

1. Introduction

Let me start with a personal anecdote to illustrate the core example framing my subsequent discussion. I am a cis-woman in a heterosexual relationship nearing my 40s, who has never entertained the prospects of becoming a mother.¹ Sociologists understand this increasing Western trend as living a childfree life to denote those who “emphasize that childlessness can be an active and fulfilling choice” (Gillespie 2003, 123). From my earliest age onwards, living a future life that is childfree was a clear and obvious choice for me. In fact, to say that I have *chosen* this way of life is slightly misleading: I never knowingly made such a choice since I never questioned my desire to remain childfree or entertained the possibility to the contrary. Despite my lifelong conviction to remain childfree, I have consistently failed to secure a legally available voluntary sterilization. First, I was too young and might change my mind. Then I was too invested in an academic career (and might change my mind were my professional situation less precarious). There have been times when physicians have point-blank refused to discuss the matter with me. And I have been told that it would be unethical for *any* doctor to perform the sterilization as it is difficult to reverse and unnecessary medical procedure. Whether I have been covered by national health services or a private insurance policy has made no difference to the justifications offered.

My story is far from unique. Anecdotally, I have heard it many times from other childfree females in heterosexual relationships. And although there is a paucity of scientific research on this issue, a recent study by Cristina Richie (2013) for the *Hastings Center* (an independent, nonpartisan bioethics and public policy research center) echoes this. In the course of her research, Richie writes, she did not encounter a single story of a woman granted sterilization upon first request. Rather, “[e]very story I have come across has spoken to the barriers, criticism, and refusals of sterilization for childfree women” (Richie 2013, 39). Access to sterilization is “usually repeatedly denied, often by humiliating the women into giving up the request, requiring

¹ The prefix ‘cis’ denotes those who have typical gender identities and presentations. So, roughly put, it denotes women-born-female and men-born-male. This presupposes a *prima facie* distinction between gender and sex. Speakers ordinarily seem to think that ‘gender’ and ‘sex’ are coextensive: women and men are human females and males, respectively, and the former is just the politically correct way to talk about the latter. Feminists typically disagree and many have historically endorsed a sex/ gender distinction. Its standard formulation holds that ‘sex’ denotes human females and males and depends on *biological* features (chromosomes, sex organs, hormones, other physical features). Then again, ‘gender’ denotes women and men and depends on *social* factors (social roles, positions, behaviour, self-ascription) (for more, see Mikkola 2012). It is worth noting that some works cited in this paper do not consistently follow this convention and often use ‘woman’ and ‘female’ synonymously.

that they jump through procedural hoops, or second-guessing the legitimacy of the patients' desire for sterilization, despite the legal eligibility [in the US] for voluntary sterilization for any competent person twenty-one years or older" (Richie 2013, 36). By contrast, childfree males apparently encounter little to no difficulties receiving vasectomies. Although there is a lack of scientific data on vasectomies and childfree men, Richie's research found that "childfree men have almost no trouble finding a doctor to perform a vasectomy" (2013, 40). This disparity cannot be explained on clinical grounds or in terms of risk: for instance, the American College of Obstetricians and Gynecologists' Bulletin 'Benefits and Risks of Sterilization' states that both female and male sterilization are "safe and effective methods of permanent contraception" (2013, 392). Denying female sterilization on the grounds of higher risk does not then explain the disparities in refusal rates.

In this paper, I wish to examine what might explain this disparity, and suggest that it points to female patients' reduced credibility. Examining the reasons given to refuse voluntary sterilizations (especially for childless females) indicates that female patients encounter particular sorts of credibility deficits and more of the 'doctor knows best'-ethos than male patients – an ethos that conflicts with the doctrine of informed consent. In particular, I will examine my example case with Miranda Fricker's (2007) innovative recent work on epistemic injustice in mind. Fricker argues that members of structurally disadvantaged groups encounter a particular sort of injustice that harms them in their capacity as knowers: they sustain testimonial injustice.² *Prima facie* the phenomenon Fricker elucidates explicates credibility deficits encountered by childfree females. The paper investigates how plausible this is. To anticipate, my examination tells us two things: first, it points to a possible explanation of ways in which female patients in general face credibility hurdles. Although my core case will be of females seeking voluntary sterilizations, the analysis I offer should afford us theoretical resources to examine why female patients more generally are believed less about their medical conditions. This exposes ways in which medical practitioners seemingly fail to keep their (explicit and implicit) gendered normative assumptions in check. Second, my case study of female voluntary sterilizations tells us something interesting about Fricker's analysis of testimonial injustice. In short, although female patients in general conceivably sustain testimonial injustice of the kind Fricker outlines, the example of voluntary sterilization points to a subtly different way in which individuals can suffer testimonial injustice too. The injustice does not pertain to being considered less credible about one's immediate and current beliefs and desires; rather, the credibility deficit pertains to one's *future* – supposedly

² Fricker holds that members of stigmatized groups can sustain another kind of epistemic injustice too, which she calls 'hermeneutical'. My focus here will, nevertheless, be solely on the testimonial kind of epistemic injustice.

authentic – beliefs and desires. And, I contend, this future-oriented testimonial injustice is morally problematic in a different way to the presently sustained testimonial injustice.

