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Feminist Theories of Evidence and Biomedical Research Communities: A Reply to Goldenberg

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In a recent essay — "How Can Feminist Theories of Evidence Assist Clinical Reasoning and Decision-making?" — Maya Goldenberg discusses criticisms of evidence-based medicine (or EBM) (Goldenberg 2013). She is particularly interested in those criticisms that make use of an epistemic appeal to the underdetermination of theory by evidence. That the choice of medical treatment regimens, for example, is often, if not always, underdetermined by the experimental evidence, suggests that something in addition to the evidence must be at play when treatments are championed by EBM protocols. Values, or other biases, are often mentioned as additional factors. In these cases, we have reason to be suspicious of claims to value-neutrality and objectivity that are often used to promote evidence-based medicine. Interestingly, she notes, it is feminist philosophers who most often critically deploy underdetermination theory, though they also typically offer a solution: all is not lost, some kind of objectivity can still be salvaged in research contexts. The solution typically involves reconfiguring notions of objectivity as a property of democratic and diverse research communities.

Goldenberg notes that, for many healthcare researchers, including critics of EBM, feminist philosophical prescriptions for such idealized communities can seem unrealistic. The problem that results is that worries about the role of values in research, highlighted by underdetermination theory, are acknowledged but left unsolved. As Goldenberg explains, critics of EBM are left then to "despair over the perceived unapologetic subjectivism of value-laden science, and can offer no means for negotiating clinical decision-making without the previous security of an objectivist account of evidence" (2013, 2). Taking a cue from me (Clough 2003, 2008) and Elizabeth Anderson (2004, 2006), Goldenberg concludes her essay by offering an alternative feminist solution to the problem of values in research that appeals to familiar rules of evidence but does not require idealized communities — an alternative, she hopes, that will be more attractive both to critics and supporters of evidence-based medicine.

I think Goldenberg is exactly right in her characterization of the ways that the underdetermination theory is used by feminist philosophers, notably, Longino (1990). According to Longino, values, such as political beliefs, operate as normative background assumptions that inevitably play a role in research settings, especially when the explicitly available empirical evidence is equivocal or otherwise underdetermining. Additionally, Longino argues, values can have powerful effects on which kinds of empirical data get marshaled as evidence and how the data are described. As Goldenberg notes however, for Longino, values are not themselves bearers of empirical content (Longino 1990, 75). Values, on Longino's view, are epistemically and ontologically distinct from evidence claims. So the only way to address the potentially biasing role they can play is not through empirical assessment of the values themselves, but through the careful balancing of a diversity of values in our research communities. Longino's prescriptions for a democratically organized and diverse research community then follows, based on the entirely reasonable claim that it is easier for us to identify when and where values are influencing scientific reasoning, if those values are different from our own.

There are (at least) three problems that arise at this point. Goldenberg discusses the problem with which I have been perennially concerned in my own work; namely, the relativism that results when the empirical features of values are downplayed. For example, that feminist values have stronger inferential relationships to empirical features of the world than do values informed by more "traditional" understandings of the relationships between women and men, is precisely what makes feminist values normatively persuasive in biomedical research contexts or anywhere that feminist values are relevant. If this empirical feature of values is downplayed, as it is in Longino's work, then there is no objective way to decide between values. Instead, all values, even feminist values, are seen as biasing features that need to be managed. When this non-empirical characterization of values accompanies a discussion of their inevitable and ubiquitous role in decisions between competing medical protocols, then we are left with a relativistic understanding of biomedical practice, and no objective way to explain how or why it is that some treatment protocols are more efficacious than others.

Goldenberg then addresses a second problem I had not anticipated, namely, that Longino's own prescriptions for a diverse research community are often unrealistic, at least in the short-term. If a democratically organized and diverse research community is needed to properly balance the biasing role of values in science and if developing such a community requires time and money, then in the short-term, on a budget, it is not obvious how the biasing effect of values is to be managed. Goldenberg's answer to this problem is to note that, following my own prescriptions, the development of such communities might be a good in itself, but not one that is needed to manage the potentially biasing role of values. We can instead analyze the empirical strengths and weaknesses of values themselves, and choose to feature and support only those values for which we can show strong inferential links to good empirical evidence. Goldenberg presents a useful case-study of medical decision-making that follows just this protocol.

So far so good!

