude adopted by one person, nor is it a stance taken up by one person.

Instead, on my view respect is a communicative relation between persons that occurs

against the backdrop of unequal expressive resources in oppressive societies. Against this

backdrop, both the agent expressing herself and the agent attempting to understand her

must both guard against social sources of misunderstanding. Although adopting a

respectful attitude, or a stance of respect should help one to achieve an understanding of

the other's perspective I have located the respect in the understanding achieved among

persons rather than locating respect within a single individual. Respecting one another in

unequal social circumstances requires sensitivity and dialogue, but it also requires

changes at a social level to improve the available expressive resources and the ways in

which these are generated. It requires working to remove the forces of oppression and

domination at work within particular social structures. The responsibilities to remove

oppressive features of the social structure does not lie with the communicating diad

alone: it is a responsibility that is shared among the members of wider community. This

makes sucesfully achieving respectful relations more difficult and more precarious than

they were on Darwall's account of second-personal respect, but I see this as a feature of

communicative respect rather than a defect.

I also examined how changing the concept of respect from one that involves only an attitude to one that involves an understanding between persons will change the requirements of respect in health care contexts. In the clinical cases I described the communicative view of respect was able to identify disrespectful situations that would be overlooked using the traditional concept of respect adopted in bioethics or the second-personal account of respect provided by Darwall (2006). When I described Tara's experience with a delayed diagnosis of choriocarcinoma, only the communicative view of respect was able to provide an adequate account of the disrespect Tara experienced from her doctor. The communicative view of respect was also able to describe the tensions that Parks described when she was trying to both provide respectful care to her patients and meet the demands of her home care agency. The responsibility for eliminating the communicative failures that constitute the disrespect in these cases does not lie with the doctor, Tara, or Parks alone. The communicative view of respect requires us to share the responsibility for changing social structures that lead to miscommunications.

In research contexts the communicative view of respect can help clarify the view of respect that is implicitly adopted by the *Tri-Council Policy* (2010). The communicative view provides a better theoretical grounding for the requirements outlined in the *Tri-Council Policy* than traditional interpretations of respect would provide. The communicative view of respect requires us to attend to what is known, and what is unknown within a particular social context because epistemologies of ignorance contribute to misunderstanding one another. This feature of the view relates directly to medical (and other) research, since it is through research that we come to gain social understandings. Research is not solely responsible for creating social understandings, but

it is one important contributing factor. Because of the important role of research in creating social understandings, a communicative view of respect requires us to attend to whether the knowledge they create reflects or ignores the experiences of marginalized groups within their societies. If the knowledge created through research does not reflect these understandings then that knowledge will disrespect or devalue the experiences of those groups and will make it more difficult for them to press their concerns to others within their society. One important way of ensuring that the views of marginalized groups are accurately represented within research is by including them as participants in research. We need to give marginalized communities an opportunity to participate in research—not just to exclude them because it is too much trouble.

One final advantage of the communicative view of respect that I identified in this chapter is that the communicative view of respect can make sense of Powers and Faden's argument that respect is one fundamental dimension of well-being that health policy should seek to promote. It is not clear what this would mean on the bioethical or second-personal view of respect. On a communicative view of respect health policy promotes respect in one of two ways. First, health policy promotes respect when it helps to create better understandings of the experiences of oppressed social groups as the members of these communities understand those experiences. It undermines respect for members of these groups when it draws on misunderstandings and mischaracterizations of these groups and thereby contributes to the perpetuation of the inadequacies of expressive resources within a given society. If we want to create policy that promotes respect then we will be required to include members of marginalized groups in deliberations about health policy. We will also have to look at the policy decision-makers since they are at

greater risk of disrespecting the populations subject to the policy by the very nature of their work, which requires a good deal of third-personal deliberations. Second, health policy disrespects the populations subject to the policy when the policy makers conceive of those subject to the policy as a "problem" to be treated, managed, or cured. I argued that individuals are less likely to conceive of members of their own group as a problem, but will instead conceive of them as persons who have problems. The communicative view of respect requires a process of communicative participation that begins at the earliest stages when the problem addressed by the policy is identified.

