Philosophers Talk Back to Anthropologists

Kal Alston
University of Illinois at Urbana-Champaign

I was taught to be a tough interlocutor at the feet of my professors at the University of Chicago — one of whom delivered this year's Kneller Lecture. We were to learn, through modeling, not to be intellectually passive receptacles but to question and to contest. This response is intended as a demonstration of the skills so taught and of the intellectual spirit so developed.

By ascribing moral disgust to either Western feelings of moral superiority or identity politics, Richard Shweder sidesteps what he claims to want to argue for: pluralistic moral sensitivity. He, in the cases he cites, gives us precisely the most hysterical readings possible. If we believe his *intellectual* disgust at the way that "identity politics" distort the reports of complex social and moral relations, then I am the last person in the Society who ought to be his respondent. I do not accept that. I believe that my students in the Introduction to Women's Studies would testify (or complain) that although I encourage them to read gender and sex ideologies critically, I do not tell them what conclusions to *reach* — even about social facts that are "obvious" to them — like skinny models in ads *cause* eating disorders — much less about practices from which they are very distant. Yet I am not neutral and objective; and I believe that I can simultaneously withhold judgment long enough to admit of the complexity of a problem and to recognize ideological formations that may obstruct my view and the articulation of the phenomenon. This self-diagnosis explains why, perhaps, I am a philosopher and not a social scientist. I attribute this ability to my father's lifelong, divinity-school-style model of the morally invested educator and to my education at the University of Chicago.

Shweder sets both his examples up disingenuously. If FGM and syphilis are not (*bodily*) enough to creep out a bunch of philosophers, I don't know what is. But while I know people who have reacted the way that Shweder describes — those *reactions* are not the only possible source of negative social and moral judgments. Shweder succeeded in doing something I learned about at Chicago — using stories to make the strange familiar and the familiar strange. We are already set up to feel outraged by the cases, then to be guided by him to understand those "feelings" as unjustified because of our historical, cultural, or geographic distance.

Here are two examples of how Shweder problematically sets us up:

First, by connecting Bush to the "universalistic" stance, Shweder guarantees that many people in the room — in light of current world events — will necessarily distance themselves from it. Shweder gives us *reasons* to be suspicious of this first goal (which he calls moral progress, but which I think he has mostly positioned as moral *convergence*) and *reasons* for us to be annoyed by Posner's brand of relativism. But the third path, Shweder's, is not, however, well illuminated by his choice of examples.

On FMG or What's Wrong with Pamela Anderson's Breasts?

Shweder cautions us to abandon "moral horror" as a knee-jerk response to these practices. Yet he himself gives us the most fraught description of "anti-FGM activists groups" by suggesting that the only force for being against such practices is being *convinced of the monstrousness of African parents*, wishing to strip mothers of legitimate parental authority and a sense of Western moral superiority. So he invokes Western (read white) liberal guilt. He makes a set of empirical claims that are not agreed to by organizations like the WHO and Amnesty International — who by the way include their own African women's testimony on both sides and make *distinctions* between four kinds of genital modifications and condemn the most extreme. Tradition is no guarantee of moral sufficiency. I think it is simply wrong to suggest that no Western women are capable of recognizing violence against women who live differently from them, or that people, wherever they live, cannot be *educated* and socialized to accept practices that may be inimical to their well-being. That's the way hegemony and ideology work to reinforce power relations without the necessity of physical force. We in the U.S. don't give parents 100% medical latitude over their children — where there is perceived to be a compelling state interest to the contrary.

Second, the continued existence and valorization of a practice in the face of resistance and/or criticism is not itself morally persuasive. For the same reasons that it makes sense to interrogate our responses of disgust, we ought to subject practices *and their justifications* to interrogation.

Tuskegee or the (White Man's) Burdened Populations

Shweder selects this study to justify a repudiation of IRB (which, by the way, he doesn't really do). Tuskegee may be one study that is often cited to talk about informed consent, if it is true, but it is *not* the only study. So even if the benign reading of the study could be shown to be true, I remain unconvinced that university and/or federal support should be given for research that has no regard for human subjects.

I will not do a point by point refutation of the points Shweder raises, but I think it is interesting that he begins with the unveiling of his *own* ignorance — his presumption that the Tuskegee subjects had been *infected* with syphilis by the government. I don't know when I was first made aware of Tuskegee, but I *never* was taught that uninfected people were infected. Although this belief is prevalent, the fact that it is false does not negate the negative moral and social effects of this study. Yet, the concept of informed consent was taught to me with Tuskegee as *one* of several examples of failure. For several reasons:

First, "forty years." They followed these men for forty years and never told them that they were not in fact being treated for "bad blood." The *U.S. Public Health Service* (not Tuskegee) began the study — to last *six months*, not forty years. It is true that the men in the study received free medical care and burial insurance, but they were never given the choice to opt out. Nurse Rivers and Dr. Dibble were added at the insistence of the head of Tuskegee — because the study was originally intended to show the *need* for funding treatment programs during the Depression.

After the first major paper was published, local physicians were asked not to treat men in the study and they decided to follow the men until death. Nineteen children were affected.

Second, our pluralist Mr. Shweder wants to strip the "racist" label from the study because of the participation of African Americans. At the same time he wants us to seriously consider the *local* nature of morality. Well, twentieth-century Alabama is not so removed from us in time or space that we cannot recognize that it (whether in the place of Macon County in 1932 or 1962 — remember Birmingham's Dynamite Hill and the four little girls killed there) was built on, sustained by, and proud of its racism as a guiding principle. This recognition is not based on a conspiracy theory about government-sponsored infection but on the social and moral realities surrounding the selection of *only* poor African American men as subjects — a context in which they were a "burdened" population. If the best thing we can say is that *only* 28 of them *died* from syphilis itself (although up to another 100 died of complications so related) the justification for forty years of silence *with* or *without* the cooperation of Black medical professionals is weak. The expendability of these men and their families should not come as a surprise to any student of the local morality. That the uncovering of Tuskegee contributed to the IRB system seems to be less a case of universalistic moral judgments than a recognition of specific wrongs in a specific location.

The legacy of Tuskegee goes far beyond 28 dead men to a legacy of mistrust and paranoia about governmental and medical establishments that has contributed to the reluctance of many African Americans to go to doctors for diagnosis of now-treatable illnesses like diabetes and hypertension as well as to the significantly higher mortality rate of African American women from breast and cervical cancer.

I do not concede that I must believe in some peculiarly liberal notion of moral *progress* or convergence in order to connect moral problems (near and far) to attempts (even if flawed) to avoid making the same errors again — in ways that may or may not have immoral intents but do have harmful moral effects.