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Taking Reproductive Justice Seriously: Special Cluster Editor's Introduction

Allison B. Wolf

In 1997, Dorothy Roberts published her groundbreaking book, *Killing the Black Body*.[1] There, she showed that the mainstream reproductive rights movement was too narrowly focused on the ability to access safe and legal abortion. Such a limited focus, argued Roberts, ignores the experiences of women of color wh0 struggle both to access safe and legal abortion and to *have* children when they choose to do so (for example, by avoiding forced sterilization programs or coercive welfare policies that require birth control). Put differently, the narrow vision of reproductive freedom proffers by pro-choice activists as revolving around the right to terminate pregnancy has prevented us from understanding that reproductive liberty goes beyond this. "It must [also] encompass the full range of procreative activities, including the ability to bear a child, and it must acknowledge that we make reproductive decisions within a social context, including inequalities of wealth and power."[2] Focusing so narrowly on access to abortion, in other words, has impeded us from going beyond reproductive rights to fighting for reproductive justice.

Kimala Price proffers that the primary goal of the reproductive justice movement is to move beyond the pro-choice movement's singular focus on abortion toward broader control over one's reproductive life. Given this, SisterSong: The Women of Color Reproductive Justice Collective, defines reproductive justice as: "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls."[3] As such, it includes:

(1) the right to have a child;

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[1] Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* , (NY: Pantheon Books), 1997

[2] Ibid, p. 6.

[3] SisterSong: Women of Color Reproductive Justice Collective. http://sistersong.net/reproductive_justice.html, accessed Jan. 18, 2013.

(2) the right not to have a child;

(3) the right to parent our children;

(4) the right to control our birthing options;

(5) the commitment to fight for the conditions needed to realize these rights.[4]

All four of the essays in this issue's special cluster attempt to advance these goals.

Sonya Charles's essay, "Whose Ethics? Making Reproductive Ethics More Inclusive and Just," leads off the cluster by interrogating issues in the creation of life and our obligations to fetuses. While many bioethicists are increasingly advocating that parents are *morally* (though not legally) obligated to use prenatal genetic diagnosis to ensure that their babies are born healthy, Charles points out how these discussions ignore what is already happening to women of color throughout the United States in the name of "protecting babies," such as incarcerating women "for fetal health." More broadly, these discussions within bioethics seem to take white, upper-middle class, Christian morality as universal, ignoring the myriad or ways that other ethnicities and cultures relate to the idea of disability or procreation. In doing so, Charles highlights why the reproductive justice literature must be taken more seriously by mainstream bioethics.

Gabriela Arguedas Ramírez continues interrogating the ways that the reproductive lives of women of color are continually under the regulation and supervision of the State. More specifically, in her essay, "Abortion and Human Rights in Central America," she explores the many challenges Central American women face in their quest to obtain access to safe and legal abortion throughout the region. Her work goes beyond the traditional debates on abortion typically found in the North American literature (which focus on individual choice) by framing the issue as a social, structural, institutional, matter that is inextricably linked to the norms and ideals of

[4] Ibid, 14.

Western, liberal, democratic political thought. More specifically, she presents a detailed legal and philosophical case that guaranteeing access to safe, legal, abortion is required for the nations of Central America to be legitimate democracies. In doing so, she follows Dorothy Roberts dictate to "link reproductive health and rights to other social justice issues."[5] In the process, she shows that ensuring access to safe and legal abortion is inherent to a society is ability to be a mature democracy.

While Arguedas expands on a more traditional reproductive justice approach to abortion,

While Arguedas and Charles focus on issues before birth, the next two essays forming the cluster focus on the ability to procreate. Allison B. Wolf's "Birth without Violence" focuses on the causes and responses to what she terms "metaphysical violence" in labor and delivery (as distinguished from the also all-too-common physical and emotional violence and coercion used in birth settings that has come to be known as obstetric violence). Wolf begins with the disturbing trend that post-partum women are increasingly being diagnosed with Post-Traumatic Stress Disorder (PTSD) as a result of their birth experiences. After detailing and condemning the existence of this distinct type of obstetrical violence, Wolf turns to María Lugones's work to suggest how this violence can be resisted. The clear implication of her piece is that reproductive justice requires that women be able to give birth in non-violent *and* non-traumatic settings.

Finally, Barry DeCoster's "Ethical Complications of Birth Plans" explores one form of resistance that women have been employing for decades to avoid the kind of violence Wolf discusses – birth plans. Despite the ubiquitous nature of such documents, however, DeCoster points out that their ethical implications remain undertheorized. Even more concerning, he says, is that birth plans often fail to achieve both their ethical and practical goals. For those of us

[5] Price, *op cit.* 43.

committed to reproductive justice, which includes the right to control one's birthing options, DeCoster is putting an important item on our agenda while also raising additional questions like: Who has access to making birth plans? And, which women's birth plans are and are not taken seriously?

As all of the essays in this volume illustrate, we still have a long way to go to achieve reproductive justice. And, this is wrong -- all women deserve reproductive justice, not simply reproductive freedom. We hope that the discussion in this issue of *Janus Head* will lead to even more positive work to further the cause.

Abortion and Human Rights in Central America

Gabriela Arguedas-Ramírez

Translated from Spanish to English by Gabriela Argueda-Ramírez and Allison B. Wolf

Abstract

This essay aims to show that the nations of Central America must create access to safe and legal abortion as well as promote a political dialogue on the subject that is based on reason and science, rather than religion. Not only does prohibiting abortion constitute a violation of women's human rights, but, based on international human rights law as well as the minimum duties of civil ethics, failing in to provide such access or dialogue would mean failing to meet the standards of a legitimate democratic state.

Keywords: Abortion, Human Rights, Women, Democracy, Ethics, Central America

Introduction

Complete bans of abortion constitute human rights violations, specifically of the human rights of pregnant women. In fact, there are no robust arguments from either the legal or ethical perspective to justify such bans. This is not simply my opinion. The doctrine and jurisprudence of the Inter-American Court of Human Rights, the European and the African human rights systems, and the human rights system of the United Nations, all maintain that the absolute criminalization of abortion is an irrational excess that lacks a basis within the international law of human rights. And, reports from the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) [6] and the United Nations Human Rights Commission,[7] all argue that the absolute criminalization of abortion constitutes an arbitrary obstruction of the fundamental rights of women.

I argue that in a mature democracy (the product of what Rawls refers to as a well-ordered society[8]), the Legislative Branch is obligated to amend or repeal any unjust or illegitimate legal norm, especially those rules that violates its people's human rights. And, because of the serious nature of the obligation to uphold human rights, public opinion should not determine how legislatures act in this area, but rather, the facts about the issue, evidence and argumentation. As such, even if the legislative reform needed to amend a human rights violation is unpopular, members of Congress must approve it. Therefore, I argue that Central American Legislative bodies

[6] Convention on the Elimination of All Forms of Discrimination against Women

[7] See the conclusions that the Committee of CEDAW has published from Honduras (2016), Guatemala (2015), Costa Rica (2017), El Salvador (2017) y and that 2009 Amnesty International published about the prohibition of abortion in Nicaragua.

[8] As J. Mandle and D. Reidy state in *The Cambridge Rawls Lexicon*: "A deeply ingrained ideal of democratic regimes is that a just and well-ordered society is one that treats its members as autonomous agents, "respecting their wish to give priority to their liberty to revise and change their ends, their responsibility for their fundamental interests and ends, their autonomy, even if, as members of particular associations, some may decide to yield much of this responsibility to others."

must overturn their laws criminalizing and punishing abortion both as an ethical imperative and to maintain their claims of being mature democracies.

The Legal Context of Abortion in Central America

Let us begin by understanding what is going on in Central American penal codes as they relate to abortion. In all Central American countries, abortion is a crime punishable by imprisonment. In Honduras, El Salvador and Nicaragua, there are no exceptions to these laws; abortion is always criminal and punishable. In Costa Rica and Guatemala, there is an exception when the abortion is performed to protect the health or save the life of a pregnant woman (therapeutic abortion), but this exemption is applied in a non-transparent manner, without accountability by doctors, and in the absence of a mechanism or protocol to ensure that this choice is offered to all the women who require it and guaranteeing that the women are the only ones who make the final decision.

The following table summarizes the status of abortion legislation in this region.

Table 1

Abortion-Related Legislation in Central America

Country	Legislation the Penalizes Abortion
Nicaragua	Penal Code of Nicaragua CHAPTER V Of Abortion Art. 162.- The one that causes the death of a fetus in the womb or through abortion,

	will be reprimanded to 3 to 6 years in prison, if this occurred without the consent of the woman or if she is under 16 years old; and with a prison term of 1 to 4 years if it is done with the woman's consent. The woman who has given consent for the abortion, will suffer the penalty of 1 to 4 years of prison. In the case where violence, intimidation, threats, or dishonesty were employed to perform the abortion in the first case, or, in order to obtain consent in the second case, then the penalty will be imposed in its maximum duration, respectively. When as a result of abortion, or of abortive practices carried out on a woman not on tape, believing her pregnant, or using inappropriate means to produce the abortion, the death of the woman will result, the penalty of 6 to 10 years of

	imprisonment will be imposed; If any injury results, the penalty will be 4 to 10 years in prison. If the agent habitually devotes himself to the practice of abortions, the penalty in its maximum duration will be applied in each case. Physicians, Surgeons, Apothecaries or Midwives who abort any woman, with or without the woman's consent, will suffer the penalty of five (5) to ten (10) years of imprisonment, plus the accessory of special disqualification. Art.163.- If the offense was committed to hide the dishonor of the woman, either by herself or by third parties with the consent of the woman, the penalty shall be imprisonment of one to two years. If the death of the woman occurs, the penalty will be three to six years in prison.

Honduras	Penal Code CHAPTER II ABORTION ARTICULE 126. Abortion is the death of a human being at any moment of pregnancy or during labor. Whoever intentionally causes an abortion will be punished as follows: 1. With 3 to 6 years of imprisonment the woman consented 2. With 6-8 years of imprisonment if the agent acted without the mother's consent and if they did not employ violence or intimidation; 3. With eight (8) to ten (10) years of imprisonment if the agent uses violence, intimidation or deception.

	ARTICLE 127. The penalties indicated in the previous article shall be imposed and the penalty of fifteen thousand (L.15,000.00) to thirty thousand (L.30,000.00) Lempiras to the doctor who, abusing his profession, causes or cooperates in the abortion. The same sanctions will apply to medical practitioners, paramedics, nurses, midwives or midwives who commit or participate in the abortion commission. ARTICLE 128. The woman who brings about her own abortion or consents to another person performing it, will face 3-6 years in prison.
El Salvador	Art. 135.- If the abortion is committed by a doctor, pharmacist or by persons who carry out auxiliary activities of said professions, when they dedicate themselves to said practice, they shall be punished with imprisonment of six to twelve years. In addition, the penalty of special

	disqualification for the exercise of the profession or activity for the same period shall be imposed. INDUCTION OR HELP ABORTION Art. 136.- Anyone who induces a woman or facilitates the economic or other means for an abortion to be performed, shall be punished with imprisonment of two to five years. If the person who helps or induces the abortion is the parent, the sanction will be increased by one third of the maximum penalty indicated in the preceding paragraph.
Guatemala	ARTICLE 139.- Attempt and miscarriage. The attempt of the woman to cause her own abortion and her own wrongful abortion, are impunity. Wrongful miscarriage verified by another person will be punished with imprisonment of one to

	three years, provided that such person has prior knowledge of the pregnancy. ARTICLE 140.- Specific aggravation. The doctor who, abusing his profession causes the abortion or cooperate in it, will be sanctioned with the penalties indicated in article 135, with a fine of five hundred to three thousand quetzales, with disqualification for the exercise of his profession from two to five years. The same sanctions will be applied, where appropriate, to the practitioners or persons with sanitary title, without prejudice to what is related to the contest of crimes.
Costa Rica	Penal Code SECTION II Abortion ARTICLE 118.- Abortion, with or without consent, that causes the death of a fetus will be punished:

	1) With a prison sentence of three to ten years if it was done without the consent of the woman or if she is under fifteen years of age. This penalty will be two to eight years, if the fetus (*) had reached six months of intrauterine life; (*) Note: In the wording of paragraph 1 of Article 118 it is evident the lack of the adverb of "no" negation to make sense of its objective. The way it appears in the original text lacks logic, because the penalty is less for a more serious event. Note that the subsection below does contain the indicated adverb. 2) With one to three years of imprisonment if it was done with the woman's consent. This penalti will be six months to two years if the fetus had not yet reached six months in utero. In these cases, the penalty will be higher if it results in the death of the woman.

	ARTICLE 19.- Procured abortion. The woman who consents or causes her own abortion will be reprimanded with imprisonment of one to three years. This penalty will be from six months to two years, if the fetus had not reached six months in utero. ARTICLE 120.- Abortion honoris causa. If the abortion has been committed to hide the dishonor of the woman, either by herself or by third parties with the consent of the former, the penalty will be three months to two years in prison. ARTICLE 121.- Abortion with impunity. The abortion practiced with the consent of the woman by a doctor or by an authorized obstetrician is not punishable, when it was not possible the intervention of the first, if it was done in order to avoid a danger to

	the life or health of the mother and this has not been avoided by other means. ARTICLE 122.- Wrongful abortion It will be punished with a fine of sixty to one hundred and twenty days, whichever is the cause of an abortion.

As shown in the table above, Central American laws on abortion are highly restrictive, causing a situation incompatible with the minimum criteria of respect and protection of women's human rights to physical and mental health, personal freedom and life. El Salvador is the country that has shown the most legal harassment towards women, reaching the unprecedented extreme of condemning women who had spontaneous abortions to 30 years in prison (Januwalla, 2016) (Center for Reproductive Rights, 2014)

Under both right- and left-wing governments, Central American countries have maintained the same position regarding the criminalization of abortion. They have adopted the positions of the ultraconservative social groups and the Catholic and evangelical religious hierarchies, while ignoring the voices of the feminist social movements, human rights advocates, the binding resolutions of the Inter-American Court of Human Rights, the observations of the CEDAW, the

UN Human Rights Committee, and the Special Rapporteurships, among other institutions. This shows that there is a disproportionate weight of the conservative sectors of a religious nature in the parliamentary processes and in the management of the Executive branch.

Human Rights as the Baseline for Legislative Debate

A fundamental legal and ethical premise of democracy that Central American countries seem to be ignoring is that public opinion repudiating abortion is irrelevant. This is not to say that citizens cannot exercise their political rights or have the liberty to express their opinions – clearly this is false. Instead, what I am saying is that, from a legal perspective, the obligation to uphold fundamental freedoms is not subject to the authorization of the majority. If complete bans of abortion violate human rights, the legislature must act, regardless of public opinion (in the same way as they would have to act to protect the human rights of people of color or LBGT folks regardless of public opinion).

In addition to the above, in strong and legitimate democracies, members of Congress are bound to legislate in adherence to both the legal system of their countries and international law on human rights. And, this implies that they must submit the law-making process to the international human rights guidelines and standards. If, in any given case, a member of Congress finds him or herself in a moral conflict, because what is being discuss implies something morally inacceptable in their particular cosmology/religion, she or he has the responsibility to, at least, not hinder the discussion procedure. This member of Congress may express her/his position on the matter under discussion, but if it is about the elaboration of a rule or reform aimed at amending a denial of a human right, her/his obligation will be, at least, not to encumber the parliamentary process.

And, let us be clear, as I have already shown, international human rights dictates are clear that criminalizing abortion is a human rights violation. Parliamentary ethics and legal obligations

directly demand adherence to the highest international standards on human rights, respect for the basic liberties of every citizen and commitment to the core values of pluralism and democracy. So, the principles of parliamentary ethics[9] require legislators to not use their position of power to legislate according to their particular interests, to impose their beliefs or those of their social group or to obstruct the correct procedure of parliamentary debate. (Chávez Hernández, 2006) Beyond this, the book *Human Rights: Manual for Parliamentarians*, published by the Office of the United Nations High Commissioner for Human Rights, in 2016, for example, states:

> *International human rights bodies have repeatedly expressed their concern about the link between carrying out an abortion under conditions of risk and maternal mortality rates, which affects the enjoyment by women of their right to life. Most international human rights law, including article 6 of the ICCPR and article 2 of the ECHR, has been interpreted with the expectation that the right to life begins at the moment of birth. In fact, in the history of negotiations of many treaties and declarations, of international and regional jurisprudence and of a large part of legal analysis it is indicated that the right to life, as explained in detail in international human rights instruments, does not It is meant to be applied before the birth of a human being. The denial of a pregnant woman's right to make an informed and independent decision on abortion violates or poses a threat to a wide range of human rights. International human rights bodies have characterized the laws that typify abortion as discriminatory and as a barrier to women's access to health care (see, for example, General Comment No. 22 of the CESCR Committee). Although Article 4 of the ACHR stipulates that the right to life is protected "in general, from the moment of conception", the regional human rights monitoring bodies of the Americas have underlined that this protection is not absolute. The Inter-American Court, in particular, has determined that embryos do not constitute persons under the ACHR, so they cannot be granted an absolute right to life. Most international and regional human rights bodies have established that any prenatal protection must be consistent with the mother's right to life, physical integrity, health and privacy, as well as to the principles of equality and equality. nondiscrimination". (p.138)*

Similarly, the Committee on Economic, Social and Cultural Rights of the UN said in a May 2016 report on the right to sexual and reproductive health:

> *"28. The realization of women's rights and gender equality, both in legislation and in practice, requires the repeal or modification of discriminatory laws, policies and practices*

[9] Also see *Background Study: Professional and Ethical Standards for Parliamentarians*, published in 2012 by ODIHR (*Office for Democratic Institutions and Human Rights*) and the manual *Common Principles for Support to Parliaments*, published by IPU (*Inter-Parliamentary Union*), in 2014

> *in the area of sexual and reproductive health. It is necessary to eliminate all obstacles to women's access to comprehensive services, goods, education and information on sexual and reproductive health. In order to reduce maternal mortality and morbidity rates, emergency obstetric care and skilled attendance at deliveries are needed, particularly in rural and remote areas, and preventive measures for abortions at risk. The prevention of unwanted pregnancies and unsafe abortion requires States to adopt legal and policy measures to guarantee access to affordable, safe and effective contraceptives to all people and comprehensive education about sexuality, in particular for the teenagers; liberalize the restrictive laws of abortion; ensure women's and girls' access to safe abortion services and quality post-abortion care, especially by training health service providers; and respect the right of women to make autonomous decisions about their sexual and reproductive health "(p.8)*

In other words, a state policy aimed at protecting both gender equality and the right to health of women requires the integration of various strategies to 1) avoid unwanted pregnancies through timely access to sexual education and contraceptive methods, 2) protect the health of pregnant women and 3) ensure access to safe abortion. Given this, we must counteract the false idea permeating Central American (and other) societies that deems abortion as a mere act of frivolity or of women's irresponsibility to show it as the human right that it is to try reducing the number of abortions, they can promote all those effective strategies to avoid unwanted pregnancies, which are based on scientific evidence and are coherent with the human rights framework. The criminalization of abortion is not one of those strategies. Therefore, in matters of abortion where absolute criminalization is in force, it is crucial to eliminate that obstacle, which constitutes a violation of the human rights of women.

The Case of Artavia Murillo and Its Implications for Central American Abortion Laws

Now, one does not have to take my word for it – the international legal framework to which all of these Central American nations choose to belong supports these same positions. According to their regulations and agreements, all the states that make up the OAS must incorporate the doctrine and jurisprudence that comes from the Inter-American Court of Human Rights in the interpretation and production of legal regulations. One such doctrine was expressed in the Court's

judgment against the Costa Rican State in the Artavia Murillo case, which put forth an extensive and detailed analysis of the arguments usually used by those who insist on defending the absolute criminalization of abortion. Therefore, all States in the OAS are bound by their ruling.

In Table 2, we find excerpts of the reasons refuting arguments criminalizing abortion. The central elements for the subject in question are highlighted in bold.

Table 1.