CHAPTER 7   CONCLUSION

In this dissertation I have explored the concept of respect and the role that it has played in bioethics. I began by noting how prevalent the concept is in important health policy and health ethics documents, but that it is often unclear whether the concept is doing any work within those documents. The danger of invoking the concept of respect without using the concept in a substantial way is that 'respect' risks becoming a platitude invoked for rhetorical effect to make us believe that the policy or ethics document is respecting persons, their dignity or their human rights but without going any distance toward *actually* respecting those things. In the second chapter I looked at the introduction of the concept of 'respect for persons' and 'respect for autonomy' in the bioethics discourse. I argued that the concept of 'respect' was introduced in order to prevent serious abuses in medical research and widespread paternalism in the clinic. In early bioethics discussions we find a number of different concepts of respect with slightly different objects: either 'persons' or 'autonomy.' Despite this variation, respect for autonomy has been one of the most significant ways to understand 'respect' because it can be put into practice through obtaining informed consent from potential research subjects and patients. In the first edition of Beauchamp and Childress' canonical *Principles of Biomedical Ethics* (1979) we don't find 'respect for autonomy' but instead 'the principle of autonomy.' The first edition does include the idea that we should respect individual autonomy, but it is really their concept of autonomy that does the work. Little wonder, then, that feminist bioethicists focused on this concept of autonomy in their criticisms, which I explored in Chapter 3.

Beauchamp and Childress (1979) understand autonomy to be an individual's ability to make informed choices about medical treatments or participation in medical research. Feminist bioethicists criticized this concept because of its narrow focus on individual decisions and the lack of attention paid to the ways in which unjust social structures constrain the autonomy of individuals in a multitude of subtle ways (e.g. Sherwin 1992). This important feminist criticism focused on our selves not as rational creatures, but as relational beings embedded in a web of interconnected relationships which often involve unequal power that results in oppression and domination. Mainstream bioethicists, such as Beauchamp and Childress (2009) acknowledged this criticism but it tended to be interpreted in a way that did not require much adjustment to the importance they place on individual decision-making in medical contexts. I argued that this way of accommodating the feminist concept of relational autonomy mislocates the required revision. When we understand autonomy as relational in the feminist sense, we are required to adjust other elements of our moral theory. In particular, the concept of respect needed to be re-thought (as I have done throughout this dissertation). I argued that in some places in later bioethics (i.e. the *Tri Council Policy* (1998 and 2010) and Powers and Faden (2006)) we do see an implicit appeal to a different concept of respect that requires more than merely accepting the autonomous decisions of individual patients. Although these works make an explicit appeal to use the concept of respect in some way, they are frustratingly unclear about how they understand the concept.

In order to get clear about the concept of respect I returned to the work of Immanuel Kant, since he is credited as the philosopher who best explained the concept of respect. I argued that although Kant does stress the importance of our autonomy, he

understands this concept in a significantly different way than it has been used in bioethics. For Kant, only those decisions that are made by submitting one's maxims (i.e. hypothetical imperatives) to the categorical imperative would count as an autonomous decision. Decisions based on feeling, desire, fear, and so forth would not count as autonomous on his view, unless these decisions would conform to the categorical imperative if the maxim were submitted to it. Bioethicists have not required patients to make decisions in this way, and asking patients to engage in such strenuous intellectual endeavours at a time when they are highly vulnerable, ill, and possibly afraid of their death might be asking too much. Further, few health care providers are likely to understand Kant's view well enough to assess whether a patient's decisions would conform to the categorical imperative.

Happily, Kant describes respect for persons in a second way as well. When Kant talks about respect for persons he talks about respect for their dignity. Dignity in Kant's view describes the absolute intrinsic moral worth of human beings. Each individual has this kind of value, according to Kant, and this value means that each individual has inalienable worth. Every human being is owed equal moral respect, according to Kant, because we all have dignity. This kind of dignity does not just apply to rational adults, but instead can be extended to cover non-rational beings as well. Rational nature places constraints on how we extend dignity, however. For example, we would be required to recognize the dignity of children because they will one day develop reason even if they are not yet fully rational. I argued that Kant's discussion of human dignity and its scope has much in common with feminist discussions of relational personhood. The discussions emphasize different aspects of human beings, either our rational nature or our relational

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nature. Both of these aspects are morally significant and we need not opt for one over the other. Instead we can hold both to be of fundamental moral importance at the same time. In sum, Kantian dignity provides a foundation for the requirement to respect one another as intrinsically valuable moral beings. This intrinsic value must be thought to apply to those of us who can form relationships and reason together as moral beings, but we can also extend this value to others who do not have these abilities.

