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KNOWLEDGE, AUTHORITY AND IDENTITY:  
A PROLEGOMENON TO AN EPISTEMOLOGY OF THE CLINIC

**ABSTRACT.** Disputes about theory in bioethics almost invariably revolve around different understandings of morality or practical reasoning; I here suggest that the field would do well to become more explicitly contentious about knowledge, and start the task of putting together a clinical epistemology. By way of providing some motivation for such a discussion, I consider two cases of resistance to shifts in clinical practice that are, by and large, not ethically controversial, highlighting how different conceptions of epistemic authority may contribute to clinicians' unwillingness to adopt these changes, and sketching out some initial suggestions for epistemic analysis of clinical practice.

**KEY WORDS:** bioethics, epistemic authority, epistemology, natural childbirth, SUPPORT

It may be a shade hyperbolic to refer to anything going on in bioethics with so pugnacious a phrase as “theory wars,” but there has been a fairly prolonged, sometimes rather sharp discussion about what kind of theory best informs the characteristic practices of this field. The flash points of these struggles have centered around disputes about *moral* theory. Do we need anything that could reasonably count as a moral theory as we go about the business of bioethics? If so, should it draw on principles or rules, cases or phronesis? If not, what kind of tolerably general normative-interpretive structures or strategies do we need? Narrative theory? Social scientific analysis?

My job in this essay is to open another front in the field's disputations about the kinds of resources it needs to develop in order to discharge its tasks. We ought, I think, to be much more engaged in discussing what kind of *epistemological* theory is both defensible on its own account, and well suited to our work. I am much attracted by a kind of social epistemology informed by ideas in which feminist epistemologists have been particularly interested – the epistemic significance of one's social standpoint, the concept of “strong objectivity,” careful attention to social and institutional structures that distribute the authority to make and enforce claims to know, the notion of an “epistemic community.”<sup>1</sup> In this paper, I enter a brief for such a conception.

There are a number of hotly contested matters in bioethics that seem to lend themselves to an “epistemic turn” – the contest between “clin-



ical judgment,” and evidence-based medicine, to take an obvious example [8], and the futility debate, for another [9]. However, my strategy here for making this turn in general attractive, and for motivating the kind of epistemological approach I favor, will be developed in the course of considering two patterns of clinical practice which are clearly of bioethical interest, but where the usefulness of an epistemically oriented analysis may seem less patent: the clinical resistance to the “demedicalization” of birthing, and the failure of the SUPPORT intervention to modify problematic professional responses to dying patients. I will portray both these situations rather agonistically: as contexts in which different knowledge claims and forms of justification clashed, sites in which a challenge to the epistemic authority of professional health care providers was mounted and turned away. I will then argue that an important component of assessing clinical resistance to efforts to tailor treatment to the values of the laity will involve paying greater attention to how the clinic recognizes or discounts claims to knowledge entered by differently situated and identified players in health care dramas. Strategies for changing such resistance, where appropriate, will have better prospects for success if they attend to what people who seek to involve themselves with health care institutions and providers – whether as patients, or in other roles (as “recipients” of health care perhaps, or as bonded intimates of patients or recipients) – claim to know, and what structures and practices might make it more likely that what they do know will be recognized and acknowledged.

#### PREGNANCY IN THEORY AND PRACTICE

In the mid-nineties, the medical anthropologist Elizabeth Bogdan-Lovis was struck by two apparently conflicting trends: the continued – indeed increasing – employment of medical modalities in birthing (episeotomies, cesarian sections, epidural blocks, forceps deliveries), and the tendency of many women to want to give birth in a low-tech, “natural” fashion – a desire whose safety seemed strongly supported by data reported in reputable journals. Bogdan-Lovis has provided an interesting survey of the relevant literature in the area, and has plausibly defended an interpretation of these trends that is interesting in itself, and of considerable relevance to “standard” bioethical practice[10, 11].

