

Rationally Speaking #199: Jessica Flanigan on “Why people should have the right to self-medicate”

Julia: Welcome to Rationally Speaking, the podcast where we explore the borderlands between reason and nonsense. I'm your host, Julia Galef, and with me today is Professor Jessica Flanigan.

Jessica is an assistant professor at the University of Richmond, where her work focuses on applied ethics and normative ethics. She's recently published a book titled *Pharmaceutical Freedom: Why Patients Have a Right to Self-Medicate*. That's the argument that we're going to be talking about today.

Jessica, welcome to the show.

Jessica: Thank you for having me.

Julia: Patients having the right to self-medicate is basically the idea that if patients want to take pharmaceuticals for some medical condition, they should be able to do that without getting permission from a doctor in the form of a prescription.

When I first encountered your argument, just the topic sentence version of your argument, I assumed that you were going to be saying the version of it that I've heard before, which is: patients should have this right because people have the right to autonomy. Even if they make decisions that are bad for them, or make them worse off, that's still trumped by the fact that they should be able to make decision about their own body. That argument is somewhat interesting, but it's not *that* interesting to me -- because you have to buy into the premise that autonomy is this fundamental right that trumps people's welfare. If you don't buy into that, then it's a non-starter.

Then, as I kept reading your essays on the topic, I noticed you were saying something much more interesting than that. You were saying that the right to self-medicate doesn't depend on accepting these fundamental values around autonomy. It's actually something that follows logically from other rights that we have already granted patients, as a society in the field of medical ethics. Namely, the fact that patients have the right to refuse treatment. That they have to give their informed consent before doctors can treat them. That logically implies that they should have the right to self-medicate.

Jessica: Right.

Julia: A very interesting form of the argument. Would you mind laying out the basic case of ... Start with: what is the right to refuse treatment? What does that entail? How does that imply that patients should have the right to self-medicate?

Jessica:

That's a great summary. The right to refuse treatment is something that we all take for granted nowadays in medical ethics, but it wasn't always something that was taken for granted. It's legally protected and widely accepted throughout the 20th century. Today, when you go to the doctor's office, and in the clinical context, you have the right to make an informed decision about your own care, even if your doctor disagrees with you. Your doctor may, for example, recommend a treatment and say, "If you refuse this treatment, you'll have really bad medical consequences." If you refuse a blood transfusion, for example. Bad outcomes.

Nevertheless, you would be within your rights to say, "I understand that I'll have bad medical outcomes, but nevertheless, I'm going to refuse the blood transfusion."

There's different justifications for why we grant patients the right to refuse now, and why we see it as a moral progress that patients now have the entitlement to refuse even medically advisable treatment. One justification for letting patients refuse, nowadays, is that it'll have better medical outcomes, even though the thing that refusal rights entitle people to do is to refuse treatment when they disagree with medical expert. Nevertheless, having it as an institutional rule, the right to refusal promotes a better doctor/patient relationship, more trust between doctors and patients, and so medical outcomes could be promoted.

Also, health shouldn't be just about medical outcomes. It could have good consequences to let patients refuse because even though the doctor might be the expert about what's good for a patient's health, the patient is the expert about what's good for her life, as a whole.

Julia:

What's a case in which what's best for someone's health might not be what's best for them more broadly?

Jessica:

Think about the example I gave earlier, about refusing a blood transfusion. Some people have religious commitments, so it's not that their view is that blood transfusions are bad for you health when medically indicated. They're not denying the medical outcomes favor blood transfusion, but they deny that a blood transfusion would be in their interest, as a whole, because they conceive of their overall interest as being living in accordance with their religion and not necessarily doing the thing that promotes health.

A doctor will be the expert about health, plausibly, but the religious patient is the expert about how health and religion weigh against each other in their life, as a whole. The judgment about whether or not it's in a patient's overall, all things considered, interest to make a refusal decision ... If you think that that should just be informed by whoever the expert is, therefore we have a reason to think that the patient is generally going to be the expert. Because the relevant thing in question is not what's good for health, but what's good for a person's life.