Unfortunately, there is, I think, a third problem. And I have been worried enough about it to make it the focus of a paper due out in the next issue of *Contemporary Pragmatism* ("Pragmatism and Embodiment as Resources for Feminist Interventions in Science", Clough 2013). It is important to note first that Longino's account doesn't actually require a diverse community, she simply makes the point that a diverse community is likely to be one that reflects diverse values. But then not only is the empirical content of particular values besides the point for Longino (a problem recently revisited by Kristen Intemann, 2010), so is the need for a diverse community. That a diverse community looks to be beside the point in my own account is not a feature that I want to celebrate, necessarily. What follows is a preview of some of my concerns on this score and how I propose to address them.

Goldenberg, Intemann, and I agree that there is good reason to prefer feminist values over, say, sexist and racist values, insofar as the former "are better supported or warranted" by the evidence (Intemann 2010, 793). So we should include feminist values in our biomedical research, not for the sake of having a diversity of values, but just in case the feminist values are epistemically stronger than available competitors. That is,

where relevant, medical researchers should listen to, incorporate contributions that contain, or are sensitive to, or at least do not contradict, feminist values. But we need not only to include feminist values, but also to include those researchers, such as white women, and people of color, who are typically marginalized in and/or kept out of biomedical research communities. I agree with Goldenberg that this is an ideal that might be materially difficult in practice, however, I argue, it is an ideal that is consistent with, indeed supported by, the same empirical commitment to feminist values that she endorses for inclusion in biomedical decision-making and that she imagines will be palatable to biomedical researchers.

Imagine a biomedical research community that contains only privileged, male members (most research communities at the moment). Imagine they respond to the inequity of their membership by reading and becoming expert in some of the relevant literature produced by the relevantly marginalized or by attending a conference on issues of inequity, but they stop short of diversifying the membership of their community. How do you then argue not only that the right values, as typically but not exclusively articulated by particular bodies, get included, but that the particular bodies themselves get included? I agree with Intemann that the production of feminist values is contingent on a variety of circumstances and is neither needed for every research project, nor produced by particular people automatically by virtue of being embodied in any given way—not all women are automatically feminists, for example (Intemann 2010). This makes good sense, but then it makes it seem as if we don't need a diverse community so much as we need the right values for particular projects. Intemann and I want both, and so does Goldenberg, what is needed is to show that it is in the interests of empirically adequate biomedical research to have both.

To review, feminism is first and foremost a theory about power, who has it, who doesn't, and why. Given that power, including the power associated with the practices and knowledge claims of biomedicine, is differentially defined, produced, and distributed according to a complicated mix of embodied markers ("gender," "race," etc.), and given that we know these embodied markers are irrelevant and arbitrary when used as criteria for considering the intellectual abilities of medical researchers, then if the bodies that make up research communities reflect only a privileged subset of these bodies, we can be confident that differently embodied knowers are being systematically discriminated against, for example, in hiring, funding, and support. In these cases, research communities are reflecting inequity; power has not been distributed equitably. Part of the normative feminist project is to encourage a more equitable definition, production, and distribution of that power in biomedical research settings, as elsewhere. What needs to be clear is that when there is a normative failure of equity — as in most medical research communities that contain only privileged men — this inequity is rightly characterized as an empirical failure. These research communities reflect sexist and racist policies that discriminate against particular kinds of bodies for reasons known to be irrelevant to skill in biomedical research, that is, the policies are empirically inaccurate reflections of the way things are in the world.

Again, the feminist response to sexism and racism is a political charge of inequity that is persuasive insofar as it is a claim for which feminists have amassed a great deal of

empirical support; failures resulting in this kind of inequity are epistemic failures to consider the weight of the best evidence currently available regarding, for example, what kinds of bodies are capable of good biomedical research.

Recall that Longino's view is that political beliefs, feminist or otherwise, are not themselves bearers of empirical content, so acting against a political value of equity, say, by leaving a research community of privileged men intact, is not itself an empirical failure. So if we are committed only to addressing empirical failures in the ways circumscribed by Longino, then we do not have the normative resources we need to address the inequitable distribution of power in research communities through the hiring, funding, and support of marginalized bodies.

I have argued that we need to be more holistic in our understanding of what counts as the kinds of evidence to which a good biomedical researcher ought be responsive, and that feminist values are exactly the kinds of evidence that should count. Further, we need medical researchers to appreciate that the normative contribution of feminist theory is one that calls both for the inclusion of feminist values where relevant in biomedical research, and for diverse research communities, because this two-pronged feminist political contribution is co-constitutive with the epistemic project of increasing the empirical adequacy of biomedical research. By the standards of evidence-based medicine accepted by biomedical researchers, you need both. Of course we can't have both at all times and in every kind of biomedical community, but in any case, the goal is not a static end point, it is rather an on-going developmental process of critical reflection and engagement.

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