I will first outline briefly the idea of informed consent and my example case (Section II). Next I will spell out the phenomenon of testimonial injustice (Section III). In Section IV, I will consider whether Fricker’s analysis provides a way to explain putative credibility deficits females seeking voluntary sterilizations encounter. I will end with some concluding remarks about what the discussion tells us about informed consent (Section V).

2. Refusing Sterilizations and Informed Consent

In recent decades, the medical doctrine of informed consent has become dominant and it has replaced the ‘doctor knows best’-ethos (for an introduction to the relevant debates, see Eyal 2012). The doctrine is shorthand for informed, voluntary consent given by healthcare subjects capable of making their own health care decisions. Consent is fully informed “when a capacitated (or ‘competent’) patient or research subject to whom full disclosures have been made and who understands fully all that has been disclosed, voluntarily consents to treatment or participation on this basis” (Eyal 2012, 2). Informed consent provides the legitimacy requirement for many health care decisions and justifies why certain infringements of bodily integrity are prohibited. There are a number of factors that justify informed consent, the most important for my purposes being protection against paternalism, securing doctor-patient trust and autonomy.

Looking at the case of female sterilization (and gender in medical interactions more broadly) suggests that female patients lack credibility when they attempt to make informed decisions pertaining to reproduction. Somehow they are not seen as capacitated subjects. For a start, the case of female sterilization demonstrates that female subjects are not protected from the ‘doctor knows best’-ethos. Bioethical literature in general shows that female patients in healthcare interactions are particularly vulnerable to paternalism due to gender stereotypes. For instance, doctors more readily dismiss female patients’ reports of pain (Rogers and Ballantyne 2008, 50). A live-assumption still seems to be that “expertise about women’s bodies lies with the medical profession rather than with the woman herself”, which can lead to a distrust of the woman’s own experience “in favour of the (trusted) clinician’s expertise” (Ibid., 51). Female patients encounter greater disbelief about their symptoms and they are not trusted as reliable historians about their own conditions. Physicians are frequently “patronizing, detached, disrespectful ... and unwilling to trust the reports of their women patients. Subjective experiences of illness and treatment are frequently ignored” (Dressler 1996, 147). The patronizing attitudes encountered and the lack of trust between patients and healthcare professionals generates a state of affairs, where “women do

not enter the medical encounter on an equal footing; they do not have the same status as medical subjects or as recipients of medical care as that enjoyed by men” (Rogers and Ballantyne 2008, 52). This imbalance is clearly visible when we compare the seeming ease with which childfree males can obtain vasectomies to the (often) lengthy battles that childfree females must undergo in order to obtain sterilizations.

The lack of trust in the sense of credibility is apparent in many stories pertaining to my example case. Medical professionals appear to be more knowledgeable about female subjects’ bodies and ‘authentic’ states of mind, given the oft cited reasons for refusing sterilization: one is too young or has too few children; therefore, one is likely to change one’s mind and regret the procedure in the future (Richie 2013). Reflecting this, the American College of Obstetricians and Gynecologists recommends that “[w]omen who have completed their childbearing are candidates for sterilization” (2013, 395). However, they do not specify what it means to have ‘completed childbearing’ and clinical practice clearly shows that this is not usually determined from the female patients’ point of view, but from the medical practitioners’.

Furthermore, it seems that the sort of credibility presupposed by the doctrine of informed consent is missing on the part of the female patients due to an autonomy-deficit. Beauchamp and Childress define *personal autonomy* in relation to informed consent as follows: it “encompasses, at a minimum, self-rule that is free from both controlling influences by others and from certain limitations such as an inadequate understanding that prevents meaningful choice” (Beauchamp and Childress 2008, 100–101). Females seeking voluntary sterilizations are not usually thought to be controlled by others. But they are typically thought to lack some relevant understanding about themselves that prevents their choice from being meaningful: that their future selves will probably come to regret the procedure. And so, it seems that an informed decision to voluntarily sterilize oneself is not possible because female subjects seeking the procedure are not free from *future-oriented* limitations that hamper meaningful choices here and now.

Let me pause here for a moment to discuss regret. One question pertains to empirical evidence: if females often do in fact regret voluntary sterilizations, this might provide a good justification for refusing them. After all, reversing sterilization is difficult and usually quite costly. However, it is far from clear how widespread regret is. As Richie put it, there is “a paucity of data on childfree women, sterilization, and regret, pointing to a need for research and perhaps a trial period of providing sterilization for childfree women who request it” (2013, 40). Since most voluntary sterilizations are performed on females who already have children (and who have ‘completed their childbearing’), we simply have no good empirical evidence about how many

voluntarily childfree females regret the procedure. Furthermore, the available research on regret that Richie cites dates back to the 1980s (and again looks at US-females who already have children). The social, political, and economic circumstances for females both worldwide and in the US have changed considerably since these studies. So, in order to make judgments about rates of regret, we need newer research that reflects today's gender relations and expectations. Finally, in order to make judgments about whether regret justifies refusing female sterilizations, we should compare the regret rates of childless females with those of childless males. But again the relevant research is insufficient. For one thing, the issue of male childlessness, sterilization and regret is woefully understudied. For another, the extant data on regret over vasectomies is "most often framed in terms not of the man's regret but the regret of his *female* partner" (Richie 2013, 40; italics mine). I take it that the methodological problems here are obvious and easy to spot.