Julia: Got it. Go on.

Jessica: I was just going to say that there's a third thing, which is of course, we all know people who aren't necessarily the best decision-makers when it comes to their lives, as a whole, also.

We can think about cases like that in medicine – so, you could imagine a person who's refusing life-saving therapy that will be effective for misguided reasons. And you try to convince her, but she's not persuaded. It really is the case that a refusal decision ... for example, like refusing chemotherapy ... will on balance, mean that she has less well-being, or that her interests are frustrated over the course of her life. Or that she doesn't live as long as she could've.

Even then, it still is, for the autonomy reasons that you cited earlier, wrong to force people to undergo medical treatment when they don't consent to it.

There's the three different reasons that you have the right to refuse.

Julia: Great. Maybe before you answer the rest of the first question that I posed to you, maybe you could tell us a little bit about: how did this increasing respect for patient's right to refusal ... and I guess increasing respect for patient's autonomy ... how did that happen over time? Was there some impetus, or was it a very gradual, societal value shifting around this?

Jessica: It was gradual, in a way, over the course of the 20th century. Medical battery wasn't considered illegal or morally wrong.

Julia: What is medical battery?

Jessica: Performing treatment on a person in a way that they didn't consent to, on a person's body. The doctrine of informed consent has two parts. One is, you can't do stuff with people's body, if they didn't say it was okay. Then, another is that you also have to tell them. They have to be informed. It includes rights against force, but then also rights against deception.

People didn't really have either of those rights on the table before 1914, at least not legally protected. There was this woman named Mary Schloendorff, who was undergoing an examination under ether, and she previously had said, "I don't consent to any kind of surgery." Then, her physician did a hysterectomy. This was in 1913.

Then, she woke up, found out that the surgery had been performed on her, suffered a series of complications related to the surgery, and sued. That's the landmark case in getting informed consent rights on the table for patients. That was 1914.

Nevertheless, it was slow going. It wasn't widely accepted in medicine, even a generation ago. In 1967, they did a survey of oncologists, and 90% of

oncologists in the late 60's said that their usual practice was to not tell people that they had cancer, if they thought that finding out that they had cancer would've been bad for them. That's pretty recent. That's within some people's memory.

In 40 years, the practice of medicine has really radically changed to recognize that in clinical context, patients have the authority to make these intimate, personal decisions about their bodies.

Julia: Great. Then, returning to the second part of the question that I had asked you: How do those reasons that you cited for giving the patients the right to refusal, and the right to informed consent, how do those imply that we should also, in your view, give patients the right to self-medicate?

Jessica: Well, imagine two patients, Debbie and Danny. Debbie has diabetes, and her doctor is like, "You should definitely start insulin treatment." Debbie understands the risk of refusing insulin, but she's also not willing to live by a schedule. She thinks it's not in her overall interest to have to monitor medication all the time. She knows herself.

She's like, "You know what? I hear what you're saying, but I'm going to give it a shot without insulin. I'm going to try a diet and exercise." That's within Debbie's rights.

Now imagine same condition, diabetes, but different patient, Danny. He has diabetes, and his doctor's like, "You know what? Right now, let's try a diet and exercise."

Danny's like, "You know what, Doc? I know myself. I'm not going to do it. I'm not investing the time and energy in that, and I'm also really worried about what's going to happen if I fail at this. I want to go straight to medication."

Now, there's nothing intrinsic about the risks of access versus refusal. That means that a patient would be well-qualified to make a refusal-based decision against medical advice, such that we would grant here that entitlement, but not well-qualified to make an access-based decision about her treatment in the same. His or her treatment.