Bogdan-Lovis concludes that the failure of efforts to better the odds that more women would deliver children in circumstances consistent with their own best hopes stems in important part from an influential, but faulty liberal feminist analysis of what has been standing in women’s way. Feminists of many stripes have encouraged women to resist what

is construed as a general social tendency to pathologize distinctively female powers and experiences, and in particular, to be dubious about the professional medical response to birthgiving. On Bogdan-Lovis's analysis, liberal feminists responded to the overmedicalization of birth by trying to "empower" individual women in terms both ethical and epistemic. Reasons to see pregnancy, labor, and birth in nonmedical terms were provided; critiques of the consequences of medicalized birthgiving as they affected both mother and child were shared; the possibility of finding reasonable alternatives was explored; women's right to elect those alternatives if they so wished was endorsed. Armed with the right information, with a sense of the moral significance of their own autonomous choices, and with allies within and without the medical establishment, women would be able, in general, to achieve the kind of experiences in giving birth that they valued. The chances of achieving such results would, it was confidently believed, be abetted as more women became physicians themselves.

The most that can be said for this approach is that it was an instructive failure. Despite data that the medicalization of childbirth does not, in general, improve outcomes, rates of cesarean sections and other intrusive interventions continue to rise [12]. Liberal feminism's reliance on the power of education and informed choice was, Bogdan-Lovis concludes, regrettably class biased and naively reductionist; against an entrenched institutional structure harboring both economic and professional reasons to maintain the status quo, its efforts were in vain.

If Bogdan-Lovis is correct in thinking that the contemporary character of birthgiving continues to fall far short of what many women reasonably hope to experience, and that the analysis and strategies of liberal feminism have inadvertently contributed to that failure by both misdiagnosis and misprescription, bioethics would do well to take her lesson on board; surely, there are strong analogies between liberal feminism and bioethics. Both put a great deal of faith in normative analysis, education, informed choice, rational persuasion, and respect for autonomy as tools for guiding and effecting social change. If medicalized childbirth frustrates many women's values, can add to their pain, and possibly even increase risk to them and their children, – and if, in addition, this state of affairs continues despite informed, concerted efforts to change it – bioethics should be just as scandalized as feminism.

It might, of course, be the case that the present character of childbirth is not out of step with the considered preferences of the majority of women facing delivery. Even should that be the case, however, there are still at least two grounds for concern, both of which implicate epistemic issues. One worry is that the prevalence of more or less intensively medicalized

births seems out of step with what one might reasonably expect, given both the literature, and the experience of other developed countries, where less medically intensive obstetrical practices seem to produce outcomes at least comparable to those in the U.S. This suggests (although it does not demonstrate) that obstetrical practice is not being guided by the best available understanding of the facts and probabilities involved. The second worry emerges from the experience of women who did very much desire natural or only minimally medicalized childbirth, and did not get it; even if their experience is not representative, some explanation is required if medicine is to forestall the charge that the agency of these women is not being unjustifiably dismissed or diverted.<sup>2</sup>

Bogdan-Lovis has done close ethnographic analyses of the experience of particular women who deeply desired “natural” childbirth, assiduously prepared to give birth in the fashion they valued, but found that when it came down to it, their efforts were often thwarted. Many of these women ended up having just the kind of labor and delivery experience they did not want and had tried hard to avoid. Bogdan-Lovis’s accounts of their experiences provide further insight into the fine-grained character of the resistance they encountered, as well as interesting information about how they interpreted their experience.