There are more theoretical reasons too to find the appeal to regret insufficient. Even if some females come to regret the procedure, this does not justify the hampering of females' autonomy. First, regret is not even a *prima facie* indicator that some choice was uninformed or non-autonomous in the sense noted above. Imagine that on aesthetic grounds I prefer vintage cars. Imagine further that I know full well that such vehicles are likely to pose many technical challenges as well as to cost time, money, and effort to maintain. Nevertheless, I purchase one. If I subsequently come to regret the purchase, should we *therefore* conclude that my original purchasing-action was not autonomously undertaken, and that it did not encompass self-rule that is free of control and limitations in a manner that hampers meaningful choice? I think not. Regretting that I bought the car may simply be an indicator that I have changed my mind about what is valuable to me. Perhaps I simply no longer place such great value on the car's aesthetic features, and I have formed new views about what I generally speaking value in a car. Regret may of course go together with hampered decision-making powers. But there is no reason to take regret *per se* as an indicator of uninformed, non-autonomous choice. Conversely, I may very well undertake some course of action without being free from limitations that prevent meaningful choice: perhaps I was misled about the high maintenance costs of a vintage car. Had I known these costs, I would not have purchased the vehicle. Nonetheless, I might not regret the purchase because the car affords me other joys (like aesthetic pleasure). In short, informed decision-making is one thing and regret is another. Thus, we cannot appeal to regret *per se* to justify withholding voluntary sterilizations. In an extremely illuminating manner, Richie writes: "regret is the competent woman's burden, not the doctor's. Very few providers of other permanent elective treatments like plastic surgery refuse treatment over fear of regret. Why should sterilization be different?" (2013, 39). In fact, she notes further that other permanent surgeries,

including transitioning and plastic surgery, are available to minors. This should give us pause as to “why tubal ligations [surgical procedures in which fallopian tubes are blocked, tied or cut] are not offered to competent women of age” (Richie 2013, 39).

This all suggests that childless females of childbearing age are not seen fit to choose voluntary sterilization. They lack credibility, competence and/ or autonomous decision-making powers to make informed decisions about and to choose meaningfully some courses of action pertaining to their reproduction. Thus, voluntary sterilizations are denied them. Ironically, given intersectionality the situation for some trans* women, women of color, those occupying disadvantaged socio-economic positions as well as for women with atypical bodily functioning is precisely the opposite: they too are seemingly taken to lack credibility, competence and/ or autonomous decision-making powers, and historically these groups of women have also been denied reproductive control – but with the result of being *forced* to undergo sterilization.³ These examples point to a general pattern: those designated as women are not taken to be credible and competent to make informed decisions about their own bodies. Despite many feminist advances over the past 40 years, women still lack reproductive control.

3. Understanding Credibility Deficits

As I see it, the basic problem is as follows: childfree females requesting voluntary sterilizations encounter credibility deficits in being considered unable to make competent, informed and autonomous decisions about reproduction. But what frames and undergirds those credibility deficits? Bulk of the forthcoming discussion examines this issue as involving testimonial injustice. However, before discussing Fricker’s analysis of this phenomenon, let me briefly consider two alternative explanations. First, one could suspect that profits and Big Pharma play an explanatory role. Continued non-permanent contraception contributes to pharmaceutical companies’ profits. Were permanent options like sterilization widely available early on in females’ ‘reproductive lives’, this would eat into the profits to be made and should give pharmaceutical companies incentives to curb such permanent options. We should not underestimate the power and influence of pharmaceutical companies. For instance, in 2005 The House of Commons health committee

³ Some recent US-research suggests that African-American, Latinas and low-income women are more likely to use female sterilization than whites and women with higher incomes (after controlling for intersectionality). By contrast, for white and higher-income heterosexual couples male vasectomy is more common as a means of contraception than voluntary female sterilization. That said, there is also evidence that minority and low-income women too experience barriers to sterilization: they also report being dissuaded by healthcare professionals on the basis of being too young or having too few children (White and Potter 2014, 550).

examined the UK pharmaceutical industry and found that it “buys influence over doctors, charities, patient groups, journalists, and politicians, and whose regulation is sometimes weak or ambiguous” (Ferner 2005, 855). Whether this sort of power explains the core case that I am looking at is less clear though. In short, it does not explain the seemingly disparate degrees of difficulty that childfree females and males respectively encounter in obtaining the procedure. If profit-making considerations were overriding, pharmaceutical companies would presumably seek to maximize profits by developing profit-making non-permanent contraceptives for males too, and they might lobby against the apparent ease with which male patients are granted vasectomies. Although I am far from convinced that any ‘noble’ aims are driving the pharmaceutical industry, profit-making aims do not seem to explain what goes on in my example case.