There's also nothing about people making decisions about their own bodies. That means that they would have rights against being coercively prevented from making their own decision in the refusal context, but not have rights against encountering legal threats or penalties in the access-based case. I think that's an asymmetry because it feels different to be refusing versus wanting to have access.

There's a case that brings out the point that having access to a treatment is also a right against interference. Take, for example, reproductive choice. If women have rights to contraception, or rights to abortion, a law that made it so that they were legally prohibited from having effective access to those

types of choices would be an interference with their ability to make a decision about their body. Even though it's an interference with other people's ability to provide an access to the necessary means to make those decisions about their bodies. In prohibiting people from providing effective access to a treatment decision, that's still a form of interference with a person's ability to make that treatment decision.

Julia:

You did put your finger on the part of this argument where I had the most hesitation, which is the idea that there's this symmetry.

But I think I would've framed the asymmetry slightly different than you did. I would've said that there's at least two different kinds of thing that we mean by autonomy. One is the right to do things that we want to do to our bodies, and the other is, the right to not have other people do things to our bodies that we don't want them to do. The latter is the thing that the right to refusal is designed to protect.

It seems to me that we, as a society, people's moral intuitions, in general, put more importance on the latter. In the same way that ... This isn't the same dichotomy, but it feels analogous. The same way our folk moral intuitions put more importance ... There's more of a prohibition against *causing* harm than there is against *failing to prevent* harm. We would judge someone more harshly if they killed someone as opposed to if they simply failed to stop a murder from happening.

You could certainly argue that there's no logical reason to prioritize one over the other from a pure, consequentialist basis. Someone dies either way. Nevertheless, if our project here is to say, "Look. The moral rules and norms that we, as a society, have already accepted imply a right to self-medicate," then the fact that our moral intuition feels this asymmetry between these two different kinds of autonomy, between the right to do things to our body, and the right to not have other people do things to our body -- that asymmetry, if it exists, whether or not we think it's justified, seems relevant.

Does that make sense?

Jessica:

Yeah. There's two things. The first is, you're saying, "Well, it seems like there's a difference between the right to do something versus the right to not have other people interfere with you." I feel that. I do think that there's a relevant moral distinction between causing harm and interfering with people versus allowing harm to happen. I think that's a very fundamental part of morality, so I'm denying some of the things that consequentialists would say.

But I think that legal restrictions that prevent patients from accessing the necessary means to their treatment are themselves, a form of interference. We just don't see it as much. In the refusal case, it's very vivid if somebody disrespects your right to refuse treatment because it consists of force against the person, cutting open someone's body and taking out organs, or

something like that. Tricking a person, lying to them. That's a form of interference, as well. Threats of force are also a form of interference. The legal penalties that people face, if they provide access, or if they access a drug illegally, if they access a treatment illegally, those are also a form of interference against a person.

If I want to interfere with you, I could lie to you. I could use force against you, physically restraining you, or I could threaten you. The policies that I'm talking about are backed by coercive threats, so they are coercive.

Julia: Maybe the disagreement here, the difference between our views on this policy, is contained in the word "interference". It feels a little bit like you're lumping together some things that feel very different to me under the same word of "interference". Preventing people from doing things that they want to do counts as a form of interference, but so does physically mutilating someone against their will. I would class the latter as being very a different violation of autonomy than the former, and wouldn't classify them both as interference.

Jessica: Why do you think that those are different? If I threaten somebody with violence or imprisonment, if I use some threat that's backed by physical force to get them to do something ... I agree that, that's in some ways, different from physical force, but effectively, it seems like it is definitely a form of interference. If the person doesn't comply, and then they're subjected to some other kinds of penalties ... You could think that it's the *justified* use of force with legal penalty, but that's just the thing that's questioned. Whether it is force or not is different than whether it's justified or not.

Julia: I see. To make sure I understand your argument, you're acknowledging that people do see those forms of interference as different, and that they place more importance on laws to protect people from the physical interference than they do from the legal interference, but you're saying that, that distinction isn't really justified? And if people paid attention to the logical structure of the two, they would realize that their moral intuitions also should similarly forbid the legal interference for people to do things to their own body.