1 Paragraphs 222-223 P. 68-69	Systematic interpretation of the American Convention and the American Declaration The expression “complete person” is utilized in numerous articles of the American Convention and the American Declaration. **Upon analysis of all of these articles, it is not factual to maintain that an embryo be given and could exercise the rights given to it in each of these articles.** Also, taking into account what has already been pointed out in the sense that the conception only occurs within the woman's body (supra paragraphs 186 and 187), it can be concluded with respect to Article 4.1 of the Convention that the direct object of protection is fundamentally the pregnant woman, since the defense of the unborn is essentially done through the protection of women, as is clear from Article 15.3.a) of the Protocol of San Salvador, which obliges States Parties to "grant special attention and assistance to the mother before and during a reasonable period after delivery, "and of Article VII of the American Declaration, which establishes the right of a pregnant woman to protection, care and special aids.

	Therefore, the Court concludes that the historical and systematic interpretation of the existing antecedents in the Inter-American System, confirms that it is not appropriate to grant the status of person to the embryo.
2 Paragraph 224 P. 69	Regarding the State's argument that "the Universal Declaration of Human Rights [...] protects the human being from [...] the moment of the union of the ovule and the sperm," the Court considers that, according to the preparatory work of said instrument, the term "born" was used precisely to exclude the unborn from the rights enshrined in the Declaration. The drafters expressly rejected the idea of eliminating such a term, so that the resulting text expresses with full intention that the rights embodied in the Declaration are "inherent from the moment of birth". Therefore, the expression "human being", used in the Universal Declaration of Human Rights, has not been understood in the sense of including the unborn.
3 Paragraph 226 P. 70	Neither in its General Comment No. 6 (right to life) nor in its General Comment No. 17 (Children's Rights), the Human Rights Committee has ruled on the right to life of the unborn. On the contrary, in its concluding observations on State reports, the Human Rights Committee has indicated that the right to life of the mother is violated when laws that restrict access to abortion force women to resort to abortion insecure, exposing her to death. These decisions allow us to affirm that there is no absolute protection of

	prenatal or embryo life from the ICCPR (International Covenant on Civil and Political Rights).
4 Paragraph 227 P. 71	The reports of the Committee on the Elimination of Discrimination Against Women (hereinafter referred to as the "CEDAW" Committee) make it clear that the fundamental principles of equality and non-discrimination require privileging the rights of pregnant women over the interest in protecting life in formation. In this regard, in the case L.C. vs. In Peru, the Committee found the State guilty of violating the rights of a girl who was denied a transcendental surgical intervention on the pretext of being pregnant, privileging the fetus over the health of the mother. Since the continuation of the pregnancy represented a serious danger to the physical and mental health of the girl, the Committee concluded that denying her a therapeutic abortion and postponing the surgical intervention constituted gender discrimination and a violation of her right to health and non-discrimination. The Committee also expressed its concern about the potential that anti-abortion laws have to violate women's right to life and health. The Committee has established that the absolute prohibition of abortion, as well as its penalization under certain circumstances, violates the provisions of the CEDAW.
5 Paragraph 233	The Committee for the Rights of Children has not issued any observation from which one could deduce the existence of pre-natal human rights.

P. 72	
6 Paragraph 236 P. 73	In the Paton vs. Case United Kingdom of 1980, which dealt with an alleged violation of Article 2 of the ECHR (European Convention on Human Rights) to the detriment of the unborn by abortion practiced by the will of the mother in accordance with national laws, the European Rights Commission Humans argued that the terms in which the ECHR is drafted "tend to corroborate the assessment that [Article 2] does not include the unborn". He added that recognizing an absolute right to prenatal life would be "contrary to the object and purpose of the Convention." He pointed out that "[t] he life of the fetus is intimately linked to that of the pregnant woman and cannot be considered apart from her. If article 2 included the fetus and its protection was, in the absence of a limitation, understood as absolute, abortion would have to be considered prohibited even when the continuation of the pregnancy presents a serious danger to the life of the pregnant woman. This would mean that 'the life in formation' of the fetus would be considered of greater value than the life of the pregnant woman ". Also, in Cases R.H. V. Norway (1992) and Boso v. Italy (2002), which dealt with the alleged violation of the right to life to the detriment of the unborn by the existence of permissive state laws against abortion, the Commission confirmed its position.

7 Paragraphs 237 P. 73	in the Case Vo. V. France, in which the petitioner had to undergo a therapeutic abortion because of the danger to her health caused by inadequate medical treatment, the European Court said that: Unlike Article 4 of the American Convention on Human Rights, which states that the right to life must be protected "in general, from the moment of conception", Article 2 of the Convention is silent regarding temporal limitations of the right to life and, in In particular, it does not define "all" [...] whose "life" is protected by the Convention. The Court has not determined the problem of the "beginning" of "the right of every person to life" within the meaning of the provision and whether the unborn has that right to life. "[...] The problem of when the right to life begins comes within a margin of appreciation that the Court generally considers that States should enjoy in that area despite the evolutive interpretation of the Convention, a "living instrument that must be interpreted in the light of Today's conditions "[...] The reasons for that conclusion are, first of all, that the problem that this protection has not been resolved within most of the States parties, in France in particular, where it is a matter of debate [...] and, secondly, that there is no European consensus on the scientific and legal definition of the beginning of life. [...] At the European level, the Court notes that there is no consensus as to the nature and status of the embryo and / or fetus [...], even though they have received some protection in light of scientific progress and the potential

	consequences of research within genetic engineering, assisted medical procreation or experimentation with embryos. The more, it can be considered that the States agree that the embryo / fetus is part of the human race. The potentiality of this being and its ability to become a person - enjoying protection under civil law, in addition, in many States, such as, for example, France, in the context of the laws of succession and gifts, and also in the United Kingdom [...] - requires protection in the name of human dignity, without making it a "person" with the "right to life" for the purposes of article 2. [...]
8 Paragraph 244 P. 75-76	C.2.e) Conclusion on the systematic interpretation The Court concludes that the Constitutional Chamber relied on Article 4 of the American Convention, Article 3 of the Universal Declaration, Article 6 of the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Declaration of the Rights of the Child. Rights of the Child of 1959. **However, none of these articles or treaties can sustain that the embryo can be considered a person under the terms of article 4 of the Convention. Nor is it possible to draw this conclusion from the preparatory work or from a systematic interpretation of the rights enshrined in the American Convention or in the American Declaration.**
9	

Paragraph 258 P. 81	The antecedents that have been analyzed so far allow us to infer that the purpose of Article 4.1 of the Convention is to safeguard the right to life without implying the denial of other rights protected by the Convention. In that sense, the clause "in general" has the object and purpose of allowing that, in the face of a conflict of rights, it is possible to invoke exceptions to the protection of the right to life from conception. **In other words, the object and purpose of Article 4.1 of the Convention is that the right to life is not understood as an absolute right, whose alleged protection can justify the total denial of other rights.**
10 Paragraph 259 P. 81	**Consequently, the argument of the State in the sense that its constitutional norms grant greater protection of the right to life is not admissible and, consequently, this right should be fully enforced. On the contrary, this view denies the existence of rights that may be subject to disproportionate restrictions under a defense of the absolute protection of the right to life, which would be contrary to the protection of human rights, an aspect that constitutes the object and purpose of the treaty. That is, in application of the most favorable principle of interpretation, the alleged "broader protection" in the domestic sphere cannot allow or justify the suppression of the enjoyment and exercise of the rights and freedoms recognized in the Convention or limit them to a greater extent than the one planned in it.**

11 Paragraph 260 P. 82	**In this regard, the Court considers that other judgments in comparative constitutional law seek to make an adequate balance of possible rights in conflict and, therefore, constitute an important reference to interpret the scope of the clause "in general, from the conception" established in article 4.1 of the Convention. The following is an allusion to some jurisprudential examples in which a legitimate interest in protecting prenatal life is recognized, but where said interest is differentiated from the ownership of the right to life, emphasizing that any attempt to protect said interest must be harmonized with the fundamental rights of other people, especially the mother.**
12 Paragraph 261 P. 82	At the European level, for example, **the Constitutional Court of Germany, stressing the general duty of the State to protect the unborn, has established that "[t] he protection of life, [...] is not in such an absolute degree that it enjoys without any exception of prevalence over all other legal rights, "and that" [t] he fundamental rights of women [...] subsist in the face of the right to life of the nasciturus and consequently have to be protected. " Constitutional Court of Spain, "[t] he protection that the Constitution dispenses to the 'nasciturus' [...] does not mean that such protection must be of an absolute nature."**
13	For its part, in the region, the Supreme Court of Justice of the United States has stated that "[t] he reason and logic that a State, at a certain moment,

	protects other interests [...] such as, for example, the potential human life ", **which should be weighted with the personal privacy of the woman** -which cannot be understood as an absolute right- and" other circumstances and values ". On the other hand, according to the Constitutional Court of Colombia, "[t] he Congress has the right to adopt the appropriate measures to comply with the duty to protect life ... this does not mean that all those that it dictates with said purpose are justified. , because despite its constitutional relevance, life does not have the character of a value or a right of an absolute nature and must be weighed with the other values, principles and constitutional rights ". The Supreme Court of Justice of the Nation of Argentina has indicated that neither the American Declaration nor the American Convention derives any mandate by which it is necessary to interpret, in a restrictive manner, the scope of the criminal norms that allow abortion in certain circumstances. , "inasmuch as the pertinent norms of these instruments were expressly delimited in their formulation so that they would not derive the invalidity of an abortion case" such as the one foreseen in the Argentine Penal Code, In a similar sense, the Supreme Court of Justice of The Nation of Mexico declared that, from the fact that life is a necessary condition of the existence of other rights, it cannot be validly concluded that life should be considered as more valuable than any of those other rights.

The arguments revealed through these excerpts from the Artavia Murillo judgment clearly show that, within the framework of the doctrine and jurisprudence of international human rights law:

1. There is no rational basis to the claim that the absolute legal prohibition of abortion is legitimate in a democratic State, that is part of the Inter-American Human Rights System and the UN. It is not possible to derive from any official and current human rights instrument, in any of the international systems, that the total prohibition of abortion is consistent with the respect and duty of guarantee of the States regarding the human rights of women.

2. The embryo, fetus or nasciturus, depending on the chosen nomenclature, can enjoy the moral consideration, but it is neither subject of rights nor is it a person. Neither it is entitled to special protection nor to receive more protections or rights than the pregnant woman. The State must protect the rights to life and health of pregnant women, who wish to receive this protection from an exercise of their will and freedom.

3. The Inter-American Court of Human Rights, the body that ultimately interprets the American Convention on Human Rights, understands the obligations of the State, pursuant to Article 4.1[10] of said Convention,[11] as compatible with public policies for access to safe abortion, at least in certain circumstances, as guaranteed by several States parties (including Mexico, Colombia, Argentina, Chile, Uruguay, Brazil, USA, among others)

4. States that totally impede access to safe abortion are violating women's and girls' rights to life, personal integrity, personal liberty, equality before the law.

[10] Article 4.1 puts it this way: "Every person has rights with respect to her or his life. This right will be protected by the law and, in general, from the moment of conception. Nobody can be arbitrarily deprived of life."
[11] For an extensive analysis of the evolutionary interpretation of Article 4.1 of the American Convention on Human Rights, see the article "Interpretation of Article 4.1 of the American Convention of the Protection of Human Rights, Judgment of the Inter-American Court of Human Rights, case of Artavia Murillo et al. (FIV) vs Costa Rica," by Ingrid Brena, published in 2014 by *The Mexican Journal of Constitutional Rights.*

In accordance with the principles that should govern the functioning of a democratic, pluralist State, these premises should constitute the point of departure for public discussion about state obligations around abortion, including the necessary revision of legal norms that penalize it. That is to say that, in the scope of the parliamentary debate, one cannot return to a discussion where the validity or the binding nature of these affirmations is questioned.

Of course, I am not saying that there can be no discussion of these matters. To the contrary, these ideas can (and should) be freely debated and contested in other social spaces where it is possible to generate analysis and discussion. Despite this, though, we must understand that countries belonging to the Inter-American Human Rights System must comply with the jurisprudence it has produced in the matter of human rights, including abortion. Not only the law but also the principles of progressivity, non-regressivity, and conventionality control, demand it.

And, the system has clearly ruled with respect to Costa Rica in this case. The observations received by the Costa Rican State, from the CEDAW Committee in 2011 include the need to adopt -at least- the following measures:

- Develop clear medical guidelines for access to legal abortion and disseminate them widely among health professionals and the general public.
- Review the law related to abortion to evaluate those circumstances under which the termination of a pregnancy could be allowed, such in cases of incest or rape.
- Facilitate the availability and access of women to the most technologically advanced contraceptives.

And, the CEDAW Committee, the Committee on Economic, Social and Cultural Rights and the Committee against Torture have all stated that any form of coercion or obstacle in limiting access to a safe abortion (whether of an economic nature, the obligation of waiting periods for

reconsidering the decision, the mandatory psychological advice, conscientious objection without adequate control and the requirement of authorization from a third party to carry out the procedure) may constitute practices that result in a violation of women's human rights and the girls. All Central American nations are bound to follow these dictates.

Debating about Abortion in Central America

Although various narratives, including antagonistic ones, circulate in the Central American public sphere there is not a serious political debate about abortion in these countries. The *sine qua non* condition for a debate is argumentation. This implies that those who participate in a debate put forth arguments and reasons defending their positions, commit to express those positions in the most rigorous way while simultaneously listening to the arguments of others (including those who may disagree with them), and are willing to accept the argument that is better supported. Each participant in a debate can refute the arguments that she/he considers wrong or false, offering reasons and evidence; that is, counter-argumentation. Based on this description, debate is an exercise in collective reasoning, not a boxing ring. Fallacies, falsehoods, signs of aggression and violence are not allowed. Ideas circulate and the process of debating, if carried out with transparency and adherence to civic ethics, culminates by eliminating arguments that are poorly constructed or sustained on false premises. Following the notion of deliberative democracy (Habermas, 1996.), in the context of a robust democracy, public debate is the fundamental pillar on which the legitimacy of norms is based. At the same time, respect for fundamental rights is the deontological guide that all people must follow, in their exercise of citizenship.

Habermas himself brings this up in relation to abortion, the diversity of beliefs and identities and the conditions of legitimacy to establish a legal norm in this regard, and reflects the following

> *"Is there only one correct answer to the abortion question, for example? At this stage of the debate, both sides in this dispute appear to have good, perhaps even equally good, arguments. For the time being, therefore, the issue remains undecided. But insofar as what is at issue is in fact a moral matter in the strict sense, we must proceed from the assumption that in the long run it could be decided one way or the other on the basis of good reasons. However, a forteriori the possibility cannot be excluded that abortion is a problem that cannot be resolved from the moral point of view at all. From this point of view, what we seek is a way of regulating our communal life that is equally good for all. But it might transpire that descriptions of the problem of abortion are always inextricably interwoven with individual self-descriptions of persons and groups, and thus with their identities and life projects. Where an internal connection of this sort exists, the question must be formulated differently, specifically, in ethical terms. Then it would be answered differently depending on context, tradition, and ideals of life. It follows, therefore, that the moral question, properly speaking, would first arise at the more general level of the legitimate ordering of coexisting forms of life. Then the question would be how the integrity and the coexistence of ways of life and worldviews that generate different ethical conceptions of abortion can be secured* ***under conditions of equal rights****. In other cases, it is possible to deduce from the inconclusive outcome of practical discourses that the problems under consideration and the issues in need of regulation do not involve generalizable interests at all; then one should not look for moral solutions but instead for fair compromises".* (Habermas, 2001. pp. 59-60)

Based on the above, I submit that in a pluralistic and democratic society, various moral assessments about abortion coexist. And, given this, the State must ensure that, first of all, the equality of rights between those who are subject of law, that is, individuals, are protected. The political commitment in a deliberative democracy does not depend on the existence of a prior moral consensus, but on the respect -from the difference of worldviews- of the set of fundamental rights of those who are recognized as moral subjects.

This echoes the Spanish philosopher Adela Cortina, who says:

> "It is from dialogue how just solutions can be reached; a rule is fair if all those affected by it can give their consent after a dialogue held in the conditions closest to symmetry, a dialogue in which those affected have brought their interests to light transparently and are willing to give for just the final result, the one that satisfies universalizable interests "(Cortina, 2013. P 42)

These conditions are not currently met in Central America with respect to abortion. In fact, the state of the abortion discussion in Central America illustrates the failure in the aspiration for a rational and reasoned dialogue, which is so essential to the foundation for participation and democratic construction of political life. In Central America right now, sadly, there is no exchange of reasons, no exchange of arguments, no genuine listening to the other side, and no willingness on the part of many to concede when their arguments are weak because from the conservative sectors the position on abortion is increasingly fundamentalist, going so far as to refer to abortion, using words like "murder" or "death penalty."[12] The groups that call themselves "pro-life" have dominated the public circulation of discourses on abortion in the Central American region, but they have done so without offering reasonable arguments. Although on some occasions the neo-fundamentalist / neo-integrationists Catholic groups seem to provide acceptable reasons, their rhetorical strategies are aimed at placing affirmations of maxims in the debate, which can only be accepted by those who share this religious worldview. They do not start from principles that can be universalizable or adopted as part of a secular ethic. For example, they begin from the assertion that an embryo or a fetus is a person with rights, whose life must be protected above the life of the pregnant woman. But these moral considerations are only valid on the basis or religious precepts and, as such, will only be accepted by those who share the moral maxims that inspire such sacrificial ethics. They cannot be extrapolated to the rest of the population, much less serve as a basis for the establishment of compulsory compliance laws for all people. So, people are expressing views but not actually engaging in debate.

[12] For example, in Costa Rica, the “pro-life” activist Alexandra Loría Beeche, has said in the press that the decree that would regularize non-punishable abortion is a norm that "would allow killing sick children", to refer to fetuses with malformations incompatible with extrauterine life. (Zúñiga, 2017)

The inflexibility that characterizes the position of these self-proclaimed “pro-life” groups even leads them to demonstrate against the decriminalization of abortion in cases where the life of the pregnant woman is in danger (known as "therapeutic abortion"). Moral positions like this illustrate patterns of behavior that are known as maximum ethics. Cortina and Martínez (2013) put the point this way:

> "The ethics of justice or minimum ethics are concerned only with the universalizable dimension of the moral phenomenon, that is, those duties of justice that are required of any rational being and that, ultimately, only make minimum demands. The ethics of happiness, on the contrary, try to offer ideals of good life, in which the set of goods that men can enjoy are presented hierarchically to produce the greatest possible happiness. They are, therefore, ethical maxims, which advise following their model, invite us to take it as an orientation for conduct, but cannot demand that it be followed, because happiness is a matter of advice and invitation, not of demand "(p. 118)

Using religiously-grounded principles or morals promote these ethics of maximums and, as a result, make it impossible to build a minimum civic ethic -in the context of a democratic society. Civic ethics, within the framework of a social, democratic, plural, and human rights-based state, calls for the exercise of citizenship, based on a minimum of common justice agreements. From this perspective, adopting the moral precepts of a certain religious system as the basis from which to establish the common minimums of a civic ethic and the guide decision-making in the public sphere would be undemocratic and authoritarian, since it would force the whole of society to comply with mandates that do not arise from the debate and the socially constructed agreement.

Conclusion

The dynamics of public discussion and civic debate are delineated by the rules of legitimate democracies, international law, and various schools of Western philosophical thought. Based on these, public debates should be based on the most robust and rigorous scientific or technical evidence of the subject under discussion along with secular ethical principles that do not require participants to adhere to specific ideology. Every participant in the debate should express her/his

ideas in a way that allows the rest of the people to understand the meaning of what they want to honestly communicate.

If we really understand these guidelines, we see that they are not being followed in Central America with respect to abortion. If they were, we would take human rights as the ethical basis for the discussion and combined with empirical realities facing women, we would see that what should be under discussion in most Central American countries is the normative procedure needed for lifting the legal obstacles that prevent access to safe abortion, at the very minimum, in certain extreme situations. In addition, it would be clear that these countries (as democratic states) are obligated to limit the political power of religious conservatism, which in Central America has caused a series of obstacles not only in terms of abortion, but also in access to sex education, contraceptive methods and reproductive justice. To not do these things would call these countries' identities as legitimate, mature, democracies that respect human rights into serious question.

