The Decision to Know: Pregnancy and Epistemic Harm

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> *Knowledge seeking processes and its product are inextricably linked. Knowledge is a human creation and can only be as good as the efforts that go into attaining it.*
>
> *—Lorraine Code*

There is a sense in which the solution to the question ‘Should we pursue knowledge of *x*?’ might strike us as an easy one. Knowledge has been, and continues to be, understood as both intrinsically and extrinsically valuable, not just in the context of philosophy, but likewise in the context of our everyday lives. In what follows, I will challenge the inclination to assert a positive response to the aforementioned question without careful consideration of what ‘knowledge of *x*’ amounts to in the context of our deeply relevant, though often ignored, subjective life-circumstances. I will argue that, in some cases (and in one fully fleshed-out example in particular) pursuing knowledge is not always advisable. In cases like these, consideration of what I call ‘epistemic harms’ will be paramount in a decision of whether or not to pursue certain kinds of knowledge, and, additionally, that we can begin to develop a notion of wisdom as an epistemic virtue which will help guide us in these considerations.

With attention to both the subjective features of the knower and the object of knowledge which, according to Alcoff, are only available to us through a thick account of the circumstances, we shall see that there exist instances where we are better off not knowing, and, furthermore, that we require the epistemic virtue of wisdom in discerning when it is appropriate to pursue knowledge and when doing so may cause undue harm (2000).

In the narrative that follows, I recount my own experience with a pregnancy that was misidentified as high-risk. I hope that in sharing this account it will become evident that considerations of the circumstances of both the subject and the object of knowledge can impact whether it would be wise to pursue such information.

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Our case begins with a procedure that has become a greatly anticipated event in most women's pregnancies—the 20-week ultrasound. As I watched the screen breathlessly during the exam, 20 weeks into my first pregnancy, counting every wiggle, trying to discern the different body parts recognizable to me, the narration from the ultrasound technician slowly tapered, until finally the room was silent with the exception of deafening mouse clicks freezing and unfreezing images on the screen. I looked from the wand on my belly, to the screen, to the technician, and back again, reading appropriate worry from each. Finally, the technician excused herself to summon the doctor. The doctor, one I had not yet met, took his position at the machine and ran the wand over and along my swollen abdomen, without a single word. He shut off the machine and began, "well, here is what concerns us …."

This *ordinary* level-three ultrasound had revealed three markers of Down syndrome. The markers detected included a thick nuchal fold, an echogenic bowel, and choroid plexus cysts, all of which were conditions that, up until that point, I had never heard of. I was told that, alone, these markers didn't indicate any problem with my baby, but together, they increased the likelihood of having a baby with Down syndrome quite dramatically. Because I was so young, I had not elected to do any of the screening tests for genetic defects earlier in the pregnancy, but now I was urged to have my blood drawn in order to discern the likelihood of Down syndrome from yet another measure. I hastily agreed. Everything that day happened so quickly. In less than half an hour I went from a hushed, expectant anticipation in the waiting room to unrestrained sobbing in the exam room. I quickly submitted to taking tests I had actively chosen not to take just weeks prior (decisions made mainly based on how low risk this pregnancy *should* have been, and had been understood to be). Before I knew it I was in the car on the way home trying to decide what to tell my friends and family—whom to tell, even.

The 20-week ultrasound has become an assumed, if not required, diagnostic test in pregnancy. It is used to detect structural abnormalities of the fetus, the position of the placenta, and a myriad of other details about the pregnancy that are not discernable from the exterior of a woman's womb. They have been, for the most part, embraced by women as a chance to have a visual manifestation of their fetus, even in uncomplicated pregnancies (they are even performed commercially for this purpose!).

They are performed at 20 weeks—late enough so that measures of fetal growth and placental position are at least moderately relevant for projections of how the remainder of the pregnancy and labor will go—and early enough that, if abnormalities are detected, something can still be done about them. Here, the expression 'to do something' means to do further testing on the mother and the fetus, and, in some cases, to actually perform surgery on the fetus, to prepare for surgery after birth, to prepare the family for dealing with whatever abnormality has been detected, or to terminate the pregnancy. Such ultrasounds, however, are rarely pitched to women in this way—that is, if they are pitched at all.

There are some general worries about the use of ultrasound technology in pregnancy which are worthy of mention here. Indeed, they play a central role in how doctors can be assumed to become the best knowers and protectors of the fetus during pregnancy, and how mothers can become irrelevant or even an interference. These worries concern what the use of ultrasound does to our ideas, as a society, about the woman and the fetus, as well as what it does to the budding relationship between mother and baby. Ultrasounds turn the mother into something to be looked *through* in order to access information about the fetus. Ultrasound technology works by making the mother invisible in order to come to know things about the fetus. This fact subsequently results in an understanding of the fetus as extractable from, or independent of, the mother (Rothman 1993; Hilden 1996). Depicting fetuses themselves as somehow isolatable from the context in or conditions under which they live is understandably troubling and not only influences the relationship a mother has to her unborn child, but likewise has affected the way onlookers, whether family or society as a whole, come to understand pregnancy in general.