Jessica: Yeah. My thought is ... Say that you think that interference ... You're saying, "Well, what do you mean by interference?"

Say that you think that interference is a violation or a presumptive violation of somebody's authority to make choices about their own body, or make choices that they have a right to make. Legal penalties, presumptively, also would violate that. It could be justified. It's either some legal penalties that interfere with your ability to make your own choices, but it's justified. Things that say, "You can't push people. You can't hurt people," or something. That would interfere with my autonomy to hurt people, but it

would be a justified law. Whether or not it's interference, definitionally, that doesn't settle the separate question of whether it's justified.

What I'm saying, then, is these laws do interfere with people's choice. And since we already think that that range of choices ought to be legally protected in this context, notice that since we reject this kind of interference with that range of choices, the kind of interference from physicians, for example... then we should reject also legal interference with that range of choices, interference by public officials.

The same reasons we support right to informed consent, and we reject interference by physicians -- the medical outcomes, the violations of autonomy, your health, your well-being, and your rights -- those same reasons that we think that there shouldn't be interference by doctors and medical choices are also reasons to think there shouldn't be interference by public officials.

I see that people are much more accepting of interference by public officials than they are of doctors. But they didn't used to be accepting of interference by public officials. In the past, people thought that rights of self-medication were a thing, and they didn't accept interference by public officials. They did think that it was okay for doctors to interfere in these clinical contexts.

Julia: You're pointing the idea that are intuitions are more malleable than we might think that they are, because they have shifted over time.

Jessica: Right. You were like, "Well, we as a society, think X but not Y."

I was going to say, "We, as a society" -- I don't even know ... First of all, I don't even know who that would be. The mean social value, whatever that is, that shifts over time. It would, I hope, be informed by the force of argument. One thing that I am presenting [is] "Look, there's this inconsistency in how we're approaching medical choices. We should change our mind."

We could change it one of two ways. We could ditch medical autonomy in the clinical context, and be like, "Oh, I guess I don't care that much about informed consent, after all." Or, you could reject paternalism, and affirm medical autonomy in the public health context, which is what I favor.

I think it's the wrong way to go to resolve the asymmetry by abandoning the informed consent. We should reject these paternalistic policies instead.

Julia: To take a somewhat different tack now: we've been talking about the third reason, of the three reasons you said that underlie this right to refusal. That's autonomy.

But the first two were empirical. They were reasons to think we end up with better outcomes, patients end up with better welfare, if they have the right to refusal -- both because of the better relationship it promotes between

patients and their doctors, and also because it allows people to choose things that are actually better for themselves, because they're the best judge of that.

I'm wondering if the different intuition, between the right to refuse treatment and the case of the right to self-medicate, maybe the difference in intuition is because people who don't agree with you suspect that the empirical consequences of a right to self-medicate will be large enough that they outweigh the autonomy consideration. That patients will end up making bad enough decisions for themselves that the benefits of autonomy are outweighed by that.

Maybe you could talk a little bit about what you estimate, empirically, the consequences to be to welfare of a right to self-medicate.

Jessica: I'm not a social scientist, so I'm not out there, doing my own studies of the empirics of self-medication --

Julia: Sorry -- I was going to say, you could also talk about how bad the consequences would have to be for you to no longer support the right to self-medicate. Like, if we thought that 90% of patients would end up taking drugs that would kill themselves unintentionally -- that's a very extreme case, but just to lay out the spectrum -- would the autonomy consideration still dominate even then?

You can give evidence that you know of, about the actual empirics, if you want, but I think this is the main thing that I'm interested in.

Jessica: First I'll talk about the empirics. There's not a lot of research on the effects of these policies because it's hard to get a good research design where it'll randomly assign you to a policy system.

