THESIS

A SOPHISTICATED LOGIC OF ENHANCEMENT: A DISABILITY-SENSITIVE, WELFARE-MAXIMIZING STANCE IN PHILOSOPHY OF MEDICINE AND PROCREATIVE ETHICS.

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ABSTRACT

A SOPHISTICATED LOGIC OF ENHANCEMENT: A DISABILITY-SENSITIVE, WELFARE-MAXIMIZING STANCE IN PHILOSOPHY OF MEDICINE AND PROCREATIVE ETHICS.

Julain Savulescu and Guy Kahane have developed a compelling yet controversial set of arguments that provide a theoretical and action-guiding grounding for the fields of medicine and procreative ethics. In medicine, they argue that medicine should do much more than merely treat patients; instead, it should "enhance" them to enjoy the greatest possible welfare. They argue that enhancement is justified by the same moral principles that justify treating patients in a medical setting. Similarly, in procreative ethics, they contend that when pre-natal selection is available, a similar welfare-maximizing principle should inform what children we should bring into existence. They argue that the "most advantaged child" among those that could be selected ought to be selected. There is something deeply compelling about these arguments but also deeply concerning; we should, of course, want the greatest welfare for ourselves, others, and our children, but we should also worry that accomplishing these ends via medicine and procreative selection may be using inappropriate means, relay implicit prejudices, or even constitute a kind of eugenics. In this thesis, I interrogate Savulescu and Kahane's arguments for the logic of enhancement and argue that a compelling and largely cohesive view emerges that has significant implications for the philosophy of medicine and procreative ethics. The view is, however, imperfect. Several adjustments and compromises must be made to make the view fully cohesive and to accommodate the highly compelling arguments made by disability rights theorists. In suggesting these adjustments and compromises, I ultimately defend the logic of enhancement from its most potent objections and contend that it is a highly illuminating view for ethical and theoretical work in the philosophy of medicine and procreative ethics.

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Introduction

In this thesis, I will highlight the work of Julian Savulescu and Guy Kahane, who developed the principle of “procreative beneficence” and, more generally, what I will term “the logic of enhancement.” The logic of enhancement contends that we should come to understand both the philosophy of medicine and procreative selection through the lens of well-being and that these conclusions are a natural extrapolation from the principles that are already axiomatically applied in paradigmatic bioethics cases. In what follows, I will explain the logic of enhancement’s two prongs—its position in the philosophy of medicine and its stance on procreative ethics—in more detail and then tease out why its conclusions initially appear difficult to swallow. My inquest will conclude that while the logic of enhancement expresses some important moral and conceptual arguments, the authors have not fully considered the implications of their view, which may ultimately undermine their preferred conclusion. My contribution to the discussion will be to restrict and define the scope of the logic of enhancement so that it emerges as a clearly applicable, philosophically robust, and ethical way to approach medicine and procreative ethics. Throughout the project, I will be building up to discuss the philosophy of disability, specifically the critiques disability rights advocates levy against the logic of enhancement. I understand these critiques as the strongest arguments against the view that, if it can avoid prejudiced conclusions in this hotly debated and often fraught discussion, I take it to be indicative of a very plausible stance.

Chapter 1: A Crisis in the Philosophy of Medicine

In medical contexts, a commonsense notion we are usually happy to apply is the distinction between therapy and enhancement. Typically, therapy is thought of as something like “the use of biotechnical power to treat individuals with known diseases, disabilities, or impairments, in an attempt to restore them to a normal state of health and fitness.”[1] Conversely, an enhancement is “the directed use of biotechnical power to alter, by direct intervention, not disease processes but the “normal” workings of the human body and psyche, to augment or improve their native capacities and performances.”[2] Given this distinction and our normal uses of terms like health, disease, and fitness, we might think that therapeutic interventions rather than enhancing interventions should define the proper domain of medicine. We might also use the distinction between therapy and enhancement to roughly denote an ethical or legitimate use of biotechnology from the illegitimate or unethical. While this framing is initially plausible, the ambiguousness of our definitions in and around medicine makes this distinction much more difficult to navigate.

In what follows, I will first lay out the key terms and definitions that underpin the distinction between therapy and enhancement and note both the ambiguities and utility of those terms. Next, I will survey the theories that develop different philosophical notions of these terms from the philosophy of medicine. These theories, I will argue, are all inadequate or overly cumbersome for the purposes of normative inquiry, so it will be necessary to explore other alternatives. One of these alternatives, devised by Marc Ereshefsky, provides a useful

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[1] Beyond Therapy: Biotechnology and the Pursuit of Happiness,13

[2] Beyond Therapy: Biotechnology and the Pursuit of Happiness,13

framework to update the philosophy of medicine and our uses of the terms therapy and enhancement but lacks a specific normative principle for guiding normative inquiry. I will then argue that our colloquial understanding of health and disease points to “wellbeing” as the normative criterion that underpins the philosophy of medicine. This criterion can, at last, provide a clear answer regarding the distinction between therapy and enhancement: there isn’t one. I will conclude by considering objections to this new way of conceptualizing medicine and then transition to its implications for procreative ethics.

The Ambiguity of Medical Terminology

When I say that medical terminology is ambiguous, I mean that there are multiple understandings of the terms in question but that there is no consensus on how we ought to employ them or arbitrate between these understandings in different contexts. There is, of course, the distinction that we are working towards understanding—therapy vs. enhancement—but there are other important concepts that undergird our colloquial understanding of these terms. The tentative definitions of therapy and enhancement I introduced above refer to fitness, disability, impairment, health, and disease. In service of understanding the distinction between therapy and enhancement, in this section, I will explore and defend more robust philosophical definitions of health and disease. Later, in the section “Disability and The Logic of Enhancement,” I will defend definitions of disability and impairment, concepts that will benefit from the discussion here.

Disease and health are closely related terms that are often defined in terms of each other. Health could be understood as the absence of disease, whereas disease might be defined as something that detracts from health. Of course, such circular definitions won’t cut it for a satisfactory analysis. In the philosophy of medicine, three theories make up an established canon that attempts to provide more robust definitions. Naturalism turns to scientific theory to attempt to describe health and disease as natural kinds, that is, things that can be found in the world, rather than a product of humankind's value judgments, interests, or interpretation. Paradigmatic sciences like chemistry and physics carve the complexity of the world into its smallest and most distinct parts: atoms, elements, and fundamental forces of the universe. The investigation into health and disease, according to the naturalist, can be a similar kind of science that can be divided into fundamental categories of normal, abnormal, healthy, and diseased. Normativism about health and disease swings in the opposite direction, postulating that health and disease are normatively laden terms that only indicate prescriptive judgments about what ought to be considered normal, healthy, and diseased. From this perspective, various judgments that inform what we think an ideally healthy human is like determine what conditions are seen as healthy or diseased. Seeing both naturalism and normativism as having serious problems, hybrid theories attempt to synthesize these approaches to get their respective benefits and avoid their drawbacks. I follow Marc Ereshefsky in arguing that all three canon theories fail to provide adequate theories of health and disease for normative inquiry.

Naturalism

The idea that health or disease are natural kinds is quite common amongst philosophers and medical professionals, yet even the most sophisticated of these naturalistic theories struggle to articulate these concepts as such. In an attempt to provide a value-free account of health and disease, Christopher Boorse has articulated the most philosophically robust version of Naturalism, known also as the Bio-Statistical Theory (BST). Boorse develops four key notions in his account of health and disease defined here:

> 1. *The reference class* is a natural class of organisms of uniform functional design; specifically, an age group of a sex of a species.
>
> 2. A *normal function* of a part or process within members of the reference class is a statistically typical contribution by it to their individual survival and reproduction.
>
> 3. *Health* in a member of the reference class is *normal functional ability:* the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency.
>
> 4. A *disease* is a type of internal state which impairs health, i.e. reduces one or more functional abilities below typical efficiency.[3]

From these definitions, we can understand health as an "absence of disease" and disease as a statistical abnormality of functioning within a specific reference class. The reference classes Boorse proposes are species, age, and sex as the relevant groups to which we can ascribe normal functioning. Species constitutes a relevant reference class as it would be strange to say that we should think about human health in terms of what is healthy for amphibians (humans are not understood as being diseased because of not being able to breathe through our skin in water). Age is relevant because of the distinct ontogenetic differences between young and older members of a species that constitute normal biological functioning (erectile dysfunction or menopause are considered normal for older humans while they are abnormal for younger humans.) Finally, sex is an important distinction because, again, what is normal in the female reference class is distinct from a male reference class (we do not understand a male being diseased given that he lacks a uterus.) Perhaps unsurprisingly, Boorse develops the naturalist account of health and disease in tandem with an evolutionary understanding of the goal towards which all our biological systems aim, namely survival and reproduction. A biological system is

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[3] Boorse, 1977, p.555

thus considered functional when it performs a statistically normal contribution towards the ends of survival and reproduction compared to its relevant reference class of species, age, and sex.

While appearing seductively coherent, the defender of Naturalism quickly encounters some serious concerns. Some of the concerns are internal to the view. For instance, Boorse acknowledges that there are conditions that his naturalist view doesn't capture that are typically considered as notable pathologies in normal medical practice, such as "congenital absence of the appendix, perhaps dextrocardia, and calcification of the pineal gland."[4] Furthermore, the naturalist view cannot accommodate phenomena like universal disease, where what is statistically normal in a population in terms of functioning is, in normal medical practice, considered a disease. Boorse notes that "dental caries, lung irritation, atherosclerosis, and benign hypertrophy of the prostate in old men are diseases typical of the whole population or a sex or age group."[5] It would also be impossible to discuss "universal genetic disease" on this account: a genetic affliction that an entire reference class has.[6] Another concept that the Naturalist model is hard pressed to accommodate is that of "positive health," understood as the view that "physicians and mental-health workers should actively aid individuals or communities, in maximizing their quality of life, and developing their full human potential."[7] The problem arises because of Naturalism's alleged value-neutrality. To speak of positive health seems to necessarily import terms of value and what is good for human lives, and this is something a naturalist position cannot do.

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[4] Boorse ,1977, p.565
[5] Boorse, 1977, p.566
[6] Boorse, 1977, p.567
[7] Boorse, 1977, p.568

Other critics point out that the view struggles with basic empirical accuracy, and this might undermine the BST use for even the “objective” sciences like etiology, biology, or taxonomy, which study or classify diseases independently from their effects on patients. The concepts essential to Naturalism—reference classes, normalcy, and proper functioning—are in theory informed by “pure biology.” Yet, as Ereshefsky argues, the naturalist view fails at its primary goal of being naturalistic as these very same concepts make the view un-naturalistic. A truly naturalistic theory would account for the fact that biological taxonomy does not inform us what *functionings* are normal in a species as “species” is fundamentally a genealogical, not teleological, notion. It is thus unclear how Boorse’s teleological notion of a species maps onto the accepted genealogical one, which does not require a “specific qualitative design or nature of an organism…to be a member of a species.”[8] Otherwise said, one does not have to look, act, or function like a typical member of a species (as the naturalist view seems to assume) to be a genetic member of it. Yet, this teleological component of the naturalist theory runs deeper than the problem of reference classes.

Boorse’s naturalism also assumes that there is but one biological goal to which normal functioning can be attributed: “survival and reproduction.” Ereshefsky writes,

> Biologists describe many types of states that organisms have, and many of those states have nothing to do with fitness. There is eating for eating’s sake. There is non-reproductive sex. There is the release of endorphins. Biology describes various states organisms can be in, and one type of state happens to concern fitness. Biology does not tell us that surviving and reproducing, versus achieving other kinds of states, are the goals of organisms. That choice comes from outside of biology. By choosing fitness as the goal of organisms, Boorse violates a main tenet of naturalism—that biology and biology alone should tell us what is ‘health’.[9]

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[8] Ereshefsky, 2007, p.222

[9] Ereshefsky, 2007, p.223

The error that Naturalism makes here is that, even while it is true that the many states an organism can have are the result of natural selection which selects traits according to their contribution to survival and reproduction (and thus a kind of teleology), it is a mistake to think that this evolutionary goal also describes what is *healthy* for individuals. We can affirm the natural teleology described by natural selection and evolutionary biology while also denying that this teleology describes what is healthy for an individual.