The second alternative explanation might be straightforward stereotyping. For example, one healthcare area where a clearly disadvantageous gender difference exists pertains to diagnoses of coronary heart disease (CHD). Female patients are woefully under diagnosed for CHD even when they present identical symptoms to male patients, who are correctly diagnosed. A number of studies have established that female patients are disadvantaged in primary care relative to CHD. Whether one is female or male

has a significant influence on all four aspects of doctors’ diagnostic strategies [asking additional questions, conducting physical examination, forming possible diagnoses, conducting diagnostic tests]; in each case women receive less attention than men presenting with CHD symptoms ... Doctors would ask men more questions than women (on average 7 and 5.7 questions, respectively), and perform more extensive examinations for men than women (5.1 compared to 4.3 parts of the body or body systems would be examined, respectively). (Arber et al. 2006, 108; see also Abuful et al. 2005)

Furthermore, the patients’ gender rather than age, socio-economic status, race, or ethnicity was “the main patient characteristic systematically influencing doctors’ diagnostic behaviour regarding CHD” (Arber et al. 2006, 112). In fact, the group of women most likely to be misdiagnosed is that of midlife females whereas midlife males receive the greatest attention from doctors. This disparity in diagnostic behavior cannot be explained simply in terms of risk profiles. Although it is true that CHD is more likely to affect midlife males than midlife females, it is also true that CHD correlates with certain socio-economic classes and racialized groups. Nonetheless, studies show that “patients’ class and race did not influence doctors’ decision-processes, despite the well-known CHD risk profiles by class and race” (Arber et al. 2006, 112). What seems to undergird differences in diagnostic behavior is gender stereotyping: CHD is stereotypically seen as an illness affecting midlife males rather than midlife females, which would explain why doctors take greater

care in their diagnostic behavior when faced with midlife males presenting CHD symptoms and why they overlook CHD when midlife females present identical symptoms.

That the above misdiagnoses involve gender stereotypes strikes me as *prima facie* plausible. But stereotyping works in the CHD and my core example cases in a subtly different way. In the former case, the problem does not seem to be one of credibility deficit or that female patients are disbelieved about their symptoms. Rather, it is about *misinterpreting* those symptoms as being symptoms of something other than CHD (like indigestion). And so, my contention is that the case of voluntary sterilization of childfree women cannot be explained by simply appealing to gender stereotypes. That is, although both cases conceivably involve stereotyping, my core case involves something further that in combination with stereotyping explains the requisite credibility deficits. In order to understand such additional feature(s), Fricker's analysis of testimonial injustice looks promising.

What then is testimonial injustice? To begin with, it is an exercise of a particular type of social power: that of identity power, whose exercise depends to a significant degree upon "shared imaginative conceptions of social identity", like gender and ethnicity (Fricker 2007, 14). Such shared conceptions contain stereotypes, which Fricker understands fundamentally in a neutral manner as "*widely held associations between a given social group and one or more attributes*" (Ibid., 30; italics original). We rely on stereotypes as heuristics in testimonial exchanges in order to make spontaneous evaluations about our interlocutors' credibility. However, if the stereotype embodies a prejudice against the speaker, the exchange becomes epistemically dysfunctional and ethically bad: "the hearer makes an unduly deflated judgement of the speaker's credibility" and "the speaker is wrongfully undermined in her capacity as a knower" (Ibid., 17). Fricker discusses the example of Marge Sheerwood from the novel *Talented Mr. Ripley* to illustrate. Marge's fiancée Dickie disappears under odd circumstances and Marge (rightly) suspects that Dickie's newfound friend Tom Ripley has killed him. However, Marge's intended future father-in-law dismisses her accusations as 'women's intuition' and brands her a hysterical woman who simply cannot face her fiancée leaving her for another woman. This example demonstrates the exercise of identity power by Dickie's father in that the background assumptions framing judgments about Marge crucially turn on shared (1950s) gender norms, relations, and expectations. This diminishes Marge's status as a reliable witness and a credible knower. Despite her fiancée's philandering past, she *knew* from the cues around her that Dickie had not left her, but was dead. Still due to certain negative identity-prejudicial stereotypes about women, Marge unduly experiences a credibility deficit, and in not being recognized as a knower, she experiences testimonial injustice. That is, she is subject to:

A widely held disparaging association between a social group and one or more attributes, where this association embodies a generalization that displays some (typically, epistemically culpable) resistance to counter-evidence owing to an ethically bad affective investment. (Ibid., 35; italics original)

This renders the testimonial exchange dysfunctional in generating a credibility deficit. Fricker is careful to point out that not all prejudicial stereotypes contribute to testimonial injustice. Rather, the injustice must be systematic, not incidental. So, the injustice produced is not due to prejudice *simpliciter*, but due to “prejudices that ‘track’ the subject through different dimensions of social activity – economic, educational, professional, sexual, legal, political, religious, and so on” (Ibid., 27). Thus, the relevant type of prejudice is an identity prejudice and a negatively valenced one at that. The speaker comes to sustain a “testimonial injustice if and only if she receives a credibility deficit owing to identity prejudice in the hearer” (Ibid., 28).