There is some research, but the research is not what you would think. People think that if we didn't have prescription requirements, people would accidentally overdose all the time. There's some evidence from the 70's that middle income countries in Europe that didn't enforce prescription requirements actually had lower rates of accidental poisoning. People made riskier choices if they thought that their self-medication choices were authorized by a physician. They're more likely to make risky choices around drugs.

I think the evidence is stronger when it comes to the approval process, which we haven't talked about as much with self-medication. The right to use unapproved drugs, drugs that are still awaiting approval. The approval process kills people in two ways. It kills people because it forces them to wait for a potentially life-saving drug, so people die because the law prevents them from accessing something that could potentially help them.



It also has that effect of discouraging innovation. They're raising the cost of developing a new drug, fewer new drugs get developed, and that also leads to a loss of life.

I do think that the consequences of respecting rights of self-medication might be surprising to people. That said, I'm not as confident in the empirical arguments as I am in the more entomological arguments because it's contingent. We could imagine a world where it went the other way.

Then, you're saying, "Well, if we did imagine that world, would you change your mind?"

I wouldn't as much because I think that rights should take priority over consequences. You mentioned at the beginning that you're not an autonomy-first person with your moral theory, and I-

Julia: Well, I'm not an "autonomy-only" person.

Jessica: Yeah. I think that well-being matters, but I think that the promotion of another person's well-being is constrained by their rights. I think that people have the right to make decisions that are bad for their own welfare.

We could talk a little bit about externalities, maybe, if people make decisions that are bad for other people's welfare, they don't necessarily have a right to that.

Julia: Like people taking antibiotics when they aren't actually necessary, and that creating strains of antibiotic-resistant bacteria, for example?

Jessica: Exactly. I do not think that people have a right to use antibiotics. That's one of the few cases of self-medication which I don't think that people will have rights to, because of these negative externalities.

But I also think that's true in refusal cases. I don't think that people have rights to refuse certain vaccines under certain cases, as well, because they think that being un-vaccinated is, in some cases, tantamount to weaponizing yourself. It's similar to ... If I have a right to own a gun, that might be fine. I have rights with my gun, but I don't have a right to shoot in the air on the 4th of July, where I can expose somebody to a risk of significant harm.

I have a right to make decisions about my body. That's fine. I generally have discretion over my body. I don't have the right to shoot measles into the air on a bus, though.

Julia: Actually, now that you mention it, we do already forcibly quarantine people sometimes, if they have a contagious illness, and we have no other options. Right?

Jessica: That's right. I don't think that bodily rights are so strong that they entitle people to expose other people to an undue risk of harm that would violate their rights. There are limits, and that's also true for antibiotics in self-medication case.

Julia: Are there any other costs, or harms, that you think would result from a right to self-medicate? Other than the obvious one of some patients taking drugs that are bad for them, that they wouldn't have taken under the current system?

Jessica: Sometimes people talk about social costs, like costs to the healthcare system, if people hurt their health ... If people damage their health in some way that, that imposes costs on other people because other people are then going to have to bear the costs of paying for their healthcare.

Julia: Yeah. That's a standard way to justify paternalism about health across all dimensions, like taxes on sodas, et cetera.

Jessica: Yeah, I think if you scratch the surface of that argument though, it doesn't hold up on whatever conception you have of what we're doing with bearing the cost of the healthcare. Some people say "Well, we would all have a moral obligation to provide people with healthcare, but if you make a bunch of risky decisions and damage your health, then we're gonna have a moral obligation to provide you with even more."

But if I have a moral obligation to provide you with healthcare, that isn't silenced in any way necessarily by you requiring more. If I have a duty to care for the sick, the sick aren't preemptively liable to be interfered with or have their rights limited just because they're gonna subsequently exercise their right.

Julia: I guess the word "require" is doing a lot of work there. You could say "They don't *require* more. They're *choosing* to take on more because they're choosing to, you know, eat a lot of saturated fat" or something like that.