While Boorse sketches some preliminary replies to these concerns, there is an external critique of the view that is, in my estimation, far more pressing. This concerns the inability of the naturalist view to accommodate the intuition that healthcare necessarily deploys values and considerations about what is good for a person. The naturalist fails to capture the typical usage of the terms health and disease as deeply normatively laden, with health at least somewhat connoting “worth promoting” and disease at least somewhat connoting “something to be eliminated.” The naturalist reply to this can be that their definitions of health and disease should be understood as theoretical and philosophical notions that are unconnected with colloquial usage. They would further argue that merely because something is healthy or diseased it does not follow from their view that we should conclude anything about the desirability or undesirability of that thing. If this is the case, however, then it is unclear why we should be interested in these definitions at all. In clinical medical practice, providers are interested (or we assume they ought to be interested in) not in the statistically normal functioning of biological structures, but in terms of what is best for their patients’ well-being. If the concepts of health and disease are to be useful in this domain, then the naturalist theory does not provide us with a cogent theory for normative inquiry.

Normativism

Given naturalism's inability to provide the normative notion of health and disease that we are looking for, the next logical step is to accept the value-ladenness of these terms. Engelhardt, a proponent of a normativist theory of health and disease, articulates the normativist position nicely, writing, "What counts as health and disease for humans depends upon very complex judgments concerning suffering, the goals proper to humans, and ... the form or appearance proper to humans."[10] Normativism about health and disease does seem to describe the actual usage of the terms in colloquial and medical discourse, such that health is *prima facie* something "worth promoting" and disease is "something to be eliminated." Normativism's dependence on values and attitudes, however, is a double-edged sword. If health and disease are, as normativism claims, nothing more than social or individual values toward certain conditions or bodily states, then we are left with a highly relativistic notion that does not help us with normative discourse. On the normativist view, depending on someone's judgment or a society's judgment of a condition as good or bad, it also grants it the status of a disease entity. This raises the obvious question: whose judgment counts? This aspect of normativism ranges from unintuitive to seriously objectionable. The kinds of cases that pose a serious problem for normativism are where a state is undesirable but not intuitively a disease or because of differing judgments across various comparison classes (different cultures, across a single society, or across time.) There is little disagreement, for instance, that alcoholism is a disvalued state, but there is disagreement about whether it should be thought of as a disease.[11] This disagreement makes no sense if disease truly corresponds only to the

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[10] Engelhardt, 1976, p.102

[11] Ereshefsky, 2009, p. 224

perceived value of a condition. Furthermore, the normativist position makes it impossible to distinguish ADHD, homosexuality, prejudicially motivated diseases like drapetomania, or even certain political views from diseases according to differing societal orientations towards these "conditions."[12]

Thus, the normativist view collapses into one of two conclusions: either there is no such thing as health and disease, and these terms mean only what is deemed good and bad, or they are piggybacking off some other concept that tracks objective goodness and badness (like what does or doesn't contribute to well-being), making the terms obfuscating for the normative notion we hope to capture. To make this collapse clearer, consider the first possibility: if health and disease only mean what is deemed good or bad by a society, then the concepts of health of disease are coextensive with societal attitudes. This makes the concepts of health and disease vacuous. On this view, we gain nothing by saying "X is a disease" rather than merely saying "X is socially undesirable." This option makes medicine a highly relativistic field which not only doesn't capture the idea that medicine ought to be an "objective" science, but it also introduces a host of problems associated with relativistic yet normative theories. To avoid this relativistic conclusion, the defender of normativism can instead say that health and disease are tracking objective values, say, well-being. However, if this is the case, then health and disease may similarly be vacuous concepts. We gain nothing by saying "X is a disease" rather than saying "X detracts from wellbeing." In both options, the concepts of health and disease are merely unnecessary middlemen between values and various ways people can be in the world.

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[12] Ereshefsky, 2009, p. 224

A possible reply from the defender of normativism is to say that the concepts of health and disease are not vacuous but instead serve an important pragmatic purpose by indicating the proper domain of a response to X. For instance, that X is a disease might distinguish "X is a socially undesirable *aspect of the body that ought to be treated by medical intervention"* from the less specific claim "X is socially undesirable." It might likewise serve to distinguish "X *as a condition of the body that* detracts from wellbeing *and ought to be treated by medical intervention"* from the more general claim "X detracts from wellbeing." I think this reply is promising for the coherence of the theory, but I will say more about this updated version of normativism when discussing Ereshefsky's critique of theories of health and disease.

Hybrid Theories

The hybrid theory of health and disease tries to capture both normativist and naturalist accounts of disease to address the problems already discussed with both views. Such a view is captured in Wakefield's harmful dysfunction view:

> A condition is a disorder if and only if (a) the condition causes some harm or deprivation of benefit to the person as judged by the standards of the person's culture (the value criterion), and (b) the condition results from the inability of some internal mechanism to perform its natural function, wherein a natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mechanism (the explanatory criterion).[13]

While this view has a conceptual advantage over its opponents in that it provides criteria that, for the most part, match our intuitions about disease and its relationship to healthcare, it still fails to provide a satisfying definition of disease for arguably the same reasons a naturalist view fails. This is because, just like the Naturalistic theory of health and disease, it erroneously

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[13] Wakefield, 1992, p.384

assumes that there are cohesive theories in biology and pathology that can be relied upon to deliver a notion of statistical normalcy of functioning for human beings and other species. We have already seen in the discussion of Naturalism's weaknesses that "pure biology" does not provide us with (1) what a natural functioning is or (2) why the natural function should be thought of as the healthy or proper functioning *for the purposes of medicine.* If the integrity of the naturalistic condition in the hybrid view is compromised, as it seems to be, then it fails to deliver a coherent theory of health and disease. Furthermore, the hybrid theory fails to imagine a "value condition" as something objective rather than societally judged, and, as we've seen, this has the effect of relativizing medicine. This may be appropriate if Wakefield's theory is more interested in describing how people have used health and disease in the past, but it is of limited use when we want a prescriptive notion of health and disease. Thus, the hybrid theory inherits the benefits but also the weaknesses of its parent theories.

State Descriptions and Normative Judgments

While the conversation defining health and disease is alive and well within the philosophy of medicine, this survey of existing theories should suggest a few things. Theorists are divided on what the desiderata of a successful theory of health and disease are. For some, a successful theory is merely a descriptive theory of natural kinds, distinguishing disease entities from non-disease entities. For others, the theory should be descriptively accurate to how the terms health and disease are used and have been used throughout time. A successful theory might be used to define the proper domain of healthcare practitioners and still others think a successful theory should provide normative guidance for the practice of medicine for both what to promote and what to diminish. In other words, theories can be created to answer linguistic, historical, descriptive, or normative questions and may be inappropriate if deployed in other fields. The normativist, for example, may aptly *describe* the way “health” and “disease” have been/are used, but it is a poor guide for normative discussions given that it defines health and disease in terms of societal judgments; however, if we were to use societal judgments of good and bad as normative for the practice of medicine, this quickly leads to a very problematic relativization of medicine. Naturalism, normativism, and hybrid theories each have their merits by satisfying different desiderata for a theory of health and disease, but insofar as it is unclear what the proper desiderata ought to be, it is perhaps no wonder why there continue to be serious ambiguities in the ongoing conversation.

This ongoing conversation also suggests that perhaps health and disease are ambiguous to the point of diminished utility for normative discussions. A great deal of ink has been spilled arbitrating, arguing, and analyzing health and disease for very little gain in normative disciplines. Marc Ereshefsky proposes a promising solution for this predicament. Rather than continuing to refine our theories of health and disease, we can disambiguate these concepts by making clear and distinct their normative and descriptive components. Ereshefsky proposes we do this by reframing the discussion to “talk about the considerations that are central in medical discussions, namely, descriptions and normative claims.”[14] The following distinction is offered: State descriptions aspire only to describe different “physiological or psychological states” in patients, whereas normative claims are the “explicit value judgments concerning whether we value or disvalue a physiological or psychological state.”[15] Several

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[14] Ereshefsky, 2007, p. 225

[15] Ereshefsky, 2007, p. 225

considerations make this proposal promising for productive conversations in biomedical ethics.

Ereshefsky's distinction between state descriptions and normative claims (which I will henceforth call "Ereshefsky's proposal for the philosophy of medicine" or EPPM) represents significant progress in the philosophy of medicine on several questions and points. First, this framework allows us to have more productive conversations around difficult cases of health and disease, such as disability, mental illness, or "benign diseases." There are heated discussions around what is colloquially understood as a disability, like Deafness, where it is unclear if Deafness should be treated as a disease or if it is merely a difference that can be understood as part of the normal range of human diversity. EPPM would allow us to talk meaningfully about the genealogical or physiological phenomenon that causes Deafness without simultaneously taking a stance (even if implicit) on whether Deafness is or isn't a disease or healthy. The goodness or badness of the condition is a separate issue, and it would be intellectually and morally irresponsible to hastily classify a condition using a heuristic of "disease" or "healthy" without further discussion about how the condition actually affects, for instance, well-being.[16] A similar distinction can be made for mental illness. Some people suffer tremendously from their chronic depression, while others may see its benefits—perhaps increased creativity or it being better than a medicated state—to be worth the trade-off.[17] EPPM allows medicine to understand depression as a phenomenon independently of normative

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[16] There are significant assumptions made about the quality of life for disabled people by both lay people and bioethicists alike that result in "disability" being basically synonymous with a disease state. The section titled "Disability and The Logic of Enhancement" will detail this pervasive injustice towards people with disabilities.

[17] A 2008 study by Nancy C. Anderson reports, "the preponderance of the evidence suggests that in these creative individuals the rate of mood disorder is high, and that both bipolar disorder and unipolar depression are quite common."

judgment about how it is best treated or not treated. This, in turn, allows us to avoid the unsavory (and likely to be misinterpreted claims) about what logically or instrumentally follows from some condition being classified as a diseased state.

Furthermore, EPPM bypasses the fraught terminology of naturalism that also ultimately undercuts hybrid theories of health and disease. To talk meaningfully about a state description of the body, we do not have to assume it is natural/unnatural, normal/abnormal, desirable/undesirable, or functional/dysfunctional according to evolutionary biology or a specific reference class. These judgments may eventually fall out of additional medical or ethical discourse, but it is not inherent to the framework and is thus an improvement on normative theories of health and disease. EPPM avoids the pitfalls of normativism here as well. The primary problem that I identified with the normativist position was that, in trying to describe the actual usage of the terms "health and disease," it defines them as the product of societal values. I sketched a reply on behalf of the normativist who, if interested in creating a normative rather than descriptive theory, might define health and disease in terms of some objective value criterion and the proper domain of response, for example, well-being and pertaining to bodies. While I take this to be a fruitful line of argument for the normativist and, if this revision to the theory was made, it may be a comparably rigorous theory to EPPM, the latter theory still has the advantage of being agnostic to the assumption-laden terms of health and disease. EPPM thus allows us to focus on treating patients rather than getting bogged down by "needless distraction in medical debates."[18] Ereshefsky recounts an analogy developed by Hesslow to illustrate this aspect of his proposal:

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[18] Ereshefsky, 2009, p.225

> A person brings her car to an auto mechanic and complains that her car is defective because it does not accelerate as quickly as her friend's car of the same make and model. The mechanic replies that there is nothing defective with the car: the valves in the different cars are just adjusted differently. The car owner and the mechanic then engage in an argument over whether the car is defective. Hesslow suggests that arguing over whether the car is defective is an unnecessary and needless distraction. The owner should just tell the mechanic that she would like the car's acceleration increased. Hesslow maintains that arguing over whether someone has a disease is like arguing over whether a car is defective. Using the terminology suggested here, we should identify the physiological or psychological state under discussion and express whether that state is desirable or not. Once we frame the discussion in terms of state descriptions and normative claims we get to the issues that matter and the terms 'health' and 'disease' become superfluous.[19]

This passage demonstrates the utility of eliminating health and disease from ethical discourse because we need not worry if a given state description is a disease entity or a healthy state to consider it for treatment according to some normative criterion. We only need to worry about appraising the state description in terms of our normative criteria. A comparable normativist theory, as a theory of health and disease, has an extra, arguably unnecessary and confusing, step to inform the normative practice of medicine.

Lastly, as the final point in favor of EPPM, it also has the advantage of being consistent with how the terms health and disease have been used throughout history. Of the three big theories of health and disease, only the normativist theory manages to accomplish this, and at the great cost of relativizing medicine if it were to be used as a normative theory. EPPM can ask of a historical "disease" what was occurring from a physiological standpoint (state description) and how societal attitudes impacted the response to that state description. Thus, EPPM can guide not only our ongoing investigation of the proper domain and practice of medicine but also our historical investigation of how the terms health and disease were deployed in the past.

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[19] Ereshefsky, 2009, p.225

EPPM doesn’t, in practice, change much of how medicine functions on a day-to-day basis. Clinicians will continue to treat patients’ ailments, etiologists will continue to study the origins of those ailments, and society at large will continue to use the labels of health and disease to describe the condition of bodies. What has changed is that these practices can now be grounded and/or analyzed through a philosophically robust philosophy of medicine. In the next chapter, the importance of a robust philosophy of medicine will become clear as such a theory is useful as we analyze the plausibility of the claims made by human enhancement theorists.