This worry should remind us of the urgings of Alcoff and Code: To take into account the situatedness of the knower and the object of knowledge. In this case, the situatedness of the object of knowledge is absolutely unique. According to Hilden, ignoring the location of the fetus, the status of being within another human being, leads to misinformed perceptions about the status of the fetus in society (1996). As a result of this kind of thinking, women can begin to consider the experience of seeing their fetus on the screen as somehow more enlightening and more meaningful than the *ordinary* experiences of pregnancy, the experiences available only *to her*—experiences which produce knowledge others can acquire only *from* her. So, here it is the relevant features of the object of knowledge which, when ignored, misguide us in the kinds of beliefs we develop about pregnancy.

In her essay, "Taking Subjectivity into Account," Lorraine Code argues that relevant factors concerning a subject's situatedness, such as race, class, or gender, ought to be considered in any investigation of what the subject can or cannot rightly be said to know. She writes, "conditions that hold for any knower, regardless of her or his identity, interests, and circumstances, in other words of her or his subjectivity—could conceivably be discovered only for a narrow range of artificially isolated and purified empirical knowledge claims, which might be paradigmatic by fiat, but are unlikely so 'in fact'" (Code 1996: 191). She argues for what she calls an "epistemology of everyday lives" and urges that we turn away from artificially sterilized models of knowledge that steer clear of what she takes to be the highly relevant circumstances of located knowers (Code 1996: 192).

Thus, she begins her own account of epistemology with a particular focus on the social dimension. This position is launched via an assault on traditional "*s* knows that *p*" epistemologies for their (often implicit) assumption that '*s*' and '*p*' are merely place holders which can be replaced by any *s* or any *p*, and maintain efficacy. When you begin to scrutinize the kinds of things you substitute for *s* and *p*, however, such a schema loses its capacity to represent many (most) natural knowledge claims. According to her interpretation of such approaches to representing knowledge claims, it follows that: "If one cannot transcend subjectivity and particularities of its 'locations,' then there is no knowledge worth analyzing" (192). Only a narrow subset of human knowledge claims, according to Code, can be isolated and analyzed by an epistemology which does not attend to the subjectivity of the knower.

It is Code's contention that, "the ideal objectivity of the universal knower is neither possible nor desirable, a realistic commitment to achieving empirical adequacy that engages in situated analyses of the subjectivities of both the knower and (where appropriate) the known is both desirable and possible … Objectivity requires taking subjectivity into account" (206). So, for an inquiry to be proper, it needs to consider the subjectivity of what is known and who is knowing it.

Here there is a real worry about potentially undermining the exclusive access a woman has to the pregnancy—as the sole person actually experiencing the *being pregnant*. There are many things that are available only to the woman, or via a direct examination of or conversation with the woman; for example, the woman typically feels the activity or movement of the fetus and can both describe and, if necessary "log" this information for the provider. How engaged the fetus is in (how far its head has dropped into) the pelvis can be determined externally as well. When the woman or the doctor encounter uncertainty, ultrasound could be turned to, rather, as a second option. This raises the question of what women can rightly be said to know about their own pregnancy. Again, I do not postulate a mysterious "sixth sense" that pregnant women have access too. What they do have access to it the experience of being pregnant with that child, and for this reason their exclusive access brings something to the table.

In weighing the issues that arise from the use of ultrasound technology in pregnancy, Barbara Katz Rothman writes,

> The doctor sits between mother and fetus. He turns away from the mother to examine the baby. Even the heartbeat is heard over a speaker removed from the woman's body. The technology that makes the baby/fetus more "visible" renders the woman *invisible* … The direct relationship to the baby within them, the fetus as part of their bodies, is superceded by the relationship with the fetus on the screen. The television image becomes more real than the fetus within; it is that image to which they "bond"; it is that image they hold in their minds as they feel their babies move. ("Tentative Pregnancy" 113)

The way in which an ultrasound is traditionally interpreted as a bonding experience is quite baffling when viewed in this light. In a sense, the child has never been further away from its mother than it is at the moment of an ultrasound!

In addition to what we have thus far encountered, there are worries raised by ultrasound use in pregnancy that are likewise relevant to this investigation. For example, ultrasounds have become so commonplace they are virtually unquestioned by mothers and health care personnel. Rarely do women elect *not* to have ultrasounds, and when they do, they often face opposition from their doctors or midwives. In all of the pregnancies and labors that turn out to be uncomplicated, these ultrasounds are unnecessary. Of course, it is impossible to know for certain that an ultrasound examination *will be* unnecessary beforehand; however, the decision of whether or not to perform one should always be left up to the mother, in the form of a genuine decision, not merely in having the (unknown) right to refuse the procedure.

Giving the pregnant woman this choice validates the authority she has to make decisions about her own body and her own pregnancy and allows her the opportunity to consider how valuable information about the fetus available through ultrasound is *to her*. Denying her the opportunity to make an overt decision about whether to have an ultrasound unduly privileges the kind of knowledge available through this technology, and, likewise, the doctor's desires, leanings, and interests over the mother's. Here it is attention to the subjective features of the *subject*, rather than the object of knowledge that is relevant. For some women, this information may be highly valuable; for others, not so, and for most, a chance to pause and pose this question to themselves will uncover that they hadn't yet given it adequate attention.