Both as a childbirth preparation educator and as a social scientist, Bogdan-Lovis worked with a cohort of pregnant women who shared a number of salient traits: they seemed strongly committed to the idea that “birth works” – i.e., that pregnancy and partuition are not pathologies, but physiologically normal states and processes [11]. Further, they recognized that this commitment, or at least their shared understanding of it, was not everywhere current among healthcare providers. Accordingly, they chose their particular physicians with care, trying to get as close a match in beliefs and values as possible. Often, they took themselves to have succeeded in this task. Further, they were well-informed about the natural history of pregnancy and delivery, and were often equipped with information drawn from the medical literature strongly supporting their interpretation of pregnancy, its generally acceptable risks, and the sometimes non-negligible risks to mothers and children of medical interventions. And finally, they were often supported by friends, partners, and by “liminal” health care professionals such as labor coaches and midwives, who shared their commitments, had access to the same knowledge, and sometimes enjoyed something in the neighborhood of collegial relationships with the pregnant women’s chosen physicians.

In sum, these women seemed well equipped, from both liberal feminist and standard bioethical perspectives, to go into medicine’s house and

fashion an experience there that matched their hopes. Yet they were often profoundly disappointed; epidural blocks, episiotomies and even cesarian sections were performed. The women whose birthgiving experiences thus went awry did not give up their commitment to the “birth works!” position; rather, they thought of themselves as the rare exceptions, women with unusually difficult and dangerous pregnancies – problematically slow labors, unusually large or awkwardly oriented babies. Despite, however, coming up with a kind of explanation of why their deliveries took unanticipated courses that seemed to justify everyone concerned, several of the women involved felt not only disappointment, but a personal sense of failure.

On Bogdan-Lovis’ view, the difficulties in delivery lay not with the women, but with the parameters and practices that were deeply entrenched in the organizational structures in which they had their babies. Despite the apparent congruence in values between these women and their doctors, despite the carefully garnered information they commanded, despite the social support they enjoyed, they ran into a system with a range of powerful default settings that allowed only so much variation. The medical interventions that the laboring women received were not administered over their objections at the time – what might be called their occurrent autonomy was not violated. Rather, the understandings of what kinds of developments within the course of labor defeated the presumption that “birth works” were authoritatively vested in the medical professionals, and the institutions that support and guide them.

For example, the reigning assumption that a pregnancy whose length approaches the *average* time in labor as represented by Friedman’s Curve (about 15 hours) is in need of medically mediated acceleration, is presented to laboring women as a medical fact, not simply a highly conservative normative response to a certain piece of data. Serious pain in pregnancy becomes the license for pharmacological response, because there are no physical or imaginative resources to allow for other responses – warm baths or shifts in position are difficult when IVs are in place, and IVs are in place to provide women with nutrition and hydration that will be compatible with their becoming surgical patients – “just in case.”

The strategy of “empowering” individuals – or even dyads (the pregnant woman and her labor coach, for instance) – to achieve a much desired result that constitutes a variation of medicine’s themes, seems unpromising. Bogdan-Lovis draws the inference that a reasonable chance of a nonmedicalized birth requires a strategic withdrawal from the spaces medicine rules, and the construction of new kinds of structures – birthing clinics, or midwife-assisted home births. Although Bogdan-Lovis does

not describe these structures and practices in explicitly epistemic terms, it seems clear that they are to constitute places governed by a different epistemic framework – one in which what women desire is honored, rather than undermined by disputable challenges to what they *know* (that birth works) and to whom they can *trust* (themselves and their bodies, their coaches and partners).

### UNSUPPORTED DYING

The strategy for tailoring the experience of birth more closely to women's values and desires could be seen as an intervention into standard clinical practice – an intervention that failed because it was naive about what actually determines what goes on in obstetrical practice. As Bogdan-Lovis sees it, economic realities played an enormous role in why the women she studied found themselves accepting medical responses to their deliveries which they had quite explicitly ruled out. Economics may indeed be the spider at the heart of this web, but closer to the actual decisions, the specially authoritative knowledge claims of physicians trumped those of the laboring women and their supporters.