Chapter 2: A Well-Being-Centered Philosophy of Medicine

What Ereshefsky's proposal for the philosophy of medicine does not explicitly tell us is what normative criteria we ought to be using when we appraise cases in biomedical ethics, though I think there is a short list of plausible candidates. In investigating this issue, we might first examine why we find it not only permissible but good that the medical profession continues to operate in our societies. We may be tempted to respond that the medical profession is good insofar as it promotes health and combats disease, but, as I have shown in my analysis so far, these terms are problematic poles on our moral compass. So, as I have already alluded to, a much more rigorous and objective criterion that allows us to account for the goodness of medicine is that of well-being. This criterion also allows us to make sense of talking about "health" if we understand that health is worth promoting because it contributes to our ability to live a good life. Similarly, talk of "disease" is sensical when understanding disease as something worth eliminating because it inhibits our ability to live a good life. If this is right, then this points to some version of "well-being" as the underlying normative criterion it seems we are implicitly appealing to when we provide an account for the goodness of medicine.

A similar conclusion is reached by the bioethicist Julian Savulescu, who argues, "It is the goodness of health that drives a moral obligation to treat or prevent disease. Being healthy enables us to lead a good life. But health is not intrinsically valuable. It is instrumentally valuable – valuable as a resource that allows us to do what really matters, that is, lead a good life."[20] Thus, in line with Ereshefsky's proposal (with the addition of a specific normative

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[20] Savulescu, 2005, p.37

criterion), Savulescu suggests we should care about different human traits in terms of how they impact our well-being rather than what is healthy, diseased, normal, functional, natural, etc.

Where does this leave our investigation into the distinction between therapy and enhancement? We can now reappraise our tentative definitions:

> **Therapy** is the use of biotechnical power to treat individuals with known diseases, disabilities, or impairments, in an attempt to restore them to a normal state of health and fitness.[21]
>
> **Enhancement** is the directed use of biotechnical power to alter, by direct intervention, not disease processes but the "normal" workings of the human body and psyche, to augment or improve their native capacities and performances.[22]

As we have seen, these definitions are seriously lacking for normative inquiry insofar as they appeal to nature, normalcy, functioning, health, and disease, terms fraught with complications and ambiguity. The distinction between therapy and enhancement, which relies on these concepts, thus imports most, if not all, of the problems that were identified in theories of health and disease. In a similar move to EPPM, I suggest that the distinction between therapy and enhancement is not useful for normative inquiry in bioethics. This mystery is one of the primary motivating questions for this thesis: what are we left with once health, disease, therapy, and enhancement are excised as useful distinctions for normative inquiry in the philosophy of medicine?

Biotechnological Enhancement

As we have seen, a well-being-centered approach to the philosophy of medicine is a promising theory that doesn't have the serious weaknesses of the theories of health and disease; however, without the distinction between therapy and enhancement, Savulescu

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[21] Beyond Therapy: Biotechnology and the Pursuit of Happiness, p.13
[22] Beyond Therapy: Biotechnology and the Pursuit of Happiness, p.13

argues that this leaves us with some initially unintuitive moral obligations. He writes, "If it is well-being, not health, that is intrinsically valuable, we can see why human enhancement can become a moral obligation. Many of our biological and psychological characteristics profoundly affect how well our lives go.[23] He elaborates,

> Once technology affords us with the power to enhance our and our children's lives, to fail to do so will be to be responsible for the consequences. To fail to treat our children's disease is to harm them. To fail to prevent them getting depression is to harm them. To fail to improve their physical, musical, psychological and other capacities is to harm them, just as it would be to harm them if we gave them a toxic substance that stunted or reduced these capacities.[24]

This excerpt demonstrates the core thesis of Savulescu's argument in his 2005 paper: there is no principled distinction between treatment and enhancement on the grounds of well-being and that medical/biotechnological enhancement is continuous rather than different in kind from treatment that doctors already routinely provide. We should understand the above excerpt to be making a claim about net harm or net well-being given some treatment or enhancement such that the increase of well-being gained by being treated for a disease is the same kind of increase in well-being that a patient might receive from a biotechnological enhancement. To this point, Savulescu writes, "Enhancement is a misnomer. It suggests luxury. But enhancement is no luxury. In so far as it promotes well-being, it is the very essence of what is necessary for a good human life."[25]

Yet, there are several points of nuance that are introduced by the wording of this excerpt that are not clearly addressed within Savulescu's paper. One might first object to the language of "moral obligation" rather than, say, "morally justified" or "morally permissible". Savulescu

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[23] Savulescu, 2005, p.37
[24] Savulescu, 2005, p.38
[25] Savulescu 2005, p. 38

seems to import the language of "moral obligations" from his understanding of the relationship between medicine and disease. It is thus a matter of consistency for him to claim that if medicine is morally obligated to treat disease, then medicine is obligated to provide biotechnological enhancement. If your preferred theory of moral normativity or the reality of the relationship between medicine and disease differs from what Savulescu claims, this is ultimately inconsequential to Savulescu's argument.[26] Whether the relationship between medicine and disease generates a moral obligation, a significant moral reason, or a moral justification, Savulescu's point is that if it applies to disease, then, through a framework of wellbeing, it must also apply to enhancement.

A similar point applies to Savulescu's assumption about the proper domain of medicine. While there are myriad ways in which a medical practitioner might improve the well-being of their patients, only some of them we think are appropriate. The practitioner might prescribe medication for the patient's ailment, seek social services on behalf of the patient, write the patient a check for a significant sum of money, or volunteer to clean the patient's home. All four options would likely increase the patient's well-being, but only the first or perhaps the second option is, we typically think, the proper role of a medical provider. Given that in our societies, "physicians have been given a more-or-less complete monopoly over the prescription and administration of biotechnology to human beings,"[27] this provides a principled distinction between biotechnological enhancements as the kind that medical professionals are obligated to provide and other kinds of well-being enhancing actions. Savulescu's

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[26] Though it would be important for the philosophy of medicine more generally.

[27] Byond Therapy: Biotechnology and the Pursuit of Happiness, p.14

argument thus restricts the domain of the medical professional to the realm of well-being and, implicitly, to the application of biotechnology.

One might also reasonably hesitate at Savulescu's understanding of harm. It is not immediately obvious or intuitive that the harm derived from failing to treat disease is the same kind of harm that is derived from the deprivation of a (or the failing to benefit via) biotechnological enhancement. Savulescu seems to understand harm similarly to the widely received counterfactual comparative account of harm (CCA):

> An event *e* is a harm for a subject S just in case S is better off in the nearest possible world in which *e* does not occur than S is in the relevant e-world.[28]

Savulescu's example fits here as it seems that a subject would be better off in the world where they are treated for the disease rather than in the world in which they are not. Similarly, it seems a subject would be better off in a world in which they receive a well-being improving biotechnological enhancement than in a world in which they do not. In this sense both are clearly harms. However, this similarity speaks to one of the more significant drawbacks to this view and the one that may account for the strangeness of his example. This drawback being that the CCA "cannot respect the moral and metaphysical distinction between harms and failures to benefit."[29] While failing to treat a disease (when treatment is available) seems like a "true" harm, failing to enhance (when enhancement is available) seems like a failure to provide a benefit. If true, the latter seems to generate less compelling moral reasons (or obligations) than the former.

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[28] Purves, 2018, p.2

[29] Purves, 2018, p.2

At least two things can be said in Savulescu's defense on this point. First, the CCA, though imperfect, is a rigorous, compelling, and well-received view of harm, and thus, Savulescu's argument doesn't rely on some bespoke theory of harm that would require a detailed justification for its use. Furthermore, based on my conceptual analysis of health, disease, treatment, and enhancement thus far, it is unclear how one could draw a distinction between the two options described in the initial example. If there is no meaningful distinction between enhancement and treatment, we need to turn to some other distinction to account for the dissonance of our intuitions regarding harm. Purves, in describing the benefits of the CCA, alludes to a possible source of this dissonance:

> CCA is an attractive account of harm for several reasons. First, it obeys *ontological* and *normative neutrality* in that it does not restrict harmful events to actions, and it does not entail that all harming is wrongful. Natural events might be harms for someone. A tree's falling onto me, breaking my leg, harms me, but this event is not a wrongful harm.[30]

The normative neutrality of the CCA may isolate the difference between the "harms" of failing to treat and failing to enhance. One might be an example of wrongful harm, whereas the other is not wrongful harm. Savulescu acknowledges later in his 2005 paper that enhancements vary in their ethicality, so perhaps it is a differing ethicality of failing to treat versus failing to provide enhancement rather than the veracity of the harm that causes intuitive dissonance. I think this answer is on the right track, and I will return to this point in the next section. Overall, this brief discussion makes it plausible that Savulescu's argument does not turn on some bespoke theory of harm and that his example does demonstrate that there is a comparable harmful effect between failing to treat a disease and failing to biotechnologically enhance some wellbeing-affecting traits.

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[30] Purves, 2018, p.3

Ultimately, Savulescu's thesis for the logic of enhancement is quite straightforward. If the relationship between disease and its effect on well-being is what obligates the medical profession to provide treatment, then the relationship between enhancement and well-being generates the same kind of obligation. While there are legitimate questions about some of the language, assumptions, and examples that Savulescu employs, these are peripheral to the core thesis. What would need to be developed to contradict the core thesis is some account, unconcerned with well-being, of why the medical profession is obligated to treat patients. Insofar as "the promotion of health" is often touted as this alternate account, the reader should now understand why I have gone to such lengths to demonstrate why "health" is a mostly, if not entirely, vacuous concept for ethical inquiry. If a principle of well-being does underpin the distinction between treatment and enhancement, then considering Savulescu's argument, we should understand them as really one and the same. I will, therefore, use the terms 'enhancement,' 'treatment,' "therapy,' and 'medical intervention' can be used interchangeably for the remainder of this thesis.

Considered Objections - Medical Ethics, Positionality, and Eugenics

At this point, while I find the proposal that we have a moral obligation to enhance humankind compelling, I have only presented a rough framework where the details make all the difference. Savulescu considers some powerful objections to the enhancement framework. These include the enhancement of positional and non-positional goods, the varied ethicality of specific enhancements, and responding to the charge of eugenics.

The distinction between positional versus non-positional goods arises in response to an objection that enhancing human traits will either "have self-defeating or other adverse social effects."[31] For example, a trait that biotechnology might allow us to enhance is our height. This would be self-defeating under the following scenario:

> If height is socially desired, then everyone will try to enhance the height of their children at great cost to themselves and the environment (as taller people consume more resources), with no advantage in the end since there will be no relative gain.

To enhance these sorts of positional goods—something that is only good relative to a specific context—is to fail to apply the well-being criterion essential to Savulescu's enhancement framework.[32] While an increased height might temporarily grant an increase in well-being because of the trait's social desirability, it does not, by itself, irrespective of a specific social context, contribute to one's well-being. Insofar as the manipulation of height is self-defeating, it has not increased well-being for the individual, is harmful to society more broadly (given the increase in consumption of resources), and might also harm the individual with the various conditions associated with height.[33] The more obvious candidates for enhancement include those that improve someone's well-being non-positionally; that is something inherently beneficial to well-being. This, in turn, raises complex questions about what would be purely non-positionally beneficial to our well-being, but in theory, we could agree these are the kinds of traits that are the most plausible candidates for enhancement.

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[31] Savulescu, 2005, p.38

[32] Of course, all goods can be construed to be somewhat contextual; goods are only understood according to contingent facts about the nature of human beings and the nature of the universe. Here, however, I am concerned about the difference between changeable contexts and unchangeable contexts. Societies can and do change their values and structures all the time. Within this changeable context, the self-defeating argument holds up. The context of the fundamental laws of physics and human nature are, in all likelihood, contexts that don't change, and *this* is the relevant context to discuss positional and non-positional goods. For more on this, see *Section II Part 2: Inherent Harm in the Welfarist View of Disability*.

[33] A 2018 study by Lai, F.Y., Nath, M., Hamby, S.E. et al. "confirmed previously reported height associations for coronary artery disease, atrial fibrillation, venous thromboembolism, intervertebral disc disorder, hip fracture and cancer and identified potential novel associations for gastro-oesophageal reflux disease, diaphragmatic hernia and vasculitis."