A further concern which urges us to push along in our narrative account is that ultrasound technology, though highly advanced, is *not* always a diagnostic tool; it, in this case and many others like it, is merely investigative. When an ultrasound reveals something unusual, the only course of action indicated is to *do more*. This point will be returned to later on.

Such was the case in my experience. Because the ultrasound indicated a *likelihood* of Down syndrome, the next step was to determine whether or not the baby was indeed affected. The only way to determine this with any degree of precision was via amniocentesis. After scheduling both an amniocentesis and a genetic counseling session (although my partner was not the genetic parent of the child), I came home to a freshly painted nursery, a box containing a crib intended to be built that weekend, even a significantly marked up book of baby names. I decided not to talk names. I decided not to put together the crib. I decided to tell people about the amniocentesis, and, if the test came back positive for Down syndrome *and* I decided to terminate the pregnancy, that I would tell my friends and family that I miscarried as a result of the amniocentesis. My (ironically) prolife partner suddenly started saying things like "I will support you if you decide to have an abortion," and "we can do this again—if we have to." I was horrified with her change in stance. Rothman writes, "seeking and waiting for information changes the pre-information stage of pregnancy, creates what I think of as a 'tentative pregnancy.' It incorporates the issue of abortion right into the route to motherhood and institutionalizes the conditionality in motherly love" ("Tentative Pregnancy" 1993: 85).

The talk of abortion, though, was set in motion prior to the comments my partner made to me. It started with the doctor who spoke with me right after my ultrasound. She came in to "explain" the findings of the doctor who oversaw the ultrasound. Terminating the pregnancy hadn't even crossed my mind until she indicated it as an option for dealing with a positive result from the amniocentesis, saying "we can take care of that for you too." "A one-stop shop," I thought to myself. My life was immediately put on hold by what I had learned (which, mind you, was not much of anything at all). All of my planning, all of my excitement became sour. I went from talking about "when the baby comes" to "if the baby comes." I went from collecting items for the baby to collecting receipts for the items we already had. I went from worrying about changing diapers to worrying about changing diapers for a lifetime. This expectant, paused state of being is precisely what Rothman means by the tentative pregnancy. Rothman believes that the practice of amniocentesis for genetic screening puts mothers and families into a detached and wary relationship with their developing fetus, a relationship characterized by a sense of unease and uncertainty.

This kind of relationship can cause a woman to experience some of the most exciting happenings of a pregnancy, such as the fetus's first felt kick, in a markedly different way than women not waiting for results from an amniocentesis to come in ("Tentative Pregnancy" 1993: 85).

The decision to have an amniocentesis and the related decision of whether or not to terminate the pregnancy if the results were positive collapsed into one for me. I barely thought about the amniocentesis. I barely thought about turning down an invasive, risky, and painful procedure, even after my blood tests returned indicating a much lower chance of any problems with the baby than that indicated by the ultrasound results. There seemed to be, however, no question of whether or not to proceed in collecting information. I needed *confirmation*. I don't know where this need came from, as I certainly hadn't felt it a week prior! Similarly, there was seemingly no question for the doctors or the genetic counselors I spoke with. I would have the test done.

The urgent and obvious nature of the affirmative answer to the first question of whether or not to have further testing done is indicative of the way in which a compulsion toward knowledge has influenced the medical management of pregnancy. The question of the value of knowing versus not knowing information about a pregnancy that is available through medical means is, in many ways, assumed to be answered by the medical establishment, and, predictably, answered in favor of the value of knowledge. This is a central issue to our discussion, and we will return to it toward the end of this chapter.

When I finally began to separate the two questions, one about amniocentesis and the other about termination, and turn to a consideration of the latter, it seemed that to others that decision, too, was an obvious one. To my partner, to my sisters, even to my own mother, the event of a positive result was the same as an affirmative answer to the question of whether or not to terminate the pregnancy. I had (excitedly) considered the fetus to be "my baby" up to that point. Suddenly, I was back to talking about "the pregnancy" instead of the baby—the kind of talk that characterized discussions before conception. I began to portray my experiences in light of this new way of talking, this new information—or lack thereof. Rothman writes, "The problem, or one of the problems, with the technology of amniocentesis and selective abortion is what it does to us, to mothers and to fathers and to families. It sets up a contradiction in definitions. It asks women to accept their pregnancies and their babies, to take care of the babies within them, and yet be willing to abort them" ("Tentative Pregnancy" 1993: 6).