I want now to consider another intervention into a suspect clinical practice, one that could hardly be accused at the outset of any lack of clinical savvy, or of importing foreign, feminist values into the clinic. In 1989, the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (inevitably known as the SUPPORT study) was launched with the intent of getting a clearer view of what it is like to die in American hospitals – a fate that would seem to be in store for half or more of us [13, 14]. Funded by a multimillion dollar series of grants from the Robert Wood Johnson Foundation, over 9,000 patients suffering from life-threatening illnesses were enrolled in the two-phase study, which was conducted in five U.S. teaching hospitals over a four-year period.

In the study's first two years, the goal was to achieve a more detailed, rigorously justified sense of what dying in hospitals is like. The results allowed SUPPORT investigators to identify several disturbing features attending hospitalized dying, and to design an intervention to improve the situation. The features that stood out included the following: while 79 percent of the patients who died had DNR orders, 46 percent were written within two days of death; thirty-one percent of enrolled patients had expressed a preference against resuscitation efforts, but fewer than half of their physicians accurately understood that preference; thirty-eight percent of enrolled patients spent ten or more days in the ICU; and, according to surrogates, half of all patients in the study who could commu-

nicate suffered moderate or severe pain at least half the time during their last three days of life.

The core of the strategy designed to deal with this situation was to improve information flow among the relevant parties. In Phase II's intervention arm, physicians would receive better information about the severity of a patient's prognosis. They also were better informed about patient preferences concerning CPR, about the severity of pain, about whether an advance directive had been executed, and about what patients understood about their prognoses, and how much information they wanted. This information was provided in the form of brief written reports. In addition, nurses with special training in bioethics and in communication were assigned the job of enhancing communication among patients, their surrogate decisionmakers, and the health care team. The nurses promoted discussion about advance care planning, documented patient desires, and worked to improve pain management.

There are three particularly important things to note about this strategy. The first is that it was designed by people who were very sophisticated about research design, clinical realities, and bioethics; input was provided by the physicians who had worked with terminally ill patients in the hospitals under study. The second is that the plan was enormously resource-rich. Hiring extra professional nurses for the express purpose of improving communication, reflection and pain control is something that would not likely occur outside the context of a liberally funded grant.<sup>3</sup> The third is that the intervention was a resounding failure.

When the results of Phase II were collected and examined, they showed that there had been no appreciable effect on any of the concerns identified in Phase I of the study. DNRs were not being made any sooner, physicians had no greater understanding of their patient's preferences, the number of days before death spent in ICUs or other "undesirable" states (e.g., in a coma) were unaltered, and pain control seemed no better.

SUPPORT sends the same kind of challenge to bioethics as Bogdan-Lovis's results do to liberal feminism. The idea animating SUPPORT was that, once consciousness has been raised, people will generally want a broadly palliative response to their final illnesses, and, once communication has been improved to a point where everyone knows what's going on, people will have a good shot at getting what they hope for. But this strategy misfired, and left in its wake a reaction that is in at least some respects similar to the failure of the less formal intervention designed to allow women to give birth to their children according to their own sense of what was fitting. In Bogdan-Lovis's study, the women disappointed by their birthing experience saw themselves as being the anomalies ("birth

works,” all right – just not for me), while consistently refusing to implicate their medical care providers in that disappointment. In the SUPPORT study, the family members of the patients who died reported high levels of satisfaction with their relatives’ care – despite the problematic pain control, the prevalence of “bad days” before the end of life, the lack of awareness on the part of physicians of their relatives’ values concerning how they wished to die [14]. Again, institutionalized patterns of care wriggled off the hook.

### THE EPISTEMOLOGY OF BIRTH AND DEATH

As previously mentioned, the message that Bogdan-Lovis takes home from her experience with medically managed birth is secession: women interested in nonmedicalized births should stay out of hospitals, and have their babies at home, or in birthing clinics that are independent of medical control, assisted chiefly by midwives. A similar “separatist” moral might seem to emerge from SUPPORT: don’t be caught dying in a hospital. If, like Keats, you want to cease upon the midnight with no pain, get good hospice care, either at home, or in a free-standing hospice.