There are some tough cases that include both non-positional and positional qualities; Savulescu notes intelligence as a plausible candidate for such a case. Increased intelligence would allow one to gain positional goods such as a competitive advantage in employment, but presumably, it may also allow one to become more reflective, studious, or even more virtuous, all of which may be good in themselves (non-positionally).[34] These are the kinds of complex cases that are the most prevalent when assessing possible candidate traits for enhancement. Indeed, Savulescu does not always help his argument for enhancement as his selection of examples is often of this sort. From physical, psychological, and musical ability to disability and impulse control, Savulescu presents many traits as candidates for enhancement that are far from obviously non-positional or even of mixed positionality. There is a much more complex and sophisticated discussion that needs to occur before concluding what traits are reasonable candidates for enhancement. Savulescu hints at this by contending that, to determine the ethicality of a given enhancement, we must look at various factors.

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[34] These considerations about intelligence are presumably meant to contribute to some theory of well-being. There are some theories of well-being—I have hedonism in mind— where intelligence may be negatively correlated with well-being. If this theory of well-being is applied through the logic of enhancement, then the proper medical intervention might be to modulate intelligence to maximize the patient's pleasure rather than their overall greater well-being. For this outcome and other reasons, hedonism is an implausible theory.

With regard to an individual, Savulescu presents the following table of criteria to determine the ethicality of a given enhancement:

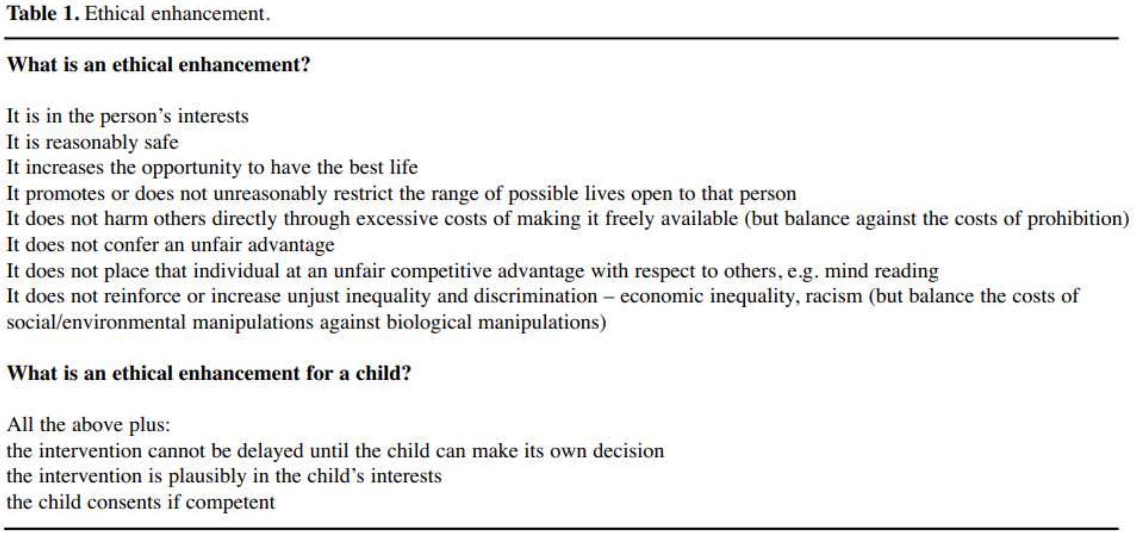

Table 1. Ethical enhancement.

What is an ethical enhancement?

It is in the person's interests
It is reasonably safe
It increases the opportunity to have the best life
It promotes or does not unreasonably restrict the range of possible lives open to that person
It does not harm others directly through excessive costs of making it freely available (but balance against the costs of prohibition)
It does not confer an unfair advantage
It does not place that individual at an unfair competitive advantage with respect to others, e.g. mind reading
It does not reinforce or increase unjust inequality and discrimination – economic inequality, racism (but balance the costs of social/environmental manipulations against biological manipulations)

What is an ethical enhancement for a child?

All the above plus:
the intervention cannot be delayed until the child can make its own decision
the intervention is plausibly in the child's interests
the child consents if competent

Figure 1, Criteria for Ethical Biotechnological Enhancement. Savulescu, 2005

This list includes a number of considerations ranging from the cost/benefit of the effects on society to notions of risk, autonomy, and justice. This shouldn't surprise us as even well-intentioned medical intervention, traditionally conceived, quickly becomes unethical without similar moral constraints. While it remains unclear if Savulescu thinks the traits he presents as candidates for enhancement meet these criteria, ultimately, these considerations both seriously constrain the logic of enhancement and save it from serious objections of eugenics or, as I will explain in more detail in a later section, ableism.

Finally, Savulescu identifies what specifically about eugenics has been so objectionable that the mere invocation of the term is meant to discredit the view or person it is levied against. The history of eugenics has become synonymous with prejudice, genocide, and Nazism, to name just a few of its unsavory connotations. This reputation is not unearned. Beginning at the start of the 20th century, eugenics was originally conceived in the United States as a “political ideology designed to sculpt societies through biological methods of population control.”[35] With bipartisan and popular support, eugenics was embraced as a scientific grounding for myriad prejudiced movements.[36] Among the targeted for policies of forced sterilization or excision from society via incarceration or genocide included, "‘degenerates,” along with the “shiftless poor,” the physically and cognitively disabled, the mentally ill, and the “diseased.”’[37][38]Women and people of color especially suffered at the intersection of these eugenic categories and their other marginalized identities.[39] As a legacy of racism has shaped many American institutions, so too can many of these institutions trace their roots to the American eugenics movement in the early to mid-1900s.[40] For example, the work “The Passing of the Great Race” by the American eugenicist Madison Grant was “pivotal in developing the policies of racial hygiene in Nazi Germany.”[41] The history of eugenics is far from an interesting but antiquated historical note. Modern-day eugenic movements based on prejudice, fear, and hatred continue into the 21st century, including discrimination and ethnic cleansing around the world and the far-right “Great Replacement Theory,” which has become disturbingly mainstream in the United States. Needless to say, responding to this horrific ongoing history of eugenics requires care, attention, and caution not to repeat the mistakes of the past.

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[35] Rutherford, 2021, p.1491

[36] Rutherford, 2021, p. 1491. Appleman, 2018, 443

[37] Appleman, 2018, p.440,442

[38] These social categories, considered biological realities at the time, constitute an additional argument against normativism as a *normative* theory of health and disease. The theory would necessarily include these categories as “real” diseases. This seems particularly problematic, given modern medical and ethical sensibilities, in the case of the “shiftless poor.”

[39] Appleman, 2018, p.439

[40] Appleman, 2018, p.443

[41] Rutherford, 2021, p.1491

Savulescu is sensitive to this history when developing the logic of enhancement writing:

> What was objectionable about the eugenics movement, besides its shoddy scientific basis, was that it involved the imposition of a state vision for a healthy population and aimed to achieve this through coercion. The eugenics movement was not aimed at what was good for individuals, but rather at what benefited society.[42]

Biotechnological enhancement, insofar as it seeks to promote certain traits via treatment or prenatal selection, is associated with a eugenic vision. This association alone, however, does not make it the case that Savulescu's argument carries over what made eugenics so morally abhorrent in the past. The view does not contain or condone a particular political vision, does not use or advocate for coercive measures to achieve its ends, and is not committed to a particular scientific understanding of genetics, heredity, or even health and disease. Furthermore, it is explicitly oriented towards the well-being of individuals but not a particular commitment to a theory of well-being. These considerations mean that Savulescu's argument should be understood as a mere framework in the philosophy of medicine that is ultimately informed by our various other philosophical commitments in epistemology, politics, and moral philosophy.

Procreative Beneficence

Let us now turn to the principle of "procreative beneficence." While the discussion of enhancement thus far has applied to extant humans, the principle of procreative beneficence applies the same logic of enhancement to future people. Given the huge advances in genetic engineering and pre-natal selection technologies, Savulescu and collaborator Guy Kahane see a potential for both reactive treatments for people with well-being-harming traits and the

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[42] Savulescu, 2005, p.38

possibility for a proactive principle of selection to increase the well-being of future children. The authors reason that these technologies give reproducers a choice to provide their children with the best possible chances of living a good life, and what moral person wouldn't jump at that opportunity, much less be opposed to it in theory? With clear parallels to Savulescu's enhancement argument in the last section, the devil, unsurprisingly, is in the details.

Savulescu and Kahane's proffered procreative principle, the principle of *Procreative Beneficence* (PB), states,

> 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 the relevant available information, to go best or at least not worse than any of the others.[43]

This principle aims for reproducers to select "the most advantaged child" from the potential children that they could produce given the combination of those reproducer's genetics.[44] The authors first argue from analogy that,

> Most people will agree that there is a moral defect in parents who intend to conceive a child by are indifferent to whether their future child will be born with the potential for a good life. 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. Until recently, however, people only had few means to promote this end.[45]

Thus, Savulescu and Kahane argue that PB is a mere extension of common-sense moral reasoning regarding procreation ethics. There is, however, a strong intuition to the contrary in parenthood and procreation ethics that begins to explain the resistance to otherwise common-sense morality.

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[43] Savulescu and Kahane, 2009, p. 274
[44] Savulescu and Kahane, 2009, p. 276
[45] Savulescu and Kahane, 2009, p. 276

In *The Case Against Perfection*, Michael Sandel articulates a plausible anti-selection parental virtue called "an openness to the unbidden." Drawing on the work of the theologian William F. May, Sandel argues that parenthood offers an opportunity for a parent to "cultivate openness through her experiences with the unbidden qualities of her child."[46] This openness, argues Sandel, is essential to parent-child relationships, and without the "humility and enlarged human sympathies" that an openness to the unbidden cultivates, the parent-child relationship is at risk of "disfigurement."[47] This disfigurement is understood as failing "to appreciate children as gifts [and] to accept them as they come."[48]

An openness to the unbidden, while a plausible parental virtue, does not seem to be under such dire threat by pro-selection principles as Sandel thinks. Replying to Sandel, Melissa Seymour Fahmy notes,

> Even if we did select our children's genetic traits, there would still be every reason to think that parenthood teaches openness to the unbidden. This is because children are so much more than their genetic features. Only the most naïve parents would presume to know what they are getting simply because they had a hand in selecting some of their child's genetic features; and a naïve parent would receive a lesson in humility soon enough.[49]

It is thus important to recognize an "openness to the unbidden" as a *parental* rather than a procreative virtue, the latter of which is the sort that might conflict with a pro-selection principle like PB. Accordingly, it is coherent to claim that parents should both practice an openness to the many unbidden traits that their children will doubtless manifest, *and* parents should do what they can to provide their children with the genetic features that will give them

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[46] Fahmy, 2011, p.134
[47] Sandel, 2004, p.45
[48] Sandel, 2004, p.45
[49] Fahmy, 2011, p.134

the best chance of living a good life. If this is right, genetic selection is not a disfigurement of a parent-child relationship, as Sandel claims, but rather a separate procreative duty.

Savulescu and Kahane further defend PB by contending with, as all procreative ethicists must, the non-identity problem. The problem can be demonstrated using the authors' following example:

> Imagine that the rubella virus mutates so that it becomes highly virulent and resistant to current vaccination, and that a rubella epidemic occurs. A couple decides to have a child. However, if the woman falls pregnant now, it is highly likely that she will contract rubella and the baby will be born with congenital rubella—blind, deaf, and with severe brain damage. In a few months, the epidemic will have passed, and she would be likely to have a normal child.... If she waits several months, a different sperm and egg will create a different child to the one which she would have had during the epidemic.[50]

The decision is thus "identity-affecting" as the choice made by the parents will bring about two different children. If the child with congenital rubella is to exist, then there is no world in which they exist without the rubella. The problem occurs given a standard counterfactual conception of harm. If the child with congenital rubella is not made "worse off," then it seems they have not been harmed by their parent's decision to procreate during the epidemic. Savulescu and Kahane are comfortable with this conclusion as they believe PB can still justify the selection of "the most advantaged child" even when this choice is identity-affecting. The choice is justified on the grounds that the child conceived after the epidemic is likely to have a better life than the one conceived during the epidemic by being caused to exist. Indeed, nothing in the formulation of PB indicates that restricts selection to prenatal screening. PB also applies to more familiar selection factors like the circumstances of parents. In addition to a child's genetics, their parents' age, financial stability, and environmental context can also greatly affect how their lives go. Thus, it is consistent with PB to say that procreators have significant moral reason to

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[50] Savulescu and Kahane, 2009, p.276.

have a child when they have achieved "optimal"[51] conditions for their future child's well-being rather than having a child in other conditions.