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Birth Without Violence: Remembering Multiplicity in the Delivery Room

Allison B. Wolf

Abstract

In 2010, Taffy Brodesser-Akner published an article entitled, "How Childbirth Caused my PTSD," on Salon.com. Much to my surprise, her claims that she was seriously traumatized by childbirth encountered strong resistance and disbelief. In trying to understand the source of this resistance, I discovered a type of violence, which I refer to as "metaphysical violence," that is often overlooked, yet prevalent, in what many people in the United States understand as normal childbirth practices and protocols. In this essay, I will use María Lugones's *Pilgramages/Peregrinajes* to offer a detailed account of what constitutes metaphysical violence, how it functions, and why it is so damaging to at least 9% of post-partum women who meet the criteria for PTSD and the 18% of post-partum women who show some sign of the disorder. Then, I will offer suggestions for how we can help women who may be victims of metaphysical violence during birth avoid some of the trauma it so often induces.

Keywords: Birth, Violence. Lugones, Obstetrics, Feminism

Birth without Violence: Remembering Multiplicity in the Delivery Room

In her 2010 Salon.com article, "How Childbirth Caused my PTSD," Taffy Brodesser-Akner wrote:

> *The delivery of my son didn't start with a rush of water, or cramps that left me hunched. It was a decision, an edict, and with it, the drip Pitocin, a drug that induces contractions. The contractions came big and loud, almost immediately at one minute apart. My cervix wouldn't dilate, though. I was eventually given the narcotic Stadol, which caused me to hallucinate through a very long night. Twenty-four hours later, clear-headed but still not dilated, I told my doctor I didn't believe the induction was working, that I wanted to discuss other options. But before I knew it, he began painfully separating the membrane guarding my bag of waters.*
> *"He isn't examining me," I yelled at my husband. "He's* doing *something."*
> *In a hushed tone, the doctor asked the nurse for the hook, a mechanism that breaks your water.*
> *"Why did you do that?" I asked when it was done. "I thought we were going to talk about it!"*
> *His voice was cold, flat. "You're not going anywhere," he said.*
> *My C-section came 30 hours after admission. It was a middle-of-the-night affair: a chilly operating room, an oily anesthesiologist, a clock on the wall that would not tell me when this would be over. I didn't think I would make it out of that hospital alive.*[13]

Brodesser-Akner's experience and post-partum struggles eventually led to a PTSD (Post-Traumatic Stress Disorder) diagnosis. She is not alone.[14] 9% of post-partum women meet the criteria for PTSD and 18% show signs of the disorder.[15] I am one of them.

After giving birth to my son, I had nightmares, severe depression, and flashbacks. I spent most of my time anxious, afraid, and/or crying. I distrusted my body and other people. I felt as if

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[13] Taffy Brodesser-Akner, "How Childbirth Caused my PTSD," *Salon.com,* February 17, 2010, http://www.salon.com/2010/02/18/ptsd_in_childbirth/

[14] See the Human Rights in Childbirth website, http://humanrightsinchildbirth.com, for further examples.

[15] Rachel Zimmerman, "Birth Trauma: Stress Disorder Afflicts Moms Study Suggests That PTSD May Be More Common Than Previously Believed," *Wall Street Journal,* August 5, 2008, http://online.wsj.com/news/articles/SB121789883018612223?mg=reno64-wsj&url=http%3A%2F%2Fonline.wsj.com%2Farticle%2FSB121789883018612223.html%3F

the experience destroyed "me." And, worse, nobody got it --- until three years later, when I read Brodesser-Akner's piece.

Her story seemed so familiar. Finally, someone understood. Finally, I did not feel alone or crazy. It was so affirming. So, I was shocked to learn that the responses to her piece ranged from deeply skeptical to outright hostile; the anger was palpable. Brodesser-Akner's experience defied the cheery birth myths her readers appeared to desire. And they seemed to think that discounting and discrediting her would erase the damage. How could an account that made so much sense to me be met with such hostile resistance?

I thought I found an answer. In my article, "Metaphysical Violence and Medicalized Childbirth,"[16] I suggested that the root of this resistance was that despite the fact that there are numerous types of violence, we only recognize two – physical and emotional. This is conceptually and practically problematic. Conceptually, we are operating on, at best, an incomplete understanding of violence and, at worse, an inaccurate one. Practically, it obscures the ways birthing women may be victims of violence, which leads us to leave victims isolated, suffering, and without help.

This is what happened to Brodesser-Akner and myself. Because we did not face obvious physical or emotional violence, people assumed that we were not survivors of violence. And so, our claims to what I am calling "childbirth-related PTSD" made no sense and were not given uptake. So, we suffered in isolation, unable to access the help we needed. This could have been avoided, I argued, if we had recognized another type of violence – metaphysical violence – as this is what caused our childbirth-related PTSD.

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[16] Allison B. Wolf, "Metaphysical Violence and Medicalized Childbirth," *International Journal of Applied Philosophy*, 27:1, Spring 2013.

I continue to believe that explanation, still my response has also provoked further questions. For example, how does metaphysical violence work? What does it do to people? How can we help women not feel destroyed if they too are victims? These are questions that drive this essay. I will explore them by, first, briefly exploring the nature of trauma and oppression to demonstrate why those concepts alone do not provide an adequate conceptual apparatus for understanding "childbirth-related PTSD." Next, I offer a general account of metaphysical violence (i.e. violence that affects who or what one is) and delineate its relationship to trauma and oppression. I then use María Lugones's discussions of oppression, practical reason, and conceptions of self in *Pilgramages/Peregrinajes* to elaborate on what metaphysical violence is and how it functions. I conclude by suggesting that remembering women's multiplicity in the delivery room could help them navigate metaphysical violence during birth without being destroyed by it.

Beyond Trauma and Oppression

Some argue that understanding what happened to women like Brodesser-Akner and myself merely requires understanding the nature of trauma. Others suggest that it requires understanding the nature of oppression. As I will now show, these concepts alone will not provide the answers.

The word "trauma" is derived from the Greek word, "to wound." In the context of mental health, it generally refers to a psychological wounding or "an emotional response to a terrible event like an accident, rape or natural disaster."[17] Although paradigmatic trauma-inducing events are violent or abusive experiences, other common causes of trauma include: severe illness or injury, the death of a loved-one, divorce or termination of an important relationship, moving, and abandonment.[18] Generally, such events are unexpected or unanticipated, the person is emotionally

[17] http://www.apa.org/topics/trauma/. last accessed April 6, 2016.
[18] http://www.healthline.com/health/traumatic-events#Overview1.
http://www.psychguides.com/guides/trauma-symptoms-causes-and-effects/. Last accessed April 6, 2016.

unprepared for the event, and the person cannot prevent it from happening.[19] When such events "overwhelm the individual's ability to cope, and leave that person fearing death, annihilation, mutilation, or psychosis, [then] the individual may feel emotionally, cognitively, and physically overwhelmed," which we refer to as "trauma."[20]

Trauma triggers the body's stress response, which is a "physiological reaction caused by the perception of averse or threatening situations."[21] This response releases certain hormones and activates the limbic system, leading to heightened anxiety, hyper-vigilance, and hostile behavior.[22] Many recover from stress, but some develop post-traumatic stress disorder.

In previous editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, PTSD was considered an anxiety disorder. But, in the most recent edition, *DSM-V*, "it was moved to a new category: 'Trauma and Stress-Related Disorders.'"[23] Those who meet the criteria of PTSD have the following characteristics and symptoms. First, they were directly or indirectly exposed to a traumatic event. Second, they re-experience that event or have intrusive thoughts, memories, flashbacks, or psychological reactivity to reminders of the event. Third, they have a negative mood or cognitive alterations, like memory problems, negative beliefs or distortions about the world, a distorted sense of blame or oneself or others related to the event, severely reduced interest in previously enjoyed activities, or feeling detached, isolated, or disconnected from other people. Fourth, they have increased arousal symptoms involving difficulty

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[19] Jaelline Jaffe, Ph.D., and Jeanne Segal, Ph.D., and Lisa Flores Dumke, M.A., "Emotional and Psychological Trauma: Causes, Symptoms, Effects, and Treatment," http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/38434/Trauma.pdf, Last accessed April 6, 2016.
[20] http://www.sidran.org/resources/for-survivors-and-loved-ones/what-is-psychological-trauma/, last accessed April 6, 2016.
[21] Neil R. Carlson (2013). Physiology of Behavior, 11th edition. Pearson Education.
[22] *Ibid*
[23] Staggs, Sara, "Symptoms and Diagnosis of PTSD," *Psych Central,* http://psychcentral.com/lib/symptoms-and-diagnosis-of-ptsd/, last accesses April 7, 2016

concentrating, irritability, difficulty falling and staying asleep, hyper-vigilance, or being easily startled.[24]

This overview of psychological trauma and PTSD describes some of what Brodesser-Akner and I experienced. Our children's births included unexpected events that we could not stop, leading to feeling emotionally overwhelmed. Beyond this, we experienced PTSD symptoms, such as nightmares, anxiety, reliving the events, blaming oneself or other negative mood cognitions, feeling isolated, alone, disconnected, and hyper-vigilance.

Still, "trauma" alone provides an incomplete explanation of our experience. While it helps explain *what* we experienced, it does not answer the nagging question: *How* did I get PTSD from giving birth? After all, trauma is triggered by a specific event or events that result in profound loss – death, assault, security, etc. But it seems weird to see childbirth this way; normally childbirth is not seen as an event involving loss. Moreover, according to the *DSM-V*, we did not experience a major Trauma. It is hard to see, then, how "normal" birth could qualify as traumatic.

Some feminists may be tempted to argue that women are traumatized because they were victims of oppressive birth structures in the U.S. maternity care system. Such theorists point to decades documenting physicians acting with greater ease to act on, fix, and control women's bodies than they do men's bodies, especially in the birth context.[25] They point to the long history of medicalization that both devalues women's bodies and reconceptualizes them as diseased and dysfunctional and requiring repair. In other words, their answer to "How did this happen?" is that

[24] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders –V,* 5th edition. 2013

[25] The literature detailing these sorts of criticisms is vast and well established. Some examples include: Robbie Davis-Floyd, *Birth as a Rite of Passage*; Dorothy Roberts, *Killing the Black Body*; Wertz and Wertz, *Lying-In;* Barbara Katz Rothman, *On Labor*; Jennifer Block, *Pushed;* Ricki Lake, "The Business of Being Born."

you have been victims of a culture of paternalism that has taken control of your body and its functions from you. Put simply, "you experienced oppression in birth, which traumatized you."

Can oppression explain why Brodesser-Akner, I, and others have been/are being traumatized in birth? It is tempting to say yes, especially if one believes that the U.S. maternity care system is oppressive. However, 'oppression' fails to provide us with the answers we seek, because trauma and oppression are not inherently connected. Oppression is a systematic and structural phenomenon that comes in many forms (such as systematic exploitation, violence, marginalization, cultural imperialism, and powerlessness).[26] It includes political, social, economic contexts, and psychological contexts and fragments and mystifies one's experiences.[27]

Oppression can certainly involve trauma, but not all trauma is oppression. First, people may be oppressed but not be traumatized. Second, trauma results from a specific event(s) that can be part of a larger social structure, but they can also be random. Third, trauma-inducing events may target members of specific groups but can and does also target specific individuals as such. One can then be oppressed without experiencing trauma and one can experience trauma that is unrelated to oppression. Consequently, even if the U.S. childbirth system were oppressive, this alone would not explain the increasing numbers of post-partum women with PTSD.[28] Conversely, the existence of birth trauma does not mean that the childbirth system is oppressive, since trauma can occur even if it is not. So, the presence or absence of oppression in birth does not answer how women get PTSD from birth – our core question.

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[26] Marilyn Frye, "Oppression," *The Politics of Reality*, (The Crossing Press), 1983, p. 2; Iris Marion Young, "The Five Faces of Oppression," *Justice and the Politics of Difference*, (Princeton: NJ), 1992.
[27] Sandra Bartky, "On Psychological Oppression," *On Femininity and Domination*
[28] Note that I am not saying that the system is not oppressive, I am saying that, even if it is, that alone does not explain what we are seeing around post-partum PTSD.

To summarize where we are, if we are trying to better understand what happened to women like Brodesser-Akner and myself, appealing to definitions of trauma and oppression alone will not provide the answers. While trauma describes some of our symptoms, it does not explain why we experienced it in a context so many associate with overwhelming joy and where we cannot detect any obvious violence. And, while some may agree that the U.S. maternity care system is oppressive, this would fail to explain why women have PTSD, as PTSD is not an inherent effect of oppression. Understanding the relationship between PTSD and birth requires bringing in a new concept -- metaphysical violence.

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I am in my guest room, alone, one week after giving birth for the first time. I am crying.
I don't know why.
I have a son.
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The Problem: Metaphysical Violence

As just highlighted, PTSD is often associated with violence – being a victim of violence, witnessing violence, or (willingly or unwillingly) participating in violence. And, when most people think of violence, they do not imagine a woman delivering a baby. This is not because violence never occurs in birth. Feminists have and continue to uncover violence as it appears in birth – for example, court-ordered Cesarean sections, intimidation in the delivery room, and obstetric practices and tactics that mirror those of batterers.[29] The problem is that this conceptual

[29] See, for example, Sonya Charles, "Obstetricians and Violence Against Women." *American Journal of Bioethics*, 11:12 (December 2011): 51-56; http://www.may28.org/obstetric-violence/; Kim Lock, "We Need to Talk About Obstetric Violence, (Sept. 30, 2014), *Daily Life*, http://www.dailylife.com.au/news-and-views/dl-opinion/we-need-to-talk-about-obstetric-violence-20140930-3gydt.html.

picture of violence is incomplete; there are many kinds of violence, including metaphysical violence.[30]

In essence, metaphysical violence is a type of violence that affects who or what one is; it is violence aimed at the very being of its victim. It alters the subjectivity of those at whom it is directed, which then affects their ability to understand and make sense of themselves and their experiences. The defining feature of metaphysical violence, then, is that it induces an alteration in the subjectivity of its victims, resulting in existential and ontological confusion about who they are or what they have experienced. They are unintelligible – they make no sense to themselves or others.[31] This may occur by: erasing the person's self or identity-constituting aspects; denying that she is a self or an entity with moral standing; preventing her from engaging in activities needed to develop or sustain a self; or obfuscating key aspects of the self. And, metaphysical violence can cause: difficulty acting on one's volition, feeling at home in the world, constructing desires, and making one's context or experience intelligible to herself or others.[32]

According to theorist Slavoj Žižek, there are (at least) two types of violence: subjective and objective. Subjective violence is performed by a clearly identifiable agent whereas, objective violence is often simply woven into our everyday practices, language, and routine.[33] As Žižek explains: "Subjective violence is … seen as a perturbation of the "normal," peaceful state of things. However, objective violence is precisely the violence inherent to this "normal" state of things."[34] In other words, subjective violence is visible precisely because it is a deviation from the

[30] Kristie Dotson, for example, has identified epistemic violence in her article, "Tracking Epistemic Violence, Tracking Practices of Silencing," *Hypatia,* 26:2, Spring 2011, 242
[31] In my own case, just kept crying. When people asked what was wrong, I could not say – I had no language, I too was confused. I did not know who I was or what had happened, I just knew I felt lost.
[32] Wolf, *op cit*.

[33] Slavoj Žižek, *Violence,*(NY: Picador), 2008, 1.
[34] *Ibid,* 2.

normal state of affairs whereas objective violence is often the invisible by-product of the "normal." Consequently, we cannot apprehend them from the same positions; one is apprehended from the perspective of the normal and the other is perceived only by exposing the normal as the malleable social construction that it is.[35]

Metaphysical violence can occur in either the subjective or objective forms. In the subjective form of metaphysical violence someone's subjectivity is altered in the ways I described by an event that deviates from our "normal" experiences – sexual assault, burglary, bullying, or being the object of someone else's emotive wrath. In the objective form, it results from social, economic, political, or linguistic institutions functioning as expected – not engaging with a homeless person, speaking about a sick or disabled person as if she were not present, or refusing to accept someone's credentials to practice medicine because they were obtained abroad. In this form, while it may be malicious, metaphysical violence need not be. In the birth context, for example, because the metaphysical violence is experienced as a result of routine childbirth protocols, many obstetricians perpetrate it unintentionally – they just want to help women but the ways they have been taught to do so actually harm them.

Now that we have a clearer account of metaphysical violence, I want to more clearly delineate the relationship between it, trauma, and oppression because the overlap between the concepts may lead to confusions of how metaphysical violence differs from the other two and, thus, why it better explains childbirth-related PTSD. The same event can sometimes be described as traumatic and as metaphysically violent. Sexual assault would be a prime example of this. But, the two are distinct. Practically, this is most obviously demonstrated by the fact that (as we saw

[35] *Ibid,* 2.

earlier) many things cause trauma, not just metaphysical violence. Conversely, someone may experience metaphysical violence and not be traumatized.

Conceptually, the concepts are also distinct. Whereas trauma refers to the psychological and physiological responses to an event, metaphysical violence refers to ontological aspects of the event and those effects (though the ontological issues will often provoke the physiological stress responses described earlier). Describing it as traumatic draws our attention to the result, whereas describing it as metaphysically violent draws our attention to *how* the result *makes sense*. So, even in cases where the same event can be described as traumatic and as metaphysically violent, we should not conflate the two.

We see something similar in the relationship between metaphysical violence and oppression. There are conceptual differences between oppression and metaphysical violence. First, while oppression is always structural by definition, metaphysical violence need not be; it can occur in a singular event and be random. Second, while oppression is directed primarily at social groups, metaphysical violence is directed at individuals as individuals. It can clearly be true that the reason an individual is facing metaphysical violence is their social group membership,[36] but this need not be the case. as it could, for example, be aimed at privileged individuals. Third, while metaphysical violence can place people in double-binds, it need not do so. Hurtful language, for example, may attack another's being, even if there are many contexts where such language would be deplorable or get no uptake.

Despite these differences, it is also true that an event may be simultaneously characterized as oppressive and metaphysical violence. For instance, metaphysical violence, especially in its objective form, is systemic; it is part of society's normal routines and protocols. If those protocols

[36] In this case it could be part of Young's "Violence" face of oppression

were also oppressive, then it would be appropriately deemed metaphysically violent. And, if the protocols are metaphysically violent (i.e. if they erased or denied herself) they would also likely be accurately described as oppressive. Still, oppression calls our attention to the structural features that limit agency within the event, whereas metaphysical violence calls our attention to how this limiting of agency is experienced within the event. So, in cases where metaphysical violence is structural, it *may be* the same as oppression, but the concept "metaphysical violence: is helpful because it describes the *sense* of a particular kind of violence (which may be but is not always structural and hence oppressive) from the point of view of the experiencing *subject*, whereas oppression would describe structural metaphysical violence from the point of view of the structural. And my point is that we need to make sense *from within* this experience if we are going to find *ways out of it*—especially if we want to do so before we destroy the oppression. Metaphysical violence helps us do this.

The concept of metaphysical violence, then, finally answers our core question: Why do post-partum women have PTSD or related symptoms as a result of childbirth? In short, because they have been victims of metaphysical violence. Metaphysical violence left her confused, unintelligible to herself or others, and traumatized. Metaphysical violence led her to wonder who she is now.

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I'm pumping in my dining room watching the machine suck the milk out of my breasts three weeks after my son's birth. It still hurts. Suddenly, I laugh and scream to my sister "Look how I'm being milked!" Then, I sigh and say "I used to have a Ph.D." …For months I walked around the house, sometimes with leaking or milk-bulging, painful, breasts screaming, crying, or lamenting that I used to have a Ph.D.

Clarifying the Workings of Metaphysical Violence: Practical Syllogisms

At this point, we are left where I left off my last inquiry – we now can explain (broadly) what Brodesser-Akner and I experienced in those labor and delivery rooms and we understand a bit about what metaphysical violence is and why it was so difficult to identify. Still, as I said in the introduction, there are more questions requiring answers. I will now turn to these.

