In-Person Abstract Book

WESTERN MICHIGAN UNIVERSITY

TIMPE [KEYNOTE]

Systems That Harm: The Ethics of Scaffolding for Support

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Humans are fundamentally interdependent and social beings; we depend not only on other individuals in our communities, but also on the social systems that structure them. Drawing on work in disability studies, I first show a number of ways social systems can harm through unjust treatment. Especially worrisome are those systems where their failures cannot be accounted for by unjust actions of individuals within those systems. I then argue that we have a social obligation to collectively build systems that will provide minimal conditions of justice for everyone in our communities.

If You're Reading This Essay, You Should Probably Have Children

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Herasight

Environmentalists often argue that people should have fewer kids to save the planet, often invoking anthropogenic climate change as the biggest threat. They argue that people in the developed world have higher carbon footprints than those in poorer countries, and thus that those people who already have especially low birthrates in countries like Italy and Japan should have even fewer children. I argue that the reverse is true: that those in richer countries tend to innovate solutions, such as new forms of energy, new ways of tackling pollution, and the invention of new scientific innovations that make both life and the environment better for the whole world. The problem, I will argue, is that people in developed countries have far too few children, and that the whole world will be much worse off if these people heed the advice of many intellectuals to have fewer children.

13 Reasons Pathologized: Depression, Agency, and the Ethics of Suicide Intervention

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The Netflix drama *13 Reasons Why* is a show that depicts that suicide of a teen girl who leaves behind cassette tapes of the reasons that influenced her decision to end her life, including issues of bullying, stalking, drunk-driving, and sexual assault. In response to the show's popularity, the NASP put out a statement regarding what they saw as a dangerous depiction of suicidal reasoning: "…[T]he series does not emphasize that common among most suicide deaths is the presence of treatable mental illnesses" the statement reads, "…Suicide is not the simple consequence of stressors or coping challenges, but rather, it is most typically a combined result of treatable mental illnesses and overwhelming or intolerable stressors"[1] The implication is that we ought to locate the tragedy of teen suicide in a different place than the show does. Rather than the tragedy being that the ills of the world might sometimes give a teenager a reason to end her own life, the tragedy is that there are not reasons to end one's life, at least not good reasons. An easily treatable mental health condition somehow takes over their agency such that they mistakenly come to act on these reasons anyway.

In this presentation I will critically interrogate this idea that mental health conditions like depression provide distinct kinds of causal chains leading people towards suicide that warrant a shift away from engagement with the reasons the suicidal person would list for their ideation. From one perspective on well-being, a choice to end one's life will rarely make sense it forecloses the possibility of good days ahead with no benefit; thus, they conclude, the person with depression must be irrational. But a depressed person often has reasons rooted in non-additive considerations about the narrative of one's life as a whole, which can make a choice to die in a particular way at a particular time make sense. In this talk I will argue that it is risky to discredit a depressed person's agential considerations wholesale because it can amplify feelings of being misunderstood, pathologized, and helpless. Instead, I aim to lay the groundwork for an ethics of suicide that recognizes the complex interplay between agential and non-agential parts of one's psychology that can lead a person with depression to consider suicide.

[1] National Association of School Psychologists. (2017). 13 Reasons Why Netflix series: Considerations for educators [Handout]. Author. Archived at https://web.archive.org/web/20170606043608/https://www.nasponline.org/x39020.xml. Accessed May 8, 2017.
I do not in this talk address the issue of the potential for copy-cat suicides, which I take to be a much more concerning feature of the show.

Medical Invasiveness as Bodily or Doxastic Harm

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The concept of medical invasiveness feels intuitive yet is perplexingly vague—evident in the multiple competing definitions and criteria in the bioethics literature. Clarifying what it means for a medical intervention to be invasive is important because invasiveness is a normatively laden, if not morally relevant, concept that routinely guides shared decision-making between patients and clinicians, especially for high-risk or costly procedures.

A "standard account" of medical invasiveness is that invasiveness = bodily incision or insertion. De Marco et al (2023) argue this view cannot capture crucial aspects of its everyday use—especially its sensitivity to similar options and for nonphysical procedures—and propose a (theoretically) quantifiable, non-harm-based account. Others counter that the standard account (Slack and Higgins 2023) or the view of invasiveness as reducible to certain bodily harms (Affleck et al 2023, Rudnick 2011) provides superior explanatory virtue and simplicity for laypeople and busy clinicians.

I think these competing accounts capture important intuitions and are at least partially reconcilable: invasiveness implies some harm to an agent (without whose consent the act would be a violation), yet not all forms of invasive medical acts entail bodily incision/insertion. For this, I argue that two kinds of harms each sufficiently, but not necessarily, explains the concept of medical invasiveness. One kind is bodily harm, broadly including possible pain, bodily integrity, and disability. Following Baril (2024), another kind is doxastic harm—particularly privacy intrusions that undermine one's ability to disclose and control facts about intimate details of their body. This two-part account of harms better captures our intuitions that even physically painless medical interventions (such as psychiatric interviewing or breast exams) are often considered invasive, while retaining parsimony and clinical practicality.