Jessica: Right.

Julia: And actually, I think probably my example of a soda tax was a bad example of paternalism, because a tax is kind of a way of internalizing the externalities of making it so that people can choose to worsen their health if they want to, and they're just paying it for themselves. Paternalism would be more like banning sodas or something like that.

Jessica: Right. I think that the tax is paternalistic, actually.

Julia: Okay!

Jessica: But I see that that's a more controversial case. A clearer case would be a ban on something. "You can't buy heroin at Walgreens." That's paternalistic.

Then people will say, "Oh, but if we let people buy heroin at Walgreens and they have bad health effects, we'd have to pay for it" -- and I think if somebody has a right to something, they can't be made preemptively liable to be interfered with or have their other freedoms limited, in virtue of the fact that they're gonna subsequently exercise that right. Or we can't limit how they exercise their bodily choices just because we're gonna have to pay for it down the line, if we have a standing general obligation to pay for people who are sick.

You might think we'd all have that obligation. Healthcare is just something that is beneficently provided, or that you provide by consent. There's no duty to provide healthcare for people. If that's the case, then you could just not provide it to people who you think have acted in a way that makes it so that they are responsible for their negative health outcomes.

I don't think that that's a good way to go. I think that's kind of expressively bad to send that signal towards people, but I don't think that it's ... How do I put this?

I don't think that you can say to a person, "Oh, in virtue of the fact that we don't like your choices, we're not going to provide you with healthcare," unless you told them in advance that that was what was gonna happen. In which case maybe they would waive it to healthcare, but whether you think healthcare is a right or not, either way, whatever justification you have for providing people with healthcare, those two justifications aren't gonna justify paternalistic limits on people's choices on the grounds that their choices are going to have social costs.

Julia:

Hm. From the way I'm understanding your argument, it sounds like your pointing at the right to refusal laws ... You're pointing to the logic behind those laws as also applying to any kind of thing that people might want to do to their bodies.

In your paper, and I assume in your book, although I haven't actually read the book yet, just your papers on the subject ... In your paper, you're focusing explicitly on the right to self-medicate, but it sounds like the exact same logic would apply to the right to take illegal drugs or the right to, I don't know, not wear a seatbelt.

Is there any distinction between the right to self-medicate and all of these other rights to take risks with your body that you think your argument applies more to one than the other? And if not, why did you just focus on the right to self-medicate?

Jessica:

I think that self-medication has a clear parallel with informed consent, and I think informed consent is something that a lot of people already accept, so that's a good foundation to build an argument against paternalism with respect to drug policy. Self-medication includes things like the right to die, the right to use recreational drugs, in addition to investigational drugs and

prescription drugs, but that's nice because there is a nice symmetry. That's talking about health-oriented drug choices when it comes to access and refusal. If you can make that case, then that's sort of a good "thin end of the wedge" to push a more general argument against paternalism.

In other contexts, I don't think that there's that symmetry. It's not like, "Oh, if you believe in informed consent, you shouldn't believe in seatbelt laws and other arguments against seatbelt mandates, which are similar in structure in that they're built on a kind of pluralistic moral foundation where it's about both the consequences of the laws and also the rights violations that the laws entail. But they don't appeal to this initial symmetry between refusal choices and access choices.

However, more generally, I do think that my argument and strategy for all these cases is one of single standards. I think that there's a lot of double standards and justifications for public health paternalism and public policy more generally, where we hold public officials for laws to lower moral standards than we would hold people to in private contexts,

Julia: How so?

Jessica: And I think that that's a good general theme. I think sometimes people will say things about public officials where they are saying, "I wouldn't be able to treat a person in that way." So if I found out that my neighbor was growing some plant that I didn't like, I wouldn't be able to go to my neighbor's house and be like, "I don't like that you're growing that plant. Stop it. You certainly can't sell that plant to other people or set the plant on fire or anything like that."

