

Deaf or deaf? Questioning alleged antinomies in the bioethical discourses on cochlear implantation and suggesting an alternative approach to d/Deafness

Patrick Kermit*

Department of Social Work and Health Science, The Norwegian University of Science and Technology (NTNU), Trondheim, Norway

(Received 1 October 2008; accepted 20 December 2008)

The assumption that there exist two mutually exclusive conceptions of d/Deafness – a medical/biological as opposed to a socially constructed one – is an underlying premise for much of the ongoing bioethical discourse on paediatric cochlear implantation. This text first presents this discourse and then analyses the alleged antinomy. Using the original Kantian conception of antinomies, it is argued that trying to judge which is more ‘true’, nature or convention, is futile. Against the backdrop of the history of deaf education and recognition of signed languages as fully fledged languages, a three-fold, intertwined approach to d/Deafness is suggested that includes: deafness as physical impairment, Deafness as lingual belonging and deafness as socially constructed disability. Whether or not cochlear implants represent something useful or something harmful to deaf children depends on how the interaction between the different notions of d/Deafness is understood.

Keywords: deafness; ethics; cochlear implants; disability; impairment; language

Introduction

This text is a philosophical attempt to analyse parts of the ongoing bioethical discourses on paediatric cochlear implantation¹ and deafness as well as general discourses on the understanding of disability. In the first part of the text I present a critique of a particular way of arguing that is commonly used in the ongoing bioethical discourse on cochlear implants. This way of arguing has as its premise that there exists an antinomy – two mutually exclusive conceptions – between two ways of being d/Deaf. This critique represents a refinement of an argument I have presented in earlier work (Kermit 2007). In the second part of this text, I discuss if my argument offers a possibility to forge new conceptions of deafness and disability, based on a philosophical argument of the mutual interaction between nature and social conventions. My conclusion is that the ethical evaluation of cochlear implants must be based on a consistent approach to d/Deafness as a phenomenon involving biological, social and linguistic aspects. With this broad approach, implants may represent something beneficial to prelingual deaf children. However, if deafness is narrowly conceived as an impairment-induced disability, implants may cause harm.

*Email: patrick.kermit@svt.ntnu.no

The bioethical discourse on paediatric cochlear implantation did not start as a theoretical discussion among scholars; it was rather brought to their attention:

Some radical Deaf activists in the United States in the 1990s seized on the cochlear implant as a central issue in articulating their position as a linguistic and quasi-ethnic minority. They argued that cochlear implants were a form of genocide, that Deaf children were literally being killed and reborn as hearing children... These members of the Deaf community were successful in affecting social debate on this issue in the broader hearing community. (Nakamura 2006, 144)

This rejection of a technical device designed to return some hearing to deaf persons has intrigued many, especially since some of the fiercest critics of the implant are themselves deaf. The previous quote from Nakamura frames a seemingly sharp and antinomic division between two different notions of deafness, and it may be the antinomic aspect that has inspired a number of scholars to contribute to the bioethical discourse. On one hand, to be deaf apparently means to have a hearing impairment. On the other hand, people who regard themselves as members of signing communities often refer to themselves as Deaf people. The Deaf scholar Paddy Ladd defines the difference in this manner:

The lowercase 'deaf' refers to those for whom deafness is primarily an audiological experience. It is mainly used to describe those who lost some or all of their hearing in early or late life, and who do not usually wish to have contact with signing Deaf communities, preferring to try and retain their membership of the majority society in which they were socialized.

'Deaf' refers to those born Deaf or deafened in early (sometimes late) childhood, for whom the sign languages, communities and cultures of the Deaf collective represents their primary experience as essentially akin to other language minorities. (Ladd 2003, xvii)

The case of paediatric cochlear implantation hence seems to represent a true philosophical antinomy or dichotomy. It seems to be a case in which two scientifically established and consistently defined conceptions of a phenomenon mutually exclude and contradict each other. A medical/technical attempt to ease or cure impairments like a lack of hearing should not cause much controversy. Such attempts are in line with the best medical ethical traditions to try to ease or cure disease, and until the implant was invented nothing could be done to help those whose hearing impairments were so severe that ordinary hearing aids were of no use. On the other hand, that Deaf people are a linguistic minority is scientifically documented beyond reasonable doubt (e.g., Stokoe, Jr. 2005). The signed languages Deaf people use are as fully fledged and natural as spoken languages are. It would thus seem possible to question cochlear implantation and perhaps even argue that implantation is a form of forced normalization. If one can argue that prelingual deaf children belong in some way to a signed language and its culture, attempts to alter this belonging by means of surgery could be ethically questionable.

Part 1: on true and false antinomies in bioethical discourses

The classical Kantian conception of true antinomies is that each of the two offered explanations to the same phenomenon can state its own consistency by demonstrating the improbability or inconsistency of the other (Kant 1989). To Kant it was thus

the recognition of true antinomies as such that was important, and he did not attempt to solve them by favouring one explanation over the other.

The hallmark of much of the bioethical discourse on paediatric cochlear implantation has, however, been the attempt to refute by argument one of the two notions of d/Deafness. What in effect is being discussed, then, is the question: 'Are d/Deaf people "really" deaf or Deaf?' The premise in these discourses is a rather simple one: if it can be argued theoretically that one of the two notions of d/Deafness is ontologically 'truer' or carries more conceptual weight than the other, this would provide an ethical argument supporting the case for one of the alleged 'sides' in the discourse. The dispute over whether or not a deaf child should be implanted would thus seem to be settled once and for all by the force of the better argument.