Even though metaphysical violence and oppression are distinct, I read Lugones' work on oppression as having similar goals to my project – trying to understand an experience from within to find a way out of it. I read Lugones as trying to describe what it is like to inhabit the experiencing space of one who is being oppressed and looking for a way out *from* the experiencing of oppression. Given that there are overlaps between our goals and the concepts of metaphysical violence and oppression, I was drawn to her analysis when thinking through metaphysical violence in birth and how to help women who face it. As I will show, her work on the relationship between oppression and practical reason, oppression and the self, and her suggestions for resistance provide insight into how metaphysical violence operates within the context of childbirth and offers direction for how women can navigate this terrain without being destroyed by it.

Lugones (like Aristotle) understands the practical syllogism "as reasoning that ends in action."[37] The ability to formulate and enact a practical syllogism refers to the ability to formulate reasons, intentions, and plans and then being able to execute them.[38] Oppressed peoples face two possibilities in relation to their practical syllogisms: form syllogisms that they cannot complete and/or complete syllogisms that conform to the oppressor's will.[39] So, oppressed people can either formulate intentions without the ability to bring those intentions and plans to fruition or they can

[37] María Lugones, *Pilgramages/Peregrinajes: Theorizing Coalition Against Multiple Oppressions*, (NY: Rowman & Littlefield), 2003, 56.
[38] *Ibid*, chapter 2
[39] *Ibid*, chapter 2

formulate intentions and plans according to the options available to them under oppression. While oppressed peoples clearly engage in practical reason, to paraphrase Lugones, they 'choose' between alternatives that they would not have chosen except for the oppressor's mediation. Once the oppressor manipulates the alternatives, they must proceed to reason practically and choose the alternative the oppressor wants them to choose.[40]

While focusing on oppressive structures might explain what causes certain experiences to occur, I am interested in what it is like to *be a pregnant/laboring woman in the system*. To that end, part of the experience is having the chance to formulate numerous desires about how they want to give birth without the ability to complete them. At best, they can communicate their desires to their team and hope they comply. For example, a laboring woman may create a birth plan and discuss her wishes with her obstetrician, but she has no ability to implement it. She can, at best, formulate a syllogism that she cannot ultimately enact.

To the extent that a laboring woman can complete her syllogism, her actions cannot be self-directed; it is only possible to complete a syllogism that conforms to the dictates and protocols of "normal" childbirth in the U.S. For example, laboring women can assent to or reject an epidural or rooming in with her baby, but they cannot execute syllogisms that selects an attendant, birth position, or location of comfort. They reason among the options created by others without control over the choices. In both types of circumstances, then, we see the pattern of undermining women's ability to formulate and/or implement their practical syllogisms in childbirth.

A core aspect, then, of how metaphysical violence works in birth is the way the protocols of "normal" childbirth thwart the laboring woman's practical reasoning. But the problem is not simply thwarting practical syllogisms. After all, we all have our practical syllogisms thwarted

[40] *Ibid,* 56.

sometimes in ways not attributable to violence. For example, I may have planned to buy my favorite burrito for dinner after my plane lands but, if there is a delay and my plane lands after the restaurant is closed, my practical syllogism has been thwarted. So, there must be more. I suggest that the other piece is denying the woman's curdled-multiplicitous self.

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"Why did you do that?" I asked when it was done. "I thought we were going to talk about it!"

His voice was cold, flat. "You're not going anywhere," he said.[41]

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I have just arrived at the hospital after over 48 hours of active labor. I tell the nurse and obstetrician that I would like an epidural because the contractions are really strong. They tell me I need to wait until they can put on an electronic fetal monitor

About 20 minutes later as I writhe in pain, naked, in the hospital bed I look at the nurse horrified and surprised expression. "Wow! These contractions are so strong! How have you managed without an epidural?"

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The Laboring Woman As A Multiplicitous Self

The relevance of this discussion of practical reasoning becomes clearer when we connect it to Lugones' account of the self. Recall, Lugones is not simply interested in exploring the

[41] Brodesser-Akner, *op. cit.*

experience of oppression, she also seeks liberatory and resistant possibilities. In keeping an eye toward the conditions required for this, she realizes that if the oppressed are reduced to singular selves, operating within a singular world or logic, then it appears that those possibilities do not exist. This is understandably troubling. But there is hope, namely that we are multiple and we occupy and travel between multiple worlds. Now we see the possibility of resistance.

In "Purity, Impurity, and Separation," Lugones details how the search for unity underlying the diversity is a long-standing philosophical quest. Pointing back to figures such as Aristotle or Descartes, who searched for a singular essence that defines a subject, Lugones maintains that theirs was an exercise in futility and domination. There is no singular self to be found, she argues, we are all multiple. Still, she reveals how such attempts to reduce the multiple to the singular are fundamentally exercises in control; diversity is unruly and difficult to manage, but a unified, singular being can be handled. As such, refusing such a reduction is always a resistant act.

At this point, some object to this picture. They argue that searching for a singular self is not an act of control but rather an accurate ontology of the self. Such objectors readily agree that there can be multiple aspects or parts to a self, but they are all, ultimately, part of the same underlying singular self. This singular self then unifies all of the parts into a singular whole. Lugones rejects this ontology; a multiplicitous self is not one self with many parts. There is no underlying unity, but rather, "there are no parts to be had."[42] To view someone in that way would be to fragment her; to see someone as a sum of her parts rather than as a dynamic, curdled, and constantly developing being would not see "her" at all. The subject can only be understood when we see all of her selves simultaneously, related and intermingled; She can only be seen when she

[42] Lugones, *op cit,* 90

is conceived as a multiple subject who is dynamic, curdled, and constantly evolving in relation with multiple, interlocking, oppressions.[43]

To help us understand this, Lugones explores two senses of the Spanish verb "*separar*," or "separation." The first sense is an operation of purity, which requires the complete separation of a whole into its pure constituent parts. This sense of *separar* is illustrated by an exercise Lugones performed as a girl – separating egg whites from egg yolks. The separation needed to be total, complete -- no yolky whites and no whitey yolks, just pure whites and pure yolks.

In contrast, there is another sense of *separar,* curdled separation. Curdling occurs when separate substances are mixed and, once combined, they cannot be separated again in their pure constituent parts. Instead, each element partially constitutes the other. For example, when we are making mayonnaise, we mix egg yolks and oil to make an emulsion. If the emulsion breaks down, it does not separate into the pure ingredients. Instead, it curdles, leaving you with oily yolk and yolky oil.[44]

When Lugones speaks of multiple selves, she refers to curdled-separate selves rather than purely separated; the selves are not separable in the first sense. Although one can identify distinct selves, once mixed, they never separate in the purist sense; they always contain elements of each other. They are curdled.

Our curdled, multiple selves operate within and are, in turn, partially constituted by multiple "worlds." But, when Lugones is arguing that we live in multiple worlds, she is not referring to traditional understandings of this term; she rejects the traditional Western

[43] *Ibid, 141.*
[44] *Ibid,* 122.

philosophical understanding of "world" as the sum of all things, a worldview, a culture, a utopia or a possible world.[45] To the contrary, Lugones conceives of a "world" as:

> A place inhabited by 'flesh and blood people'' an actual society, given its dominant or nondominant culture's description and construction of life in terms of the relationships of production, gender, race, sexuality, class, politics, and so forth; a construction of a small portion of society; an incomplete, visionary, non-utopian construction of life; a traditional construction of life; a community of meaning.[46]

As Mariana Ortega summarizes, "a world in this sense is thus incomplete, and it is not monistic, homogenous, or autonomous.[47]

As curdled-multiplicitous beings who inhabit different worlds, we have abilities to do some things in some worlds that we may lack in others. Amongst those things are creating and enacting practical syllogisms; in different social contexts and logics, we can create some types of syllogisms and not others. As Lugones explains: "The practical syllogisms that they go through in one reality are not possible for them in the other, given that they are such different people in the two realities, given that the realities hold such different possibilities for them."[48] In fact, if one tries to enact a practical syllogism from one context and self in another, it becomes clear that this cannot be done because "the action does not have any meaning or has a very different sort of meeting than the one it has in the other reality."[49] For example, if I stand in front of a classroom full of students and begin to conduct an exercise in that world, students will (usually) comply. However, if I just get up in front of random people at a shopping mall and enact the same plan, it will fail. The syllogisms that I can create or execute in one world do not transfer to another. I am unintelligible (at least as certain selves) in some worlds but not others.

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[45] Mariana Ortega, *In-Between: Latina Feminist Phenomenology, Multiplicity, and the Self*, 65 and 92.
[46] Lugones, *op cit,* 26.
[47] Ortega, *op cit,* 65.
[48] *Ibid,* 57.
[49] *Ibid,* 57.

As should be clear, since the worlds we operate within overlap, we occupy multiple worlds simultaneously and travel between and among the worlds. As we move between worlds, we actually experience ourselves as different people in different "worlds" and it is "the shift from being one person to being a different person," that Lugones refers to as traveling.[50] I do not transform into a totally different and separate person from my previous selves when I travel to different "worlds." Rather, I change and develop both in response to the "world" that I am currently inhabiting and in response to my memories of my self in other "worlds."

Understanding multiplicity further illuminates the workings of metaphysical violence -- in addition to thwarting the ability to form and complete syllogisms, it denies the curdled-multiplicitous self. Metaphysical violence then, both attacks a woman's agency and/or self-understanding by thwarting her ability to create and execute her practical syllogisms and by reducing her to a singular subject. This is always an exercise in control. Moreover, the singular subjectivity to which she is reduced does not possess the characteristics that she previously attributed to her self – empowered, intelligent, respectable, independent, epistemically authoritative. Worse, the process may even present a self that does not adhere to the woman's self-image or values. In this move, the woman feels as if her self is under attack, or even, obliterated.

Now we can expand our understanding of metaphysical violence in birth. First, as we saw earlier, in standard, U.S. childbirth protocols, the laboring woman's practical syllogisms have no force – they either make no sense or she is unable to execute them. Even if there is a good reason for others to thwart the laboring woman's syllogism, this is not her interpretation. From the

[50] *Ibid*, 89. Of course, there are different ways of traveling among worlds – one could do so myopically and unaware of the way that their identities shift with shifting contexts or they can do so being very cognizant of these adjustments. And, the shift to different people "may not be willful or even conscious, and one may be completely unaware of being different in a different 'world,' and may not recognize that one is in a different 'world,'" which is one reason that many do not realize their own multiplicity.

laboring woman's perspective, what was rightfully *her* call to make was wrongly made by someone else. She was not engaged. Her abilities (for example, to make a decision about rupturing membranes) were not recognized or respected. Her multiplicity was erased and she was reduced to a singular being. Regardless of intent, this was about controlling her and the birth process; she was reduced so that she could be managed. Consequently, she feels like she was not "seen" as herself; she feels as if she were just a vessel to deliver a baby and nothing more. And therein lies the violence – in the erasure, in the denial of one's curdled-multiplicitous self, in the destruction of the identity-constituting elements of the laboring woman, in rendering her unintelligible.

And now we can understand why this traumatizes some women who got through this experience, especially if we/they operate on the perception that there are only single (not multiple) selves. If, for example, a woman thinks that she is a singular self with a set of unchanging, essential, characteristics and then she has an experience that challenges her ability to define herself according to those characteristics, she may feel destroyed by birth. She is no longer who she thought she was. "Maybe I never was those things, maybe I was deluding myself all along" she wonders. Or, even if she was once a certain person, she doubts whether she will ever be that person again.

Metaphysical violence, then, is not just about thwarting practical syllogisms, it is also about doing so in a context that simultaneously negates the woman's reality that she is a moral agent capable of executing her own syllogisms or, at least, be involved in the process of their formation and implementation. It denies that she cannot be reduced to the person in that delivery room and engages not the person she thought she was, but rather, someone who she does not recognize. In doing so, metaphysical violence denies the woman's curdled-multiplicitous subjectivity, treating someone who is central to the process as if she were peripheral, treating someone who is multiple

and dynamic as if they were singular and static, treating someone who travels through many worlds as if they occupy only one. And this conceptualization suggests where we can find the resistant, liberatory, possibilities.

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I look at my midwife as I consent to the cesarean section. She looks at me disappointed and betrayed. Her eyes say: "I told you this would happen if you came here."

They wheel me away.

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I am in the operating room hysterically crying as they prepare to operate. I remember my aunt, Linda, who died giving birth nearly 38 years before. It was realizing that in another time I would have certainly shared her fate.

How many people have had that thought?
I panic.

As I cry, I beg the anesthesiologist: "Please don't let me die."

He looks at a nurse and says: "She's too hysterical." He places a mask on my face and says "good night."

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Remembering Multiplicity: One Way to Resist Metaphysical Violence

If the above assessment is valid, then it points to Lugones' suggestion of remembering multiplicity as a possible remedy. If the metaphysical violence and its trauma are rooted in denying the woman's curdled-multiplicitous subjectivity, then helping women remember it could blunt the traumatic effects (or, at least, the severity of their impact). After all, despite her perception, the laboring woman was, and still is, a curdled-multiplicitous subject. She still exists – and *she* never

stopped existing. There were always worlds where she formed and executed her practical syllogisms. There were always worlds where she was more than a body birthing a baby. But, because of metaphysical violence, she forgot that; she cannot see it. But we can help her remember herself in other worlds both during and after labor. We can help her remember her multiplicity, remember herself form and execute practical syllogisms in other contexts, remember herself in other worlds. In doing so, she resists the reduction from multiple to singular and the depiction of her subjectivity projected in the birth system. Lugones summarizes the point best:

> the connection between the practical syllogism, ontological plurality, and liberatory theory lies in the fact that the oppressed know themselves in realities in which they are able to form intentions that are not among the alternatives that are possible in the world in which they are brutalized and oppressed.[51]

The potential of this idea is reinforced by recalling that remembering and maintaining one's multiplicity is an act of resistance that can help empower the woman. After all, if reducing a multiplicitous subject to a singular one is an act of control, keeping one's multiplicity present resists that move. The liberatory possibility, then, enters in the memory of her multiplicitous existence.[52]

To help see how this could work, let us recall Lugones' example of the maid. As they go about their daily lives, her employers almost do not perceive that maid at all; she is just part of the background. They do and say things in front of her they would never do in front of friends or family. In this context, their perception of her is totalizing – in their apprehension, she is completely reduced to the maid and nothing else. But, theirs is not the only perception. Her memory of being a curdled-multiplicitous self allows the maid to escape this totalizing arrogation by remembering herself in other worlds, worlds where she may have a partner, family, friends and,

[51] *Ibid*, 59.
[52] *Ibid*, 58.

where she can formulate and complete practical syllogisms. So, while the maid cannot change how her employers perceive her, she is able to escape the totalizing nature of the apprehension by remembering her multiplicity.

While not analogous circumstances, I think this example presents can point to hope for laboring women. Laboring women often feel as if obstetricians and attendants perceive them in totalizing, reductionistic, ways.[53] The women feel as if they treat them not as present persons but as part of the background (the potential problems that could arise in birth is the foreground holding their focus). They feel their attendants acting as if she is not there by ignoring her wishes, pleas, and ideas by speaking and acting as if she is not present.[54] And then women feel as if that gaze is totalizing; they cannot conceive of any other context but the one they are in. But, like the maid, if she can remember her selves in other worlds. She can remember that the world she currently inhabits is not the only one and the self being perceived (and even animated) in that labor and delivery room is not "who she really is," then she can escape the totalizing nature of the gaze that she feels she is experiencing and its consequences. Remembering her multiplicity will help her see that *she* – the curdled-multiplicitous, resisting self - still exists even when she feels that she does not. Maybe, her syllogisms will be thwarted in this world, but there are many places where they are not. Yes, she may be unintelligible or submissive or erased in the hospital context but there are other contexts where she is intelligible, respected, and active. In remembering this, she can preserve her sense of self in the midst of practices that, intended or not, threaten it. As such, they recognize their own curdled-multiplicitous subjectivity and realize that – even a bad – birth did not destroy them.

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[53] Regardless of the factual validity of this perception.

[54] One example the author experienced was during her second cesarean section. Throughout the surgery, the obstetrician kept discussing her lack of body fat with the other attendants and commented continuously on the body types of "most of the women" on which he performs this operation.

I do not simply believe this could work for theoretical reasons. I had childbirth-related PTSD in my first birth, but not my second. I think some of this is attributable to being able to remember my multiplicity throughout my second pregnancy and labor. The second birth was not really what I had wanted, but it was not traumatic. It did not destroy me.

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Birth 1

I am in the birth center after laboring for 36 hours. The pain is so intense. I can't sleep. I can't eat. I'm exhausted. I want an epidural. I want to sleep. I want to just have this baby. But, if I go to the hospital, if I have an epidural, will I betray all of my values? My years of research on birth?

I call my friend Jen. I tell her all of this. She tells me that I am betraying nothing. I can still be me and have an epidural.

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I want my favorite burrito.
My mom goes out and brings it to me.
Then I go to the hospital.

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After three and a half days of labor, I consent to the cesarean section. If I don't, I am certain I will die. Like my aunt. Like so many women over the centuries. Wait, I am being too dramatic. Maybe if I just hold out a little longer …
I'm unconscious.
The surgery has started.
In the middle of the cesarean, the obstetrician goes to the observation window to show my husband my badly bruised uterus, which was on the verge of rupture.
She says: "so she'll never doubt she needed this."

Later, my husband finds her and says "thank you." He hugs her. I never see her again but I would do the same I am so grateful.
So grateful that I cry as I write this.

Birth 2

My new midwife asks me if she could read some of my work.

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In between contractions we debate the best "birth music"

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Every time I have a contraction, the anesthesiologist comes and asks if I have "changed my mind on that epidural." The midwife, doula, and I joke at how similar it is to so many birth stories I have read.

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I am exhausted in the birth suite, unable to believe that I am thinking of an epidural again. My doula rubs my back and explains why an epidural for maternal exhaustion is medically justified.

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Something has changed. The baby's position is wrong. I tell my team. They tell me that they can't confirm. Calm down.

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I have been pushing for over two hours – the mirror that has been placed so I can see my baby come into the world is mocking me. Nothing is happening. I can't believe I'm here again. The universe has fucked me.

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I am being wheeled into
the operating room to have the
cesarean that I have prepared
9 months to avoid. My midwife is
whispering in my ear: "you made the right
call."

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On the operating table. Everyone starts to laugh.
My midwife says: "Wow! You were right! This baby
is diagonal and face-up!"

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"Congratulations, you have a baby girl"

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Pushing for Empowerment: The Ethical Complications of Birth Plans

Barry DeCoster

Abstract

The birth plan has become an increasingly institutionalized tool of Western birth practices, used both in medicalized and midwifery settings. Limited empirical research has been done on the efficacy of birth plans in achieving a commonly-ascribed goal: empowering women in their birth experiences. Still, less work has been done on the ethical dimensions of birth plans. As such, this tool has become nearly ubiquitous in birthing practices, yet they warrant further reflection. In this paper, I articulate the ethical goals of writing birth plans. I frame the birth plan as a narrative project: one that women are encouraged to write out, after careful consideration, as a kind of story that articulates the values, experiences, and relationships that are most important to shaping their experience of a "good birth." Given the importance of the birth experience for many women, birth plans are ethical projects that the attempt to reframe and improve the deeper political dimensions of birth and patient choice. Birth plans are meant to structure the experience, guide women's understanding of the process, and foster important clinical relationships. In this way, they are similar to advance directives, which are written to shape successful end-of-life care. Yet, the success of birth plans as tool for this ethical work is questionable. This tool aiming at women's empowerment and ethical self-reflection often sets women up for a kind of ethical injury, in the attempt to avoid unwanted physical harms of labor and delivery. Birth plans are not legally binding, despite how they are framed as pseudo-contracts. Instead of resisting the challenges of a medicalized birth and to be empowered agreements, birth plans often set women up to fail, often aiming at unreasonable expectations. In my argument, I ask to identify for whom the birth plan works, and in which ways the birth plan experience can be improved. Finally, I address how the failure to give birth plans uptake during emergencies often undermines the patient-physician relationship, working against the primary goal of empowerment.