Fricker’s elucidation of testimonial injustice seems nicely to explain what goes on (and wrong) in the example case that I am discussing. For a start, refusing voluntary sterilizations involves the exercise of identity power: shared gender stereotypes and conceptions about what women are like and what they want are operative. Refusals of sterilization involve biologically essentialist views about gender (perhaps coupled with views about women’s irrationality): that being a woman is essentially tied to reproduction and that at some point those with female bodies will want to fulfill their essential biological function of child-bearing. It is not uncommon for childfree females to be told that their ‘biological clocks’ are just dormant and that they will start ticking in due course. In the end, child-bearing is what women *really* want – a judgment usually made in an authoritative manner by a third party with little familiarity with the females in question. Denials of sterilization on the grounds that the female is too young or has not borne enough children reflect such social identity based stereotypes. Clearly identity power is not solely exercised by male medical practitioners. In fact, whether the practitioners are male or female is irrelevant. It is the identity of the recipient that matters: what attributes are associated with the recipient’s social group membership. And attributes conveying biologically essentialist views about reproduction are certainly associated with those designated as women.

Now, in order for this to result in systematic testimonial injustice, the stereotype must embody a prejudice against the speaker, which makes the exchange epistemically dysfunctional: the medical professional must make an unduly deflated judgment about the credibility of the childless female requesting sterilization. Further, the deflated judgment must involve an operative negative identity-prejudicial stereotype that “*displays some (typically, epistemically culpable) resistance to counter-evidence owing to an ethically bad affective investment*” (Ibid., 35). That is, resistance to counter-evidence must be a “piece of motivated irrationality”, where the motivation is ethically noxious

(Ibid., 34). The hearer is not making a mere epistemic mistake due to (say) insufficient knowledge; rather, they display an ethical flaw. Thus, instances of negative identity prejudice have “ethically bad motivation” underlying them (Ibid.), and why resistance to counter-evidence is due to an ethically bad affective investment. With respect to my example case, the situation would go as follows: medical professionals make unduly deflated credibility judgments about childfree females because attributes conveying biologically essentialist views about reproduction are associated with being a woman. Therefore, childfree females are not taken at their word about choosing a childfree life. However, if a medical practitioner denying voluntary sterilization has never encountered a voluntarily childfree female and their community only includes pronatalist females – ones whose “cultural discourses establish a template of femininity, whereby motherhood is perceived to be the cornerstone of adult femininity and the desire for motherhood and the role of mothering central to what it means to be a woman” (Gillespie 2003, 123-4) – the association and subsequent credibility deficit would be an instance of epistemic bad luck. The medical practitioner would not be epistemically or ethically culpable. I take it, however, that as a matter of fact most Western medical professionals (and people in general) have encountered cases to the contrary. Subsequently, the ‘your biological clock will start ticking’-response to a childfree female’s sterilization request does display resistance to counterevidence – and *prima facie* this resistance is grounded in a negative identity prejudice. This affords an elucidation of how female patients in my example case apparently sustain testimonial injustice, which undermines the doctrine of informed consent.⁴

4. Does Testimonial Injustice Explain Credibility Deficits?

Above I outlined ways in which my example case fits Fricker’s analysis. Closer inspection, however, shows that testimonial injustice does not explain precisely what goes on with refusals of voluntary sterilizations for childfree females. (Although there may well be other doctor-patient exchanges that testimonial injustice does explain.) First, consider the claim that the exchange must be epistemically dysfunctional in order to involve testimonial injustice: a medical practitioner must make an unduly deflated credibility judgment of a childless female. Determining whether this holds, however, is actually quite tricky since it would require knowledge about the medical practitioner’s mental states: we would need to know whether the credibility judgment was unduly. And this is difficult to pull off: since we cannot examine others’ mental states by ‘looking in’ from the outside (so to speak), we must rely on the medical practitioners’ subjective

⁴ In fact, the credibility deficit must also be ethically bad in order to count as an instance of testimonial injustice: the female patient must be wrongfully undermined in her capacity as a knower. I will not discuss this aspect here though, since nothing hangs on it for my purposes.

reports. Roughly, we must infer credibility deficits from the information subjectively reported to us. But this method is clearly fallible and it is not so easy to say when the credibility judgment is *unduly* deflated. We cannot know for certain if subjective reporting is sincere. Moreover, credibility judgments are likely to be context-sensitive, which again makes it hard to assess whether some judgment was unduly or not. Just by querying medical practitioners, we are unlikely to settle the matter. And so, it is hard to establish whether instances of my example case were epistemically dysfunctional, despite evidence that is suggestive of this.