Deaf activists and their academic supporters (Lane 1999; Harris 1995; Ladd 2003) seem to be defending the least popular 'side' as a majority of partakers in the discourse (Balkany, Hodges, and Goodman 1996; Cohen 1994; Davis 1997; Johnston 2005; Levy 2002; McCaughey 1995; Nunes 2001; Harris 2000; Savulescu 2002; Tucker 1998) draw the conclusion that, since deafness is primarily a disability, it is a good thing to try to ease or even to prevent deafness.

Not all of the latter scholars focus on paediatric cochlear implantation (some engage in the general discourses on disability, others are concerned about questions related to reproduction), but in effect many of those supporting the notion that deafness is primarily a disability use versions of the same argument, here formulated by Neil Levy (2002, 149): '[I]t is not true that the deafness is not a disability, since it is not the case that all the disadvantages associated with it are social in origin'. This is an argument stating that even though all socially created barriers that Deaf people face could be alleviated, the physical hearing impairment would still be there. Deaf people are thus disabled:

Deafness is a disability ... because there is a real loss of expected function ... The disadvantages an individual may experience due to a disability are not purely the result of the social construction of that disability. (Johnston 2005, 434)

From this perspective, the bioethical implication for the discourse on cochlear implants is that it is questionable to refrain from implanting a deaf child, as this will mean upholding the child's disability instead of easing it.

I want to draw attention to some additional aspects of this argument. First, notably none of the partakers in the discourse denies that signed languages are languages and that being a member of a linguistic minority is a valid aspect of Deafness. Yet, they choose to place decisive weight on the physical hearing impairment when they conclude that implantation is recommendable and ethically sound. The physical impairment of not hearing is considered ontologically more relevant than the linguistic aspect of being Deaf. Secondly, the two previously cited scholars both use similar terms to refer to a social aspect associated with a certain understanding of deafness as disability ('socially originated disadvantages' and 'social construction of disability' respectively). This use of terminology indicates an impulse from another theoretical discourse also characterized by antinomies resembling the difference between being deaf or Deaf; the discourse on the 'medical' versus the 'social' model of disability. At some point it seems, these different pairs of concepts have been merged or at least mixed.

The merging of models of disability with an alleged dlDeaf antinomy

In order to question the reasonableness of treating paediatric cochlear implantation as a bioethical problem where a 'physical or medical phenomenon' seems to oppose something of 'social' origin, it makes sense to track the origins of these concepts of the social and medical in the general history of disability activism and research. In 1966 the German sociologists Peter Berger and Thomas Luckmann published 'The Social Construction of Reality: A Treatise in the Sociology of Knowledge' (1991). The work introduced the term *social construction* into the social sciences and soon became a very influential theoretical impulse in these fields. Berger and Luckmann analyse our everyday social contexts or 'reality'. One of their main points is that social interaction (and not some other form of causality) develops conventions. As these conventions are institutionalized they become something we tend to take for granted and something that also can decide the different social roles we play. Thus, social reality is socially constructed.

It is within this theoretical framework that attempts to describe disability as a social phenomenon can be placed. From the beginning of the 1970s both scholars and activists challenged the notion of disability as a primarily medical concept related to some sort of impairment. In this 'family of social approaches' (Shakespeare 2006, 6), some views were more polarized and radical than others. In Britain for example, the Union of the Physically Impaired against Segregation (UPIAS) claimed that disability was caused not by physical impairments, but solely by what they labelled socially constructed barriers. This radical approach has been theoretically elaborated and labelled 'the social model of disability' by, among others, the sociologist Mike Oliver (1996). It is important to note that Oliver probably would reject the notion that he represented some sort of social constructivism as he sees his theoretical framework as neo-Marxist and materialistic. I (as well as, for example, Tom Shakespeare, see below) do not recognize the relevance of this distinction. Oliver supports his view frequently, using arguments from and references to feminism and civil rights movements, both emancipatory projects heavily influenced by social constructivism. Above all, Oliver reduces the significance of impairments and sees them as little more than human variations. This is an approach which might serve those opposed to the notion of deafness as a state of being that one should attempt to correct, for example by means of cochlear implants. In a famous quote, Oliver says that an 'aeroplane is a mobility aid for non-flyers in exactly the same way as a wheelchair is a mobility aid for non-walkers' (Oliver 1996, 108). He states that non-walkers are discriminated compared with non-flyers as all sorts of arrangements are made in order for the latter group to fly, while numerous socially constructed obstacles (such as stairways instead of elevators) prevent non-walkers from taking full part in society and deny them the same possibilities as walkers have. The implication of this argument is that the concept of disability would cease to exist if all socially constructed barriers were eliminated.

The ultimate discriminatory act against people like non-walkers is to label them disabled with reference to impairments. Linking impairment and disability makes the latter something a person is unfortunate to 'have' because of something caused by nature and not by other people. To scholars such as Mike Oliver, such placing of the disability within a person is above all something that takes place in settings related to health care, rehabilitation and medicine. Here disability is constructed as a medical problem. Oliver, among others, thus claimed that the adversary to the social model of

disability was 'The medical model of disability' (Shakespeare 2006, 2), which constructed disability as a personal tragedy caused by an impairment. This way of framing different opposing approaches to disability has attracted much attention. Especially in Britain, the social model of disability has gained a sort of supremacy as the approach considered to grasp the 'true' meaning of disability: 'The legend is of a polar switch: the social model replaced the medical model, thanks to the pioneering activists of UPIAS and the academics who followed them' (Shakespeare 2006, 10).

No one has attempted a systematic matching of the social versus the medical model of disability with the concepts of Deafness versus deafness. When the aforementioned bioethicists tacitly transform the question of deafness versus Deafness to a question about pathology versus social constructs, the validity of making this transformation in itself should thus be analysed. The transformation plays a decisive role as a key premise for much of the discourse on paediatric cochlear implantation. Should this premise prove to be questionable, this will affect the discourse.