Something important to note about Savulescu and Kahane's defense of PB so far is that it does not rely on a specific notion of well-being for which a myriad of competing theories exist. PB implies that for whatever plausible theory of well-being the relevant parties decide to implement, PB still applies and maintains that the relevant parties have a significant moral reason to select the child that has the best prospects for well-being on that theory. In this way, their defense of PB does not depend on the success of any given theory of well-being but does depend on the value of well-being itself. The latter is much easier to defend as we all implicitly use some notion of well-being to navigate even just our daily lives.

Another important thing to note is that while PB itself is a well-being-maximizing principle, the authors do not present it as the only principle or consideration to take into account while making procreative choices. [52] Savulescu and Kahane note the welfare of the parents, the welfare of existing children, the effect on a broader community, and "other moral constraints."[53] While sprinkled throughout the paper, this will be one of the areas where serious pressure can be put on PB, but more will be said in the disability and the logic of enhancement section. For now, we will examine why PB itself is a maximizing principle that culminates in a "significant moral reason" amongst others.

Savulescu and Kahane consider several "competing principles of procreative selection" to bolster PB as their chosen candidate. The table below shows these competing principles

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[51] Where the conditions are "best or at least not worse than any of the others"

[52] Savulescu and Kahane, 2009, p.280

[53] Savulescu and Kahane, 2009, p.278

(which are quoted directly from the text, whereas the summarized reasons for rejection are my own unless otherwise indicated).

Table 1: Competing Procreative Principles.

Competing Principles of Selection	Primary Reason for Rejection by S&K
Procreative Autonomy (PA): If reproducers have decided to have a child, and selection is possible, then any procreative option selected by reproducers is morally permissible as long as it is chosen autonomously.	"According to this principle, it is permissible for parents to select the best, but it is equally permissible for them to select the worst. [PA] is an extremely implausible moral principle."[54]
The Minimal Threshold View (MTV): 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 *life worth living* over any that does not; they have no significant moral reason to choose one such possible child over any other. **The Minimal Threshold Constraint on Reproduction:** If reproducers cannot choose a child whose life will be worth living, then they ought not to have a child at all.	MTV cannot accommodate the idea that parents should care about their children's future well-being. Authors accept The Minimal Threshold Constraint on Reproduction, but it doesn't provide guidance for procreative decision-making between possible children whose lives would be worth living.
The Satisficing View (SV): 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.	This view cannot support the intuition that "if A and B are identical in all regards except one, and A is superior in that regard to B, we have reason to choose A."[55]
The Prevention of Harm View (PHV): 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 experience the least suffering or limited opportunity or serious loss of happiness or good compared to others.	This view might rule out procreation altogether if coming into existence is inherently harmful, as some authors have argued. However, this view also can't accommodate the goodness of competing potential benefits.
Respect for the Autonomy of Future Persons (RAFP): If reproducers have decided to have a child, and selection is possible, then they have a significant moral reason to aim, not to maximize expected well-being, but to maximize *expected autonomy.*	"It seems to us doubtful that having a wider range of choice is valuable in itself, *independently,* of its contribution to expected well-being."[56]

Savulescu and Kahane's discussion of competing principles of procreative selection convincingly articulates why, in cases of selection, we must consider a principle that gives us

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[54] Savulescu and Kahane, 2009, p.279
[55] Savulescu and Kahane, 2009, p.280
[56] Savulescu and Kahane, 2009, p.282

reason to select for maximal benefit to accommodate some very basic intuitions about how well-being ought to be promoted.[57]

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[57] I suspect the Prevention of Harm View and the Minimal Threshold Constraint may yet be important in a discussion of whether we should procreate at all, but assuming the choice to procreate has already been made, then there is still reason to prefer PB over the other competing principles of selection seen here.

Chapter 3: Disability and the Logic of Enhancement

The final section of Savulescu and Kahane's 2009 paper seeks to apply PB to the case of disability and what it has to say about the permissibility of selection concerning disability. Here, where theory meets application, the most important and controversial aspects of the logic of enhancement emerge. Furthermore, there is a significant history of dissonance between bioethics and the disability rights movement that informs this praxis. People with disabilities, as discussed in the last section, have long been the target of eugenic and discriminatory movements, and many within this movement feel as if this gruesome attitude towards them hasn't changed since. Harriet McBryde Johnson, a lawyer and disability rights advocate, recounts this feeling of persecution in her 2003 article "Unspeakable Conversations," where she discusses her meeting with the bioethicist Peter Singer. While she reported that Singer himself was a respectful, gracious, and accommodating host, she understands his views on prenatal selection and infanticide as a sort of implicit threat against disabled lives like hers.[58] Worse, the field of bioethics, as a dominantly situated institution, places the burden of proof on disability rights community to justify their existence. This dynamic between the disability rights movement and mainstream bioethics also results in and from myriad forms of hermeneutical injustice perpetrated against the disabled community, which all arguably culminate in the unwillingness of bioethicists to seriously engage with and utilize the significant hermeneutical tools the disabled community has developed to understand their own experiences such as the social or mere-difference model of disability.[59]

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[58] McBride, 2003, p.1

[59] Wieseler, 2020

Even when bioethicists acknowledge and seem to understand these tools, the disability rights movement is still dismissed and framed as "a second-class civil rights movement, with less legitimacy than other such movements."[60] The tension between the philosophy of disability and the logic of enhancement frames what I take to be *The Question* to be answered about the logic of enhancement: does it necessarily entail the conclusion that people with disabilities should be selected against in procreative decision-making? If the logic of enhancement responds in the affirmative, then the view is at odds with the best theories of disability and may be morally unsalvageable. Here, I will explore this tension and propose a solution between these two literatures.

In Section I, I will begin by introducing how disability has traditionally been understood, Savulescu and Kahane's *Welfarist* View of disability, and a "mere-difference" view of disability, as argued by Elizabeth Barnes. In Section II, I will make some terminological distinctions to reconcile the disparate terminology used by these authors, then explore the weaknesses I see with the "mere-difference" view of disability. Section III will then adjudicate between the *Welfarist View* and the mere-difference view of disability by looking to see which definition can be corroborated with actual people's lived experience of disability. It will also explore the implications of adopting one view over the other. Section IV will explore additional considerations that complicate the issue more than the mere-difference view or *the Welfarist View* initially suggests. I will conclude in Section V.

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[60] Amundson and Tresky, 2008, p.112

Section I: Competing Definitions

Disability has traditionally been understood through the medical model and the social model of disability. The International Classification of Functioning, Disability and Health (ICF), developed by the World Health Organization, succinctly summarize the characteristics of each view:

> The *medical model* views disability as a problem of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. Management of the disability is aimed at cure or the individual's adjustment and behaviour change. Medical care is viewed as the main issue, and at the political level the principal response is that of modifying or reforming health care policy. [61]

An initial issue with the medical model of disability is that, as I have argued, it invokes vague and problematic concepts like health and disease that don't provide us with a normative direction or even a value-free description of human physiology and psychology. The medical model can be updated, however, with a more rigorous philosophy of medicine: a welfare-based model. This results in what Ron Amundson has called the Standard View of Disability, "that disabilities have very strong negative impacts on the quality of life of the individuals who have them."[62] Such a view invokes the medical model of disability insofar as it suggests medical intervention as the proper response to disability and, while prevalent, is unsupported by the data. People with disabilities consistently report having a good quality of life, only slightly less than their non-disabled counterparts.[63] Consequently, bioethicists and disability rights theorists have developed conceptions of disability that attempt to update and correct the Standard View.

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[61] World Health Organization, 2001, p.20

[62] Amundson, 2005, p. 103

[63] Albrech and Devlieger, 1999

The social model of disability captures a plausible interpretation of disability. The ICF defines the social model of disability:

> The *social model* of disability, on the other hand, sees the issue mainly as a socially created problem, and basically as a matter of the full integration of individuals into society. Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence the management of the problem requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is therefore an attitudinal or ideological one requiring social change, which at the political level becomes a question of human rights. For this model disability is a political issue.[64]

The social model is very close, if not ultimately coextensive, with Elizabeth Barns' "mere difference view of disability. Barnes offers a preliminary definition of "mere-difference" views of disability, stating, "According to mere-difference views of disability, having a disability makes you nonstandard or different, but it doesn't by itself make you worse [or better] off."[65] The "mere-difference" view improves on the ICF's formulation of the social model of disability by reintroducing the moral currency of well-being which makes comparison with competing views more straightforward.

Initially, the difficulty with maintaining this Barnes' view of disability is that "it is hard to think of a disability that—given the way the world is now—is more likely to have a positive effect on a person's well-being than is the absence of that disability."[66] Here, Barnes keys us into the crucial notion that much of the suffering associated with disability can be attributed to the discrimination against disabled people by society. This discrimination takes on myriad forms, but all boil down to the fact that society is built according to an able-bodied norm even when

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[64] World Health Organization, 2001, p.20

[65] Barnes, 2014, p. 89

[66] Barnes, 2014, p.100

many realistic options exist to make society accommodating of disability. Given this, Barnes clarifies that,

> The mere-difference view isn't simply the view that, on average, disabled people aren't any worse off than non-disabled people. It is perfectly consistent with the mere difference view that the actual well-being of disabled people is, on average, lower than that of non-disabled people, simply because of how society treats disabled people.[67]

Savulescu and Kahane also recognize social models of disability, articulating them as "a stable intrinsic property of subject S which (1) deviates from the normal functioning of the species to which S belongs *and* (2) which tends to reduce S's level of well-being *because* members of the society to which S belongs are prejudiced against such deviation from the normal."[68]

Barnes argues that the case of disability is analogous to other instantiations of human diversity like sex, gender, sexual orientation, skin color, etc. It is, for instance, perfectly consistent and factual to argue that the actual well-being of racial minorities in the United States is, on average, lower than that of white people without claiming that there is something intrinsically harmful or bad about being a member of a racial minority. This is because the United States was historically built according to norms and policies that benefitted white people, and some of those racist policies and norms, still deeply entrenched in society, continue to negatively affect the well-being of those who differ from the white norm.

Savulescu and Kahane develop a model of disability that incorporates all the elements from these previous models, including disability as an individual trait, a welfarist understanding of disability, and the social/societal aspect of disability. They incorporate this understanding in the following definition of disability:

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[67] Barnes, 2014, p. 90

[68] Savulescu and Kahane, 2009, p.287

> A stable physical or psychological property of subject S that (1) leads to a significant reduction in S's level of well-being in circumstances C, when contrasted with realistic alternatives, (2) where that is achieved by making it impossible or hard for S to exercise some ability or capacity, and (3) where the effect on well-being in question *excludes* the effect due to prejudice against S by members of S's society.[69]

Savulescu and Kahane dub this the *Welfarist View* of disability for its direct association between the reduction of well-being and the presence of a disability. Similarly to the Standard View, in this definition, harm has been baked into the concept of disability, and it would, therefore, be definitionally incoherent to claim that there is such a thing as a benign disability. Reconciling this conclusion with other definitions will be the aim of Section II.

For their part, the ICF's preferred understanding of disability is known as the "biopsychosocial" model of disability, which purports to be a combination of the social and medical models of disability. While their framework incorporates important aspects of both models, its aims are ultimately aimed at pragmatic considerations rather than providing philosophically rigorous definitions of disability. This alleged union of the medical and social model of disability is never spelled out in this otherwise comprehensive document, and there is good reason to think that a union of the medical and social model would be an unhappy one. At key points, the medical and social models make incompatible claims that cannot be resolved without jeopardizing the essential commitments of one or both models. In other words, according to these models, disability is either a political or a physiological problem, and without further conceptual resources, neither can acquiesce to understanding disability as the opposing model does. Thus, while the biopsychosocial model of disability has admirable aims,

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[69] Savulescu and Kahane, 2009, p. 286

it ultimately fails to explicate the necessary distinctions to articulate when disability should be understood medically rather than socially.

Section II Part 1: Terminological Clarity

Savulescu and Kahane, even while their *Welfarist View* is closer to the medical rather than the social model, are not oblivious to the pervasive ableism present in many societies, so their definition of disability importantly includes the criterion that "the effect on well-being in question *excludes* the effect due to prejudice against S by members of S's society."[70] This is the predicament that I set out to resolve in this section: how can Savulescu, Kahane, and Barnes all claim that disability needs to be understood in the absence of ableism, and yet Barnes claims that disability is an inherently morally irrelevant[71] mere difference, while Savulescu and Kahane claim that disability is something that is inherently harmful (and thus of moral concern).[72] Where, precisely, does their disagreement arise? Savulescu and Kahane's definition provides some light on the issue. The intersecting conditions of their definition create

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[70] Savulescu and Kahane, 2009, p. 286

[71] I say morally irrelevant here in the same way that other mere differences in human diversity are morally irrelevant. For instance, the mere fact that someone is a woman, gay, genderqueer, of a racial minority, etc., does not *ipso facto* make them suffer or worse off than any other human (or, at least, we assert there shouldn't be.) There is, however, an important sense in which these differences may constitute a moral difference when it comes to what kind of care, accommodation, or inclusion in society they receive. Insofar as there are medical, emotional, historical, contextual, etc. differences in these populations, "moral treatment" may look different accordingly.