For me, the appointments for genetic counseling and the amniocentesis coincided. I met with the genetic counselor, who took a family history (again, Down syndrome *is rarely* hereditary) and advised me to have the amniocentesis. Ultrasound is used while performing amniocentesis so the doctor can discern the best place to insert the needle and draw fluid with respect to the position of the baby and the placenta. The doctor chose, in our case, to push the needle directly through the placenta to draw fluid. This decision made the procedure more difficult and riskier. During the procedure, I watched the baby squirm and wriggle on the television screen. I watched the needle penetrate her sanctuary; I jokingly postulated that she disliked this. They finished the procedure by switching the machine to its three-dimensional mode and printing a picture of the baby. They told me it was a girl. Following the amniocentesis, the doctor recommended that we schedule a subsequent ultrasound to determine whether or not the choroid plexus cysts had resolved themselves. These, I was told, could pose problems in their own right. Several days later, I received a phone call from the genetic counselor. The baby did not have Down syndrome, nor any of the other genetic abnormalities detectable from the tests involving amniotic fluid. That evening, I finally chose a name for my baby girl.

At 6 months gestation, I came back in for the ultrasound to determine whether the choroid plexus cysts had resolved themselves. They had. The ultrasound technician, however, light-heartedly mentioned that the placenta looked "sparkly," a term she apparently coined and used to describe the appearance of increasing calcification of the placenta on the ultrasound screen. The placenta, normally depicted as fairly dark on the ultrasound screen, was adorned with a coat of little white flecks, indicative of a prematurely aging placenta. A placenta generally ages prematurely due to environmental factors, such as exposure to cigarette smoke—not a concern in my pregnancy, so I was not terribly worried at that point. At my subsequent appointment with the obstetrician (the same obstetrician who introduced the language of termination several weeks prior) the tone changed. We were urged to schedule weekly biophysical profiles and told that it was likely that they would need to deliver the baby early, since the aging placenta was not going to sustain her for the normal duration of pregnancy.

My pregnancy had so swiftly turned from something joyful and exciting to something anxiety-ridden and disheartening. Every week, for 2 months, I rode the two busses to get to the doctor's office, careful not to exert myself too much for fear of depriving the baby of oxygen, careful not to slip and fall on the December ice, to lie down on the table in the ultrasound exam room and watch my baby kick and squirm, swallow and expel the fluid that surrounded her. Every week the placenta, to them, appeared worse and worse. Every week it took a little longer for her to achieve all of the tasks she was meant to accomplish in the allotted 30-minute period (a developing fetus' movements tend to slow naturally as they grow in their confined space). Every week I left feeling more anxious, more fearful, that something would happen to her without my knowing it. I wanted to be able to constantly watch her on the screen. I wanted assurance that she wouldn't slip away from me in the days between my visits. Eventually, I got just that. The doctors decided that weekly exams were not sufficient, and asked me to begin coming in twice a week. The only time I felt reassured that she was indeed alive and well is when they told me so. Every time I felt her squirming or kicking I worried it was too frequent or too far between, as both, I was told, were indicative of a problem.

My body had turned into a treacherous place for a baby. It was as if while I was alone with her she was constantly in grave danger. The mere status of being inside of me put her unnecessarily at risk. She was only safe while being observed by the doctors, by individuals who could interpret her actions and translate them back to me in reassuring tones. I was told that passing a biophysical profile was "good for 48 hours," meaning that no harm would be expected in the 48 hours following one of these exams. This, of course, seemed absurd to me, but I was reassured again and again that it was so.

During the last few weeks of my pregnancy the weather turned very cold. I was happy for the excuse to curl up on the couch and closely monitor the baby's routine in my belly. I ventured out only for groceries (lots of them) and doctor's visits (lots of those, too). Finally the doctors decided that we should "come up with a plan" for her arrival. I was told that having one would relieve my anxiety, a complaint I was naive enough to mention when the doctor uncharacteristically asked me how *I* was doing. The plan they came up with was to do an amniocentesis to test for lung maturity at 36 weeks gestation and, in the event that the results were positive, to induce labor. The appointments were scheduled and, in a way, doing so did indeed alleviate some of my worries. I had an endpoint in sight. I only had to keep her alive for a few more weeks and, once she was out of me, she would be *safe in the doctor's arms*. I started worrying about lung maturity rates and induction procedures. I read up on premature babies, crossing potential hazards off my list as the pregnancy extended into 34 weeks, 35, then 36.

> But are women enemies of fetuses? Women, in fact, do not refuse such procedures nearly as often as they should … for most women, in the course of a wanted pregnancy, the fetus becomes real, precious, treasured. The overwhelming majority of women accept gratefully the cesarean sections their doctors offer—believing that it is best for the baby, even when the current data show quite clearly that probably three out of four cesarean sections in America are not necessary. (Rothman "Recreating Motherhood" 1989: 167)

The day of my scheduled amniocentesis and potential induction finally arrived. The ultrasound technician completed one final biophysical profile and printed out Carlin's last ultrasound photo, a barely visible profile of her gigantic foot. At this point, I had collected about 30 of them. My experiences of the moments leading up to her birth were so different from what I had imagined a mere 8 months previous. The doctor entered the room and began setting up for the amniocentesis. Because I had had one before, I started to worry about the pain of the procedure. Then I started to worry about the pain of childbirth.