Though this merging of perspectives is not systematically developed, there are examples of scholars writing in a manner that implies the possibility of such a merging. An early example of such an attempt can be found in the article 'Cochlear implants: Their cultural and historical meaning' by Harlan Lane (1993). John Vickrey Van Cleve, the editor of the book *Deaf history unveiled*, where Lane presented this text, wrote the following as an introduction:

This last essay may well be the most controversial. In it, Harlan Lane makes the provocative argument that an 'audist establishment' of special education teachers, audiologists, medical doctors, and psychologists have worked together to create a medical model of deafness. Lane believes that this medical model has limited deaf people's achievements and stigmatized them in American society. He insists that a cultural model, one that would view deafness like blackness, for example, is the one that would most liberate deaf people. The particular object of Lane's criticism is cochlear implants, the latest technological devices that are advertized as improving deaf people's lives. (Van Cleve 1993, 272)

Here, Lane's perspectives highly resemble those of the social versus the medical model of disability. He states that a medical model of deafness as a disability has been created in order to refute other notions of d/Deafness that may have a greater emancipatory potential. In other writings, however, Lane clearly rejects the notion that Deafness is a socially constructed disability, whereas deafness is a medically constructed disability. On the contrary, he emphasizes that Deaf people have little to gain politically by joining ranks with other disabled people as disabled and Deaf interests are quite different: 'Where people with disabilities cherish independence, culturally Deaf people cherish interdependence' (Lane 1995, 180). As Lane thus identifies deafness as a medical construction of deafness, he rejects the notion that Deafness has anything to do with being disabled due to socially constructed barriers. This rather fine distinction is, however, on one hand not recognized in the previously described bioethical discourses. On the other hand, the question still remains of whether Lane manages to explain clearly the significance of differentiating between being disabled due to socially constructed barriers and being Deaf. Belonging to a lingual minority is not a disability, but as most signing people are deaf, it is perhaps important to recognize the interactions between living with hearing impairment, the experience of social exclusion and having a minority language. Then it might be the general constructions of antinomies that should be questioned. There are problematic aspects of both the alleged antinomy between a social and a medical model of

disability, the loose attempt of merging it with the concepts of d/Deafness and the notion that there is a gap between being deaf and Deaf. In the following paragraphs I will thus review recent critiques of the social model and track the historical origins of the deaf–Deaf distinction. By doing so, I further expand the question of whether paediatric cochlear implantation can be framed as a bioethical problem, whereby solving the antinomy between the medical and the social is the main objective.

Criticizing the social model

In his book, *Disability rights and wrongs*, Tom Shakespeare (2006) challenges the ‘social model of disability’ and questions its hegemony, especially in the UK. He offers several arguments for why the model should not only be criticized, but be abandoned. One of his arguments is that the social model’s total rejection of the notion that disability involves aspects of a person’s physical or psychological disposition is inconsistent. There are important differences, for example, between non-walkers and non-flyers, and not all of these differences are social in origin.

The social model should be understood as a partly political response conceived by people working for increased social justice. As such, it has been successful. For example, in political argumentation, activists have been able to mobilize the model and use it to address questions of accessibility and the like. The model has not, however, been transformed into a consistent social theory according to Shakespeare. Instead of constituting a theoretical framework for seeking an ever deeper understanding of disability as a phenomenon, the social model (at least in Britain) has become not only a framework for scientific approaches to a phenomenon, but at the same time, a normative premise indicating that research should support the notion that disability is caused solely by socially constructed barriers. In order for the social model to retain its position not only as a scientific framework but also as a normative guideline, the medical model has served nicely as an antagonistic position that could easily be criticized. Shakespeare, however, questions the existence of the medical model. Although there is a complex of medical approaches to disability – many of which can be questioned – there is little to support the notion that there is a unified medical model developed by people in the medical field (Shakespeare 2006; Kristiansen and Kermit 2007).

Shakespeare does not deny that disabled people in their daily lives face several disabling mechanisms or barriers of social origin. However, he rejects the way the social model has positioned itself and the alleged medical model as mutually excluding approaches whereby only one – the social model – represents the ‘true’ understanding of disability. Thus, the social model is ‘a good idea that became ossified and exaggerated into a set of crude dichotomies which were ultimately misleading’ (Shakespeare 2006, 13).

Even though Shakespeare’s critique is directed mainly towards the social model of disability, whereby he insists that impairment is a part of being disabled, this doesn’t mean that he argues in the same manner as the authors of the bioethical discourses on d/Deafness. He does not seek to decide which of the two models should be considered the ‘truer’ one. On the contrary, Shakespeare takes the critical realist position that both ‘natural’ and ‘social’ factors need to be taken into account when approaching the phenomenon of disability. He sees disability as ‘a complex interaction’ between factors intrinsic and extrinsic to an individual. For him this way of approaching disability means first, considering both the social conventions

and the natural/biological circumstances resulting in the formation of the concept. Second, the complexity of conventions and natural/biological circumstances respectively can also be analyzed. The basis for this approach is the ambition of obtaining thicker descriptions (Kristiansen and Kermit 2007, 280) instead of an oversimplified model.

Other scholars have picked up Shakespeare's trail and tried to make clearer distinctions between which physical and social factors constitute impairment. Vehmas and Mäkelä (2008) suggest the use of the term 'brute facts' for framing the physical/natural aspects of impairment, and oppose these to 'institutional facts' which designate the framing of the social construction of impairments. I will return to this distinction later after a short investigation of the historical origins of the deaf-Deaf distinction.