[72] It is not quite correct to interpret Savulescu and Kahane's view of disability as saying that some conditions or disabilities are inherently harmful. Rather, the notion of harm is central to the concept of disability in their view. This is what I mean to capture here. Given that their view of disability considers how a condition affects well-being in "circumstances C," the *Welfarist View* is actually highly contextual. I will unpack what I mean by "inherent harm" in terms of this contextual definition in Section II Part 2, but I think framing the disagreement between the *Welfarist View* and the mere-difference view in this way will make it easier to understand where exactly this disagreement (or lack thereof) occurs.

a logical space that can be explored in the Venn diagram below.

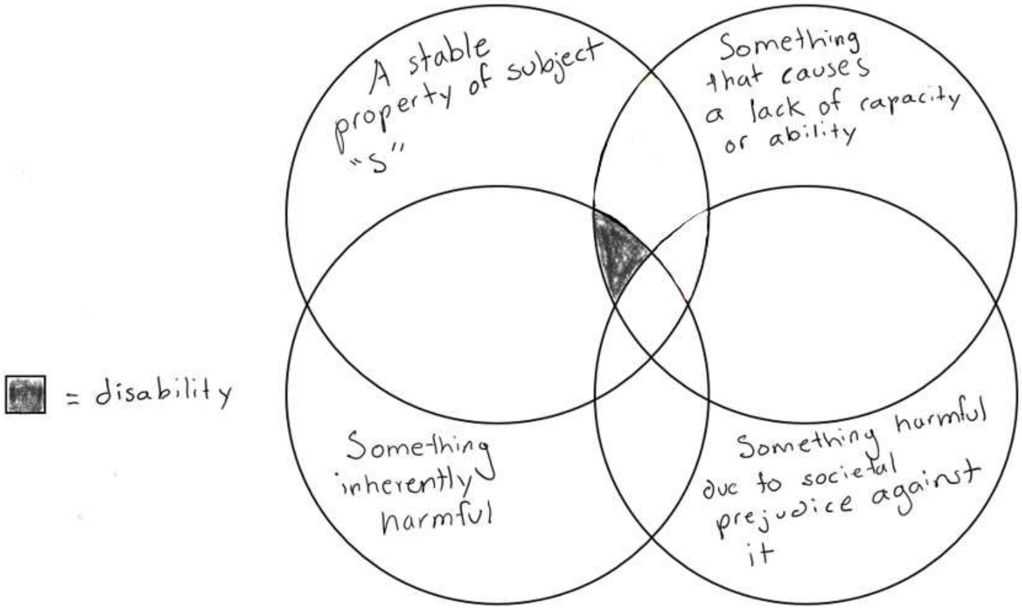

Figure 2: Logical Venn Diagram of Savulescu and Kahane's Definition of Disability

Disability, in Savulescu and Kahane's sense, can be found at the intersection of the following conditions: "(1) a stable physical or psychological property of subject S that (2) leads to a significant reduction in S's level of well-being in circumstances C, when contrasted with realistic alternatives (which I have termed "something inherently harmful" here for simplicity)[73], (3) where that is achieved by making it impossible or hard for S to exercise some ability or capacity, and (4) where the effect on well-being in question *excludes* the effect due to prejudice against S by members of S's society."[74] However, the very same logical space can be

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[73] See previous footnote.

[74] Savulescu and Kahane, 2009, p. 286 (numbers in parenthesis changed to highlight all four necessary conditions of the definition)

used to represent a “mere difference” view of disability.

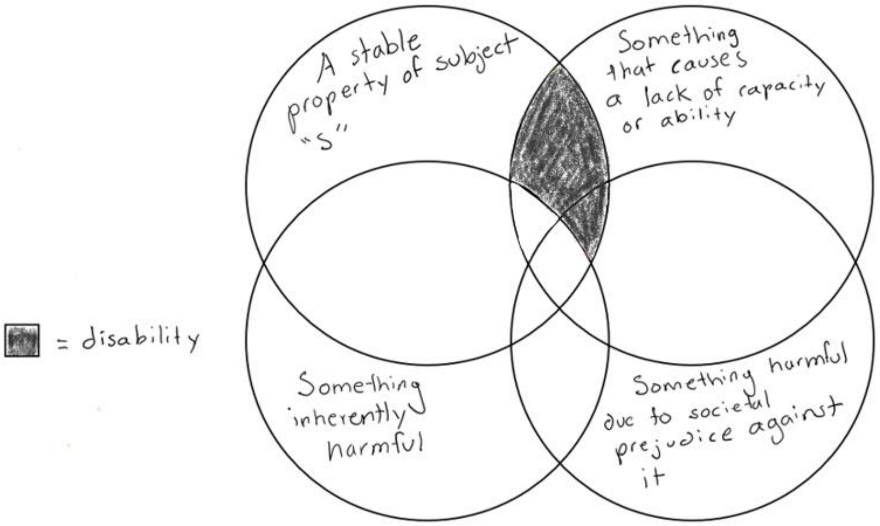

Figure 3: Logical Venn Diagram of Barnes' “Mere-Difference View” of Disability

These diagrams reveal that Savulescu and Kahane are discussing something different from what Barnes is as they inhabit different regions of the logical space. Given this, it is no wonder why terminological confusion occurs between these authors. To amend this confusion, I propose using the definitions captured in this final diagram below to synthesize both definitions.

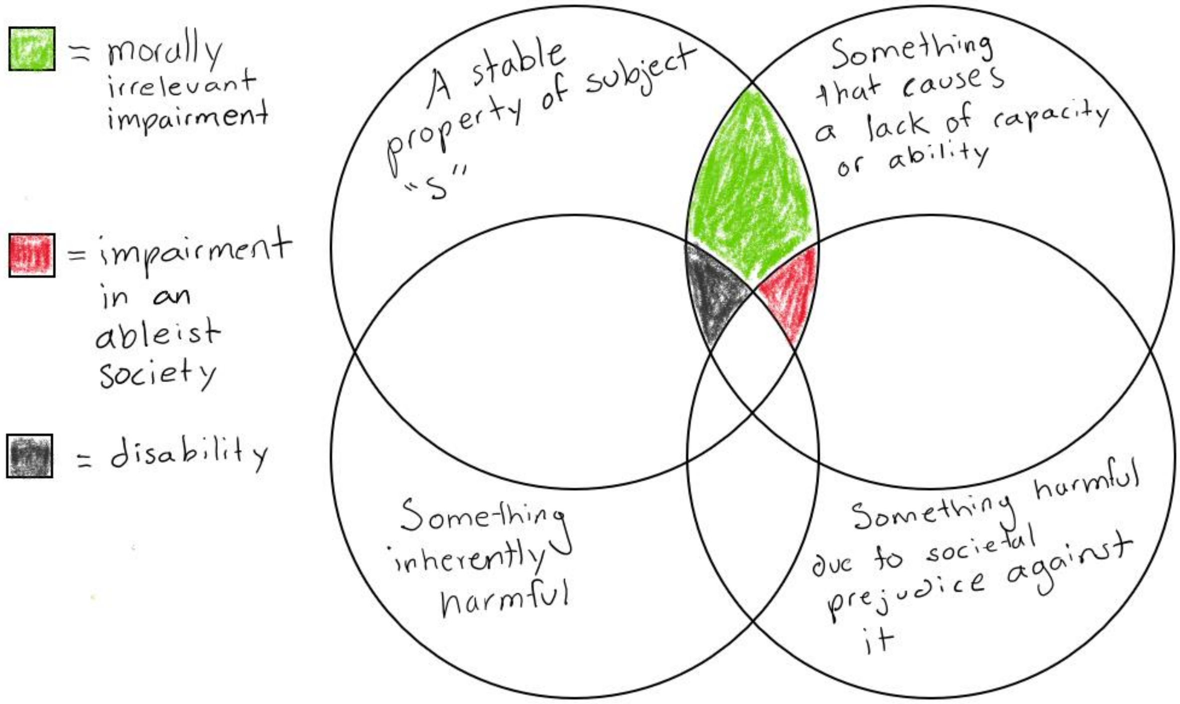

Figure 4: Logical Venn Diagram of Disability and Impairment

This diagram retains Savulescu and Kahane's definition of disability while dividing Barnes's definition into two categories of "impairment." This division demonstrates the descriptive claim of a mere-difference view of disability in red, that otherwise morally irrelevant impairments can incur harm for those with them because of how they are discriminated against by society. The green area of the diagram presumably represents the normative claim of the mere-difference view of disability that, with the proper societal attitude and accommodations, impairments would be morally irrelevant instantiations of human diversity.

Insofar as Savulescu and Kahane's definition creates space to accommodate Barnes's definition, I will preserve their definition of disability over Barnes's in the following discussion. By doing this, I don't mean to imply that Savulescu and Kahane's definition couldn't altered to be understood by a mere-difference view (though the following paragraph suggests there is good reason why the mere-difference view might need to invoke new terminology to do so.) Accordingly, in the discussion that follows, I will substitute “impairment,” where Barnes uses “disability” to preserve “disability” as a category of conditions that are inherently harmful to have.

This diagram reveals that an important consideration is missing from Barnes’ definition: the definition doesn’t entertain the idea that some disabilities are inherently harmful. Indeed, it would seem that implied in a “mere-difference” view of disability is the idea that there are no inherently harmful disabilities, only impairments that are harmful because of the discrimination they receive as a result of living in an ableist society. This will shift our definitional discussion to one of soundness: are there such things as inherently harmful disabilities in Savulescu and Kahane’s’ sense, or are all impairments harmful merely because of ableist prejudice? Conversely, are “mere-difference” views of disability inadequate, given examples of intrinsically harmful disabilities? Clearly, a great deal hinges on a thorough assessment of the “impairments” in question.

Section II Part 2: Inherent Harm in the Welfarist View of Disability

I argued in part one of this section that the *Welfarist View* identifies harm as inherent to disability. This is an oversimplification, so in this section, I’ll be adding some nuance for the purposes of charity to Savulescu and Kahane’s argument and to demonstrate that a more nuanced understanding of their view does not change the conclusion of my analysis. The nuance of their view is found in a superficially innocuous part of the *Welfarist View’s* definition—what are circumstances C? These circumstances can significantly change what disability is and what exactly procreative moral principles prescribe in the case of disability. The authors, in line with their motivation towards using the definition in other projects, leave the circumstances of the *Welfarist View* nebulous so that the definition will apply across various contexts, societies, and potential human enhancements. To illustrate this, they write:

> [What qualifies as a disability], however, must involve a counterfactual alternative that is realistic: not being able to fly or read others' minds are not plausibly described as disabilities, even if possession of such fantastic capacities would make our lives go better, just as it is not a misfortune that we do not live to 150, *although it would be in a world where this had become a realistic possibility*.[75]

What counts as a disability in the *Welfarist View* is thus a deeply context and person-relative notion."[76] There are many conditions that we might think of as disabilities in our current circumstances that, in specific contexts, seem to conflict with this categorization. Savulescu and Kahane provide some useful examples of this point. The examples of asthma and Deafness are used to illustrate the context relativity of disability:

> What makes it harder to lead a good life in one circumstance may make it easier in another. The atopic tendency which leads to asthma in the developed world protects against worm infestations in the undeveloped world. Deafness would be a positive advantage in an environment of extremely loud and distracting noise.[77]

The example of color blindness illustrates the person relativity of disability:

> Although it involves some disadvantage, colour blindness constitutes a mild disability. But now imagine that some master painter became colour blind. Such a person might be prepared to spend vast sums of money to correct his colour vision. This represents the value of colour vision to that particular person in his context. For such a person, colour blindness might be a severe disability.[78]

While this context and person relativity is useful for a more universally applicable definition, for the purposes of this discussion, we are concerned with specific contexts—namely, the ones

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[75] Savulescu and Kahane, 2009, p.286 (Emphasis mine)

[76] Savulescu and Kahane, 2009, p.286

[77] Savulescu and Kahane, 2009, p.286

[78] Savulescu and Kahane, 2009, p.287

we should use when making procreative and medical decisions. The other criteria of the *Welfarist View* can help us determine what these might be.