Keywords: Birth Plans, Birth Ethics, Empowerment, Medicalization, and Resistance

"Pushing for Empowerment: The Ethical Complications of Birth Plans"

> "Despite it all, I had high hopes for how the birth of my son, at a major hospital in the medical mecca of Boson, would unfold. I purposefully chose a female obstetrician. Armed with a birth plan, the latest fad in obstetrical empowerment, I knew I would sail through labor wearing my favorite black spaghetti-strap nightgown—no johnnie for me! The lights would be dim, an epidural anesthetic juicing my spine only if absolutely necessary. I had written won my instructions for the nurses to read so that even if I was in too much pain to explain it to them myself, my plan would be clear."[55]

Introduction

Since the early 1980s, the birth plan has become an increasingly institutionalized tool of Western birth practices, equally at home in both medicalized and midwifery settings. Limited empirical research has been done on the efficacy of birth plans in achieving a commonly-ascribed goal: empowering women in their birth experiences.[56] Still, less work has been done on the broader ethical dimensions of birth plans. Thus, this tool has become nearly ubiquitous, yet they warrant further reflection. This tool aiming at women's empowerment and ethical self-reflection often sets women up for a kind of ethical injury, in the attempt to avoid unwanted physical harms of labor and delivery.

In this paper, I articulate the ethical goals of writing birth plans. I frame the birth plan as a narrative project, which women are encouraged to write out, after careful consideration, as a kind of story that articulates the values, experiences, and relationships that are most important to shaping their experience of a "good birth." Given the importance of the birth experience for many women, birth plans are ethical projects that attempt to reframe and improve the deeper political dimensions of birth and patient choice. Birth plans are meant to structure the experience, guide

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[55] Tina Cassidy, *Birth: The Surprising History of How We Are Born* (New York, NY: Grove Press, 2006) 2–3, online, Internet, 10 Mar. 2019.

[56] Paul Burcher, a physician and bioethicist, describes the tensions between empirical and normative work of birth plans: "The Ulysses contract in obstetrics: a woman's choices before and during labour" *Journal of Medical Ethics; London*. 39.1 (2013): 27.

women's understanding of the process, and foster important clinical relationships. In this way, they are similar to advance directives written to shape successful end-of-life care.

Yet, the success of birth plans as tool for this ethical work is questionable. Birth plans are not legally binding, despite how they are framed as pseudo-contracts. Instead of resisting the challenges of a medicalized birth and to be empowered agreements, birth plans often set women up to fail, often aiming at unreasonable expectations. In my argument, I ask to identify for whom the birth plan works, and in which ways the birth plan experience can be improved. Finally, I address how the failure to give birth plans uptake during emergencies often undermines the patient-physician relationship, working against the primary goal of empowerment.

In this paper, I articulate the moral goals of writing birth plans. I then ask whether birth plans make women's lives better or improve clinicians' experiences.

What is a 'Birth Plan'?

Most women who have given birth in the last two decades may likely be familiar with the birth plan as a possible tool for planning or imagining what kind of birth experience they may want.[57] Today, they are described in most books marketed to women about planning for birth, such as the commonly read *What to Expect When You're Expecting*.[58] Historically, the birth plan was first developed in the late 1970s, in large response to the women's health movement. The written birth plan become common in the 1980s, but its historical roots go further back. [59] It comes out of

[57] While I focus on pregnant women's experiences in this paper, it is important to note that partners, husbands, and family members may also partake in the writing of birth plans and/or be influenced by them. Given the limits of this paper, I will not always draw attention to these additional experiences directly, although that is not to dismiss their ethical importance.
[58] Heidi Murkoff and Sharon Mazel, *What to Expect When You're Expecting, 4th Edition*, vols., 4th ed. (Workman Publishing Company, 2008).
[59] Judith Lothian, "Birth Plans: The Good, the Bad, and the Future" *Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 35.2 (2006): 295.

women's healthcare movement, trying to resist medicalized birth. In prior moments, women had sought better pain management. Following this success, women developed the birth plan into a wider tool, one aimed at giving greater planning ability around birth, and perhaps the secondary goal of greater control around birth.

Birth plans are typically written documents meant to express women's goals and expectations about their birthing experience. Birth plans are formatted in a variety of ways, from detailed personal narratives to a common "tick box" form provided by hospitals, to web pages downloads, to notes taken on a verbal conversation. Some are brief (less than one page) articulating main goals. Others work as narratives, with explanations about why a certain procedure is requested or refused. A quick internet search for "birth plans" will provide one with a vast range of posted examples of peoples' personal birth plans, shared both with clinicians and with the public. In addition, users often provide narratives about birth plans, such as explaining why they have added (or opted not to add) certain features to their plans.

The birth plan can cover a range of topics, from the clinical (e.g., whether the pregnant woman wants epidurals or episiotomies considered/offered, wishes about C-sections, the goal of a standing and mobility while in labor) to what might be called the experiential factors (e.g., what music to play in the room; who should be present at delivery). Birth plans may also cover postnatal care issues, e.g., circumcision, vitamin K drops, or PKU tests. Women are often counseled to prioritize their goals, and then to discuss the plan with their midwife or obstetrician. Print materials often emphasize that these are articulations of what the woman wants, but this is not a "prescription" or "set of orders" for the clinicians at delivery.

The successful rise in popularity of the birth plan developed from women's health movements, but also from successes in bioethics in changing clinical practices, especially around

end-of-life decision-making. Do Not Resuscitate (DNR) orders, living wills, and health care powers of attorney have been developed to articulating patients' values and preferences at the end of life. Here, the goal of achieving a "good death" means interrogating patients' wishes and needs, say, around use of CPR, breathing tubes, or medications. Much like the birth plan, DNRs articulate which clinical actions are to be allowed, but this is shaped by patients' themes of respect, control, and lessening anxiety when patients at the end of life and their families must engage with clinicians. In part, by articulating these values and goals in writing, the hope is patients can receive the kind of care they wish from clinicians, without emotions or clinical "emergencies" overriding in these important moments.

However, there are limits to this analogy of birth plans to end-of-life documentation. While these other end-of-life documents have legal or policy protections, there is no legal standing for birth plans. They are not legal documents, despite the similar attempts to seek control. Despite mirroring the legal or policy language, birth plans are instated (at best) a documentation meant to ease discussions between pregnant women and clinical staff and may often be part of patients' medical charts. While women's demands may be made such documentation, clinicians often resist birth plans, noting that such promises cannot be guaranteed. They do not override hospital policies, nor does the birth plan itself replace other documentation about the woman's consent (or refusal) to other procedures.

Birth Plans as a Response to Medicalization of Birth

As a tool, the birth plan was crafted in the momentum of the women's health movement as a resistant response to the medicalization of birth. The exact definition of medicalization is often contested, but it largely refers to the reshaping of non-medical problems and variation into medical problems. A second related problem is that this changes agency, allowing only clinicians the

epistemic voice and authority to speak on these matters. When thinking about the medicalization of birth, specifically, then the feminist criticism focuses largely on what are appropriate medical interventions, are they utilized in the proper frequency (e.g., the questioning of C-section rates in the United States), and whether women have a voice in their own birth experiences given the traditional medicalized script by which births typically take place.

In writing a birth plan, women are outlining a kind of clinical agency that they are seeking. As such, it is more than a list of acceptances and rejections of clinical tools. The birth plan creates an agent who is either embracing or rejecting a medicalized framework of birth. But as I outline in greater detail below, often the work of birth plans are dismissed. We might describe such moments as acts of what Allison Wolf describes as metaphysical violence in the clinic: moments where agency and identity are undermined or prevented, typically improving clinical authority over the moment at hand.[60]

The reflective criticism of medicalized birth is an ethical project to the degree in which it allows women to resist unnecessary or unwanted medicalized experiences. The birth plan was one small tool, working to empower women to craft the kind of identity she wants to have (or to avoid) as a woman giving birth. Rather than seeing birth as exclusively a medical challenge demanding medical responses and oversight, it centralizes the experience of birth within the woman's larger life and goals. Birth plans here help women to reflect on what kind of patient she wants to be; whether she even wants to become a patient in the clinical setting of a hospital; who can help her achieve these goals?

[60] Allison B. Wolf, "Metaphysical Violence and Medicalized Childbirth:" *International Journal of Applied Philosophy*. 27.1 (2013): 101–111.

Why Write a Birth Plan? What are Women's Goals?

Although there has been much written about the crafting of birth plans, there has been surprisingly little ethical analysis of them. The explicit goals of birth plans frequently overlap in the clinical and lay literatures on birth. Here, I want to lay a foundation for analyzing the ethical goals of writing a birth plan, which are about allowing women to reflect on what kind of birth experience they would like to have and what kind of relationship they are seeking with clinicians. In the next sections, I identify three frequent goals cited as to why women might craft a birth plan: education of the woman; facilitate communication; and allow greater control and empowerment.

Education

For many women, writing a birth plan allows them time to educate and reflect about what the birth experience might entail. She might learn about possible birthing situations and procedures, which is the goal of quality childbirth education. This work may be especially important for women in their first pregnancy, since both the bodily experiences and the clinical culture may be new to them. Part of what happens here, though, is the expansion of women's moral imagination about what they may want, as well as how and who to ask for support in seeking these goals. Without such preparations, women may not know when and whether to ask, say, for pain medications during labor. The drafting of a birth plan facilitates this, in that many systems ask women to reflect on what medical services they are seeking (or seeking to avoid). Thus, in the creation of the birth plan, women are educated about not just medical facts, but the important ethical work of reflection on one's personal values, which may require the *creation* of those values for moments she has not previously considered or experienced. Yet many women remain frustrated when this act of moral self-definition remains one-sided—that is, fails to achieve uptake from others.

Improving Relationships via Communication

Another common goal for birth plans, one which has important ethical importance, is the improvement of relationships in birth, both between the pregnant woman and clinicians, but also with the woman and her other (non-clinical) support team, such as partners, duals, or family members. Many women, following suggested procedures, develop their birth plan and review it with their midwives or obstetricians. The plan is negotiated, and at the end of the meeting, everyone agrees it is a workable plan. At its best, this is how the birth plan is meant to foster communication and a sense of trust between patients and clinicians. Copies of the birth plan are distributed, including placed within the medical charts, ensuring its availability on the day of delivery.

In these relationships, the birth plan lets the woman communicate her goals and values clearly and in advance of birth. Birth plans thus help her articulate how she wants to be treated herself, but also her requests and expectations of others. Thus, the important ethical work here is communication of values, but allows for a foundation for developing multiple trusting relationships.

The results of this ethical work here are mixed. If one searches online for birth plans, one will also find numerous accounts of plans that both worked to support these relationships, with as many reports of failures. When birth goes smoothly and without complications, it is quite easy to attend to the details of birth plans. But most women expect that the birth plan covers both the uncomplicated and the complicated birth experience. Part of the planning for the future is to plan for both easy and difficult moments, and how we shall respond to both.

Consider reasonable cases when problems arise during labor. In such situations, many women report that the birth plan is quickly tossed out the window. In these moments, women may

rightly ask if the carefully crafted plan ever had real clinical support, or if instead there was a shallow agreement by clinical staff, knowing that the plan was non-binding. For these women, they often report feeling betrayed when the plan is not followed, when they realize the control they sought is largely illusory. Unless the plan has been discussed as only best-case guidance, or that it is at most a flexible plan (more on this later), then women may feel the birth plan has created a false foundation for their trusting relationships with clinicians.

Interestingly, nurses often report feeling frustrated, if not resentful, of birth plans. Physicians expect nurses to explain to patients, to cajole them if necessary, why the birth plan can no longer be followed. At these same crisis moments, patients often expect nurses to serve as their advocates by reinforcing the plan. This places many nurses, who may already be overworked, as mediators in a rigged game. In addition, there are discussions (both by pregnant women and nurses) about how to write birth plans that nursing staff will take seriously. Often, these advocate for clear language, simple plans, and ones that understand medical realities. But disturbingly, some nurses (perhaps in attempts be darkly comedic) note that they find the experience of birth plans a waste of energy, if not damaging. For example, one nurse wrote on her experience, "Sad to say but every birth plan I ever saw was ridiculous! Not to mention it was always a curse that led to a c-section!"[61] Certainly, this does not reflect all nurses and clinicians, but it does provide insight in that clinicians may not support this tool, without articulating this clearly to the women they work with.

Consider a different albeit common experience, which raises further problems for communication and trust in the patient/clinician relationship. After the negotiation and agreement

[61] "Say What?! Nurses Weigh In on 'Ridiculous' Birth Plans" *Parenting*. , 6 Dec. 2012, online, Internet, 1 Jan. 2019. , Available: https://www.parenting.com/blogs/project-pregnancy/melanie-parentingcom/birth-plan.

about the birth plan, will the birth plan be helpful during the delivery process? There is no guarantee the birth plan will be reviewed by midwives, nurses, or obstetricians as a reminder of what the woman's birth goals and preferences might be. And, being human and busy, clinical staff might be understandably unfamiliar with the details that are so deeply important to the woman in labor. Much like other information available, it is often common that the medical chart is provided a cursory review, if at all. More challenging, there is no guarantee the midwife or obstetrician will be on call the night one goes into labor. The attending may never read your plan or may have little motivation to take your plan to heart. As such, they may never know your preferences, or had little to no engagement in the crafting of this plan for shared values.

If women struggle to hold onto their original plan—say, to avoid episiotomies—clinicians often play what I think of as the trump card in the deck: "You want the baby to be safe, don't you? You don't want to harm the baby, to risk the baby's death?" Continuing the metaphor, at this point, most women just fold. Despite the work to craft and articulate the ethical values important to the pregnant woman, such clinical comments are common and largely eradicate the work intended by birth plans. Rather than feeling supported, women here may feel ignored—or worse, attacked—by the clinical staff she's working with.

Control

Although the not always an explicit goal of birth plans, the writing of such a plan often is intended to give women a greater sense of control over her birth. More than just articulating important values, a plan brings order to a complicated and important experience. We develop plans to bring order to many aspects as of our lives, not just birth. One mother compared the experiences of planning for birth to that of planning one's wedding, and the dangers of not planning:

> "The other is the problem of simply letting things happen without any planning. Would you simply "wing it" on your wedding day with no preparation? Not likely. Our wedding

> day is no less important and equally as stressful as birth. Not to mention there are unpredictable events at nearly every wedding. Planning your wedding well in advance can ease some of the stress for a new couple, just as writing a birth plan can make a birth experience a bit easier for everyone."[62]

It may be reasonable to say that planning reduces stress for the bride and her guests, as well as for the woman in labor and the clinicians involved. However, taking the comparison at face value, when I hire a wedding planner to help guide me through the chaos, I am in charge as the one hiring for this service. This is not the case with the birth plan. While women work with a physician, she may be reasonably understood to be doing much of the work. In addition, we rarely give women the option to "fire" a physician when she is in labor. She can make requests, but as noted above, a woman's consent can be undermined easily if the baby.

There's something curious here about comparing these two "important" days of a woman's life. Rebecca Kukla discusses this comparison by articulating a damaging double-standard women face. On the one hand, Kukla writes, "When women were first encouraged to draw up birth plans in which they specified their preferences…the laudable idea was to help women become at least partial agents of their own births, rather than passively submitting to medical management. However, over time, formulating a birth plan has moved from an empowering option to a social duty."[63] On the one hand, the culture around birth plans has evolved to nearly require women to create such a plan: women who fail to draft a birth plan are criticized as being uninterested, disengaged mothers, failing to live up to the newly evolved ethical duties expected of pregnant

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[62] As quoted at: "Our Birth Plan" *The Journey: Before and After Childbirth*. , 26 Jul. 2010, online, Internet, 1 Jan. 2019. , Available: https://happymommy85.wordpress.com/2010/07/26/our-birth-plan/ Original post no longer available.

[63] Rebecca Kukla, "Measuring Mothering" *IJFAB: International Journal of Feminist Approaches to Bioethics*. 1.1 (2008): 74–75.

women as ethical patients. But on the other hand, we penalize or dismiss women who articulate unrealistic expectations or get medical facts incorrect.

Further, women are often left unclear as to whether the plan is "set in stone" or merely advisory. Women are typically counseled to remain open to change, even while trying to gain stability in writing birth plans. Nearly every guide to writing a birth plan informs women to remain "flexible" as complications may arise, despite best efforts to avoid them. Note here that birth plans do not allow space for a "Plan B" or backup plan. The focus is on the expected, perhaps idealized, birth experience, while addressing the likely questions and challenges this woman may face given her clinical particulars. It is unlikely that all deliveries will go according to plan, as happens in all of medicine. Rather than have multiple plans articulated, nearly every book and article encourage women to "remain flexible" in their expectations since birth "doesn't always go according to plan." While the exact language may vary, there is a consistent and perhaps reasonable warning here to women that birth plans may have limits. But what does "flexibility" mean here, especially if you are seeking means to resist the damages of a medicalized birth, to regain a sense of control over one's birth experience?

In jettisoning the birth plan, the woman is immediately returned to a pre-plan state. Her needs are rendered irrelevant, inarticulate, and control is returned to clinical judgment. The call to "remain flexible" is not a tool of resistance, in that it asks the vulnerable patient to change, without any examination, critique, or change to the dominant system that generated the problem. This loophole to the birth plan is, rather, a strategy for returning the woman to the position she originally sought to avoid, returning her to the master narrative of "doctor knows best."

The Question of Empowerment

At this point, it is important to address a major ethical question around the use of birth plans: do birth plans empower women in their birth experiences? Empowerment here is importantly different than clinical efficacy or patient autonomy, but the way this term is frequently used in birth warrants our attention to its use. Although a valiant aim, I am often uncertain what women, clinicians, and bioethicist mean by their use of the term. In the quote at the top of this article, Tina Cassidy uses the term. The initial read is positive and supportive. But one can re-read her words as ambiguous: is she as birthing mother being empowered, or is "obstetrical empowerment" somehow continuing to support the status quo of obstetrics?

As Iris Marion Young writes, on the difficulties of pinning down a definition: "Empowerment is like democracy: everyone is for it, but rarely do people mean the same thing by it."[64] The term "empowerment" is most frequently used within feminist literature, and other liberation struggles. Despite being frequently used within both the birth movement and clinical bioethics literature, there has been rather little that finalizes a definition of empowerment.[65] The remaining problems might also be how to identify whether we've achieved it, and perhaps—if it is being misused—what harm may result.

Carine Mardorossian describes her experience with developing a birth plan, which I think can serve as an exemplar of the experiences of many women:

> "Like many other women of my generation, I thought that because I was an enlightened and educated person who had assimilated feminism's lessons, I was somehow less likely to be affected by the structures of power that surrounded me. I believed that my enlightenment in fact allowed me some measure of distance and control vis-à-vis

[64] Iris Marion Young, "Punishment, Treatment, Empowerment: Three Approaches to Policy for Pregnant Addicts" *Feminist Studies*. 20.1 (1994): 48.
[65] Virginia L. Warren, "From Autonomy to Empowerment: Health Care Ethics from a Feminist Perspective" in *Bioethics, Justice, and Health Care*. Ed. Wanda Teays and Laura M. Purdy, vols., 1st ed. (Wadsworth Publishing, 2000), 49–53.

> potentially disempowering situations. I had knowingly chosen a more impersonal and clinical setting for delivery, and I was determined not to let the environment in which I was to give birth have any bearing on my relationship to the birthing experience or to my husband. Their script, I thought, would not affect ours.
> Little did I know, however, how meaningless our script would become in the context of labor and hospital practices. It was not that the medical staff was unwilling to accommodate our wishes but that our wishes quickly sounded hollow and trivial in the institutionalized context of the hospital where only systematic procedures appear reasonable and acceptable." [66]

Ultimately, part of empowerment in medicine is giving voice to patients to decide how they wish to be treated. Whether birth plans work towards empowering patients is not, then, obvious.