Amniocentesis is considered to be more risky to a pregnancy earlier on. An amniocentesis is rarely done prior to 16 weeks because at any time sooner, a sufficient volume of amniotic fluid is not available to draw in order to run tests without serious risk to the pregnancy. The primary risk from amniocentesis is not, as you might expect, damage to the fetus but, instead, the induction of labor. The later into the pregnancy an amniocentesis is performed, the more likely it is that the fetus will survive if labor is triggered. At 36 weeks the risk of inducing labor was not as serious as it had been at 20 weeks. For this reason we moved on without hesitation.

Again, because of its prominent position, the doctor decided to go through the placenta to draw fluid. After several minutes of trying, the doctor removed the needle from my belly and I finally glanced back up at the screen. A rush of fluid was visible to me and, as the doctor hastily edged out of the room, I asked the ultrasound technician what I was seeing. "Blood," she answered, and through the doorway we heard the doctor's voice over the phone ordering a stat cesarean section. The needle had ruptured the placenta, and my blood was rushing into the amniotic sac.

The doctor returned to the room, along with a nurse and a wheelchair, hurriedly explaining what had happened and that the baby needed to be delivered right away.

As I was rushed through the hallways connecting the office building and the hospital, for the first time in several months I felt inexplicably tranquil. Here, the life of my baby was acutely at risk, by the hand of my own physician, and, instead of feelings of fear, I was entertaining a sense of relief. I knew that in a matter of moments, she would be safely in the world (as if she weren't somehow already)—no longer in a constant state of peril.

Because of the damage done to the placenta, there was no hope of natural birth, nor even induced labor. Instead, preparations were made for an emergency cesarean delivery. At this point a cesarean section *was* necessary because the uterus had indeed *become* an unsafe place for the baby. (Notice, it hadn't always been unsafe—a belief I was agonizing under for the last 2 months). The uterus was unsafe, however, not because it was in labor, but because it was quickly filling with blood.

I had read and heard about the procedure but was completely unprepared for what came next. After I donned the smock and endured a humiliating shave by my nurse, I found myself accompanied by just one unfamiliar nurse. I walked into the operating room, trembling. The room was bright, windowless, and cold. I sat on the bed and leaned forward so they could administer the anesthesia into my spine. As I started to become numb, I was situated into a supine position, with the lower half of my body completely exposed to everyone in the room but myself—a sheet was erected to further separate me from what was going on, to maintain a sterile field (my bottom half being more sterile than my top, of course). My arms were strapped down and I could feel nothing but cold—the cold of the air on my skin, the cold of the anesthesia working its way up my waist, the cold of the saline and anxiety medication winding its way through my veins. I wondered if the baby was cold too. Adrienne Rich writes,

> "but women are now asking what psychic effect a state of semihelplessness has on a healthy mother, awake during the birth, yet prevented from participating actively in delivery. No more devastating image could be invented for the bondage of woman: sheeted, supine, drugged, her wrists strapped down and her legs in stirrups, at the very moment when she is bringing new life into the world." (1976: 170–171)

They started cutting. I couldn't feel the cuts, but I could feel the pressure. I could tell they were doing *something* to me. I could tell they were doing things to me I would not be okay with if I were allowed to bear witness. I begged them to stop the surgery and wait until my partner was there, but they assured me she would be there in time for the delivery. I watched the clock; I prayed that they would slow down. I started to cry. Finally, the door opened and they allowed her in. They immediately hijacked her attention and began explaining what they were doing to me. I honestly do not recall if they had been explaining it to me all along and I just hadn't listened, but regardless, they were no longer talking to me. I told my partner I was scared and the anesthesiologist overheard. He said he would give me something to calm me down. They delivered the baby and, after weighing, washing, and drying her, they handed her to my partner, who brought her over to show me. When they took her away to be monitored, they called my partner to the other side of the sheet and showed her my placenta. The doctor said, almost triumphantly, “it looks good—except for the abruption!”

In another depiction of delivery, this time of a vaginal delivery, I find echoes of these same horrifying descriptions of women no longer in control of what is happening to their bodies:

> certainly a woman who was unconscious, semistupefied, amnesiac, or simply numb from the waist down cannot have experienced giving birth as an accomplishment, something over which she had no control. But what of the woman who is encouraged in childbirth-preparation classes to see herself as a member of a “team” delivering her baby? Though she may help and watch in a mirror, she is not the primary actor. Positioning and draping her in such a way that she cannot directly see the birth, not allowing her to touch her genitals or the forthcoming baby, tells the mother that the birth is something that is happening to her or being done to her, not something she herself is doing. The birth is managed, conducted, by the other members of the team, those who are telling her what to do, and physically manipulating her and her baby. (Rothman “Giving Birth” 1982: 177)

There was something fitting in the fact that Carlin’s birth had little or nothing to do with me. I was neither an active participant nor particularly informed about what was going on. From the moment that I had my 20-week ultrasound until the moment she and I were released from the hospital, Carlin was cared for and managed by someone other than me. Her first 36 hours in this world were characterized by the dim lights and constant beeping of the NICU, difficult IV placements (which are nothing like IV placements for adults, with the most prominent veins in infants being those in their heads), and one delirious mom, heavily medicated and recovering from major surgery, peering over her plastic container. Diapers were changed and weighed by nurses; food was administered intravenously. She was finally released to “my care” only to be hovered over and eventually removed from my hospital room on account of “low body temperature.” Later I was told by our pediatrician that the best remedy for low body temperature in a newborn is skin-to-skin contact with the mother, not the warming lamps they lay infants under like french-fries. Breastfeeding sessions were observed and critiqued by lactation consultants.