But even if a kind of separatism is a prudent practical response to these forms of clinical recalcitrance, both stories raise questions too pointed to be ignored. Why didn’t information about patient preferences, which there is plenty of reason to believe were clearly expressed and reflectively formed, carry practical authority in clinical settings? Why were the mothers of new babies, and the families of recently deceased relatives, so accommodating about the results that ran athwart some of their most significant interests? Whatever the final form of satisfying answers to such questions may be, they will have to come to terms effectively with an epistemic point: knowledge crucially relevant to appropriate clinical response did not receive effective uptake on the part of those whose decisions and actions crucially determined what transpired in these cases. Further, the rejected knowledge emerged from the experience and values of people situated as patients.

Consider three domains about which clinically relevant knowledge claims may be made, and presumptive authority to enter such claims is recognized. One domain concerns *the values and preferences of the recipient of care* as they bear on health care decisions. There is a tendency in bioethics to see the recipient’s authority in this domain as conditioned only by questions of general competence – if someone has the ability to express a choice informed by an adequate grasp of the presenting condition, the alternative responses, and their possible sequelae, and can map

such information on to a reasonably stable set of evaluative attitudes, then they have what they need to make decisions that others should always regard as highly relevant, and often (with respect to refusal of treatment, for example) determinative.

A second domain concerns *the facts and probabilities about the nature of the underlying disease and what kinds of interventions might be expected with what degree of confidence to have what kinds of effects*. This, traditionally, is left very largely in the hands of physicians, their consultants, and their professional colleagues from allied disciplines. A third domain concerns the extent to which *the flow of pertinent information is recognized, facilitated or frustrated in the clinical setting*. Educational activities that go on in hospitals – attendings guiding residents, M&M conferences, Grand Rounds, and so forth, fall under this heading. But a source of special interest in this domain is the translation of information, and the negotiation of its attendant practical authority, across the professional-patient divide. As the knowledge about which patients are, in theory, taken to be expert will typically affect events only insofar as their care providers regard it as authoritative, that knowledge has to be acknowledged and recognized as salient. In SUPPORT, special trained nurses were formally assigned responsibility for keeping this epistemic border traffic moving along; in the birthing study, midwives, coaches and partners had this responsibility. In both cases, then, it was recognized that the knowledge that has its origin in the patient needs at least a conduit, and probably an advocate as well. In both cases, the flow of information was deflected.

It is important to get clear about why and how this information went off the rails, and there is nothing like looking if you want to find something out. In the birthing cases, Bogdan-Lovis's ethnographies put on view some events that may have put a crimp in the ability of the laboring women to recognize their own beliefs as constituting authoritative knowledge. For example, in the case of "Susan," a woman whose delivery was proceeding too slowly for her physician's comfort, we are privy to a scolding she gets from her doctor on her second office visit while labor is going on. The scolding leads to a promise on Susan's part to be "compliant" and a decision on the part of her midwife not to accompany Susan to the hospital, since interprofessional relationships seem to have soured. Susan, bereft of an important ally, and perhaps emotionally undermined by her physician's having "laid down the law," ends up enduring an aggressive manual removal of her placenta [11].

The SUPPORT study has touched off a flood of publications; the *Annals of Internal Medicine* reported recently that there were nearly 100 articles

published or in press that have had as their basis SUPPORT data [15]. Some of these studies consider and test various hypotheses about why things went amiss; ethnographic information derived from the experience of the nurses assigned to the intervention arm of the trial will be of great interest in this connection as it emerges. The circumstance of high family approval ratings of relatives' terminal care also seems particularly intriguing. Did families (and perhaps patients) think that patient views about end of life issues, and about pain control, were so unimportant in the context of their care setting that it was not appropriate or worthwhile to assert those views with the kind of vigor it might have taken to get some results? Did the nurse-facilitated conversations enjoyed by those in the intervention arm seem so anomalous against the general clinical backdrop that their ineffectiveness seem unremarkable?