The *Welfarist View* importantly instructs us that disability can only be understood when we exclude the effect of prejudice on well-being from society. "Society," however, is a complex concept describing both a social environment and the physical "man-made" environment that a society creates; after all, society is what we inhabit as both social and embodied beings. It would be an incomplete description of society to only discuss the social phenomenon of our species known as society (the politics, communities, relationships, etc.) without also describing the physical environments (habitations, infrastructure, resources, etc.) we inhabit. Based on this blended social and physical concept of society, excluding prejudice from society includes not just eliminating negative attitudes towards people with impairments but also an active inclusion and accommodation of them in the physical environment we construct. The way I've defined the elimination of prejudice against people with impairments also defines the necessary and sufficient criteria of a non-ableist society. The non-ableist society is thus characterized by a society that is equally socially and physically accessible to all who live within it, and it is from this context that we should understand the application of the *Welfarist View* when it comes to impairment and disability.

We can now understand my earlier simplification of the *Welfarist View* that a disability is "inherently harmful" as "something is a disability when it, all other things being equal, the impairment reduces someone's well-being even in a non-ableist society." Yet, given that there could be multiple ways in which a non-ableist society is structured[79], it is more correct to say that my use of "inherently harmful disability" is shorthand for "an impairment that reduces someone's well-being in *every* non-ableist society." Let us now reconstruct Savulescu and Kahane's definition:

> A disability is a stable physical or psychological property of subject S that leads to a significant reduction in S's level of well-being in every non-ableist society when contrasted with realistic alternatives where the reduction of well-being is achieved by making it impossible or hard for S to exercise some ability or capacity.

This definition shows that the relevant circumstances for the application of the *Welfarist View* are, other things being equal, the world in the present moment without the influence of ableism. Thus, the *Welfarist View* has been significantly constrained by a consideration of justice (the elimination of prejudice). This conclusion should not be surprising given my analysis of the definition in the previous section; however, it should now be clear how it is reasonable to interpret Savulescu and Kahane's person and context relative account of disability as equivalent to "harm inherent to the disability."

Section III: Soundness and Implications

In an abstract sense, Savulescu and Kahane clearly agree that "the lives of the vast majority of disabled people are not merely worth living but good" and that "*simply because* a condition deviates from normal functioning [does not entail] this condition makes a person's life go worse."[80] Yet, elsewhere throughout the paper, the authors assert rather than argue that

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[79] When we postulate about what non-ableist societies could look like, perhaps there are ways of constructing these societies in mutually exclusive ways. A non-ableist society might have different kinds of government or economic systems that might change the way in which people are accommodated and included or what accommodation and social inclusion look like. So, while the outcome of a non-ableist society may look very different, a universal feature will be the inclusion and accommodation of people living with impairments, as I have defined it. I think this should make my distinction of "every" vs. "a" non-ableist society moot.

[80] Savulescu and Kahane, 2009, p. 285

some of the conditions that would qualify for their notion of disability include some forms of autism spectrum disorder (ASD), Down syndrome, color blindness, and Deafness.[81] Several considerations make these poor examples. Rather than being paradigmatic cases of inherently harmful impairments, people with Down syndrome, autistic people, people with color blindness, and Deaf people are instead paradigmatic cases of people who enjoy high levels of well-being when they are accommodated and included in society.[82] Assuming, as one reasonably may, the harm of these conditions can be largely or entirely attributed to how they are treated in prejudiced societies, the *Welfarist View* should not consider these conditions disabilities. Rather, these conditions should be understood as impairments within an ableist society, not as inherently harmful conditions. This counts favorably towards a "mere-difference" view of disability insofar as autistic people, Deaf people, and people with Down's syndrome are typically taken to have a disability by broader society. Using these conditions as examples also reveals that Savulescu and Kahane's *application* of the *Welfarist View* may be suspect.

There are, however, some conditions, typically thought of as disabilities, that seem clearly harmful, regardless of how they are accommodated and included by society. Such conditions, after properly applying the *Welfarist View,* include Tay-Sachs disease, chronic depression, cystic fibrosis, harlequin ichthyosis, Sanfilippo syndrome, or epidermolysis bullosa. These disabilities are agonizing for individuals, even in, importantly, a non-ableist

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[81] Savulescu and Kahane, 2009, p.281(ASD), p.283 (Downs Syndrome), p.287 (color blindness), p. 288 (Deafness)

[82] One need only look to the extensive testimony of the lived experience from members of these populations to see this corroborated. Though there are reasons to dismiss the personal testimony of subjective experience, these reasons apply universally to subjective testimony, not just the testimony of people with impairments. If we take the subjective testimony of any person seriously, then we must also take seriously the subjective testimony of people with impairments.

society. No one with these conditions thinks that their suffering can be attributed entirely or even in large part to how society treats them if, tragically, they survive long enough to contemplate such things. The existence of these conditions and the suffering they cause, regardless of how society includes or accommodates them, count strongly in favor of the existence of impairments that are inherently harmful, which, in turn, validate the *Welfarist View* of disability. Furthermore, the "mere-difference" view of disability seems inadequate to account for the harm of these conditions.

How we define and understand disability has serious ramifications for bioethics and for how we understand Savulescu and Kahane's various projects. The logic of enhancement and the principle of procreative beneficence suggest that we ought to enhance individuals with disabilities to improve their well-being and that we should select against children with disabilities. While it seems compassionate, moral, or even obligatory that we apply the logic of enhancement to alleviate or prevent the suffering of those with agonizing conditions like Tay Sachs or chronic depression, the whole enterprise takes on a darker, much more controversial valance when we think about what conditions Savulescu and Kahane take to be disabilities.

The enhancement or prenatal selection against those who are autistic, Deaf, or have Down's syndrome strikes many as eugenic in orientation rather than compassionate given its, at best, shoddy basis in the *Welfarist View* of disability. Furthermore, this concern over properly applying the logic of enhancement is not hypothetical. The logic of enhancement is already improperly applied in the case of people with Down syndrome. Conor Friedersdorf reports for the Atlantic that:

> In Iceland, nearly every fetus with [Down syndrome] is killed. CBS News reports that The United States has an estimated [pre-natal] termination rate for Down syndrome of 67 percent (1995-2011); in France it's 77 percent (2015); and Denmark, 98 percent (2015).

> The law in Iceland permits abortion after 16 weeks if the fetus has a deformity—and Down syndrome is included in this category.[83]

Insofar as this is likely a misapplication of the logic of enhancement, it helps to explain the caution, reservation, and even disgust many disability rights theorists have with it. It further suggests that the policies based on an understanding of the logic of enhancement should exercise serious caution given its demonstrable propensity to be misinterpreted.

Section IV: Other Considerations – Idealization, Complicity, and Alternatives

So far, I have argued by defending the *Welfarist* View of disability that there is a significant moral argument in favor of prenatally selecting against or enhancing people with disabilities, defined as people with inherently harmful impairments. There is, however, still an unanswered pragmatic and moral question concerning people with impairments who will live in ableist societies: should we try to improve the well-being of people with impairments in ableist societies by changing society or by changing them/preventing them from coming into existence? Both would arguably increase well-being, but they are not equally just. Furthermore, this question is more difficult to answer than it initially seems because it pertains to improving well-being in an ideal or actual world. An impairment that would be morally insignificant in the non-ableist society is morally significant in the actual ableist society we live in. We are left with the question: should people fit the world, or should the world fit people? What our moral principles suggest, while equivalent in an ideal world, come apart in the actual ableist world we live in, as shown in the following table:

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[83] Friedersdorf, 2017

Table 2: Ideal World and Real World Comparison of Impairment Selection

	Actual World (Ableist)	**Ideal World (Non-ableist)**
Well-being maximization (PB)	Select against impairment.	Don't select against impairment.
Considerations of Justice	Don't select against impairment.	Don't select against impairment.

Barnes offers a compelling argument that the risk of real-world suffering cannot inform our moral principles like the logic of enhancement or procreative beneficence.[84] This is because of the source of the discrepancy for differing recommendations in the actual world: unjustly, there are varying degrees of risk associated with any characteristics that deviate from what is taken to be "default" by societal norms, most likely the norm of a straight white male. There are risks to well-being associated with being a woman, a person of color, intersex, having a queer gender or sexuality, and one's disability status at the very least. Thus, if our moral principles like procreative beneficence or the logic of enhancement are based upon the real-world risk to well-being in prejudiced societies, we end up reinforcing unjust hegemonic norms. These moral principles cannot endorse enhancing impaired individuals to fit able-bodied norms nor support selecting against impairment in potential children without also endorsing similar actions towards women, people of color, those with diverse genders or sexualities, etc., who also have elevated risk to their well-being in modern society. Such a conclusion that society should "enhance" or select against minoritized individuals "*for their own sake"* would be clearly unjust and immoral because to do so would suggest there is something inherently

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[84] Barnes' discussion pertains to plausible "non-interference" principles. I think an identical argument applies to the moral principles that feature in this argument.

harmful about not being a straight white man rather than the much more plausible claim that society is prejudiced against diversity. Barnes's argument here is if we value well-being neutral instantiations of human diversity, as it seems we do and should, then we have no basis to prenatally select against or medically alter people with impairments.

A footnote of Savulescu and Kahane's 2009 paper seems to acknowledge this as they write:

> It is often objected that, given existing racial prejudices, PB implies that mixed race couples might have a reason to have children with lighter skin because having darker skin is socially disadvantageous. But when these parents consider the question only from the perspective of the good of their future child, then it is no objection to PB that, in these unjust circumstances, there is a reason to prefer the fair skinned child. We often have to make compromising choices in unjust circumstances, including choices about the good of our children. The same problem would come up when choosing to send their child to a mixed race state school or a white private school. But this isn't to say that parents ought to select the fair skinned child. The reasons given by PB can be defeated or outweighed by other moral reasons. Many would say that they would be defeated in this case. Parents shouldn't choose the fair skinned child because of the expected prejudice. It's better to change pernicious attitudes than to reinforce them through capitulation.[85]

Given this understanding, it is unclear why they recognize the overriding considerations of justice when considering other instances of human diversity but not in the case of people with impairments. It further seems that Savulescu and Kahane would agree with Barnes' assessment such that the logic of enhancement must not be based on actual world risk and that ideal world considerations must inform these moral principles.

An additional consideration we should also recognize is that simply because one should not do something does not imply that it is easy or without cost. Simply by agreeing that we shouldn't select against or enhance people with impairments who will live in ableist

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[85] Savulescu and Kahane, 2009, p.290

societies, we have not addressed the all too real difficulties and costs that will be incurred to those parents and communities whom I've argued should raise, accommodate, and include people with impairments. Many parents and communities faced with the prospect of raising, accommodating, and including people with impairments are not prepared for this task, and many will take on a serious moral cost to themselves, giving up nights, weekends, and much of themselves to care for their children whose well-being depends on this extensive care. Some parents and communities will fail to provide the sort of accommodation and inclusion that children with impairments require to flourish, considering this high cost or because of their ableist prejudice against impaired individuals. They will instead be implicated in the societally caused suffering of the impaired child or otherwise offload their moral responsibility to similarly ill-equipped institutions.

There are several important considerations to this point. We should first note that the moral cost imposed on parents and communities should similarly not be attributed entirely to impairment itself but also to the society in which they live. It is not difficult to imagine a society that is constructed in such a way that the increased cost associated with raising impaired children is distributed amongst its constituents through, for instance, robust social support institutions that help parents and communities provide the sort of care and accommodation that result in a flourishing existence for children with impairments. We can further easily imagine a society that creates places and environments where impaired adults can live meaningful lives and contribute to their community, understanding that these environments and contributions may look different from how people without impairments contribute and live in the community. Given the realistic possibility of such societal changes to accommodate people with impairments, I hope this demonstrates why I am not claiming that it is a moral failing of parents and communities who are unable to provide the kind of care their impaired child needs despite their best effort. The effort required to overcome the harm of prejudiced social environments that someone is born into is somewhat supererogatory from what can be expected of many parents, certainly in the kind of ableist societies we live in today. Yet, it is still important to recognize that even in non-ableist societies, children with impairments will require more care and resources than the average child, and this cost must be accounted for somewhere.

Second, it is important to note that the moral cost of impaired children is not unique to children with impairments. Take, for example, exceptionally gifted children who will no doubt require more attention from caregivers to remain stimulated and intellectually enriched. These children need significantly more care than average, but would we still say that there is a moral cost (that comes from the increased burden on caregivers) associated with having these sorts of children as we would with impaired children? In one sense, we can agree that a higher cost is entailed in both cases; however, it would be an expression of an ableist bias to claim that a child who is gifted and creates a strain on the caregivers is desirable while the impaired child is not. So, while I agree that it is right to think about the intensity of care as a cost we should consider in procreative and biological/medical ethics, it is not exclusive to impaired children/people and applies to other children/people who, for some other reason, also require more than average care.[86]

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[86] The principle of procreative beneficence is consistent with this conclusion. A footnote of Savulescu and Kahane's paper states, "[The principle of procreative beneficence] is a claim only about the same number choices: about selection of one child out of those possible. It is not meant to offer guidance in choices between, e.g., one versus several children of differing endowments." If we understand "endowments" as those qualities that impact the child's well-being, then per the argument of this paper, neither intellectual giftedness nor impairment provide guidance for cases of prenatal selection.