Tracking the concepts of dIDeafness

From the way Ladd (2003) defines the difference between being deaf and Deaf at the beginning of this text, one might get the impression that Ladd supports the division between the medical model and Deafness that Lane suggests. It is unclear, however, whether or not it is reasonable to compare the deaf-Deaf distinction with the social versus the medical model of disability. As much of the bioethical discourse on cochlear implantation is based on the tacit assumption that such comparison is possible and reasonable, it is important to check carefully what happens with Deafness when the social model is challenged. I will start here by conducting a short investigation to track the origin of the deaf-Deaf pair of concepts.

For signing people, it comes quite naturally to distinguish between not hearing and signing. For example, in Norwegian Sign Language the sign 'DEAF' sometimes translates as 'having sign language as one's first language' (capitalized Deaf) and one would often prefer to use the sign for 'HEARING IMPAIRED' when addressing the state of not hearing (lowercase deaf). This is, however, not always a clear rule. A hearing person who signs fluently (because s/he has Deaf parents, for example) and engages in a conversation with another signing person s/he doesn't know and who happens to be deaf might get the polite question 'ARE YOU DEAF?' Even though the sign used here would be that which can also translate as being a signer ('DEAF'), this is a question concerned with physical hearing status and not lingual capacities. Thus, the polite answer will then be 'NO, I AM HEARING'. This example shows that there might be more than two concepts of deafness in play. Beside the issues of being a signer and being unable to hear, there is also the question of sharing the social experience of being unable to hear.

This is where the significance of Deafness becomes apparent. The exact origin of this concept is uncertain, but many refer to the article 'Language and maintenance of ethnic boundaries in Deaf community' by Markowicz and Woodward (1978), where the distinction between deafness and Deafness is used and defined as follows in a footnote:

Throughout this paper we use the convention of capitalizing the word 'Deaf' when it refers to any aspect of the Deaf community and its members. Uncapitalized 'deaf' refers to the audiological condition of deafness. (34)

The difference between this straightforward explanation and the definitions offered by Paddy Ladd (2003) is notable. Markowicz and Woodward (1978) are not

implying that there exists a gap between these two notions, but they state a need to distinguish terminologically between a group sharing a language and impairment. This need for new terminology in the seventies was probably not the result of the temporary social approaches to disability. It was rather an effect of the linguistic discovery that signed languages are as fully fledged and as natural as spoken languages. (As mentioned previously, we owe this understanding especially to the American linguist William C. Stokoe Jr. (Stokoe, Jr. 2005; Armstrong, Karchmer, and Van Cleve 2002)) This new recognition replaced previous notions of signed languages as only crude and primitive communication systems and called for new ways to grasp deafness conceptually. It is in this context the deaf–Deaf distinction also arises. The understanding that signed languages are languages, called for terms to describe people using a sign language, a term that could be distinguished from – but not replace – terms with audiological connotations. That signed languages are real languages is thus on one hand only a linguistic scientific discovery. On the other hand, the ethical implications identified by Deaf people are related to this discovery's potential for liberation from what suddenly appeared to be oppression from hearing people. As mentioned earlier, Shakespeare points out that also the social model of disability had a great emancipatory potential. In the Deaf context such emancipating effects are intimately intertwined with the notion of signed language as real languages, and it is not obvious that we are dealing with the same kind of emancipation with the social model and with signed languages.

In order to reach finer distinctions than the one between hearing impairment (deafness) and Deafness presupposed in the mentioned bioethical discourses on cochlear implants, two related questions will be discussed in the following paragraphs. First, it is necessary to analyse theoretically the mentioned tendency to place more weight on 'brute facts' (see earlier) than social conventions. This is what the majority of bioethicists arguing for paediatric cochlear implantation do. Secondly, the unmasking of something considered to be a 'brute fact' as really a convention has a specific ethical implication.

Nature versus freedom

It is not new to argue that nature's 'brute facts' should carry more ontological and conceptual weight and be considered as more 'true' than the changeable conventions decided among individuals in a given society (Hacking 2003). Positivism is an example of a position basically holding that only the observable things in the world (e.g., those that can be measured and weighted) represent the truly existing. During the era of enlightenment, philosophers like David Hume argued that man is nothing more than a thing among other things, and nothing exists in man's mind before he starts to collect sensible impressions (he is like a clean blackboard, a '*tabula rasa*').

Hume also recognized the particular ethical implication of such a view: if man is a thing among other things, and as such has his actions determined by laws of nature that he can not affect, he bears no moral responsibilities, has no free will and cannot be considered a free moral agent.

Hume's position outraged the German philosopher Immanuel Kant, but he nevertheless recognized that the positivists had a point. There exists a real antinomy between the notion of natural laws and free will. Kant frames these mutually exclusive positions of positivism and a position implying that man's rationality must be taken into account in what he labels his 'third antinomy' in the '*Critics of pure*

reason' (Kant 1989). The antinomy consists of a thesis and an antithesis. The first is formulated as follows:

Causality in accordance with the laws of nature, is not the only causality from which the appearances of the world can one and all be derived. To explain these appearances it is necessary to assume that there is another causality, that of freedom. (Kant 1929, 409)

The antithesis is as follows: 'There is no freedom; everything in the world takes place solely in accordance with the laws of nature' (Kant 1929, 409).

It is worth noting that Kant rejects the extreme opposite position to that of (radical) positivism, namely solipsism. A solipsist holds that the free rational mind is the only thing we really can know the existence of. The solipsist thus recognizes his/her own ability to pass moral laws, but does not recognize the existence of physical reality or natural laws.

As these philosophical discussions may seem very theoretical, Kant's suggestion for how the thesis and antithesis in the third antinomy can be reconciled is important to our case of different approaches to different aspects of deafness accentuated in the debate on cochlear implantation.