Wittgenstein's famous advice – *denk nicht, sondern schau!* – sometimes needs to be supplemented.<sup>4</sup> Often we need to both look and think, and in the remainder of this essay, I want to deploy a concept that might help us understand the information about how knowledge flows, is diverted or dammed, as well as to highlight the kind of information that needs to be garnered if clinics are to be appropriately hospitable to forms of knowledge other than those in which physicians and other professionals assert a proprietary interest.

#### DO WE STILL NEED PATIENTS?

Margaret Urban Walker has introduced the useful term “epistemic fire-walls” to refer, broadly, to patterns of social thought and practice which hide, obscure or undermine knowledge that threatens the legitimacy of some social practice [17]. A powerful and ubiquitous form of the epistemic firewall, on her account, is the construction and assignment to people of certain kinds of “necessary identities,” understood to attach to a person from birth and so taken to be “natural.” A prime example is the identity typically assigned to (and enforced upon) female human beings: “woman.” One of the ubiquitous features of the variants of this identity as they have been widely distributed across times and cultures is that it places those who have it in disadvantageous positions *vis-à-vis* human beings identified as “men,” and among the disadvantageous features of those positions have included authority over access to knowledge, and over what is regarded as knowledge.

What is crucial about necessary identities is just this: coupling practices of epistemic delegitimization to a status, and then regarding that status as “natural,” provides a handy justification for those practices – indeed,

it might be said to remove them altogether from the need for discursive justification. The world simply is such that women's intellects lack deliberative authority, that too much education will cause their wombs to wither, that hormonal cycles make their judgments unreliable. This strategy also reveals the attractions of attaching a social status to some biological marker – it distracts attention from the social practices involved in ascribing and policing the identity and its consequences by making the whole matter seem natural, rather than contrived, necessary, rather than optional.

In addition to the liabilities still attending to the identity of “woman,” I want to suggest that another epistemically disabling identity was operating in the cases at hand – the identity of *patient*. While “patient” is not a necessary identity in the sense that we think of it as something one is typically stuck with from cradle to grave (as we still erroneously tend to do with gender assignments) it does present itself as necessary in that it so closely attends biological events that seem largely or altogether out of our control – being ill enough, or traumatized enough, or in so precarious a physical state as to seek out the services of health professionals. Neither the need nor the response to the need strike many of us as optional matters.

So, if “patient” can serve as something like a necessary identity, as opposed to a discretionary role, does it also function as an epistemic firewall, as a device that hides contrivances under the guise of inevitabilities, in the interests of the powerful? It may seem dramatic to say so, but there is reason to take the position seriously. “Patient” is a role interdefined with other roles (physician, health care providers generally) such that the patient is by definition in need of what those occupying the other role can provide. It is telling that we seldom take seriously the ways in which physicians need their patients.

In addition to the intrinsic satisfactions many find in the practice of medicine, physicians retain an enviable place in social hierarchies of status and salary. Perhaps particularly in a context where the moral authority of providers over treatment decisions, at least in principle, is subordinated to patient autonomy, there may seem to be all the more need for providers to insist on epistemically based prerogatives to secure their position. Everybody has her own narrative, the compassionate and clued-in contemporary physician might allow – but only *our* narrative has the power of science and technology behind it. Scientifically informed medical practice remains the best avenue our culture has yet found for determining what's actually going wrong with your body, and how it might be fixed.<sup>5</sup> If *that* goes, if the physician's claim to epistemic authority becomes seen as negotiable rather than as a given, what's left to solidify a physician's status, or to

provide security in the face of the otherwise terrifying decisions doctors often confront?