The bioethicist Mary Mahowald rightly distinguishes medicine as a profession from medicine as a business. While a business has as its primary goal generating profit, a profession is "an occupation through which individuals are equipped through their education and training to exercise specific power or expertise in behalf of those who lack such power and expertise. However, the goal or end of a profession is to empower the other…so that he or she no longer needs the services of the professional."[67] This may be an idealist goal, but there are realistic means to empower women towards these ends. It frequently is attempted with the language of patient autonomy, listening to the voice to patients in deciding best actions. But as addressed earlier, the writing of birth plans may be a false voice, one listened to only when birth proceeds without complications. The successful birth—one that goes according to plan—is not really an indication of the successful birth plan. It may be perhaps a matter of luck—there were no complications faced. Or, it is a symptom of the woman's own privileged social position: she has the money, education, power, authority to demand that her wishes be followed, something often lacking for

[66] Carine M. Mardorossian, "Laboring Women, Coaching Men: Masculinity and Childbirth Education in the Contemporary United States" *Hypatia*. 18.3 (2003): 124.
[67] Mary Briody Mahowald, *Bioethics and Women: Across the Life Span* (Oxford University Press, 2006) 27.

women of color. This sets women of color up for poorer health outcomes,[68] as well as frequently seen as hostile (rather than empowered) when declining medical services.

My own personal experiences with birth plans is from a distance over the last few years, via six female friends who were pregnant, and my friendship and support to them provided in various ways through their birth experiences. These women were all white, college educated (many with advanced degrees). Most wrote birth plans as either preparatory work, or some with the stronger conviction that it was part of their feminist identity and necessary work. Their tendency to write a birth plan may not be surprising, since women who write birth plans are more likely to be older and college educated. [69] But even for these women, the birth plan failed in that they were typically not followed for a number of reasons. Only one woman in this group told me that she was fine with it: for her, it was really not that important to have stuck to the plan. But for others, the plan was deeply important and the failure of the plan resonated into the failure to as a woman to deliver "properly."[70]

Getting empowerment "right" here matters for future uses of the birth plan. Some have argued for the export of birth plans to empower women of color and women outside of the United States.[71] Given that white, educated, and financially independent women frequently find birth

[68] Nina Martin and Renee Montagne, "Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why" *NPR.org*. , n.d., online, Internet, 1 Jan. 2019. , Available: https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.
[69] Shad H. Deering et al., "Patients Presenting with Birth Plans in a Military Tertiary Care Hospital: A Descriptive Study of Plans and Outcomes" *Military Medicine*. 171.8 (2006): 778–780.
[70] Allison B. Wolf, "Birth without Violence" *JanusHead*. 17.1 (2019).
[71] Eileen A Yam et al., "Introducing Birth Plans in Mexico: An Exploratory Study in a Hospital Serving Low-Income Mexicans" *Birth*. 34.1 (2007): 42–48.

plans to be less than empowering, we might proceed with caution and skepticism about expanding this tool to women who begin their clinical relationships with even fewer privileges.

To empower women in birth is not necessarily the same act as removing power from clinicians or medicine as a profession. As Mahowald writes elsewhere, the power of the profession of medicine "is morally exercised when it reduces domination by empowering the individual or group it serves. To the extent that its use dismantles their power or increases their domination, it is immoral; to the extent that its use fails to improve the status of the client or patient, it is amoral. Professional power is thus morally exercised as *power for empowerment*; it fulfills its essential purpose only to the extent that its exercise enhances the lives of those on behalf of whom the profession is practiced."[72] So, challenging the ethics of birth plans is to call upon obstetrics to reflect on how it uses power, rather a request to limit its power to serve patients.

Virginia Warren has argued for distinguishing between patient autonomy and empowerment. Both support patient decision making. But as Warren rightly notes, the standard view of patient autonomy is an individualist activity. The autonomous decisions of one woman, such as those described in a birth plan, does little ethical work to improve the autonomy of the next woman. Women make autonomous decisions despite clinical power, not in collaboration with clinical power. Empowerment, though, provides ethical improvement across bonds of community. Empowerment is accomplished with the support of others, not individualistically. Empowerment focuses on the social and political context, including how ethical decisions are made from within relationships of power that reflexively shape those same ethical decisions.[73]

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[72] Mary Briody Mahowald, *Women and Children in Health Care: An Unequal Majority*, 1st ed. (Oxford University Press, USA, 1993) 258.
[73] Warren, "From Autonomy to Empowerment: Health Care Ethics from a Feminist Perspective" 51.

Birth plans have clearly become a public tool, in that they are frequently utilized and openly discussed. But this is not the same kind of success as bringing women together. Birth plans are ultimately individualized projects. They are crafted by women without needing to work with other women. The success of one birth plan does little to improve the success for the next woman. In fact, the isolation here may allow women for whom the birth plan fails to feel even more alone, in that the failure was her own, caused by unique birth experiences or a flawed birth plan. Birth plans by themselves do no real work in critically reflecting on the causes of a medicalized experience or articulating how *women* are created as agents.

Instead, individual women write individual plans for how they hope to best navigate the medialized system of birth. As Elizabeth Bogdan-Lovis argued, this failure to empower is actually a result of the success—and unintended side-effects—of liberal feminist strategies in medicine.[74] The focus on individualistic liberal reform to ensure patients' rights, such as the focus on end-of-life documentation—ultimately worked to separate women from other women, given that communal action and reflection was no longer supported.

[74] Elizabeth A Bogdan-Lovis, "Misreading the power structure: Liberal feminists' inability to influence childbirth" *Michigan Feminist Studies*. 11 (1996): 59–79.

Conclusion

In this paper, I have argued for a more expansive ethical analysis of the birth plan, opening up questions beyond empirical efficacy, clinical satisfaction, and the basic bioethics analysis via informed consent and patient autonomy. Birth plans are meant to be tools to improve women's experiences in medicalized birth systems.

If the paper begins by asking whether birth plans accomplish their ethical goals, the conclusion is less than clear. In many ways, birth plans do important ethical work by helping women to identify and reflect on the values that shape their ethical decisions and may encourage women to embrace childbirth education in a richer manner.

I have argued here that the birth plan often fails on its own articulated goals in the practice of bringing about a good birth. Rather than promoting better doctor-patient relationships and patient empowerment—women often feel these goals remain out of their reach. Effective in achieving some goals, these pseudo-contracts are meant to inform decisions before and during birth, but within a system of change and likely unforeseen variables and clinical realities. The birth plan obscures attention to questions of social structures and powers within birthing practices. By continuing to isolate women's reflection, these do little to improve large-scale critique or change of medicalized systems of birth. As such, an individual woman seeking a good birth is often left with no tools for defending herself, for criticizing or correcting the very problems she faces. In this way, the "good birth" sought in writing a birth plan sadly often remains a fiction.

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Whose Ethics? Making Reproductive Ethics More Inclusive and Just

Sonya Charles

Abstract

As the field of assisted-reproductive technology progresses, bioethicists continue to debate whether and how the availability of this technology creates new moral duties for parents-to-be. It is rare for these debates to seriously engage with questions related to race and class. Camisha Russell asks us to move race from the margins to the center of our discussions of reproductive ethics. She argues that this shift can work as a kind of corrective that will lead to better theory. In this paper, I build on Russell's work by considering two proposals related to prenatal genetic diagnosis [PGD] that received a lot of attention and debate—Julian Savulescu and Guy Kahane's argument in favor of a "principle of procreative beneficence" and Janet Malak and Judith Daar's argument in favor of a legal duty, in certain cases, to use PGD. My analysis of each of these arguments shows how a lack of diverse viewpoints leads to bad theory. I end the paper by showing how including a diversity of perspectives shifts our focus from rights to justice.

Keywords: ART, Race, PGD, Genetics, Reproduction

Whose ethics? Making Reproductive Ethics More Inclusive and Just

As the field of assisted-reproductive technology [ART] progresses, bioethicists continue to debate whether and how the availability of this technology creates new moral duties for parents-to-be. However, many of these debates suffer from a lack of vision. Socrates famously said the wise man was one who knows what he does not know. Yet, many bioethicists seem blissfully unaware of viewpoints outside of their own – usually white, middle-class, and academic. Thanks to the work of activists, there has been a lively discussion about the implications of these technologies for those with disabilities. Still, it is rare for these debates to seriously engage with questions related to race and class.

In "Questions of Race in Bioethics," Camisha Russell asks us to move race from the margins to the center of our discussions of reproductive ethics. She argues that this shift can work as a kind of corrective that will lead to better theory.

> In the case of bioethics, then, I would argue that philosophers of race must insist upon not only the necessity but also the *centrality*, of discussions of race to the broader field. They must show that there are vital lessons to be drawn from the experiences of racial minorities for bioethics *as a whole*. (Emphasis in original. Russell 2016, 49)

Specifically, Russell believes that making race central to bioethics will shift our primary focus "from rights to justice, from consent to collaboration, and from competence to humility" (Russell 2016, 44). Russell discusses many ways race works in "our" understanding of assisted-reproductive technology. My analysis focuses more on class than race but yields similar results.

In this paper, I build on Russell's work by considering two proposals related to prenatal genetic diagnosis [PGD] that received a lot of attention and debate. First, I discuss Julian Savulescu and Guy Kahane's argument in favor of a "principle of procreative beneficence." Much of their argument rests on "our" intuitions or what they call "commonsense morality." Similar to

Russell's discussion of race and ART, I will show how their understanding of "commonsense morality" rests on certain class biases. Second, I discuss Janet Malak and Judith Daar's argument in favor of a legal duty, in certain cases, to use PGD. By putting their argument in the context of the criminalization of pregnancy, we can see how their discussion ignores the fact that many marginalized women are already being held legally accountable for pregnancy outcomes. In my analysis of each of these arguments, I show how a lack of diverse viewpoints leads to bad theory—hence the need for humility. After which, I end the paper by showing how including a diversity of perspectives shifts our focus from rights to justice.

The Principle of Procreative Beneficence

In "The Moral Obligation to Create Children with the Best Chance of the Best Life," Julian Savulescu and Guy Kahane argue in favor of the Principle of Procreative Beneficence (PB) which they define as:

> If couples (or single reproducers) have decided to have a child, and selection is possible, then they have a significant moral reason to select the child, of the possible children they could have, whose life can be expected, in light of relevant available information, to go best or at least not worse than any of the others. (Savulescu and Kahane 2009, 276)

Savulescu and Kahane are mainly interested in situations where PGD is possible. In these situations, they claim parents have a moral duty to choose "the most advantaged child" (Savulescu and Kahane 2009, 275). What they mean by a child who is most advantaged or whose life will go best is a bit vague, but would normally include selecting against disability (although they admit there may be some situations when this is okay) and selecting in favor of greater human abilities like intelligence, empathy, and general health. For example, they state: "If parents could increase the prospects of future children's lives by selecting children who are far more intelligent, empathetic or healthier than existing people, then PB instructs parents to select such future

children" (Savulescu and Kahane 2009, 290). They also explicitly state that they are focused on genetic endowments related to these traits, which makes sense given the focus on PGD. More important for my argument is that Savulescu and Kahane consider this a maximizing principle, not a baseline or threshold concept. In other words, parents have a moral obligation (when circumstances permit) to choose the child that is most likely have the best life, not just a life worth living or a good enough life. They find it counterintuitive that one would pick a least best option when given the choice.

To understand how and why diversity makes a difference here, I turn my attention to their defense of this principle. Their main argument in favor of this principle rests on "our" intuitions and what they call "commonsense morality." I argue that their analysis of "our" intuitions and "commonsense morality" is really a very middle-class view of parenting. If they had considered a greater diversity of viewpoints, then they would not be able to so easily defend this principle—at least not without more explicitly eugenic and racist arguments.

Bad Arguments

Let us begin with some key aspects of their main argument in favor of PB. They start with the idea that parents care about the potential well-being of children they choose to have. I would agree that this statement is fairly uncontroversial; however, they immediately move from this statement to a maximizing view: "If prospective parents have moral reasons to care about the potential for well-being of their future children, then it would seem that they should also have reason to aim to have children who are more advantaged rather than leave this to chance or nature" (Savulescu and Kahane 2009, 276). I find this move less intuitive and more controversial. They support this shift by drawing on other moral intuitions.[75] For example, they discuss how parents

[75] In addition to the arguments discussed here, they also introduce a case where a couple must wait a few months to conceive in order to avoid a rubella outbreak. However, their main point with that case is to show that there are

consider emotional and financial resources in their decision about when to have kids and many wait years before starting a family to make sure these resources are sufficient. Savulescu and Kahane claim this is another way of maximizing your child's options or potential future well-being. Parents are waiting until they have optimal resources to provide their children with the most opportunities to support their future well-being. Savulescu and Kahane say their argument is based on the same reasoning, only applied to genetic endowments instead of financial and emotional resources. To further support their argument, they compare the PB to competing principles that we might use to guide reproductive decisions. I will focus on the two most relevant to our discussion—the minimum threshold view and the satisficing view.

The Minimum Threshold view argues that one may choose any child who will have a life worth living. The moral demand is that parents avoid having children "who will endure great suffering and hardship" (Savulescu and Kahane 2009, 280). Savulescu and Kahane dismiss this view as an adequate principle for *selection* of possible children by restating their previous position.

> It is hard to see, however, what could support such a view, once it is allowed that parents have reasons to care about the expected well-being of their future children. Many would agree that parents would be wrong not to wait before conceiving a child if this will mean that the child they bring into existence has greater endowment. (Savulescu and Kahane 2009, 280)

In other words, if you have the ability to choose between possible future children (either through timing of conception of selection of embryos), Savulescu and Kahane do not believe it is okay to choose any child that would have a life worth living. The ability to choose requires you to have the child with the best future options. However, they do agree that the Minimum Threshold View

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normal circumstances in which we find it morally permissible or even required to make "identity affecting" choices. That is they see a main objection to their argument being the idea that we are choosing one child over another; however, whenever parents choose to wait before starting a family, they are choosing a future child over the one they would conceive at the current time. Hence we already make identity affecting choices. Since this argument is not central to my critique, I do not discuss it here.

might work as a constraint on reproduction. In other words, if the only child you can have would have a life not worth living, then you should have no children at all.

Savulescu and Kahane spend more time analyzing the Satisficing View—which they define in the following way:

> If reproducers have decided to have a child, and selection is possible, then they have a significant moral reason to select one of the possible children they could have who is expected to have a *good enough life* over any that does not; they have no significant moral reason to choose one such possible child over any other. (Emphasis in original. Savulescu and Kahane 2009, 280)

The key part for Savulescu and Kahane's argument is the last clause or the idea that parents have no significant reason to *choose* one child over another as long as all will have a good enough life. If it is possible to choose, then Savulescu and Kahane think that you have reasons to choose the best option. They believe to do otherwise is irrational: "This constraint follows from the familiar conceptual connection between goodness and rational choice. Roughly, we have reason to choose what is good, and we have *more* reason to prefer what is better" (Emphasis in original. Savulescu and Kahane 2009, 280). In other words, they believe the norms of practical reason show that their view is superior to the Satisficing View. Again, we see how their argument mainly rests on "our" intuitions and "common sense morality." The main problem is that this moral intuition does not apply to everyone. It is a specific type of parent who is focused on maximizing a child's opportunities and future options.

In *Unequal Childhoods*, Annette Lareau identifies and analyzes two main parenting styles. Middle-class parents participate in what she calls "concerted cultivation." In this model, parents cultivate children's talents—specifically, linguistic and reasoning skills as well as any natural talents such as sports or music. Key elements include "an emphasis on the development of the child through organized activities, development of vocabulary through reasoning and reading, and

active parent involvement in schooling and other institutions outside of the home" (Lareau 2003, 24). In contrast, working class and poor parents approach parenting in a way that she calls "accomplishment of natural growth." In this approach, parents "viewed children's development as unfolding spontaneously, as long as they were provided with comfort, food, shelter, and other basic support" (Lareau 2003, 238). These parents believe it is their duty to provide for basic needs (i.e. food, shelter, etc.), love their children, and set boundaries (i.e. appropriate discipline) which includes teaching their children right from wrong. If parents uphold these duties, they believe children will have what they need to grow into happy and successful adults. Unlike the middle-class parents, they do not see their children as "projects" in need of cultivating. Instead they are children who need a safe and nurturing space to enjoy childhood before they must take on the responsibilities of being an adult.

As we can see, a key difference here is the active cultivation of children as a long-term project versus a more natural progression through developmental stages. It is the more active concerted cultivation that creates the moral intuition that favors maximizing. As Jennifer Senior points out in *All Joy and No Fun*, this is a decidedly modern and middle-class view of parenting: "Today parents pour more capital—both emotional and literal—into their children than ever before, and they're spending longer, more concentrated hours with their children than they did when the workday ended at five o'clock and the majority of women still stayed home" (Senior 2014, 10). There are a number of factors that led parents in this direction. Concern over their children's future well-being is not the only reason, but it is definitely one that fuels the maximizing view that Savulescu and Kahane use to their advantage. As Senior points out, current economic insecurity has led to a kind of "arms race" in preparing children for college and future opportunities via extracurriculars:

> These mothers, too, believe that the opportunity cost of not enrolling their children in loads of extracurriculars is too great. It's the problematic psychology of any arms race: the participants would love not to play, but not playing, in their minds, is the same as falling behind. (Senior 2014, 144)

As these excerpts from Senior's work show, this kind of maximizing mentality is specific to certain social demographics. Thus, "our" intuitions depend on who is included and who is left out. This is a major problem for Savulescu and Kahane's theory as it rests mainly on "our" intuitions and "commonsense morality." Indeed, rejecting both the "minimal threshold view" (which argues that any life worth living is morally acceptable) and the "satisficing view" (which argues that any life that is good enough is morally acceptable), they seem to consider any non-maximizing view irrational: "Roughly, we have reason to choose what is good, and we have *more* reason to prefer what is better" (Emphasis in original. Savulescu and Kahane 2009, 280). Yet, it is not clear that these alternative viewpoints (especially the satisficing view) is as irrational as Savulescu and Kahane imply.

Bad Theory

To be clear, I am making two arguments against Savulescu and Kahane's theory. First, the main argument in support of their position is based on moral intuitions and "commonsense morality" that, in reality, only applies to a specific group of parents. This undercuts the strength of their argument. Second, if we compare this maximizing view to other approaches, it is not clear that it has the beneficial effects that Savulescu and Kahane assert—at least not without certain side effects. Their argument is based largely on an analogy between the way certain middle-class parents approach the project of parenting and applying that to PGD. They see maximizing genetic endowments as a natural progression from the way these parents already maximize opportunities and resources for their children. This version of childrearing may lead to economic success but can also undermine other valuable aspects of life and well-being. Senior also talks about how the

families she studied were more isolated and the over scheduling of kids' activities takes a toll on both parents and kids. In contrast, the children in families that focused on the natural growth approach had stronger ties to family, were more respectful of adults, and were better able to manage their own free time without adult guidance. Therefore, we could at least ask whether applying this maximizing principle to genetic endowments might include similar trade-offs. In sum, this analysis broadens our discussion to take a closer look at the relationship between maximizing tendencies and what we mean by well-being.

Returning to Russell's call, I believe our analysis here shows how increasing the diversity of viewpoints in bioethics can lead to insights that are useful for the whole of bioethics. Namely, it leads us to question basic assumptions and opens the possibility of a more robust conversation. For example, Savulescu and Kahane state multiple times that maximizing genetic endowments related to intelligence is beneficial, but we could ask if this is *always* a boon. Depending on your personality and other natural talents, a significantly high level of intelligence may not be necessary and could even undermine your general sense of well-being. Indeed, there are some who see a correlation between increased intelligence and anxiety and depression (Marquardt 2017). In fact, research into parental decisions related to PGD shows that different groups of parents have very different views on potential harms and benefits. In her analysis, Rayna Rapp found that Jewish parents were more likely to abort for genetic disorders that diminished mental capacities than for those that would result in physical disabilities. In contrast, Latinx parents were more likely to abort for physical disabilities than mental ones (Rapp 2000, 89–93, 283–85). To be fair, these decisions related to avoiding specific harms. If parents could "maximize" both physical and mental abilities, they may have chosen that option—we do not know. However, the reasoning they used to decide harms had to do with specific versions of the good life that gave different

weight to different genetic endowments. So, it is reasonable to ask whether all parents would want to maximize all endowments or whether there may be more controversy here than Savulescu and Kahane want to acknowledge.