As mentioned previously, an important Kantian recognition is that both thesis and antithesis can argue its own consistency by demonstrating the inconsistency of the opposing view. Those reading Kant as a philosopher trying to bridge the gap between positivism and solipsism argue that he combines these two positions in a unified theory whereby he sees man as an autonomous free agent, partly limited by the laws of nature. Kant rejects the notion of man as a '*tabula rasa*' as the world for each of us is partly a result of our objective reality and partly a result of the way we structure it. Kant's ultimate proof that extreme positivism and solipsism are both wrong is a practical proof: neither the positivist nor the solipsist can live everyday lives without denying what they would defend theoretically whenever they interact with anybody or anything (Kant 1989; Kant 1983; Fichte 1965).

The potential for emancipation when 'nature' is unmasked as freely formed 'convention'

Even though extreme positivism and solipsism may be improbable in everyday life, they are still useful concepts in this analytical process because they illustrate important ethical differences between the proposed 'medical' and 'social' approaches described above. I want to stress two points here. First, things given by nature and governed by the laws of nature tend to be conceived as more 'real' and ethically 'neutral' because they can't be easily changed by man's will (this follows from the positivist position). Second, if you can reveal that something claimed to be 'nature's order' is really a 'social convention', this provides you with a very powerful argument for making societal changes. The project of making such changes will often fit within a parallel ethical project of emancipation: not only can you claim that changes should be made, you can state that it is unethical and oppressive not to make the changes.

Both the Deaf history as well as the history of disability activism involve these points, but in order to present a textbook example, the work for increased gender equality is among the best illustrations. Already Aristotle declared women as inferior to men by claiming that women's biology was inferior to men's. Women's inferiority was thus nature's doing and not a result of a social convention. When the feminist philosopher Simone de Beauvoir, in one of her most famous quotes, says that '[o]ne is not born, but rather becomes, a woman' (Beauvoir 1961, 249) she – among other

things – addresses this way of disguising as ‘given from nature’s hand’ something which is really due to someone’s decisions.

This has an essential ethical dimension; when the ‘natural facts’ about women were unmasked as ‘social conventions’ this implied both a potential for liberation as well as the possibility of formulating accusations. As all responsible subjects in a given society share an ethical responsibility for that society’s conventions, the question of gender equality today is something that concerns all of us.

Hacking (2003) points out how the social construction of reality is always partly an ethical project. Following Kant this is quite understandable. The social structuring of reality is basically an ethical project governed by moral laws created among autonomous agents. Moreover, that conventions can be altered doesn’t necessarily imply that they are less ‘real’ than nature.

It is important to return to Kant’s reasoning and make a third point. Like solipsism, social constructivism cannot account for all things occurring in the world. We are only partly free agents, because we do not rule nature’s laws by our will. Still, following the previous example, this implies that there is a complexity involved when asking what a woman (or man) ‘is’. What it means to be a woman (or a man) is undeniably a question that also involves biology, but it is far from certain whether biology should count for more than the conventions that construct us as women or men, or that we can present a conception of biology that represents a kind of objectivity unattached to any social dimensions. I suggest the reason that biology is seen as containing ‘brute facts’ stems from our inability to change biology. Kant’s important insight regarding his third antinomy is, however, that it is impossible to frame nature as it ‘is’. Our structuring of the physical world is to some extent our own doing as partly naturally limited and partly autonomous subjects. It is thus impossible for us to ever make representations of a thing in itself (*‘Ding an sich’* (Kant 1989, 30)) As limited subjects we are bound to represent the objective nature as it appears to us.

Summing up the first part of this text, I began by noting that many scholars engaged in the discourse on paediatric cochlear implantation argue in a way which tacitly presupposes an antinomy between two and only two ways of being d/Deaf. Instead of criticizing the discourse on cochlear implants where this antinomy is deployed politically, I have questioned philosophically the validity of making the assumption that such an antinomy exist. By doing so, I do not engage with the question of implantation directly. My argument is a general one about approaches to d/Deafness; however, the argument may have implications for the ongoing discourse on implants.

Part 2: a synthetic approach to deafness as disability and Deafness

The previous analysis rejects the notion that there is a simple antinomy between deafness (as impairment) and Deafness. The bioethical discourses arguing on the grounds that deafness is a disability may thus be too narrowly conceived and of little real relevance when it comes to understanding the important bioethical aspects of paediatric cochlear implantation. Instead of two opposing concepts of d/Deafness, the previous analysis indicates the relevance of *three* approaches; deafness as physical impairment, Deafness as a lingual belonging and deafness as a socially constructed disability. However, these three aspects of d/Deafness do not constitute antinomies. It is rather the understanding of the interaction between the three aspects that may lead

to a clearer understanding of d/Deafness as a phenomenon and thus more relevant bioethical evaluations.

First aspect – deafness as physical impairment

As mentioned previously, the defining aspect of deafness as a disability for Trevor Johnston and several other participants in the bioethical discourses related to deafness has to do with the ‘loss of expected function’ (Johnston 2005). Mike Oliver’s radical suggestion, on the other hand, is that impairments should be seen as little more than natural variations (Oliver 1996).