There is a final worry regarding justice, given my conclusion here. What stance, ultimately, should parents take towards selecting for or against disability and impairment? So far, my argument would conclude that parents should select against disability in the sense defined by the *Welfarist View*. Otherwise stated, parents should, in all cases when selection is possible, select against those impairments that, all else being equal, cause a reduction in well-being in every non-ableist society. It also seems that my argument implies that parents should not select against those impairments that do not, all else being equal, cause a reduction in well-being in every non-ableist society.

There are some tough cases, however, that seem to put pressure on this conclusion. Say a couple is expecting a child, and it is known via prenatal genetic testing that this child will be born with Down syndrome. We can reasonably assume that this child will have higher than average care needs throughout their childhood and that they could live a life of comparatively similar well-being to children without Down Syndrome when properly accommodated and included in society. Now, we stipulate that the parents are living in an ableist society, and their socioeconomic circumstances are such that they will not be able to adequately be able to provide for the care needs of a child with Down Syndrome. Here, it seems we have a dilemma for these parents. They can either select against this child because of the higher care needs they will be unable to meet, or they can have the child who will, in all likelihood, live a life of reduced well-being where the well-being of the parents is also reduced. The first horn of the dilemma is uncomfortable because it seems that the parent's decision is a sort of capitulation to ableist societal norms, whereas the second is uncomfortable because it suggests parents should always shoulder the heavy burden of these unjust societal norms in their procreative decision-making.

I think this dilemma could be answered in several ways. The first is to bite the bullet and conclude the dilemma by arguing that in cases of impairments that are not inherently well-being-reducing, like Down Syndrome, parents should not select against these traits even when this choice produces less well-being overall, *including the cost to well-being incurred by the caregivers*. Let us consider a relevant analogy. If disability is another instantiation of human diversity akin to skin color, gender expression, or sex, then, at least my intuitions about selection become much clearer in these cases.[87] Similarly to the example provided by Savulescu and Kahane, say an interracial American couple is expecting a child, and it is known that this child will be born with dark skin. We can reasonably assume that being Black in America will incur lower than average well-being but need not have reduced well-being in a non-racist society. If they had the option, should the parents select against having a Black child in favor of a white child in the interest of promoting their future child's well-being? This case should strike us as absurd, and Savulescu and Kahane would agree we should "change pernicious attitudes than to reinforce them through capitulation."[88] Raising a Black child, because of the remaining institutional prejudice against Black people in America, will mean that higher care needs will be incurred to overcome this prejudice. These care needs may be greater in the case of the child with Down Syndrome, but they are not different in kind. If this analogy holds, then it suggests a similar course of action should be followed in the case of children with impairments.

Alternatively, it could be plausibly asserted that the socioeconomic status of the parents is a relevant factor in procreative decision-making such that it challenges or overrides

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[87] Uncomfortably demonstrating to me my own implicit ableist bias.

[88] Savulescu and Kahane, 2009, p.290

the normative reason provided by the principle of procreative beneficence, which is meant to be one among many moral considerations in procreative ethics We could thus argue that the inability to provide for a child who has significantly elevated care needs constitutes a reason to select against those traits that cause elevated care needs. Note, however, that this procreative principle would not be prejudiced against children with impairments because of their impairments but rather because of the elevated cost of care associated with the impairment. The principle is thus indifferent to which high-care trait is selected against. As we've already seen, PB does not provide a methodology to select among traits or children who are equally and ideally able to attain the highest possible well-being out of the many that could be selected. In this way, a solution to the dilemma could similarly avoid ableist conclusions. While promising, I also have serious reservations about this solution as I suspect that even this "indifferent" principle would be used improperly, given the implicit bias against impairments, and it would be used as an excuse to select against high-care impairments and not against other more (unjustly) societally desired high-care traits like increased intelligence.

Another way in which this dilemma could be resolved is to argue that cases like this might violate something like the minimal threshold constraint on reproduction. Savulescu and Kahane articulated the minimal threshold constraint as "If reproducers cannot choose a child whose life will be worth living, then they ought not to have a child at all."[89] Perhaps this constraint could be modified to read, "If the aggregate welfare of parents and child falls below a certain threshold, then they ought not to reproduce at all." If this were the case, then there would be a clear reason to select against the trait that incurs such tremendous cost to the

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[89] Savulescu and Kahane, 2009, p.279

parents and, thus, a dramatic reduction of aggregate welfare. It seems dubious to me, however, that even children born with impairments that require tremendously high care cost reduces the lives of their parents to a degree such that those lives are not worth living. I don't mean to endorse the idea that for something to be morally impermissible it must make a life not worth living. I do mean to test the intuition that life for the parents would really be so terrible that it justifies a kind of complicity in injustice. Furthermore, we should keep in mind that this case assumes the ability to for the parents to engage in procreative selection via various means afforded by biotechnology. Consider a case where poor parents who do not engage in any sort of procreative selection and have a child with a high cost of care impairment. We don't typically think this case represents that a terrible fate has befallen these parents or that the mere risk of this outcome creates an undue barrier for procreation. These considerations suggest that we should not think that condemning the immorality of selecting against impairment also entails a moral prohibition for poor people to procreate.

Finally, I think it is important to consider the larger context of a difficult case like this as a problem of collective action. We should note that the systemic injustice of poverty in developed countries means that these tough ethical choices are burdened by some of the most disadvantaged members of our societies. This alone constitutes an argument for changing society such that disadvantaged individuals do not have to make these difficult ethical choices in the first place. Furthermore, we should note that the reasonable choice in the circumstances of individuals, especially disadvantaged procreators, differs from the reasonable choice from a societal perspective generally. Unfortunately, societies and individuals are often slow to accept that the goal of justice is only attained through a redistribution of privilege to the disadvantaged. Insofar as people in positions of privilege are unwilling to or unable to grasp this idea, societal problems remain the burden of the disadvantaged. In response to the dilemma, we might understand that this larger context of systemic injustice might constitute some leeway or introduce competing moral principles that allow for us to better understand, evaluate, and empathize with disadvantaged procreators who are forced to make difficult decisions.

Section V: Conclusion

In this extended argument examining the interaction of the logic of enhancement with disability, I have argued that if we understand "disability" in terms of the *Welfarist View* introduced by Savulescu and Kahane, then it is true that the logic of enhancement advocates for enhancing or selecting against possible children/people who are/will be disabled. This is because to be disabled is to have an impairment that significantly reduces the well-being of that individual regardless of whether they live in an ableist or non-ableist society. I have noted that this definition of disability differs from how the term is typically used by disability rights theorists who, in terms of the *Welfarist View*, are concerned with the rights of individuals who live with impairments in ableist societies. This is a well-justified moral cause because those individuals would enjoy similar levels of well-being to nondisabled people if society did not discriminate against them but accommodated and included them. Furthermore, the disability rights theorist has strong reason to criticize Savulescu and Kahane's preliminary application of the logic of enhancement or disability because it baselessly assumes that people with ASD, Down syndrome, and Deafness suffer from disability rather than impairment in an ableist society; the latter of which should be amended via changes to society rather than changes to the individuals due to considerations of justice that ought to accompany the application of our welfarist principles. The disability rights theorist does not, however, have strong reasons to critique the logic of enhancement or the principle of procreative beneficence beyond their poor application by bioethicists, as these principles are concerned with the well-being inherent to certain conditions. To criticize these principles isolated from their application seems to amount to endorsing unnecessary suffering. Finally, I discussed that amending society to be non-ableist does not suggest doing so without cost to families and communities. However, I've also argued that this cost is justified, could be greatly ameliorated by society, is not unique to impairments, and there may be several recourses to argue for more nuanced conclusions in difficult cases. These considerations support my conclusion that there is an ecumenical position between the logic of enhancement and the philosophy of disability that can simultaneously advocate for the reduction of unnecessary suffering and for the just and equal treatment of people living with impairments.

Conclusion

Beginning with the inadequacy of major theories in the philosophy of medicine, this thesis is an exploration into what can fill the void left by the normatively vacuous concepts of health and disease. These concepts and the reliance upon them by laypeople, philosophers, and clinicians have led to the stagnation of the philosophy of medicine, numerous injustices towards people with impairments and other misunderstood states of being that humans regularly inhabit, and a general confusion about what in life is worth promoting. I have advanced the logic of enhancement—which includes a stance in the philosophy of medicine and a stance in procreative ethics—as a candidate view to reframe how we should view the concepts of health, disease, disability, impairment, therapy, and human enhancement. While promising in many ways, the view is far from perfect. My analysis of the logic of enhancement has shown that it is prone to be misapplied—even by its own authors—but can be reconciled and reined in by considerations of justice that are typified in the philosophy of disability. Theorists who advocate for the rights and interests of people who differ from the "able-bodied" norm have developed excellent hermeneutical resources, and yet these resources still seem to have a slow uptake by the broader bioethics community. I argue that this is because there is significant terminological confusion between these two literatures, but that this confusion can be resolved by standardizing our understanding of disability and impairment through the *Welfarist View* of disability.

Though the logic of enhancement is a welfare-maximizing view, I have shown how this maximization can and should be understood as seriously constrained by considerations of justice. While I have taken lengths to explain how these constraints ought to be interpreted, I haven't introduced any position not included in the original texts describing the logic of enhancement. Rather, I've used Savulescu and Kahane's own characterization of their view as requiring constraints of justice, and thus, my argument has been about how the logic of enhancement needs additional explanatory work to remain internally consistent. I ultimately resolve the tension in the view between its conceptual tenets and the author's conclusions by rejecting the latter—the idea that impairments are legitimate targets for treatment or a cause for prophylactic prenatal selection.

These constraints however, which prevent the prejudiced and eugenic conclusions that the logic of enhancement might otherwise be forced to endorse, present us with new issues to be addressed. Though I have not fully developed an argument for how societies might begin to grapple with the cost and change of direction to meet their moral imperative to make a more inclusive and non-ableist society, I have addressed some initial concerns that might arise during this process. A significant issue to be addressed is, as society at large begins this transition, it seems as if parents of lower socioeconomic status, when making procreative choices, have been placed in a difficult position: if the option for prenatal selection is present in a case where they can select between a child with an impairment (that incurs an elevated cost of care) or without an impairment, they can either choose to create a child whose needs extend beyond their means, or they can choose to select against an impaired child, an action I've argued could be seen as complicity with unjust societal norms. This position is so difficult because, from the standpoint of society, we want to say that people with impairments should exist because they could meet standards of well-being that justify other procreative choices; and yet we also want to sympathize with the parents who do not have the means to ameliorate the prejudice, and thus the negative well-being, that children born with impairments will experience in actuality. Furthermore, the parents will likely incur serious costs to their own well-being in this attempt to ameliorate the prejudice towards their child. This dissonance emerges in the case of *some* impairments and not in others and, more generally, does not appear in other cases of human diversity because some impairments do generate much greater care needs than others. I have sketched several possible solutions to this objectionable consequence of my view, and I take them to demonstrate there are plenty of resources one could use to reply to these tough cases even within the constraints of the logic of enhancement.

Ultimately, my proposal in this thesis is that we should adopt a philosophically rigorous philosophy of medicine that allows us to be precise when discussing difficult cases in medicine and bioethics in terms of state descriptions and well-being constrained by considerations of justice. I have shown that this proposal can be action-guiding in medical, bioethical, and procreative decision-making without prejudice towards any instantiations of human diversity that are not inherently well-being-reducing. Insofar as this view seeks to eliminate—via enhancement or procreative selection—instantiations of human diversity that are inherently well-being-reducing, we should recognize that this is a justified sort of prejudice against what makes lives worse, which can hardly be objectionable. I have also tried to show that we should exercise caution in labeling certain conditions as inherently well-being-reducing, owing to a long and shameful history of misapplication and pervasive injustice toward the very people in whose interests we claim to be acting. In closing, the future of medicine and society will vary greatly according to those principles by which we prioritize well-being, epistemic humility, and justice, and thus, their rigorous examination, critique, and implementation are of the highest priority. This thesis is but one proposal of how we might proceed, and though I find it compelling and consistent with these principles, I welcome criticism and eagerly look forward to additional progress in this field.

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