Second, take the claim that the credibility deficit involves some ethically bad affective investment. In many, perhaps most, medical interactions such bad motivations are conceivably absent. Or, rather: whether the credibility deficit turns on ethically bad investment is far from easy to determine. This is because instances of reduced credibility are likely to involve implicit attitudes and bias. And so, medical practitioners may make unduly deflated credibility judgments without this being transparent to them and without the judgments involving bad ethical investment. After all, stereotypes can influence our interactions with others in subtle and hard-to-detect ways. One such influence is implicit bias:

An individual harbors an implicit bias against some stigmatized group (G), when she has automatic cognitive or affective associations between (her concept of) G and some negative property (P) or stereotypical trait (T), which are accessible and can be operative in influencing judgment and behavior without the conscious awareness of the agent. (Holroyd 2012, 275)

Implicit bias affects the way we perceive, evaluate and interact with people from the groups that our bias “targets”. Importantly, even those who explicitly and sincerely express egalitarian views tend to hold implicit biases; and those from targeted groups tend to have implicit biases against others of their group (for instance, women can be implicitly biased against other women). Further, implicit biases are *not* subject to rational revision, directly under our control or attitudes that agents can introspectively access. Their existence has been amply documented and there is nothing *prima facie* mysterious about implicit bias. Social psychological research on implicit attitudes relies on and is an extension of an established cognitive science principle that “knowledge is organized in memory in the form of semantic associations that are derived from personal experiences as well as normative procedures and roles” (Jost et al. 2009, 43). Implicit bias works via automatic associative links in memory that are rendered meaningful partly, but in an influential manner, by shared cultural stereotypes. And these automatic associations tend to

occur even when the subjects *explicitly* reject the stereotypes and despite their explicit good intentions to avoid acting in prejudicial ways (Ibid., 60).⁵

Medical practitioners may explicitly renounce biologically essentialist stereotypes about women that are apparent in my example case. But given that such stereotypes are prevalent, public and resilient, it would be highly unlikely that medical practitioners are absolutely unaffected by them and that they harbor no implicit gender biases. After all, implicit biases are ubiquitous and they affect all human subjects – therefore, we have no reason to think that medical practitioners (*qua* human) are beyond their influence. It is very much an open question though whether being influenced by implicit bias is a culpable error (see e.g. Holroyd 2012; Saul 2012; Washington and Kelly forthcoming). *Prima facie* culpability requires awareness, knowledge and control. We do not usually hold those coerced to do something or children culpable precisely because they could not have acted otherwise or could not have known better, respectively. Making good the point that resistance to counter-evidence is due to bad motivations on the part of the medical professionals is not straightforward because it is far from settled that those harboring and being influenced by implicit biases are generally moved by ‘motivated irrationality’. After all, even those who explicitly and sincerely express egalitarian attitudes tend to harbor implicit biases, which raises a question about authenticity: which set of attitudes (the explicit or the implicit) is really the agent’s own? Moreover, since those from targeted groups tend to have implicit biases against others of their group, holding that harboring implicit biases is a manifestation of ethically bad investment would unduly lay blame on the victims – it would lay blame on members of groups that implicit biases typically target. Given that implicit attitudes develop early on in childhood and we cannot usually exercise conscious control over their

⁵ We can also think about implicit bias in terms of schemas (Valian 1999): we use various schemas as cognitive tools to categorize the world around us, which renders our environment and experiences intelligible to us. To illustrate: we have various schemas, including gender- and professional-schemas, which encode common stereotypes about women, men and practitioners of certain professions. Given the current state of academic philosophy, for example, it is conceivable that the male gender-schema coincides with the general philosopher-schema. This may, then, explain why women in professional settings are often automatically assumed to be part of the administrative staff or to occupy junior positions: the woman- and philosopher-schemas clash (Haslanger 2009). Tamar Szabo Gendler’s (2008) notion of *alief* provides another way to think about implicit bias. Aliefs are mental states distinct from beliefs and desires. They are associative, automatic, arational, antecedent to other cognitive attitudes, affect-laden and action generating. Social distancing provides a plausible example of an alief in action. An example would be someone unconsciously holding on to their handbag more tightly when entering an elevator with a black male, despite self-proclaimed egalitarian beliefs. Such instinctual behaviour seemingly demonstrates an activated associative, automatic, affect-laden mental state (‘black male, thief, danger!’), which is action generating (one holds onto the bag more tightly).

development, holding members of stigmatized groups culpable would be strategically the wrong course of action when aiming for social justice. Finally, the ubiquity of implicit attitudes undermines the idea that *anyone* influenced by them is culpable. Bluntly put: if we are all culpable for some x , then no one in particular is (Young 2011). It will be difficult to make bad ethical investment ‘stick’, if this is a default human condition. The upshot of the discussion is: apparent credibility deficits cannot be elucidated by testimonial injustice in Fricker’s sense if we cannot make good the claim that they involve some ethically bad affective investment. And if implicit gender bias is doing much of the work, the prospects of making good this move look poor.⁶