When we were finally released from the hospital, 24 hours passed in a dreamlike haze before Carlin was readmitted to the hospital on account of complications stemming from her premature birth and the ingestion of my blood as a result of the ruptured placenta. Even after being taken from me and delivered to supposed safety, antibodies from my blood that had entered her blood stream were attacking her and preventing her from thriving. I was endangering her from a distance, even.

She spent the next month in a world she shouldn’t yet have been in, losing weight, suffering from jaundice, and having her heels poked, with a medicated mom recovering from a surgery she needn’t have been subjected to. Carlin’s premature delivery and difficult first month in the world were the direct result of an over-managed pregnancy—a pregnancy characterized by fear and anxiety, observation and intervention, and the undermining of the confidence of a mother and the developing relationship between mother and child.

While it is acknowledged that hindsight is always 20/20, it should be pointed out that the only test that would have revealed a genuine problem with Carlin was the botched 36-week amniocentesis to test for lung maturity. No amniotic fluid was successfully drawn during the procedure, but the placental abruption caused by it necessitated an early delivery regardless of whether or not her tiny lungs were prepared to take in air. And this abruption was the only problem they noted with the placenta following delivery. That is, there was no evidence of premature placental aging, or any other condition that could have caused harm to the baby. What did end up causing a problem for her was the presence of my blood in the amniotic fluid, blood that was introduced as a result of the unsuccessful amniocentesis.

What really struck me as I gazed down at my average sized infant in the NICU was that she was the product of a completely healthy pregnancy. The only reasons I could come up with to explain the tubes and monitors coming off her had nothing to do with me. Acknowledging this fact, standing in stark contrast to everything I had been told and everything I felt up to that point, immediately relieved the cognitive dissonance built up inside me by wanting so badly to take care of my daughter and yet knowing that I was putting her in danger just by having her inside of me.

The use of indiscriminate investigative procedures such as 20-week ultrasounds can result in the overdiagnosis of problems with the fetus. This, of course, is particularly worrisome in the case of patients who are not at risk. Once the alarm has been sounded, mothers and doctors alike are compelled to continue down the path of diagnostic screening and intervention. It would be difficult, if not impossible, to turn away from the risk of Down syndrome, or, even more so, a risk of the baby's not thriving due to a prematurely aging placenta. Once the problem has been identified, whether correctly or incorrectly, a path for action has been laid down for mother and physician alike.

Even if we bracket the possibility for the kind of harm *set in motion* by these information-seeking techniques suggested above, the question arises as to whether harm can come from the mere information seeking in the first place. In other words, if we grant the possibility that procedures like screening for abnormalities of the fetus with ultrasound were 100% accurate in predicting problems, would there still be a concern about the use of ultrasound, that is, the asking of these kinds of questions, in the first place? The answer, I think, is clearly 'yes.' There is, in the case of pregnancy, something troubling in the very *asking* of these questions. A certain kind of information or knowledge about the fetus has come to be valued over another.

How is it that we have come to be asking the questions that we ask about pregnancy? Why do we need to know prior to delivery if the baby is a boy or a girl, healthy or unhealthy, upside-down or right-side-up? In the case of some of these questions, the answer is obvious: Because we can *do* something about it. For others, the answer is not so obvious. For others, the answer might be something more like, because we *can know*. To me, it is not at all clear why knowing, in this case, is any better than not knowing and, moreover, why knowing in this privileged, empirical, and scientific way is better. There is a certain kind of epistemic imperialism at play here. This epistemic imperialism sets out what the important questions are and sets out the ways in which we are to go about answering those questions. The kinds of questions we are asking and the kinds of answers we are getting are driven by, created by, the kinds of technology we have—not, instead, by any identifiable *need* we have for this particular kind of information. This sets up a false hierarchy of knowledge—privileging the information that is technologically available, making it seem more important when, really, it is only more available, and available to more professionalized, and presumably more reliable, knowers. The influence of social values, or even merely the interests of the medical and scientific community, are, in line with the suggestion of Jaggar, establishing the questions we are asking, recommending the routes we take in answering them and, clearly, offering up the answers. Jaggar suggests that we are being unrealistic in supposing that knowledge-seeking can be free from the influence of social values. She writes, "these values are implicit in the identification of the problems that are considered worthy of investigation, in the selection of hypotheses that are considered worthy of testing, and in the solutions to the problems that are considered worthy of acceptance" (1996: 176). The questions themselves in the case explored here and many others like it are being generated based not on a *need* to know, but rather on an *ability* to know.