Once I identified human dignity as the proper object of respect for persons on Kant's view, I then examined what Kant believes respect requires of us. Here there are two aspects of his theory that help illuminate what we are to do when we respect human dignity. First, we are to treat others always as ends and never as *mere* means. An end is something that has intrinsic value (dignity if the end is a person) whereas a means is something that we value only extrinsically as a way of getting to some other end. When we treat others as ends we must recognize their intrinsic value, and their ability to share in our activities with us. We must allow them to make our ends their own, and so we must not deceive them about those ends. This aspect of Kant's theory has been discussed by bioethicists, and it would continue to provide a foundation for the very important practice of obtaining informed consent from patients. But relying on informed consent alone is not sufficient for respecting human dignity. Informed consent focuses attention on the aspect of Kant's view that tells us more about what we are prevented from doing (treating others as means), but it does not go far enough in describing what we must do (treat others as ends). To understand what it is to treat another as an end I drew on the second-personal account of respect provided by Darwall (2006).

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Darwall interprets Kant's discussion of respect as requiring us to adopt a particular stance toward others. This stance involves adopting the I-Thou relation of the grammatical second-person. Darwall argues that when we adopt the second-personal stance toward others we recognize them as self-originating sources of reasons. This allows for the importance of the particularities of the individual without being biased or partial in a problematic way (Bagnoli 2007). Darwall believes that adopting a second-personal interpretation of Kantian respect allows us to see how the object of respect is the particular individual themselves rather than some fact or feature of the person (such as their autonomy or their reason). I argued that the second-personal interpretation of Kantian respect allows us to see the positive duties that follow from our obligations to respect human dignity. To treat another as an end is to adopt a second-personal stance toward the other and to take seriously the reasons for action that are offered by the other.

Both Kant and Darwall believe that equal moral respect is compatible with social inequalities. In Chapter 5 I identified an ambiguity in this statement. I argued that if we interpret this to mean that no matter one's position within a given social hierarchy one still has dignity and is still owed equal moral respect (as do both Kant and Darwall), then equal respect is compatible with social inequalities. But neither Kant nor Darwall pay sufficient attention to the effects that social inequalities have on our ability to communicate with one another. I argued that Darwall treats the exchange of reasons too simplistically and does not attend sufficiently to the complexity of understanding one another. I argued that to understand one another we need much more information about the other's circumstances. In situations of structural injustice, which are pervasive as I argued in Chapter 3, we will often have a great deal of difficulty in understanding the

reasons offered by others from social groups that are situated differently from our own group. In Chapter 5 I identified a number of ways in which oppression and domination create epistemic injustices, epistemic lacunae and epistemologies of ignorance that make it particularly difficult for individuals from dominant groups to understand the experiences of those from oppressed groups. If we care about respecting the other from a second-personal standpoint, we must take seriously the ways in which social inequalities pervert the expressive resources within a society.

In Chapter 6 I argued that taking social justice seriously requires revising our concept of respect. Respect remains a second-personal stance that we adopt toward others when we recognize their inherent value as beings with dignity, but we must now care about the communicative relation. It is not enough to conceive of the exchange of reasons along the model of exchanging a material thing, where I offer a reason and it is immediately available for the other to "pick up" in their understanding. Instead we must be concerned with the difficult process involved in understanding one another. In order to understand one another we must also be aware of the ways in which social inequalities can interfere with our understanding and we must work to eliminate or reduce those social inequalities that create the structural positioning of different social groups in ways that distort our epistemologies and expressive resources. This changes respect from an attitude that is located within a single individual to a relationship that occurs among individuals as they attempt to understand one another. Because respect is relational in this sense, the responsibilities generated by our obligations to respect one another as moral equals are shared responsibilities. One cannot resist oppression and domination on one's own; it requires collective effort. In some cases, especially for those in dominant groups,

working to eliminate oppression and to create better moral understanding might require stepping back and allowing others from oppressed groups to participate. In other cases communicative respect might require more positive effort. For example, those from oppressed groups might have to do more work to have their voices heard and this work can often be difficult as one experiences dismissal from others who do not immediately understand these experiences.