The final difficulty with applying Fricker’s picture to my example case pertains to the sort of information conveyed, which (putative) judgments of diminished credibility track. In Fricker’s central case of testimonial injustice, the speaker aims to convey some piece of information, but the hearer disbelieves the speaker on the grounds that they are not a credible witness or knower. Marge Sheerwood *knew* from the cues around her that Dickie was dead (she possessed a piece of knowledge), but her intended future father-in-law disbelieved Marge (according to him, Marge was relying on ‘women’s intuition’ rather than facts). Now, this sort of situation is deeply problematic for sure and I have no doubts that analogous, epistemically dysfunctional medical exchanges take place. But the sort of dysfunction in cases of childfree females being denied sterilizations is subtly different in an illuminating manner. It is not that the medical practitioners discount the females’ testimonies about what they at present will (a desire to lead a childfree life). What they discount is the females’ testimonies about what their *future selves* will want. That is, the piece of knowledge that is being discredited pertains to what someone’s future self will want – and relative to this, medical professionals view themselves as more authoritative than the affected individuals. My contention is that this renders credibility deficits that make use of stereotypes as heuristics in testimonial exchanges even more perverted. As Fricker puts it, in testimonial exchanges the hearer may not possess a wealth of personal knowledge about the speaker. Thus, credibility judgments must “reflect some kind of social generalization about the epistemic trustworthiness – the competence and sincerity – of people of the speaker’s social type” (Fricker 2007, 32). This seems to hit the mark in my example case: childfree females must repeat their sterilization requests time and again, which suggests that they are viewed as epistemically untrustworthy. But it strikes me as particularly insulting for a stranger to make authoritative knowledge claims about an individual’s *future* mental states with the use of quick and dirty

⁶ There is a further complication: showing that medical practitioners are influenced by implicit gender bias is one thing; but showing that *this influence* is operative when they make unduly deflated credibility judgements is another. Although clinical practice *prima facie* supports this hypothesis, proving the point would require careful social psychological experimentation.

stereotypical heuristics. It is one thing for someone to disbelieve me here and now; but it is another for someone to think that they know better what I will (really) want in the future simply due to cultural stereotypes and not based on any familiarity with me, my history, or life circumstances.

Considering the subtlety of my example case does not undermine Fricker's overall picture. However, I think that it points to a type of case that Fricker misses in her analysis of testimonial injustice. Credibility deficits do not pertain merely to immediate testimonies of wishes and beliefs. Rather, my example points to another pernicious phenomenon: credibility deficits relative to one's *truly authentic and dormant* wishes and desires. This is pernicious in two ways. First, that medical practitioners are presumed to be 'experts' and more authoritative of the healthcare subjects' (supposed) authentic desires and wishes. Second, that medical professionals are buying into the idea of there being true, authentic, and yet dormant patient-desires of this kind to begin with. This is what medical exchanges denying childfree females sterilization seemingly involve: every woman's authentic true desire is ultimately to fulfill their childbearing function. Since this true desire is still dormant (the clock is still ticking), females' current and misguided wishes and beliefs may be discounted by some 'experts' on female reproduction. Richie's recent informative research on voluntary sterilizations indirectly confirms this. Her report includes advice for females seeking sterilization, which is instructive. They should be

prepared to give a particularly strong defense for seeking this form of birth control. Simply stating, 'I don't want kids,' is likely to be insufficient. Rather, detailing the constant, unchangeable reasons for not wanting children—for example, the physical strain of pregnancy, the irreversible environmental and financial impact of having children, a commitment that is at a minimum eighteen years long—may make the motivation for sterilization seem more understandable. (Richie 2013, 43)

These are all future-oriented reasons and (in my terms) are aimed at convincing medical professionals that females' current desires and wishes are in line and consistent with those of their future selves. Since males' truly authentic desires seemingly do not include fulfilling the reproductive begetting function, their current desire for a vasectomy poses no obstacles to trustworthiness.

One might object that since becoming a parent is a paradigm transformative experience, this justifies discarding childfree females' requests for voluntary sterilization. Transformative experiences are ones that fundamentally change the persons undergoing them, and in ways that they could not have anticipated prior to the experience (Paul 2014). For instance, if a previously childfree female undergoes such a transformative experience by becoming a mother, this might