In an alternative reading of Shakespeare's *Othello*, Naomi Scheman gives an account of what she takes to be the *real* harm committed by Iago (370). Her interpretation suggests that it is not that Iago convinces Othello that Desdemona has been unfaithful but instead that Iago changes the terms, or the nature of the evidence, required to establish feelings of mutual trust in their relationship. She writes:

> Iago's skillful manipulation of the appearances (he doesn't exactly *lie*) is not a perversion of scientific reasoning, but, in its power to seduce Othello, a demonstration both of the incapacity of such reason to comprehend aspects of the world that lie beyond it and the defenseless inability of that world to provide a logical, rational proof of its own reality. It needs—demands—no proof, but pressed to give one, it will inevitably fail. (1998: 370)

This can be seen as a move similar to the one being made by medical professionals in the case of the relationship between mother and unborn child. What was once a relationship built on the emotional and intellectual insights of the mother (and the other women surrounding and attending to her during the pregnancy and labor) and the physical sensations of the mother alone is now a relationship forced to fit into an unfamiliar mold, subjected to novel questions as well as procedures for answering those questions which are responsible for changing the character of their relationship.

We ought to ask ourselves who Iago is to set out the questions at issue in the relationship between Othello and Desdemona. We ought to ask ourselves who the doctor is to set out the questions at issue in the relationship between mother and child. It is time, then, to establish *our own* questions, to determine for *ourselves* reliable methods of answering them (methods that might well call on medical expertise), and to provide some tentative answers. The question proposed here, again, is whether knowledge is always more valuable than ignorance. The reasoning behind the response I advocate involves a recognition of some potential 'epistemic harms.' Epistemic harms can be understood as very much like physical harms: They are the intellectual harms suffered by the knower and the known alike resulting from certain types of knowledge gaining procedures and, in some cases, from the knowledge gained itself. We have encountered several of these already, including the impact of ultrasound use on the perceptions of the mother regarding her baby and the thrust of probabilistic knowledge of risk to pursue more and more evidence to engender worry and fear. Let us look at some more.

According to Amy Hilden, pregnancy should be about developing a relationship with the fetus, about experiencing certain changes in your body and your life that are characteristically female (100). Pregnancy, moreover, should be about a growing sense of confidence in yourself as a mother. When medical intervention procedures are allowed to escalate out of control, it changes the whole tone of pregnancy. It can turn pregnancy into a medical crisis. It punctuates the felt flips and kicks of the fetus with fearful rather than joyful anticipation. The escalation of intervention in pregnancy undermines the epistemic authority and control that the woman has over her pregnancy. When an individual's attempt to make meaning for herself is thwarted by a society's or an institution's incompatible understanding of an issue, Fricker deems it a case of hermeneutical injustice (2007: 155). She writes:

> When you find yourself in a situation in which you seem to be the only one to feel the dissonance between received understanding and your own intimidated sense of a given experience, it tends to knock your faith in your own ability to make sense of the world … [it] stem[s] most basically from the subject's loss of epistemic confidence. The various ways in which loss of epistemic confidence might hinder one's epistemic career are … that it can cause literal loss of knowledge, that it may prevent from one gaining new knowledge, and more generally, that it is likely to stop one gaining certain important epistemic virtues, such as intellectual courage. (163)

Two different yet intertwined claims that women have to knowledge about pregnancy, I believe, need to be disentangled here. On the one hand, the historical practice of midwifery and the techniques, approaches, and insights passed down by women to women throughout human history which has now been replaced by the modern, medicalized approach to pregnancy we are more familiar with today do indeed suggest that there is some kind of special access, some practical insight women have to matters of managing pregnancy (Rich 1976: 149). Even if we bracket this possibility, there is yet another kind of knowledge that women have access to that is or can be challenged by technologically driven ways of knowing about pregnancy; women who are pregnant, or who have been pregnant, have what is called experiential knowledge of their pregnancy and of pregnancy in general. This kind of knowledge is not to be taken lightly and has the potential impact of altogether shifting the way an individual sees the world, and sees herself in the world (Shapiro 2009, 2010: 59). This kind of knowledge, however, is not meant to compete with or mimic the kind of knowledge available through the evidence-based, empirical information-seeking technologies used in pregnancy. It is of a different kind altogether. At the same time, this kind of knowledge is indeed threatened, rather than being helpfully supplemented, by these technologies. In fact, this kind of knowledge takes a back seat to the kind available to the physician by looking *through* the mother, whether it be by needle or by sound wave.

With these two distinct flavors of potential knowledge only women have about their pregnancies in mind, it is not the case that I am arguing that I, or any other woman, is in a position to know better than my doctors about the health and viability (or lack thereof) of my daughter *in utero*. What *is* being argued is that the preference for having the kind of knowledge available through medical diagnostics may be unfounded, and the quest for this kind of information disrupts the course and experience of pregnancy and its epistemic consequences. The privilege of and search for this kind of information about the pregnancy, however accurate or inaccurate the results, pushes aside the importance of the kind of knowledge a woman *can* have about her pregnancy, dramatically alters the way she experiences it, and depletes the sense of (and actual) control she has over how it unfolds.