Additionally, I address some conflationary concepts—notably, Bluhm et al's (2023) notion of "lifestyle invasiveness," which I argue is reducible to and better explained (to patients) as inconvenience (e.g., multiple return visits) or financial costliness, extrinsic to the medical act itself. Finally, I discuss how the severity of medical invasiveness is context-sensitive to similar indicated interventions, using the U.S. Preventative Services Task Force's guidelines for colorectal cancer screening modalities as an exemplar.

Does Anti-Natalism Prohibit Resuscitating Preemies?

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This paper examines whether anti-natalism prohibits the resuscitation of extremely preterm infants (EPIs), using the fictional case of Preemie—a baby born at 25 weeks whose survival depends on life support. The key question is whether resuscitation constitutes saving an existing life (thesis S) or creating a new life (thesis C). If (S) is true, then Baby already exists, and resuscitation is morally permissible or even obligatory. However, if (C) is true, resuscitation is an act of creation rather than rescue.

Travis Rieder (2017) argues that resuscitating EPIs amounts to creating, not saving, a life, as they have not yet reached a stable baseline of well-being. He compares gestation to a continuous process of creation rather than repeated acts of rescue. This raises the issue of moral status—if EPIs have direct moral status, then resuscitation is an act of saving. However, under various moral status theories, most EPIs fail to qualify: Sentientism excludes EPIs born before week 24, personhood theories largely do not recognize them, and consciousness-based views suggest fetuses do not attain subjective experience until at least week 31.

If Rieder's Thesis holds, then EPIs lack moral status, making their resuscitation an act of creation, which anti-natalism claims is always impermissible (at least in a world like ours). However, refusing to resuscitate EPIs appears cruel, particularly to their parents, creating a dilemma for anti-natalists. This paper explores this "Cruelty Argument" and examines possible responses from anti-natalist perspectives.

Maddening Delusion: Thinking Anorexia and Schizophrenia

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This presentation will build on the emerging discipline of Mad Studies to critically interrogate how we came to think about delusion in the way we do. In particular, it will raise questions about how cultural framings of illness or delusion impact which experiences are considered intelligible. It will critically interrogate this point in relation to two different forms of illness, anorexia and schizophrenia, raising questions about which forms of madness are granted cultural intelligibility—and how we think about madness itself.

Paternalism in Medicine Revisited: A Thinker-Based Framework with Exception for Irremediable Mistakes

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This paper advances a thinker-based theory of paternalism, which holds that unwarranted interference in an agent's decision-making deprives them of critical opportunities to learn from their own mistakes and thus undermines the development of their rational capacities. It illustrates, however, that not all medical paternalism is unjustified. In cases where the patient's choice risks an irremediable mistake—most notably, decisions that will lead to death if left entirely to the patient—limited paternalistic measures may be ethically permissible, precisely because once death occurs there is no further chance for the patient to learn from that error.

Drawing on Kantian concepts of rational agency, the framework first outlines the core thinker-based objection to paternalism: shielding patients from the experiential costs of error risks stunting their future ability to engage in reflective, reasoned judgment. A principled exception then emerges: when the stakes involve mistakes that cannot be undone—above all, the irreversible act of dying—clinicians may justifiably delay acceptance of a refusal to preserve the patient's ongoing capacity for reflection and growth.

Two clinical vignettes illustrate this approach. In one, a patient declines a non-lethal but uncomfortable diagnostic test; the thinker-based framework counsels against interference, allowing the patient to experience and learn from any setback. In the other, a patient refuses a life-saving intervention; here, temporary paternalism is warranted, not to impose treatment, but to maintain the opportunity for reconsideration before the decision forecloses all future learning.

Ultimately, informed consent is re-conceived as a pedagogical practice, balancing respect for rational agency with the ethical duty to protect the opportunity for learning where it would otherwise be irretrievably lost.

SCHWEIKART

Understanding Death: Harmonizing Medical and Legal Concepts of Brain Death

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In American law the definition of death is found the Uniform Determination of Death Act (UDDA), which defines death as either: "(1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." The UDDA is a model law that has been enacted by most states. However, this legal definition has come under scrutiny in recent years, as reflected by certain events, e.g. a high-profile case exercising New Jersey's religious exemption to brain death and the advance of normothermic regional profusion, where blood flow is reestablished (for organ donation purposes) in in person declared death via circulatory criteria. In response to renewed scrutiny, a committee was formed to revise the UDDA to provide a more precise and ethically sound definition of death. But last year, efforts to revise the UDDA were paused as no consensus could be reached. The failure to revise the UDDA reflects the extreme difficulty in squaring a definition of death between the various understandings of death found in medicine, law, philosophy and ethics. This paper aims to provide a holistic overview of the modern definition of death in law and medicine, providing a historical look at the emergence of the concept of brain death, the dead donor rule, and the UDDA, and concludes with possible alternatives in how death can ultimately be harmonized between law, medicine, and ethics.