change them so profoundly that they come to see their earlier desire for a voluntary sterilization as misguided. And (the objection goes) since becoming a parent is such an unimaginable transformative experience, medical professionals should refrain from providing voluntary sterilizations. This objection faces a number of problems though. First, even women who *have* undergone this supposedly transformative experience are often denied voluntary sterilizations, and on the grounds that they have had too few children. But if medical professionals are simply being prudent and basing their judgments on the *possibility* to undergo such a transformative experience, denying females who have undergone the experience sterilizations looks puzzling. Second, I take it that becoming a parent is equally transformative for both male and female subjects. But if medical practitioners are safeguarding females' transformative future experiences of possible parenting, why are they not prudently doing the same for male subjects? If medical professionals are keener to safeguard such potential future transformative experiences for females, this again demonstrates that some biologically essentialist biases are at work in their decisions. Finally, my aim in this paper is to explain apparent disparities in actual clinical practice. But appealing to transformative experiences does not bear on explaining this state of affairs; it pertains on normative arguments about the permissibility of voluntary sterilization *per se*. That is, if parenting is such a transformative experience, this is something to consider when thinking about whether sterilization (male or female) should be available. Whatever we think about this normative issue, the fact is that voluntary sterilization is legal and in principle available to all competent adults. Clinical practice nonetheless suggests that some adults are considered to be more competent than others, and this is what I seek to explain here. Appealing to parenting as a transformative experience does not aid this explanatory task though.

5. Concluding Remarks

In this paper, I have discussed childfree females seeking voluntary sterilizations in order to highlight how certain credibility deficits undergird females' lack of reproductive and bodily control. The sort of control and bodily self-determination at issue are typically presupposed by the doctrine of informed consent. But if implicit attitudes and biases non-transparently and unwittingly lead to paternalism and autonomy-deficits in medical exchanges, informed consent is undermined. One might of course retort that paternalism is an unfortunate and incidental aspect of healthcare practice. This leaves the doctrine of informed consent intact; the fault lies with medical practitioners who fail to comply and impose paternalistic restrictions on (say) female reproduction. But I think that the above discussion points to some difficulties that we should take more seriously in formulating the doctrine: due to implicit attitudes and biases, medical

professionals may act paternalistically without this being apparent to them and with them genuinely thinking that they have acted in line with the doctrine. There is much more to say about this issue and I can here simply offer some sketchy remarks. Still thinking about this issue with an account of informed consent formulated by Neil Manson and Onora O'Neill (2007) is instructive. Manson and O'Neill articulate two ways to understand informed consent. First, the conduit/container model takes (a) the healthcare practitioner (b) to transfer some piece of information (c) to the patient/subject. But this way of thinking about the information exchange misses something that goes on in communicative exchanges. As Manson and O'Neill put it, informative communication only succeeds

within a rich practical and normative framework in which speaker and audience (a) *have* certain practical and cognitive commitments; (b) *know something of each other's* cognitive and practical commitments; (c) *adhere* to, and act in accordance with, relevant communicative, epistemic, and ethical norms; (d) *assume that* the other party is acting in accordance with such norms. (Manson & O'Neill 2007, 40)

The conduit/container model hides these dynamic, reciprocal and essential aspects of communication in general. Manson and O'Neill rather advocate an agent-based model that incorporates the rich practical and normative frameworks noted above. So, in thinking about informed consent, we should remember that agents have various practical and cognitive commitments and that communication aims (in part) to realize these commitments. Communicative success hinges on various (often non-explicit) shared practical and cognitive norms and inferential competencies. These include norms needed for speech acts to (1) be "accessible and relevant to intended audiences (e.g., *intelligibility, relevance*)" and (2) be "adequately accurate and assessable by intended audiences (e.g., *not lying, deceiving or manipulating; aiming for accuracy*)" (Manson & O'Neill 2007, 64).

Thinking about informed consent and what goes wrong in my example case with the agent-based account tells us something important not merely about sterilization, but also about informed consent. First, the dynamic nature of communication can account for communication failures due to credibility deficits. For one thing, we can make sense of this in terms of a mismatch of speaker and hearer practical and normative frameworks (a-d above). Second, my example case points to a further aspect pertaining to informed decision-making. In voluntary sterilization requests, the communication flows in the opposite direction: (a) the patient/subject intends (b) to transfer a piece of information about themselves (c) to the healthcare practitioner. Now, in thinking about informed healthcare decisions we must also take this direction of communication into account. That is, when we take the dynamic model of communication

seriously, our elucidation of informed consent should bear in mind that it is a wider phenomenon than just a healthcare professional informing a patient about some procedure. For the communicative exchange to be complete, the patient must communicate their informed decisions to the medical professional. After all, consent is fully informed “when a capacitated (or ‘competent’) patient or research subject to whom full disclosures have been made and who understands fully all that has been disclosed, *voluntarily consents* to treatment or participation on this basis” (Eyal 2012, 2; italics mine). This part of the exchange is not trivial precisely due to intransparent and non-conscious cognitive mechanisms that have significant effects on human interaction. Bluntly put, the patient must understand the doctor, but the doctor must *also* genuinely listen to the patient and view them as a capacitated subject. If this is hindered by implicit biases and stereotyping, we may unduly be viewed as incapable of voluntarily consenting to some procedures. This is what seemingly goes on in my example case. The upshot is that when thinking about informed consent and autonomy conditions in bioethics, we should take the influence of implicit attitudes much more seriously.

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