With adequate weight given to the sorts of epistemic harms caused by the pursuit of certain kinds of knowledge, through certain means, I hope I have shown that the search for knowledge can sometimes be inadvisable. That is to say, sometimes, knowledge *isn't* more valuable than ignorance.

Searching for Solutions

With these concerns in mind, it becomes prudent in closing to ask ourselves what might have been done otherwise. In answering, a frequently quoted line from § 308 in Wittgenstein's *Philosophical Investigations* comes readily to mind: "the decisive movement in the conjuring trick has been made, and it was the very one that we thought quite innocent" (103). Although undeniably taken out of context, we might interpret this to mean that we should start asking questions sooner. It was at the 20-week ultrasound, a procedure I excitedly anticipated and in no way scrutinized, that the ball began rolling in this particular instance of escalation of intervention. The very asking of the kinds of questions answerable by medical technology in pregnancy can have, and has had, the impact of setting off a destructive chain of events—a sequence of questions, answers, and approaches, that have the effect of causing the kind of epistemic harm to the mother explored in these pages.

The discipline of virtue epistemology, however, gives us a framework in which we *are* positioned to do more. To remind ourselves: First, it made room for our novel inquiry in a discipline characterized by often rigid adherence to a pre-established set of questions deemed worthy of investigation. Second, it justified our turning to the subjective features of both the knower and the known in finding answers to our questions. Third, in carrying out such an investigation, it highlighted some salient outcomes, namely, the epistemic harms, which undoubtedly deserved a closer look, and, when given one, provided an answer to the question at hand. Finally, then, virtue epistemology will help us turn our results into something pragmatic, an aim which many virtue epistemologists consider the proper end of epistemology in general.

Valerie Tiberius proposes we define wisdom as "the virtue that allows us to make choices and act in such a way that we can reasonably expect to achieve a satisfactory review of our own conduct" (215). To pursue knowledge wisely, then, amounts to pursuing knowledge in a way that allows for a "satisfactory review" of ourselves. Such a satisfactory view, I propose, necessarily takes into consideration the various epistemic harms caused by any potential pursuit of knowledge.

The epistemic virtue of wisdom, when turned in the direction of questions of whether or not to pursue a given line of inquiry, can help us sort through the potential epistemic harms, can help us attend to the relevant features of the subjects and objects of knowledge, as well as the community in which they are situated, and, in turn, help us provide an adequate response. If we are to act in accordance with wisdom, then, we are not to assume that the answer to the question of whether it is valuable to know *x* is either an unqualified 'yes' *or* 'no.' Instead, if we are indeed to achieve a satisfactory review of ourselves, the question of the value of knowledge will vary with respect to the relevant features of the knower and the known, and the epistemic harms likely to be produced by such an inquiry for both, as well as for the community in which they exist.

The account I have given of wisdom as an epistemic virtue undeniably deserves a more thorough exposition. In developing one, it is my belief that we need to look not just to the work of philosophers, but to the voices of researchers in psychology as well, for example, how we reason when faced with probabilistic information, in particular, in medical decision-making. According to Reyna and Brainerd, many people struggle with numeracy and, in particular, with probabilities (2008: 89). They identify several common mistakes we make in judging probabilities and risks and remind us that these are abilities that are required for informed medical decision-making. Although they fall short of providing a way for us to avoid these mistakes in reasoning, merely having been made aware of them has caused me to look more carefully at numerical information, especially when representing medical risks. Sedlmeier (1999) presents research into several training regimens which have been established to improve statistical reasoning, some more successful than others. While I don't advocate a battery of training regimens in statistical reasoning as required for developing the virtue of wisdom, I do believe there are important insights to be gained from what psychologists have determined has worked and what hasn't in improving our ability to reason well with statistical information.

While our account of wisdom is not a complete one, I believe that it can be properly filled out by attending to research into decision-making (medical decision-making in particular) as well as looking to other virtue-epistemologists for useful elements in their own accounts of wisdom. Elsewhere I explore these avenues more thoroughly and have found it to be a worthwhile endeavor.

It has, I hope, been shown that any response to the query of whether knowledge is more valuable than ignorance must, if in accordance with wisdom, attend to the subjective features relevant to the inquiry (those which have been traditionally overlooked by epistemologists) as well as weigh the potential for resulting epistemic harm. These claims are, at minimum, surprising, and, at best, innovative, given the leanings of the technologically-driven and information-oriented society in which we live. In knowledge seeking practices ranging from the ordinary Google search by an individual to the carefully developed investigations of highly regarded research institutions, we often attend to the potential *benefit* of gained information, but rarely regard the costs that can be incurred. We are too inclined to think that considerations of potential harm enter in only when we ask what we might do in light of knowledge we have obtained. What I hope to have shown is that pursuit of knowledge itself can be harmful and that we need to think of that pursuit as the "initial move in the conjuring trick," one that escapes notice but that can be crucial to the outcome. It is my contention, then, that the epistemic harms outlined in this paper be taken as seriously as physical harms, and, as such, consideration of them ought to precede investigation, when relevant. And where should we look for guidance in sorting through these considerations? To this, my answer is: The epistemic virtue of wisdom.

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