Further, it is hard to escape, even in thought, being configured as a patient in professional interaction with physicians, and thus hard to escape the kinds of power differentials, including a reduction of epistemic standing, that closely attend that status. A reasonable case could be made for saying that, however physicians, other health care providers, and the rest of us, ought to think of and respond to patients, the women in Bogdan-Lovis's study were not properly *patients* at all. It might well have been less dangerous to their interests had they been able to step into a role in which they were configured as adult agents consulting with medical professionals, their presence in the hospital largely to be understood as a precautionary measure. After all, these women were not ill, not traumatized, not disabled. They had – *ex ante*, anyway – a very clear understanding of why they were working with doctors and in hospitals. Why should scoldings and promises of “compliance” even arise?

There is, of course, a very strong tendency for the institution, its agents, and the women themselves, to regard these adult agents proleptically – to see them as being the patients they only might come to be – and the strength of this tendency is suggested by the very fact that it is difficult to otherwise construe lay people in a professional relationship with physicians. And if there is such a tendency for these perfectly healthy women to become transformed into patients, the pull toward seeing the SUPPORT enrollees in such a role is enormous. Those people clearly were gravely ill, and were in the hospital to be treated for those illnesses.

And yet, they were also in the hospital to die – had that not been a very reasonable expectation from the start, they would not have had the opportunity to be admitted to the study. Dying, like birthing, can also be construed otherwise than as a pathology. People who are dying may in general need a very different set of professional responses than those who are ill, and trying to get better. In a phrase introduced into the bioethical literature by Dan Callahan [20], we might say that such people want the technologies and skills that a complex set of social decisions and practices have placed firmly and solely into the hands of physicians to be used to help them achieve a “tame” death. There are at least some analogies between that quest on the one hand, and the search for a “natural” childbirth, on the other.

If epistemic liabilities attend the role of patient, in what other ways should we think of people who engage the professional services of physicians, particularly for those who seek out doctors for reasons other than “insistent” illnesses or traumas? Other, clearly nonnecessary identities –

“client,” “consumer,” “employer,” “recipient,” “partner” – all lack, for different reasons, consistently satisfying resonances. Perhaps the project of leveling the epistemic playing field between health care professionals and those they serve will be best carried out by encouraging the use of many different role-names.

None of this should be taken to suggest that an institutional tendency to dismiss or otherwise redirect the agency of people seeking health care services would be justifiable for those who are *bona fide* patients (whatever we should decide that turns out to mean). If it should happen that some features of what we regard as a feminine gender identity had their roots in biology as well as in culture, that wouldn't make disrespect for women any the less morally reprehensible either. The suggestion that we be careful about just who we're calling a patient, rather, is made in the same kind of spirit that leads critics such as Bogdan-Lovis to insist on the importance of erecting new, extra-clinical structures and practices for people giving birth. It is an effort to change a structure that hides mechanisms through which authoritative knowledge and other forms of power are channeled, leaving those from whom or to whom that power is so moved in the dark about the nature of these transactions. If we limber up our categories, and recognize that not every seeker of health care services is a patient, it may be easier to see new possibilities for understanding the role of patient, as well.

Attention to how health care practices are designed and sustained – conceptually, as well as physically and institutionally – is part of what would distinguish a developed program of employing feminist epistemological notions in bioethical analysis from the strategy characterized by Bogdan-Lovis as “liberal feminism.” A focus on the epistemic implications of patterns of understanding and action in the clinic would add as well an important element to the kind of bioethical approach that seems to have informed the SUPPORT intervention as well. To understand the normative character of various forms of health care delivery, to discern the sources of its resistance to morally motivated changes, and to craft effective tactics to promote improvement, takes more than acute ethical reasoning, good will, gentle persuasion, and reliance on informed individual decisionmaking.