At the end of Chapter 6 I provided some examples of how this view of respect could operate in bioethics. In the clinic communicative respect would continue to require physicians to obtain informed consent from their patients, but it would require more than this: it would require physicians to extend the respecting relation through the entire encounter with the patient rather than locating the respect in the obtaining of a signature on a form. It might also require physicians to examine their own implicit biases and to tread carefully where these operate. Communicative respect would require more careful listening when patients are describing their symptoms. A physician's job, by its nature, will still require them to take a third-personal perspective as they interpret these symptoms in the context of their medical knowledge and think about how these particular symptoms relate to medical evidence. So the physician will have to treat conversations with her patients as a means to the end of obtaining a diagnosis (and ultimately treating the condition). But communicative respect would serve as a reminder that the physician must also engage with the patient from a second-personal perspective against a backdrop of social inequalities that creates difficulties in understanding. The requirements of a communicative view of respect are quite difficult to meet and the respecting relation takes time. Because respecting patients takes time, policy makers and hospital

administrators need to bear this in mind as they set health policy and determine the working conditions for doctors and nurses.

In both research and health policy-making contexts I argued that a communicative view of respect would require more involvement from research subjects and the population subject to the policy. The communicative view of respect requires adopting a second-personal stance toward research subjects and populations that are subject to health policies, but it also requires a focus on directly resisting the forces of oppression and domination that are at work in unequal social structures. It is particularly important to consider communicative respect in contexts of research and policy because in these contexts there is a great danger of perpetuating the structures of oppression that I described in Chapter 3. Research is significant for a view that sees respect as a successful communication among individuals because research plays an important role in creating the epistemic resources within a given social context. If research occurs in a way that excludes the perspectives of some groups (such as First Nations in the Canadian context) then the research will perpetuate the epistemic deficiencies that are characteristic of oppressive social contexts (as I described in Chapter 5).

In health policy, the problem is slightly different, although a consideration of communicative respect remains equally important. The danger in policy-making contexts is that social policies are intrinsically related to structuring the conditions under which we act. As I discussed in Chapter 3 and section 6.2.3, domination occurs when institutional features exclude particular social groups from participating in setting the conditions for their action (Young 1990). When some social groups set the conditions under which other social groups must act there is a strong danger of perpetuating domination. For this

reason, I argued that the populations that are going to be subject to the policy should be involved in creating the policy from the very earliest stages when the problem is being identified. This obligation is particularly strong when these policies aim to reduce health inequalities, which disproportionately affect members of oppressed social groups.

In summary, I have argued in this dissertation that recognizing human dignity in contexts of oppression requires us to work to eliminate that oppression because oppression erodes agency and impairs our ability to understand one another across social differences. Kant is right that even under unequal social circumstances all individuals are still owed equal moral respect. This obligation to respect one another is what generates the obligation to work against oppressive forces that make respecting one another difficult or even impossible. We must remember that it is difficult to attempt to remove oppressive forces, however. The responsibility for resisting oppression and domination is a shared responsibility. It belongs to all members of a community and it is shared among them. If one group attempts to take responsibility for ameliorating the conditions of another group without their participation this will perpetuate oppression rather than eliminating it. Working together to resist oppression and domination has two benefits from the perspective of a communicative view of respect. First, when the participation of marginalized groups is solicited when identifying problems, posing questions and seeking solutions in research and clinical contexts then this contributes to creating less oppressive and epistemically unjust conditions in one's social context. Second, through participation oppressed groups come to have greater ability to express their perspectives and understandings of their experiences in a way that dominant groups are able to understand or take up. The requirement generated by a communicative view of respect is to work

against oppressive forces that cloud our moral insight in order to clear the way for

recognizing our equal moral dignity.

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