Julia: What plant could you possibly be talking about?

Jessica: But I know a public official thinks that, yeah, If they want to ban marijuana or ban people from growing marijuana in their own homes, then they're permitted to.

And you could have lots of arguments for why public officials have the moral authority to do it in certain cases, but I don't think that we often go through those arguments. I think that sometimes there's a law and people just think like, "Well, I guess we as a society think that's okay because it's a law," but we should question the law by the same kinds of standards of moral reasoning and justification that we hold our own conduct to.

A law could be just or unjust. A public official could be doing the right thing or doing the wrong thing, and we shouldn't think that just because something is a law that it's getting it right morally. I think we have a lot of status quo bias when it comes to just accepting our current system of law, but then...

You're probably familiar with this, but I don't know if your audience is -- There's this nice heuristic, which is the reversal test. Where people are very accepting of existing policies or existing states of affairs, and they're opposed to any kind of change.

Julia: Or they require the change to justify itself very strongly.

Jessica: That's right. They have an initial reluctance to accept any kind of change. The example that's given by the people who wrote the paper on the reversal test, Nick Bostrum and Toby Ward, is speed limits. They're like, "Oh, the law that says 65 mph, that's a really good law. We shouldn't go up to 85 miles an hour."

And it's like, "Oh, if you just switch your perspective and you think, 'Well, if you think that adding 20 mph to the speed limit would be bad, maybe we should subtract 20 mph from the speed limit in the other direction and go from 65 back to 45,'" people would be like "No, no. That would be a horrible policy change."

That was just to illustrate that we sort of accept the laws that we have as being optimal -- even from a consequentialist standpoint, not even just from a moral standpoint more generally, but having optimal consequences. But why should we accept that?

So you think, "Okay. The drug laws we have right now, we shouldn't legalize all of the recreational drugs, 'cause that would just be like chaos." You'd be like, "Oh, okay. Here are some other drugs that cause a lot of social harm, like alcohol," and some people would be like, "Oh, we tried that before and it was terrible." But why would we think that right now we're at the optimum when it comes to the justice of our laws?

Julia: In our correspondence before the show, you mentioned that when one is building an argument in applied ethics, you think it's fine or good to appeal to multiple different kinds of reasons. Sort of I think the way you've done in your case for the right to self-medication. You've appealed to the right to autonomy. You've also appealed to positive empirical consequences. In our pre-show correspondence, you said, "Even if those reasons are internally inconsistent," you think that's still a justifiable way to argue. I'd be curious to hear more about that.

Jessica: I'm not saying that to say I don't have my own view about what the right underlying moral theory is or what the right balance of moral reasons would be, but I don't think that when you're doing applied ethics it's a promising approach to start off and be like, "Okay. Premise One, utilitarianism is true. Premise Two, this is what's gonna maximize utility. Conclusion, we should just do it." Because if I don't accept the first premise, then your argument isn't going to in any way raise the price of my own beliefs.

I see philosophy in general, including applied ethics, as being "Yes, you want to convince people," but you also just want to engage with them where they are in a way that will raise the price of their own beliefs, so even if they don't necessarily-

Julia: When you say "the price of their beliefs," what do you mean?

Jessica: Make it so that they understand what holding their belief would require them to commit to more generally. I think it's fairly easy for people to just not question necessarily what their cluster or constellation of beliefs is, and every belief is going to have drawbacks. When you're doing applied ethics, it'd be great if people were like, "Oh, totally sold. That's the price of self-medication. I'm on board." That's like my first order thought, is that would be the best.

I also think if you are going to disagree with my conclusion, notice that disagreeing with this conclusion also has a bunch of entailments and commitments that would require much further defense, and those are undefended I think. I think that when you're doing applied ethics, you'll always have those two goals in mind. The first goal is to advance an argument for your thesis which is what you think is the correct thesis. The second goal is, well, if you're not going to be on board with my thesis, at least let me kind of show you the argument and the terrain, and show what must be done in order to discount my thesis. That's the first reason I'd do that.