The previous argumentation implies a rejection of both these positions. To have a severe hearing loss is impractical and challenging, and not all these impracticalities and challenges are social in origin, some have very natural causes. However, it does not follow that the physical condition of not hearing in itself constitutes disability as a sort of natural phenomenon. Moreover, if this phenomenon is judged ‘deviant’ or abnormal to the extent that someone would argue that one should strive to alter the phenomenon, this implies in itself an ethical premise suggesting that nature’s order should be changed. This might seem like hair-splitting, but it is really the consequence of Kant’s insight that we never deal with a thing in itself, but always with objects as they appears to us. So, if one argues that nature knows no ethics, one cannot consistently argue that certain natural phenomena are less desirable than others. This latter argument admittedly presupposes the ability to pass ethical laws and establish conventions, something that implies an element of social construction. This is the plain reason why biology cannot be assigned a status as a more ontologically significant or ‘truer’ approach to deafness than the other two mentioned approaches.

To argue that hearing impairment is the primary constituent of deafness as disability might not be wrong, however, as long as the other aspects of deafness are mostly irrelevant unless there is an initial hearing impairment. However, the notion that cochlear implants are ethically unproblematic because they only replace one natural condition – that of not hearing – with another more common condition – that of hearing – overlooks that cochlear implantation involves a lot more than just switching on a child’s ears. Cochlear implants are not a kind of cure that can be administered like a pill to exchange instantly lack of hearing with normal hearing, and even if implants develop into something that can be compared to a pill, the administration of the procedure will still be framed by social conventions. This recognition that attempts to change ‘only’ nature’s order involve a social cost is an essential key to understanding why many deaf people are sceptical of the cochlear implant.

The greatest natural barrier that seems to follow from a severe hearing impairment is the lack of easy access to acquiring a spoken language. Before the discovery was made that signed languages are natural languages, it was thought that this was a barrier that complicated all language acquisition and deaf children were thus subjected to special needs education where learning a spoken language and learning to compensate for the lack of hearing were the main objectives. In earlier times not many aids were available for the deaf children who tried to compensate for their hearing loss. They had to rely on the mastering of techniques like lip reading and rehearse the phonetic sounds they couldn’t hear in front of mirrors in order to master pronunciation of spoken words. The invention of hearing aids helped to

improve the hearing capacity of some hard-of-hearing children, but for the severely hearing impaired children there were no technical aids before the invention of the cochlear implant.

Historically, these attempts to teach deaf children to overcome their hearing impairments and acquire a spoken language have not been very successful. On the contrary, the identification of spoken language acquisition as deaf education's primary objective turned out to have some problematic repercussions. Learning a spoken language was time consuming and this time was spent at the expense of the time used to teach other subjects. As a result, deaf children often left school without having completed an ordinary education according to a normal curriculum. In addition, as most teachers in the deaf school taught in spoken language, the students often had to strive more to understand what was said, than to understand the curriculum's content. For many deaf students the result of repeated experiences of striving in order to understand and the according sense of having suffered defeat when understanding proved difficult led to the formation of self images as flawed and unauthentic persons. Reduced accessibility to the labour market and a career, due to poor education, effectively reinforces this image of deaf people as less capable (Kermit 2006).

In the bioethical context of paediatric cochlear implantation it is important to note that the ability to hear with an implant is by no means an automatic effect of surgery. The ability to understand and interpret sounds comes only as a result of training and habilitation. The outcome of this habilitation varies. Many implanted children achieve a good hearing capacity, though there are still no documented cases in which an implanted child has achieved normal hearing. This implies that a large percentage of implanted children are bound to strive in order to understand speech (Wie 2005).

Second aspect – Deafness

Deaf people's experiences of learning that signed languages were scientifically proven as fully fledged languages have been experiences of emancipation, not because this knowledge alleviated the physical hearing impairment, but because it unmasked as false the conception that deaf people were cut off from natural language due to natural causes.

In this sense, the notion that Deaf people are not disabled can really be defended. A deaf person's disability exists due to physical and social conditions, but having a signed and seen language as one's primary language instead of a spoken and heard one does not in itself constitute anything that should be labelled disability. On the contrary, as signed languages are natural languages at least in theory there should be nothing preventing signing people from forming an authentic identity (Honneth 2000; Taylor 1992a, 1992b) and realizing one's cognitive, social and lingual potential. With the new knowledge of signed languages, these perspectives regarding identity were in many ways spontaneously realized among deaf people, something that only increased the sense of emancipation and supported the notion of Deaf communities as linguistic minorities of interdependent people.

Still, as the argumentation in Part 1 rejected the antinomy between deafness as impairment and Deafness, it is important to increase the level of accuracy when describing the Deaf community. Several philosophical questions would be raised if it suggested that a language should be considered a pure social construction. Language

is a concept underlying all aspects of human life and it is thus unproblematic to recognize Deaf people as a lingual minority and still keep the notion that most members in this minority are disabled due to their hearing impairment as well as socially constructed barriers. As all languages are living memories reflecting the history of those who speak the language, it is interesting to note that many signs reflect the specific experience of being deaf, both socially and physically. This should not come as any surprise as it is only natural that Deaf people speak about what they have in common, and that which is very common among Deaf people are the collective and individual experiences of social exclusion, lack of recognition and social barriers.

This in itself challenges the notion that Deaf people's status as a lingual minority solves the basic questions of accessibility and social justice; questions frequently raised in the general discourses on disabilities. For example, a sign language interpreter is normally seen as a tool that can reduce social barriers deaf people are facing by translating between spoken and signed language. However, if Deaf people really want to interact with people outside the Deaf communities as equal citizens in the same society, an interpreter will not take a Deaf person far if the Deaf person has no knowledge or understanding of how this society works. The image of Deaf people living as a segregated minority in sign language 'reservations' is thus not very satisfying. The emancipatory potential of Deafness is not realized until Deaf people have the same possibility to take part in society as a whole. This is not achieved by more interpreters, but probably only when Deaf people have a bilingual capacity that enables them to interact also in settings where the majority of languages are spoken. In order for Deaf people to have the same rights and opportunities as everybody else they must have a bilingual capacity that fully enables them to participate. This accentuates questions related to which social barriers actually constitute deafness as a disability.