My point here is not to start a debate about specific traits. Instead, I simply want to point out how the intuitions Savulescu and Kahane use to support their argument skew the conversation in a specific direction. I want to question whether maximizing is always a universal good regardless of the specific traits. If our focus is on individual accomplishments in a competitive world, then *maybe* we should maximize genetic endowments such as intelligence and other talents.[76] But if we shift our view to those who know they are not going to win the educational and economic arms race (for reasons having as much to do with starting points and systemic issues than specific personal traits), then "our" intuitions are more likely to support the Minimum Threshold View or the Satisficing View. If this seems counterintuitive to Savulescu and Kahane, this is because their view is focused on personal, individual traits and gains, not on a broader view of how to support well-being for future children. In sum, they are focused on rights (responsibilities) not justice (and this is no accident).

In her work on pregnancy loss, Linda Layne illustrates how proponents of both medicalized birth and the natural birth movement emphasize control over the birth process. In the women's health movement, this control resides with the woman; thereby, also emphasizing individual responsibility (Layne 2003). As Layne points out, the belief that one can control birth and the emphasis on individual responsibility represent middle-class ideals of what birth should be like.

[76] I emphasize maybe here because it is not clear that it is even possible to maximize genetic endowments in the way they envision. For example, they ask, "How can the capacity to remember things better, concentrate longer, be less depressed, or better understand other people's feelings have the effect that one will be less likely to achieve the good life?" It is not clear to me that we can maximize all those traits at the same time so the kind of maximizing they propose may require some preliminary decisions about what to maximize or sacrifice maximizing one trait for a better balance of all traits (which seems to be moving us back toward a satisficing view).

In this way, we can see how Savulescu and Kahane's approach is in keeping with other birth messages directed at (or supported by) middle-class women. If this emphasis on control is largely a middle-class view of birth, then the very idea of putting so much energy and emphasis on a "selection" principle (versus a more general principle of reproductive ethics) is itself flawed.

Let me briefly return to Savulescu and Kahane's discussion of the Minimum Threshold View and the Satisficing View. Their main problem with these theories is that they are inadequate for a *selection* principle. They agree that the Minimum Threshold View works as a *constraint* on reproductive autonomy, but argue it is not robust enough for a selection criteria. Similarly, their comments about how it is illogical to say that parents have no significant reason to choose one child over another shows why they believe the Satisficing View fails as a selection principle. It is unclear whether it would be okay as a general rule of reproductive autonomy—that is would Savulescu and Kahane agree that it is okay to have any child who would have a good enough life? We do not know because they are committed to a selection principle. In fairness, they are primarily focused on PGD or scenarios in which some choice will need to be made. If this only applied to those who were already undergoing PGD for whatever reason, then it might be okay. However, Savulescu and Kahane go on to argue:

> …we believe that PB instructs women to seriously consider [in-vitro fertilization] IVF if natural reproduction is likely to lead to a child with a condition that is expected to reduce well-being significantly, even if that condition is not a disease. (Savulescu and Kahane 2009, 281)

Which means they are explicitly embracing the mentality of control and individual responsibility described by Layne. So far I have argued this narrow view undermines their reliance on "our intuitions" to support their argument. I will say more about the problems with a focus on individual responsibility in the final section.

A Legal Duty to Avoid Genetic Harm

In "The Case for a Parental Duty to Use Preimplantation Genetic Diagnosis for Medical Benefit," Janet Malek and Judith Daar make both an ethical and a legal argument that, in some situations, parents have a duty to use PGD. In this paper, I focus mainly on their legal argument. To be fair, their argument is narrowly tailored, but they emphasize that it could possibly be expanded to include other cases. Specifically, they argue that if parents are already using in-vitro fertilization [IVF] and know (or should know) they are at risk for a serious genetic disorder, then those parents have both an ethical and a legal duty to add PGD to their IVF regimen (and choose non-affected embryos). To support the legal argument, Malek and Daar review current legal duties to existing children, fetuses, and embryos.

In considering duties to existing children, Malek and Daar discuss legal disputes over medical decisions and tort liability ("wrongful life" cases). In cases that challenge parents' decisions to refuse or withdraw medical care, Malek and Daar point out that courts often override parental autonomy in favor of the children's welfare. Yet, when considering "wrongful life" cases, the courts are more reticent to punish parents or decide that a specific child should not have been brought into existence. To resolve this paradox, Malek and Daar argue that if we focus our attention on "those who commit the acts" (the parents) instead of "those upon whom the acts are committed" (the potential or actual children), then we can make a case in favor of parental duties to potential children.

> Once parents undertake an action on behalf of their existing/potential children, they have a duty to perform that duty with a high degree of care and in the best interest of the resulting child. That duty, as the cases mandating unwanted medical treatment demonstrate, often provokes parental anguish, which is subordinated to the anticipated beneficial outcome bestowed upon the child. (Malek and Daar 2012, 8)

In sum, Malek and Daar argue that cases of refused medical treatment are more relevant because they involve specific parental actions (or inactions) as well as the potential welfare of the child. In contrast, wrongful life suits are after the fact and (indirectly) ask the court to compare a specific life against non-existence—a much more difficult and fraught task.

When considering a legal duty to fetuses, Malek and Daar argue that case law is even more ambiguous. In general, parental autonomy seems to reign in the pre-viability phase (based on abortion law). However, when discussing children who are later born alive, the authors state that the relevant question is "whether the duty-bearer's actions were intentional or merely negligent" (Malek and Daar 2012, 9). They claim that case law related to prenatal harm is "sparse and mixed" (Malek and Daar 2012, 9). Again, they turn their attention mainly to "wrongful life" suits and say the courts seem to favor the parents and worry about eroding pregnant women's autonomy. In only one sentence do Malek and Daar mention statutes that allow fetuses to fall under child protection statutes (Malek and Daar 2012, 9). As I will argue in the next section, they would do well to spend more time on this final issue. If we look at the use of ***criminal prosecutions***, we find a plethora of cases that favor their position, but also show why a move to *legal* duties is dangerous.

Finally, Malek and Daar consider legal duties to embryos. The case law here relates mainly to third parties—namely, cases brought against fertility clinics or physicians when using ART. They discuss at least one case where a fertility clinic was held liable for not using PGD to test embryos created from an egg donor known to carry the gene for cystic fibrosis (Malek and Daar 2012, 10). They argue a case can be made to extend these legal duties from third parties to the parents themselves—especially when the parents are already using IVF.

Thus, in their discussion of legal duties parents owe their children, Malek and Daar focus on cases of refusing medical treatment, "wrongful life" cases, and cases that hold third parties responsible for outcomes. They briefly mention statutes that extend child protection laws, but do not explore this in any depth. Similarly, the peer commentaries debating Malak and Daar's argument mainly question their interpretation of "wrongful life" suits and use of the best interest standard. These commentaries also emphasize that the law, except in special cases such as medical treatment, usually only requires parents to meet children's basic needs; it does not require parents to maximize children's welfare (Flicker 2012, 30). As I will now show, this entire discussion mostly ignores another area of law that is very relevant to this debate—namely, the prosecution of pregnant women for a variety of behaviors and outcomes. Thus, both the main article and the commentaries ignore the fact that *some* women are already being held legally accountable for their procreative behaviors.

Bad Arguments

In this section, I discuss parallels between Malek and Daar's argument for a legal duty to use PGD and recent trends in criminal law. As a point of clarification, it is difficult to draw explicit legal duties from an analysis of these cases. Appellate courts often reverse these decisions and reject the legal arguments used (Paltrow and Flavin 2013, 322).[77] Yet, these cases continue to happen at an increasing rate and are often tied to relatively recent feticide laws that give personhood status to fertilized eggs, embryos and fetuses.[78] Therefore, we could argue that the status of pregnant women's behavior (and, if broadened to issues like PGD, parental behavior in

[77] While most of the higher court reviews reverse court-ordered medical treatments, not all do. *Pemberton v. Tallahassee Memorial Regional Medical Center* is at least one example where the higher court upheld court-mandated medical treatment for a pregnant woman based on avoiding harm to the fetus/soon-to-be child.
[78] Paltrow and Flavin found 413 cases over the thirty-two year period between 1973 and 2005, but have found over 200 in the eight years since 2005. These statistics indicate that prosecutions are becoming more common.

general) is currently up for debate. For this reason, it is worth reviewing the arguments found in these cases and how they might apply to our previous discussion.

As previously discussed, Malek and Daar show that the best interest standard in *parens patriae* cases provides some of the strongest support for a legal duty to use PGD. The criminal prosecution of pregnant women further supports Malek and Daar's argument by broadening the use of *parens patriae* from existing children to fetuses. For example, in their recent review of prosecutions against pregnant women, Lynn Paltrow and Jeanne Flavin found that a significant number of these prosecutions were related not to illegal activity, but to medical issues.

> Sixteen percent of the cases involved no allegation that the woman had used an illegal, criminalized drug. These included cases in which women were deprived of their liberty based on claims that they had not obtained prenatal care, had mental illness, or had gestational diabetes, or because they had suffered a pregnancy loss. (Paltrow and Flavin 2013, 316-317)

In these cases, the physician or hospital is given "custody" of the fetus along with permission to consent to or perform any medical procedure deemed necessary for the health of the fetus. Thus, women are stripped not only of their parental autonomy but also their bodily autonomy (Cherry 2007, 2001; Ikemoto 1991).

If we look at cases specifically related to court-ordered cesareans, we see they are backed by reasoning very similar to that used by Malek and Daar. Malek and Daar claim that "once parents initiate the reproductive process, they have a duty to execute that process in a manner that produces the least harm to a resulting child" (Malek and Daar 2012, 7). They also argue that, for parents who are already using IVF, adding PGD to the process creates a minimal added burden. Similarly, some of the cases involving court ordered cesareans point out that (a) the woman has taken on additional responsibilities by choosing to carry the fetus to term and (b) she is going to give birth regardless of the method.

> The balance tips far more strongly in favor of the state in the case at bar, because here the full-term baby's birth was imminent, and more importantly, here the mother sought only to avoid a particular procedure for giving birth, not to avoid giving birth altogether. Bearing an unwanted child is surely a greater intrusion on the mother's constitutional interests than undergoing a cesarean section to deliver a child that the mother affirmatively desires to deliver. (From Pemberton v Tallahassee Memorial Regional Medical Center quoted in Cherry 2001, 607)

Here we see a parallel argument that the added burden is not so great once the woman has already chosen to carry to term and some method of birth is imminent. Others have also pointed out that courts continually downplay the potential burdens to women by claiming that forced medical intervention is a temporary (and implied short-term) restriction on the woman's autonomy (Ikemoto 1991, 494). In sum, cases of court-ordered medical treatment often use similar reasoning to Malek and Daar and the continued use of court-ordered medical interventions provides more support for their legal duty to use PGD.

If we turn our attention from forced medical treatment to cases of women who are using drugs or alcohol, we see the criminal law creating new rights for fetuses that support the parental duty proposed by Malek and Daar. The preferred legal tactic has been to extend child welfare statutes to the fetus (Cherry 2007). Given the complications with applying current child welfare statutes to fetuses, some states have written new legislation to explicitly include "unborn children." One of the first and most studied is the Wisconsin statute which states:

> …[t]o recognize that unborn children have certain basic needs which must be provided for, including the need to develop physically to their potential and the need to be free from physical harm due to the habitual lack of self-control of their expectant mothers in the use of alcoholic beverages, controlled substances, or controlled substance analogs…. (Quoted in Cherry 2007, 164)

The language of this law parallels not only Malek and Daar's legal arguments, but also some of their ethical arguments. We have seen that Malek and Daar argue that parents must proceed in a way that minimizes harm, similarly this law argues that fetuses have a need to be free of physical

harm caused by the pregnant woman's actions. However, this law also claims fetuses have a "need to develop physically to their potential." This parallels Malek and Daar's ethical arguments that parents should "promote the well-being of the future child" and "broaden the array of possibilities open to future children" (Malek and Daar 2012, 4). Although Malek and Daar argue against a strong version of these claims that would require parents to maximize benefits to future children, once this reasoning is codified into law it is open for broader interpretations. For example, if a woman does not have access to adequate nutrition and subsequently gives birth to a low-birth weight infant, has she violated the fetuses' need to develop to his/her physical potential as instantiated in this law?

While these statutes are meant to extend existing child welfare laws to fetuses, they create a variety of new problems. To begin with these laws allows the state to take "custody" of the fetus in the same way a state would remove a neglected or abused child from the parents' home. However, given the physical reality that a fetus cannot be removed from the woman, the end result is much different than in traditional child welfare cases. In these cases, the woman is usually incarcerated or detained in a drug treatment program for the duration of her pregnancy so the state can enforce compliance.

Also, the enforcement of these laws tends to be more vigorous than traditional child welfare laws. As Flicker points out in her commentary on Malek and Daar's article:

> The law permits parents to be selfish, distant, or unloving, as long as children's most basic needs are met. Courts only begin to question what is in the "best interest of the child" when a child's health or safety is in danger, or during a custody dispute. (Flicker 2012, 30)

Yet, the revisions to child protection statutes to include fetuses seem to move us far beyond the limited scope of "best interest standards" outlined by Flicker. Unlike cases where children are clearly abused, malnourished, or suffering some other immediate harm, it is very difficult to

pinpoint a direct cause and effect between many prenatal behaviors and harm to the infant post-birth. Given this scientific reality, the harm from various prenatal behavior assumed in these prosecutions is often exaggerated. For example, in the Paltrow and Flavin review, the majority of cases (84%) included charges related to illegal drug use (most often cocaine) (Paltrow and Flavin 2013, 315). Yet, there is no direct causal relationship between in-utero cocaine use and specific fetal harms. In fact, recent research shows that potential harms of cocaine use during pregnancy are similar to and cannot be separated from other factors such as tobacco use and "quality of the child's environment" (Frank et. al. quoted in Paltrow and Flavin 2013, 334). In this way, the arguments for harm used in the criminal cases often do not rest on good scientific or medical evidence (Paltrow and Flavin 2013, 317-318). Therefore, the cases of prosecution are based on some need to protect children from harm, but they rest on only *potential* or assumed harm—neither of which are adequately proven.

Finally, commentators also point out how these broader child welfare statues create duties not just for parents but also for health professionals and law enforcement. Both are called upon to protect fetal health when pregnant women[79] fail to do so (Ville 1999, 332). For example, in an earlier review titled "The Detention, Confinement, and Incarceration of Pregnant women for the Benefit of Fetal Health," April Cherry states:

> Judges and legislatures have used the deprivation of physical liberty, and threats thereof, as a way to prevent drug use by pregnant addicts, to compel pregnant women to access prenatal care, or to force women to submit to their physicians' direction regarding medical treatment for the benefit of fetal health. In every case, the detention of the pregnant woman was predicated upon the "right" of the fetuses to be born healthy. (Cherry 2007, 196)

[79] Notice how these laws ignore any role the father may have in potentially harming the fetus such as abstaining from alcohol or drugs prior to conception or his role in enabling or encouraging the woman's substance abuse. Other laws, such as the fetal homicide laws, theoretically cover violence against the pregnant woman, but some have questioned how effectively these are enforced (Flavin 2009; Schroedel 2000).

If there is a reciprocal relationship between duties and rights, then these criminal cases are creating the rights for fetuses or future children upon which Malek and Daar's parental duty could be based.

To summarize, we see that Malak and Daar's analysis ignores a diversity of viewpoints to focus on middle-class (mostly white?) parents utilizing ART and their narrow focus leads to bad arguments. The arguments they present are incomplete at best as we can see how incorporating this broader context would add more support for their position. In their systematic review of prosecutions against pregnant women (or new mothers),[80] Paltrow and Flavin identify at least 413 cases from 1973 to 2005 (Paltrow and Flavin 2013, 299). In these cases, eighty-six percent of the women were charged with a crime and at least seventy-four percent were charged with a felony (Paltrow and Flavin 2013, 311). Based on this analysis, we could argue that states are already creating a variety of legal duties that *some* women have to their fetuses or future children.

However, a full understanding of this context might also lead Malek and Daar to rethink the move toward legal accountability. In the Paltrow and Flavin review, fifty-nine percent of the cases were women of color and seventy-one percent were economically disadvantaged (Paltrow and Flavin 2013, 311). Earlier reviews showed similar outcomes (Kolder, Gallagher, and Parsons 1987; Irwin and Jordan 1987). As we can see, these prosecutions are mainly directed at pregnant women from marginalized groups. We can also see that these prosecutions come with heavy penalties. Do Malak and Daar really want to create even more legal duties given this growing trend?

[80] Their review looked for any case in which pregnancy was "a necessary factor leading to attempted and actual deprivations of [a woman's] liberty"—by which they mean deprivation of physical liberty through actions such as incarceration, detention, or forced medical treatment (Paltrow and Flavin 2013, 301).

Bad Theory

If the majority of those who use ART are affluent whites, then the idea of holding them legally accountable for pregnancy outcomes would be a novel idea. Despite the variety of potentially harmful behaviors for which (mostly marginalized) women have been prosecuted, to my knowledge no parent has been prosecuted for passing on a known genetic disorder.[81] If ought implies can, we seem to hold those with the least resources most accountable and vice versa.

We also see that many bioethics arguments about reproductive autonomy seem to assume a level of power and knowledge that comes with affluence while ignoring the way structural power dynamics affect reproductive autonomy in many women's day-to-day lives. My review of criminal prosecutions shows how—in practice—the choices of privileged women are protected while the "choices" (or sometimes just circumstances) of less privileged women are penalized. In this way, criminal law reinforces "reproductive stratification"—a term used "to describe how reproduction is structured across social and cultural boundaries, empowering privileged women and disempowering less privileged women" (Greil et al. 2011, 2). There is no need to recount the variety of ways this has been perpetuated as it has been well documented in other places.[82] Given this context, we can reasonably ask whether creating a legal duty to use PGD would increase reproductive stratification.

If we create a legal duty to use PGD, we must consider the practical consequences of this policy. How will it be implemented? Malek and Daar focus their argument on a very narrowly tailored case. However, if this were instituted as a broader public policy, we would have to have a conversation about what kinds of genetic disorders would be included. Historically, our

[81] Although Malek and Daar note that third parties have been prosecuted for not performing genetic tests.
[82] For a small, but representative, sample see (Roberts 1997; King and Meyer 1997, 8-30; Flavin 2009).

conceptions of harm have been distorted in a way that protected those using ART (more likely to be white and affluent) while punishing those who participate in other potentially harmful behaviors such as use of certain drugs. At the same time prosecutors began using child protection statutes in order to prosecute women for in-utero cocaine use, there was also much media attention surrounding the increase in high-order multiple births. Despite posing similar risks to fetuses, women who carried high-order multiples were not prosecuted and, in fact, were celebrated (Shivas and Charles 2005). Given this long history of reproductive stratification, I am not hopeful our analysis of harm would be any more objective when implementing a legal duty to use PGD. For example, how do we compare various genetic disorders such as Down's Syndrome, Cystic Fibrosis, and Sickle-Cell? My worry is that our already distorted notions of harm would shape this debate in a way that further perpetuates reproductive stratification.

I have looked at Malek and Daar's argument for a legal duty to use PGD in relation to an increasing trend to prosecute pregnant women for potential harm to their fetuses. It is useful to bring these two discussions together if for no other reason than trying to find some consistency across cases. Do parents have legally enforceable duties to their ***unborn*** children? If so, then Malek and Daar's argument seems much more reasonable when put in the context of the prosecution of pregnant women for a variety of potentially harmful behaviors. However, if we have no legally enforceable duty to avoid serious genetic harm to potential offspring, then it also seems unreasonable to prosecute women for behavior that is only *potentially* harmful. All of these parallels and problems show why we should be very cautious about moving from ethical to legal arguments. We have seen how much of the reasoning used in the prosecution of pregnant women parallels the reasoning used by Malek and Daar. However, the implementation has led to an erosion of women's rights.

To be fair, when academic bioethicists turn their attention to prosecution and court-ordered medical treatment, they tend to argue against these moves and in favor of reproductive autonomy.[83] Also, most academic bioethicists have favored arguments about ethical duties recognizing the potential practical problems with legal enforcement.[84] Still, these conversations tend to be disconnected from each other and this is a problem. If we want to make strong ethical arguments and avoid reproductive stratification, then these debates must include a strong defense of reproductive justice—to which I now turn.