The second reason I'd do that is because we haven't figured it out yet when it comes to the correct moral theory. There's still moral uncertainty. Any given person might think that they have the right moral theory, or if you're working on figuring out what the right moral theory is, but building an applied ethical case in a pluralistic foundation that appeals to several moral theories is a sort of hedge.

It's a hedge against that kind of moral uncertainty where it's, "Okay. The consequentialists, they'll have some reasons to get on board with my thesis, and the Kantians and the deontologists will have some reasons. Not everybody is gonna get with my argument all the way. Not everybody is gonna endorse full rights of self-medication; for example consequentialists will accept paternalism whenever it works, to promote well-being, whereas Kantian types won't.

But I can bring as many people as I can along with me as far as I can, and if I'm doing that, then I'm also hedging against my own kind of higher order moral uncertainty about the truth of my own kind of underlying world foundation that I think is true.

Julia: Yeah. Cool. Okay, well that's probably a good place to stop. Before I let you go Jessica, I wanted to ask you for a recommendation for our listeners of a paper or book in your field -- your subfield of, I guess, either applied or normative ethics, whichever one -- that you think is sort of a good example

of reasoning or argument. Something you'd want to represent the field to someone who isn't an expert in it.

Jessica: Well, I think that one thing that's good is to read things that you really disagree with, and I have learned a lot by reading a book that I really disagree with but I love, and it's called "Whose Body is it Anyway?" by Cecile Fabre. It's about similar topics, but she is very skeptical of having this sort of extremely strong commitment to bodily autonomy. She argues for example that something like a kidney tax could be justifiable, so in just the same way that the government taxes people's labor to redistribute from people who have a lot of economic resources, the rich to the poor, maybe the government could tax people's kidneys to redistribute from the kidney-rich or the healthy to the kidney-poor, the unhealthy people who suffer.

Julia: Wait. Is the tax paid in money, or in kidneys?

Jessica: No, it's paid in kidneys.

Julia: Oh wow! That's quite a tax.

Jessica: Yeah. Kidney confiscation. In principle, the government taxing your labor is also a tax on the use of your body that's redistributed. You might think that it's even more burdensome for somebody to give a percentage of their income depending on the percentage than to give a kidney one time, so there's no reason in principle to think that a kidney tax is going to be more burdensome than taxes.

I just love the argument, because it's really revisionist and it really challenges... It really raises the price of your belief, with respect to thinking that there's this strong presumption that you have a right to your body. And it's really well done. She has other arguments against the strong commitment to bodily rights that I hold.

So that's a fun book, and there's a paper that's based off of it too.

Julia: That's great.

Jessica: And it's on a similar set of questions and totally disagrees, but I think it's great.

Julia: Yeah. It's a good companion piece to this episode and/or your book, I think.

Jessica: I'm gonna add one more person who totally would disagree, which is: Sarah Conly has a book called "Against Autonomy," and it's just the opposite of my anti-paternalism views. It's a defense of public officials being paternalistic towards people, arguing that this kind of autonomy principle is really overblown. And I learned a lot from her book too.

I would say if you're interested in the topics I've been talking about but want to get the opposite take, and also see really good examples of philosophical argumentation and fun takes, those would be two books.

Julia: That's so great. Can I just say how much I appreciate that your picks for this episode are two books that you vehemently disagree with? That's fabulous. I really appreciate that. I've experimented in the past with asking guests to recommend books that they strongly disagree with but still like and respect, and people usually have a hard time thinking of examples, let alone volunteering them of their own accord. Thank you.

Jessica, it's been a pleasure having you on the show. Thank you so much.

Jessica: Thank you for having me. It was good talking to you.

Julia: This concludes another episode of Rationally Speaking. Join us next time for more explorations on the borderlands between reason and nonsense.