Third aspect – deafness as socially constructed disability

The primary socially constructed barriers facing d/Deaf people are not everyday obstacles like sound-based media (radio and television without caption) or that the next train stop is called out in a loudspeaker and not displayed. The primary socially constructed barriers are related to the alienation d/Deaf people experience when hearing people fail to recognize the significance of sign language. This might not be very grave in an everyday setting, but if we look through the historical glasses of Deaf consciousness, the deaf education described previously is framed as the main socially constructed barrier preventing deaf children from full societal membership. The hallmark of this education was the notion that speech was the objective and signs had no place in the curriculum. Rather, sign language was not even recognized as a real language and deaf children should thus be habilitated in order to become as hearing-like as possible (something that did not prevent deaf children from signing and passing on sign language to new students nonetheless). The poor outcome resulting from this education/habilitation for many deaf children proved to be a disadvantage that prevented many from achieving a higher education, appropriate careers and the like.

The emancipatory potential of recognizing signed languages as languages thus has a very direct and practical implication. If the acquisition of a bilingual capacity is recognized as a sensible educational objective for d/Deaf children, to learn a spoken language would probably be easier with a bilingual approach where speech and signs

could be contrasted and bilingualism considered a positive extension opening opportunities instead of a regrettable necessity because a child cannot hear.

Paradoxically, cochlear implants could thus be a welcomed aid or a real threat. If bilingualism is the objective, anything that could ease a deaf child's acquisition of a spoken language should be utilized. However, if implantation is conceived as a procedure that simply switches the child's ears from 'deaf' to 'hearing', the belief that cochlear implants eradicate a disability by alleviating impairment could revive the historic notion mentioned previously that one should seek to habilitate deaf children with the objective of making them as hearing-like as possible. As the historic outcome of this doctrine of normalization has been poor and constitutes the biggest socially constructed barrier for deaf people, and given that cochlear implants are still a long way from really curing deafness, the Deaf scepticism towards the implant is understandable. Cochlear implants in this respect are not something new and revolutionary in the Deaf view, rather more of the same normalization approach that does not work and has the unfortunate side-effect of imposing a self image as inferior and flawed on many deaf children.

This argument of a three-fold intertwined notion of d/Deafness may very well be criticized for being a mostly theoretical construct, very much like the alleged antinomies between d/Deafness and between medical and social constructions of disability. The argument is not without empirical support, however. In addition to the empirical references earlier, there are anthropological studies that portray people with hearing impairments within a qualitative narrative tradition (Nakamura 2006; Breivik 2005). Though these references span from studies conducted in Japan to studies conducted in Norway, many of the life histories of the portrayed deaf and signing people display a similarity which supports the notion that the antinomic division between deafness as impairment and cultural Deafness is an over-simplification. Even people who describe themselves in a progressive manner, stating that they strongly identify themselves with the Deaf culture, also assign relevance to the specific experiences of not hearing. These studies also point to the contingent nature of the conclusions that can be drawn regarding the benefits of the implant – its benefits will depend on the society in which the child lives – and therewith also to the inadequacy of a bioethical discourse that neglects social and cultural contingency.

Conclusion: founding bioethical discourses on a consistent conception of d/Deafness

In the present article I have suggested a three-fold intertwined notion of d/Deafness that does not reject the relevance of impairment, recognizes the ethical significance of sign language and identifies the principal socially constructed barriers disabling deaf people.

As cochlear implants have been a central issue in articulating these positions, the conclusion implied earlier was not that implants should either be fully adopted or totally rejected. On the contrary, I have tried to demonstrate that it is the place the implant takes in the general approach to d/Deafness as a complex phenomenon involving both biology and convention that decides whether implants represent something potentially positive or negative to prelingual deaf children.

With both the recognition of signed languages as well as new technology like the cochlear implant, prelingual deaf children have probably never before had such an opportunity to realize their social, cognitive and lingual potential and form an authentic identity. The bioethical discourse on cochlear implants referred to here has

been based on an alleged antinomy between deafness as physical impairment and Deafness. I have argued that this antinomy is a mere chimera. The notion that bioethics is ruling upon a case in which there is a clash between nature and social convention is over-simplified and probably of little help to deaf children, their parents and professionals employed either with cochlear implantation or deaf education. First and foremost the complexity at hand should be recognized. By analysing three different ways in which d/Deafness can be conceptualized, I have tried to shed light on some finer distinctions that may prove decisive as to whether or not cochlear implants can serve the deaf child or not.

Acknowledgement

The author's work is supported by the Department of Social Work and Health Science at the Norwegian University of Science and Technology (NTNU).

Note

1. A cochlear implant is a technical device designed to improve the hearing ability of people with hearing impairments. Like conventional hearing aids, the external component of a cochlear implant picks up sound with a microphone. Conventional hearing aids amplify this sound and deliver it through a loudspeaker into the carrier's ear. This is however not very helpful for many people with a severe or profound hearing loss. Instead of amplification, the outer component of a cochlear implant transforms the sounds picked up by the microphone into an electric signal which is transmitted wirelessly to the inner (implanted) component. A small electrode is inserted surgically into the carrier's cochlea. The transformed sound signal is conveyed directly to the auditory nerve through this electrode, thus bypassing damaged portions of the ear. With training and rehabilitation a person can learn to interpret these signals as sounds.