From Rights and Responsibilities to Reproductive Justice

In closing, I hope my analysis here has shown why many bioethicists need to recognize the limits their own viewpoint in favor of seeking out a broader range of experiences. We need a diversity of perspectives in order to create better arguments that lead to better theory and, hopefully, more just proposals. Russell has challenged us to move race from the margins to the center of our discussions related to reproductive ethics. I would add that we need other marginalized voices as well. Instead of making provocative arguments about personal responsibilities that individual parents have to specific children, bioethicists should be supporting reproductive justice which would improve the future well-being of all parents and children.

Just as disability rights advocates ask us to take the broader social context into account when debating various uses of genetic testing, reproductive justice advocates ask us to consider "the complete physical, mental, spiritual, political, social, environmental and economic well-being of women and girls…." (Ross 2006, 1). In this case, we need to consider the broader social context

[83] For example, see (Adams, Mahowald, and Gallagher 2003; Mariner, Glantz, and Annas 1990; Purdy 1996; Young 1994).

[84] For example, both Laura Purdy and Julian Savulescu have argued that parents have strong moral duties to the children they create, but both also acknowledge practical reasons for not wanting to codify these duties into laws (Purdy 1996; Savulescu and Kahane 2009, 274-290).

when asking what duties parents have to their unborn or future children. If we argue that parents have an ethical duty to "select the child…whose life can be expected…to go best" or a legal duty to use PGD in order to avoid reproductive harm, then we must also ask what resources "parents" (women) have to fulfill these ethical and legal obligations. We cannot ask "parents" to avoid harm and maximize their children's interest without also asking not only whether parents have access to genetic tests and other ART resources that would allow them to "choose" the best children, but even whether they have access to things like adequate nutrition and prenatal care. An emphasis on individual responsibility while ignoring systemic oppression simply perpetuates injustice.

Both of the proposals reviewed here emphasize personal responsibility while ignoring the context in which parents make these decisions. Indeed, attention to systemic racism, poverty, and oppression would do more to increase the overall well-being of future children than the kinds of individual choices emphasized in these theories. For example, why does the question of financial security play such a significant role in the decision making of some parents? It is because we—as a society—do not provide adequate access to basic goods. Without personal financial resources, children are systematically denied access to adequate healthcare, educational opportunities, etc. Those parents who are capable of gaining access to financial resources know what a difference it can make in their children's future opportunities.[85] By adopting the maximizing mentality used by many middle-class parents and applying it to PGD, Savulescu and Kahane reinforce a personal responsibility model that shifts our attention away from systemic injustices that undermine the well-being of many children. If we incorporate the viewpoint of less privileged parents, we are

[85] Please note that I am not making a maximizing argument here. I am comparing the injustice of those who cannot even gain access to adequate resources to those who can. However, we have seen that many of those who can gain access to adequate resources also end up adopting a maximizing approach.

likely to focus on reproductive justice or the variety of contexts in which parents are having and raising children.

Similarly, Malek and Daar argue that parents have a legal as well as a moral duty to minimize reproductive harm. In the *AJOB* debate, some of the peer commentaries recognized that this kind of an argument has the potential to criminalize a variety of behaviors which would have a chilling effect on reproductive freedom. Here is a sample of the comments made:

> If generalized to all reproduction, this requirement of reproductive harm-minimization would be violated by any parental failure to minimize risks of harm to the resulting child, from cocaine use to the occasional drink of alcohol to a job with risks of toxic exposure to the failure to reduce a multiple pregnancy. (Francis and Silvers 2012, 16)
>
> We don't prosecute women when the put their fetus in harm's way with risky behavior during pregnancy. (Goldsammler and Jotkowitz 2012, 28)
>
> [The state] would be hard-pressed not to prohibit pregnant women from doing anything that might threaten the health of the children they were gestating, including using tobacco, alcohol, prescription medications, caffeine, and who knows what else! … Malek and Daar surely do not want the state to act as the reproductive police. But their proposal is not only dangerous on its own terms, restricted as they would like to be, but pernicious in its potential to turn the United States into the country depicted in Margaret Atwood's *Handmaid's Tale*. That is not a country in which any reasonable person wants to live. (Wasserman and Asch 2012, 24)

Many would like to dismiss these slippery slope arguments as unreasonable (indeed these commentators present them as fantastical outcomes), but our previous discussion shows that these implications are in fact very reasonable. Women ***are*** being prosecuted for "risky" behaviors during pregnancy that might harm the fetus including use of cocaine, alcohol, and failure to follow medical directives. None of these authors seem to realize that this injustice *already exists* for a significant number of women. This is because of whose point-of-view is or is not considered when framing the argument.

Again, including the voices of those who have been marginalized not only illustrates why this slippery slope is not theoretical, but also highlights the limits of a personal responsibility approach. For example, Paltrow and Flavin documented at least 74 cases where women were prosecuted for failing to seek prenatal care. Given that most of the women prosecuted were also economically disadvantaged, we could ask what barriers may have prevented the women from seeking care. Did they have access to insurance that would cover prenatal care? Did they have transportation to get to and from appointments? How hard would it be to schedule appointments around work schedules and childcare responsibilities? Again, we see how a personal responsibility approach frames the problem and potential solutions in a way that draws our attention away from questions related to reproductive justice and, therefore, is likely to perpetuate reproductive stratification.

In my analysis of these proposals, I have acknowledged that parents are generally interested in the well-being of their future children. What happens if we reframe this general concern and adopt a reproductive justice approach? In their 2014 report, "Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care," the Center for Reproductive Rights looks into various reasons for the high maternal mortality rate in the United States ("Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care" 2014). They document a variety of factors that contribute to a higher maternal mortality rate for women of color—especially black women in the south. These include lack of access to health care, racial discrimination in health care, and poor health services. While this is an obvious problem during the period of pregnancy and childbirth, it also sets women up to have more difficult pregnancies and births due to preexisting health issues. The report expands the scope of inquiry to look at access to family planning, sexual health

information, and post-natal care. When asked about their experiences and priorities, these women wanted access to information, resources, and adequate care.

The additional parental duties proposed by Savulescu, Kahane, Malak, and Daar would do nothing to help these women improve the future well-being of their children. Instead these proposals will lead to more discrimination and condemnation and possibly increased criminal prosecutions for this group of mothers. Adding more burdens to those who are already disproportionally burdened and potentially separating families via increased prosecutions increases reproductive stratification. In this way, the proposals we have discussed are likely to undermine the well-being of these children.

In contrast, inclusion of marginalized voices and a commitment to reproductive justice would turn our attention toward increased access to resources. How much money would we spend on IVF and PGD to improve the potential genetic endowments of one child versus the improved well-being we could gain for more children by putting that same money into access to (non-discriminatory and high quality) healthcare, post-natal care, and other support services? If bioethicists want their theories to be relevant and, more importantly, just, we would do well to broaden the conversation. I see this paper as part of a (hopefully growing) shift in bioethical analysis that makes previously marginalized voices a central part of our consideration. Doing so is not only a matter of justice but will also lead to better theories.

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Letting Words Come Inside

Learning To Live

One Day, The Everyday, Another Day, Today

Lau Cesarco Eglin

Letting Words Come Inside

It's a different book
when you read slowly, at the pace
necessary to touch
seams and notice
crevices between and around
inside is where you
want to be slow enough
to stop, go back:
It's when you can use the word
again as a delight. Again, you
go over the lines and re-member.

Everything is intensified and wonder
becomes a state
to stay in as connected
to language as to yourself
as language. Roots.

Evergreens as a gradual
way of changing.
Lose the obvious,
spend more time to discern conifers
with needles of varying sharpness
that hint at how fast
you can pass
your hand over them,

how often can you go back
to a line and touch different

depths because being pricked or pierced
or punctured is again only perceived

when reading slowly
you know that
even if *pine* is sometimes
a verb of suffering,
it is never without its clusters
of needles. Evergreen. There's a comeback
as a tree. Let the roots bring you
to language, to connect
with the pace that allows you
to be you.

Learning To Live

Of all that which I forgot and forget
and has forgotten me in return
what hurts the most is
how to feel and recognize
when I am actually feeling.

Somewhere it's still tangled
like seaweed conjures itself up
plural: every time it's algae.

It's easy when I see the red and feel
the wet gush out of my sliced thumb,
just a bit, just enough
to show me it hurts and I press
my thumb hard because streaming
is so close to too much and too soon.

But feelings aren't instant. They take
so long to be and sometimes
it is over 24 hours, one day and its dream,
to know that something is flowing out
inside and by then it's so thick and wild
flooding is inevitable. It's difficult
to be ready, to know what to do, to not
have time to articulate into the right
words that I know are drowning and drown
any return of what just happened, what might
continue to come out alive.

One Day, The Everyday, Another Day, Today

I woke up knowing that today should have been tomorrow tied to as many yesterdays as needed to arrive. And once awake, blink, long enough to close my eyes and interpret translation. Hop from one day at the botanical garden to being able to sleep on, sleep with, slip into a question and its possibilities, using the lines to hold on and carry me through. That's how I'd describe becoming. Being tide. Never the same undulation, no matter how hard you stare at the shore. There are no rules that will hold such measurements. After all, today is the disarray in a bouquet, welcomed after having figured out the countless permutations of *this is not a fixed arrangement*.

About the Author

Laura Cesarco Eglin is the author of three collections of poetry, *Calling Water by Its Name*, translated by Scott Spanbauer (Mouthfeel Press, 2016), *Sastrería* (Yaugurú, 2011), and *Reborn in Ink*, translated by Jesse Lee Kercheval and Catherine Jagoe (The Word Works, 2019). A selection of poems from *Sastrería* was translated collaboratively into English with Teresa Williams, and subsequently published as the chapbook *Tailor Shop: Threads* (Finishing Line Press, 2013). Cesarco Eglin has also published the chapbook *Occasions to Call Miracles Appropriate* (The Lune, 2015). Her poems, as well as her translations (from the Spanish, Portuguese, Portuñol, and Galician), have appeared or are forthcoming in a variety of journals, including *Modern Poetry in Translation, Eleven Eleven, Puerto del Sol, Copper Nickel, Spoon River Poetry Review, Arsenic Lobster, International Poetry Review, Tupelo Quarterly, Columbia Poetry Review, Blood Orange Review, Timber, Pretty Owl Poetry, Pilgrimage, Periódico de Poesía*, and more. Her poems are also featured in the Uruguayan women's section of *Palabras Errantes, Plusamérica: Latin American Literature in Translation*. Cesarco Eglin is the translator of *Of Death. Minimal Odes* by the Brazilian author Hilda Hilst, (co•im•press, 2018). She is the co-founding editor and publisher of Veliz Books.

Starring Role

Our House

Tony Tracy

Starring Role

thy eternal summer shall not fade
—Shakespeare

Attention received on a floodlit stage
not enough (foil characters in *Hamlet*
and *Macbeth*, derelict villain portrayed
in a campy Vaudeville skit), offstage a magnet

for troubled roles too; scenarios never read
in poems or plays, my strange appetite
for trafficking in the commerce of greed
most beguiling. Cursed with a hedonist's delight.

Those speed-fueled nights. Ill-fated, unlucky
kid we rolled for dope, a running engine.
From fingerprint files to cuffs to juvy—
a fool's walk. High drama with true suspension.

Once, atop the municipal high dive, I froze
in a cop's searchlight. Drained my beer. Then dove.

Our House

He blamed his rage on his heritage—
Cretian blood equaled Cretian temperament:
anger that required fistfuls of sedatives,
slugs of whiskey to insure the *betterment*

of its effects, though he'd just sleep it off.
Our house more than theater, more than
a show— a place of one continual standoff
after another, where what's done is **done**.

Dad made sure mythic barbarism came
to life. So after a cupped palm came the strap,
or whatever could turn a young hide aflame,
make him think twice before giving crap.

History used as a provocation, excuse
to deliver blows. But don't *dare* call it abuse.

About the Author

Tony Tracy is the author of two collections of poetry, *The Christening* and *Without Notice*. He is a Pushcart Prize nominated poet whose work had recently appeared, or is forthcoming in, the *North American Review*, *Poetry East, Hotel Amerika, Tar River Poetry, Flint Hills Review* and various other magazines and journals.

Hegel

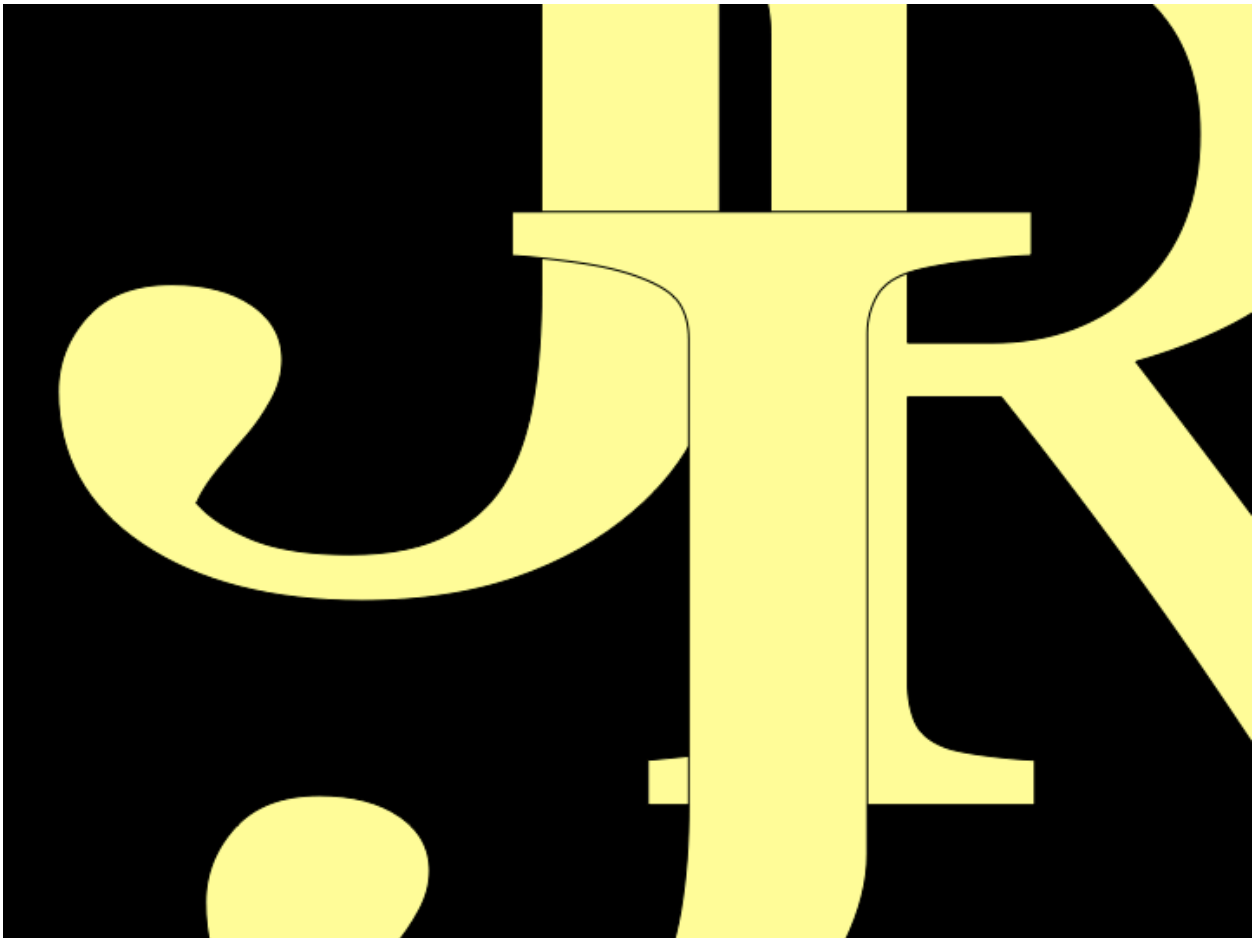
Kant

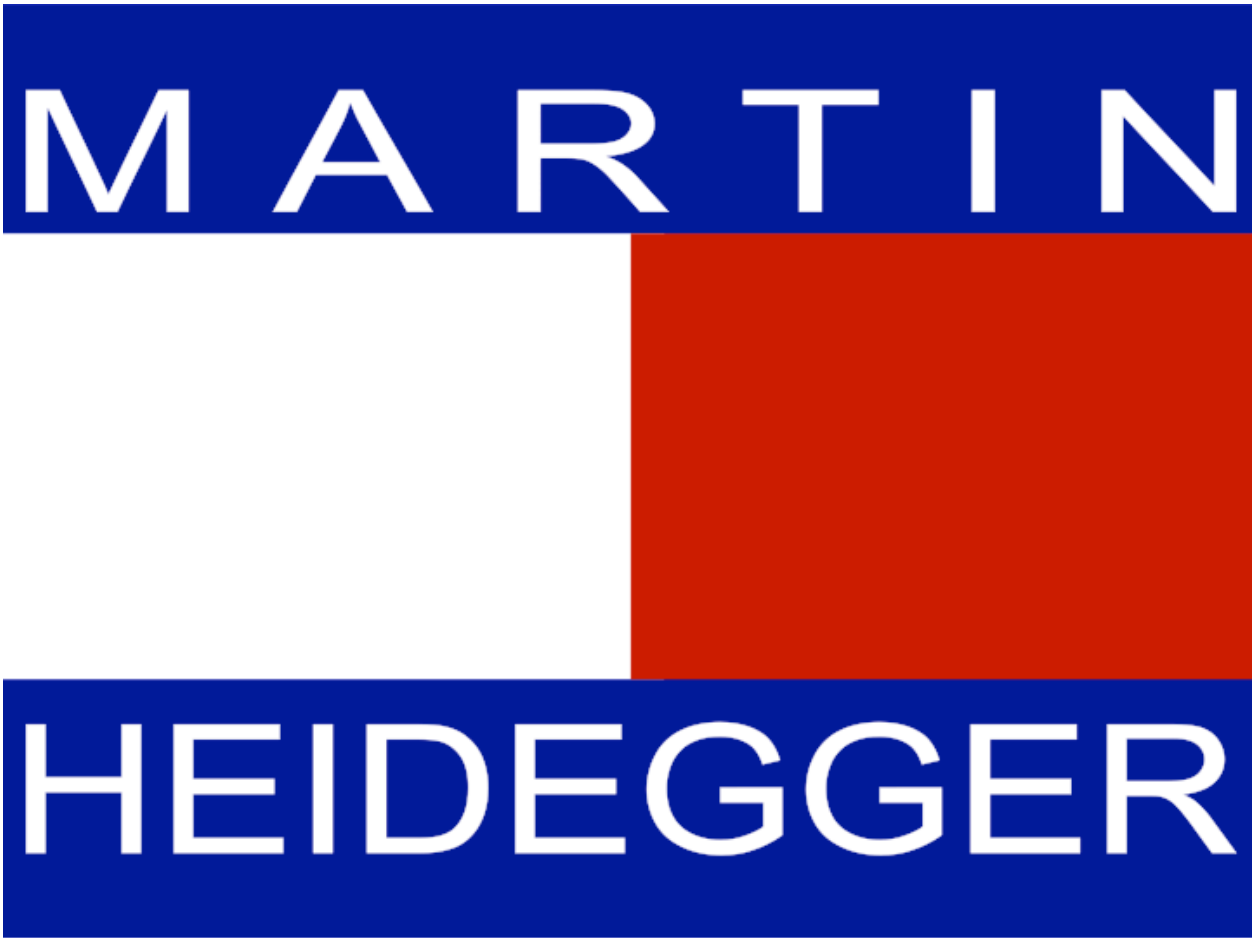
JJR

Heideggar

Petar Ramadanovic


Immanuel Kant
IK




MARTIN
HEIDEGGER

About the Artist

Petar Ramadanovic is a professor at the University of New Hampshire where he teaches literary theory. He immigrated to the U.S. from the former-Yugoslavia in the early 1990's. He is the author of numerous articles, a book titled, *Forgetting/Futures*, and coeditor of *Topologies of Trauma*. His fiction appeared in *The Kenyon Review*, *New Delta Review*, *101 Words*, *Flash Fiction Magazine*, and *Philosophy and Literature*.