It will, of course, also take a good deal more to level the epistemic playing field than coming up with satisfying new labels. It will take the restructuring of roles, of the expectations that adhere to them, and of the institutional and social habits that reinforce them. But such restructuring can hardly take place if the epistemic patterns at work within the clinic remain unclear. Nor is it reasonable to think that “epistemic firewalls” and other problematic, unacknowledged aspects of clinical life will be equally on view from all perspectives; an epistemically healthier clinic will be a

clinic prepared to take seriously the knowledge claims of many differently situated players in the effort to better understand what it actually is, and what it could come to be. Bioethicists can play an important role here, I think – although in the spirit of a critical social epistemology, they need to be self-reflective about their own claims to knowledge, about how they function in the epistemic economy of the clinic, and what their own blindspots are likely to be.

All this will be extremely difficult to do, and probably very difficult to convince anyone with any practical influence of the need of doing. At the same time, movements that expressly or tacitly challenge the conceptual and practical structures of health care are not likely to stay conveniently clustered in a few recognizable if troublesome areas. In a world where ACT-UP can defy standard research protocols and disability activists and scholars deconstruct the “medical model,” where more patients cruise the web, and more families are pressed into more intensive care-giving responsibilities via telemedicine, medicine can no longer be complacent about how it decides who is allowed to know what.

#### ACKNOWLEDGMENTS

A presentation on her research into demedicalized childbirth by Elizabeth Bogdan-Lovis given in the Philosophy Department at Michigan State University in October of 2000, was central to the form this essay took; I am grateful to Ms. Bogdan-Lovis for providing me with her unpublished as well as published work. An informal discussion group on narrative bioethics, initiated by Howard Brody was also a useful source of ideas. Hilde Lindemann Nelson gave a late draft her usual insightful read. No one, of course, bears any responsibility for my argument or my conclusions apart from myself.

I should also like to thank Professor Alex John London of Carnegie Mellon University for his invitation to write for this special issue, and still more for his patience.

#### NOTES

<sup>1</sup> For a discussion of these and related concepts, see, *inter alia*, Louise Antony and Charlotte Witt’s collection, *A Mind of One’s Own* [1], the essays in Kathleen Lennon and Margaret Whitford’s edition, *Knowing the Difference* [2], Lorraine Code’s *What Can She Know?* [3], Linda Alcoff and Elizabeth Potter, eds., *Feminist Epistemologies* [4], the essays by Rae Langton and by Miranda Fricker in Fricker and Jennifer Hornsby’s *Cambridge Companion to Feminism in Philosophy* [5], and Lynn Hankinson Nelson’s *Who Knows?*

*From Quine to a Feminist Empiricism* [6]. Despite my conviction that feminist epistemologists have fashioned some of the most useful analytic tools for the development of a clinical epistemology, I still understand epistemology rather traditionally – as a *normative* inquiry into knowledge. “Normative,” in this context, includes the notion that both “truth” and “justification” remain important ideas for the kind of approach I propose; to some extent, this distinguishes the slant I favor from sociological or anthropological inquires into how *what is taken* to be knowledge is so understood in a given culture or society or institution, and how such understandings are supported by various ways in which power is distributed in the domain in question. Social studies of knowledge are squarely pertinent to my proposal, but, as bioethics itself is fundamentally a normative inquiry, an epistemic slant on medical practices will not be as helpful as it might be if it has to shy away from issues about who actually might be in an epistemically better place to lay claim to an authoritative account of what is true about a given domain. In addition to feminist epistemologists discussed in this text, my approach has also been influenced by Alvin Goldman’s *Knowledge in a Social World* [7].

<sup>2</sup> A third point concerns the social influences on the formation of preference. What women would elect if, for example, midwives tended to occupy the same economic quintile as do obstetricians, is an interesting speculation.

<sup>3</sup> An editorial in the *Annals of Internal Medicine* puts the total value of the Robert Wood Johnson grants at more than \$29 million U.S. dollars [14].

<sup>4</sup> As given in his *Philosophical Investigations* [16] – where he is, of course, considering a particular problem.

<sup>5</sup> A revealing example of this tendency is provided by Dr. Jeffery P. Bishop [18]. See also the response by Arthur Frank [19].

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