References

- Armstrong, D.F., M.A. Karchmer, and J.V. Van Cleve. 2002. *The study of signed languages: Essays in honor of William C. Stokoe*. Washington, DC: Gallaudet University Press.
- Balkany, T., A.V. Hodges, and K.W. Goodman. 1996. Ethics of cochlear implantation in young children. *Otolaryngology-Head and Neck Surgery* 114: 748–55.
- Beauvoir, S.D. 1961. *The second sex*. New York: Bantam Books, Inc.
- Berger, P., and T. Luckmann. 1991. *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin Social Sciences.
- Brevik, J.K. 2005. *Deaf identities in the making. Local lives, transnational connections*. Washington, DC: Gallaudet University Press.
- Cohen, N.L. 1994. The ethics of cochlear implants in young children. *American Journal of Otolaryngology* 15, no. 1: 813–4.
- Davis, D.S. 1997. Cochlear implants and the claims of culture? A response to Lane and Grodin. *Kennedy Institute of Ethics Journal* 7, no. 3: 253–8.
- Hacking, I. 2003. *The social construction of what?* Cambridge, MA: Harvard University Press.
- Harris, J. 1995. *The cultural meaning of deafness: Language, identity and power relations*. Aldershot, UK: Avebury.
- Harris, J. 2000. Is there a coherent social conception of disability? *Journal of Medical Ethics* 26: 95–100.
- Honneth, A. 2000. Zwischen Aristoteles und Kant. Skizze einer Moral der Anerkennung. In *Moral im sozialen Kontext*, ed. W. Edelstein and G. Nunner-Winkler, 171–92. Frankfurt am Main: Suhrkamp Verlag.
- Fichte, J.G. 1965. *Gesamtausgabe I,4*. Stuttgart-Bad Cannstatt: Friedrich Frommann Verlag (Günther Holzboog).
- Johnston, T. 2005. In one's own image: Ethics and the reproduction of deafness. *Journal of Deaf Studies and Deaf Education* 10, no. 4: 426–41.
- Kant, I. 1929. *Critique of pure reason*. London: Macmillan Press LTD.

- Kant, I. 1983. Grunnlegging av moralens metafysikk [Fundamental principles of the metaphysic of morals]. In *Moral, politikk og historie* [Morals, politics and history], ed. E. Storheim. Oslo: Universitetsforlaget.
- Kant, I. 1989. *Kritik der reinen Vernunft*. Stuttgart, Germany: Philipp Reclam jun. GmbH and Co.
- Kermit, P. 2006. Tegnspråk og anerkjennelsen av døve som en språklig minoritet. In *Tegn som språk: En antologi om tegnspråk*, ed. S.R. Jørgensen and R.L. Anjum, 47–59. Oslo, Norway: Gyldendal Akademisk.
- Kermit, P. 2007. Bioethical discourses on deafness: Critical remarks and suggestions for a new approach. In *Constructing educational discourses on deafness*, ed. M. Hyde and G. Høie, 40–57. Oslo, Norway: Skådalen Resource Centre.
- Kristiansen, K., and P. Kermit. 2007. Book review: Disability rights and wrongs. *Scandinavian Journal of Disability Research* 9: 278–81.
- Ladd, P. 2003. Understanding deaf culture, in search of deafhood. Clevedon, UK: Cromwell Press Ltd.
- Lane, H. 1993. Cochlear implants: Their cultural and historical meaning. In *Deaf history unveiled: Interpretations from the new scholarship*, ed. J.V. Van Cleve, 272–92. Washington, DC: Gallaudet University Press.
- Lane, H. 1995. Constructions of deafness. *Disability and Society* 10: 171–89.
- Lane, H. 1999. *The mask of benevolence: Disabling the Deaf community*. New York: DawnSignPress.
- Levy, N. 2002. Reconsidering cochlear implants: The lessons of Martha's Vineyard. *Bioethics* 16: 134–53.
- Markowicz, H., and J. Woodward. 1978. Language and maintenance of ethnic boundaries in deaf community. *Communication and Cognition* 11: 29–38.
- McCaughey, J. 1995. Cochlear implants: Some considerations of a more or less ethical character. *Annals of Otolaryngology and Laryngology* Suppl.
- Nakamura, K. 2006. *Deaf in Japan. Signing and the politics of identity*. Ithaca, NY: Cornell University Press.
- Nunes, R. 2001. Ethical dimension of paediatric cochlear implantation. *Theoretical Medicine and Bioethics* 22: 337–49.
- Oliver, M. 1996. *Understanding disability: From theory to practice*. Basingstoke, UK: Macmillan.
- Savulescu, J. 2002. Deaf lesbians, 'designer disability', and the future of medicine. *BMJ* 325: 771–3.
- Shakespeare, T. 2006. *Disability rights and wrongs*. London: Routledge.
- Stokoe, W.C., Jr. 2005. Sign language structure: An outline of the visual communication systems of the American deaf. *The Journal of Deaf Studies and Deaf Education* 10: 3–37.
- Taylor, C. 1992a. *The ethics of authenticity*. Cambridge, MA: Harvard University Press.
- Taylor, C. 1992b. The politics of recognition. In *Multiculturalism and the politics of recognition*, ed. A. Gutman, 25–74. Princeton, NJ: Princeton University Press.
- Tucker, B.P. 1998. Deaf culture, cochlear implants, and elective disability. *The Hastings Center Report* 28: 6–14.
- Van Cleve, J.V., ed. 1993. *Deaf history unveiled: Interpretations from the new scholarship*. Washington DC: Gallaudet University Press.
- Vehmas, S., and P. Mäkelä. 2008. A realist account of the ontology of impairment. *Journal of Medical Ethics* 34: 93–5.
- Wie, O.B. 2005. *Kan døve bli hørende? En kartlegging av de hundre første barna med cochleaimplantat i Norge*. Oslo, Norway: Unipub forlag.