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Feminist Bioethics

Judith Andre*

Abstract

Feminist bioethics addresses issues related to women's lives in health care, health science, and health policy. Feminist bioethics can extend to analogous issues of power and oppression as they occur in race, social class, disability, and sexual orientation. The field highlights both subject matter and methodology. Concerning subject matter, much of it concerns women as patients, particularly as child-bearers; these are familiar issues such as abortion, contraception, reproductive technologies, and the medicalizing of childbirth and menopause. Subject matter also includes women as health care workers, researchers and as research subjects. Finally, feminism tries to expand the methodologies of bioethics, first by listening to what women say, in all their roles; second, by adding to the field's traditional foci on rights and justice, those of relationships and responsibilities.

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* Professor Emerita, Michigan State University
andre@msu.edu

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There are many different feminisms, perhaps as many as there are feminists. I present here my own views, after spending many decades in the field. I start with basic definitions, and some background.

Feminism: A Definition and Description

First, I define feminism as the belief that the situation of women can and should be improved. Ordinarily this belief is accompanied by some sort of action – personal, political, scholarly, or other. Notice how narrow my definition is: it does not even entail that women are worse off than men, simply that the lives assigned to women could and should be made better. "Assigned to women" here means socially constructed; all human lives are shaped by culture. Many cultural arrangements are clearly oppressive: they constrict lives in ways that are both damaging and unnecessary. This sort of oppression happens to many different groups, along racial, economic, cultural, and other lines.

What is called (in the United States) the second wave of feminism began in the 1960s, that pivotal and explosive decade of social change. The phrase implicitly refers to a "first wave" of feminism, the movement which won the vote for women in England and America. In fact, however,

feminist historians soon discovered that the "first wave" was only the most recent of many such efforts, by and for women, throughout history.

Feminist concern with the oppression of women soon developed into a concern with oppression more generally, i.e., with the situation of racial minorities, of people with disabilities, of gays and lesbians, and so on. These issues matter morally and are interesting theoretically, as they deepen our understanding of what counts as oppression and injustice. Feminists are also deeply concerned with having a voice: changing society demands being heard. This elemental need soon gave rise to new forms of scholarship. Much of what "we" know has been limited because both the questions pursued were in some sense male, i.e., chosen by people whose lives were typically quite different from those of women. Few scholars in the past were intimately and daily involved in caring for children, even their own. Few of them were at habitual risk of sexual violence. Most were economically independent, at least to the extent that they could find someone to support them in their work. Women, usually living very differently from that, can be curious, puzzled, and fascinated by subjects ignored by men. As women entered the worlds of study and research, whole new areas of study opened. It has been a matter not only of subject matter, but of method: new ways of investigating old questions as well as new ones. Ethical theory has been one of those importantly reshaped by feminism.

I should add that although women across the world and through the centuries have in various ways stood up for themselves, their sisters, and their daughters, this particular manifestation began in the United States and from the beginning has tended to focus on American women. Although that's still true, more and more work concerns (and is being

done by) women in other countries.

That, then is my view of feminism: a conviction that the lives of women can and should be made better, accompanied by some action toward that goal; for academics that action often involves their choice of subject matter and of method.

Bioethics: A Definition and Description

Now for my definition of bioethics: a scholarly and public discussion of questions of right and wrong, good and bad, as they occur in health care, health policy, and health science. Like feminism, the current manifestation of bioethics began in the United States in the 1960s. But also like feminism, bioethics has in some sense a long history. Doctors, nurses, and others working in health care have always been concerned with ethical standards. What makes today's concern distinctive is that professional norms of practice are debated publicly; in previous years the conversation happened privately, within the professions, and usually it concerned promulgating norms rather than deliberating about what they should be.

Feminist bioethics, then, addresses issues, health and health care related, that concern women's lives; it can extend to analogous issues of race, class, disability, and sexual orientation. Feminist bioethics also tries to call into question standard bioethics methodology, ways of asking and answering questions, which can be gendered just as one's choice of subject matter can be.

The subject matter of feminist bioethics includes a list of familiar

topics: abortion, contraception, reproductive technologies, the rights of pregnant women, and the medicalizing of childbirth and menopause. Notably, all of these topics concern women as child-bearers. As important as pregnancy and birth are, women's lives include far more. We differ from men not only in reproductive biology, but in other biological ways and, very significantly and closely linked to biological difference, in social position.

Mothers almost always spend more time in caring for children than do fathers. Women provide sexual gratification to men – of course this is often, and ideally, a mutual pleasure and partnership; but rape happens, and its treatment by medical personnel has gotten attention and been improved. Far more widespread are stringent social limitations on what women are allowed to do – almost always justified in terms of guarding their sexual purity. That last consideration has two root causes; the more legitimate one concerns children, and their need for committed parents. Men who know that their children are their own are more likely to be committed to protecting and supporting them. But we should not ignore the other reason women are often allowed less freedom – the fact that confining them allows men to consider not only the children, but the women, as their own.

For many reasons women's paid work tends to hold less status and authority than those of men. Furthermore, jobs are often structured on a "male model": i.e., developed for workers whose children and households are managed by others. The result is that women who work full time in the paid workforce (or in the fields, in more agrarian societies) put in "double days": they still care for the children and the home, and put in a full day on the job.

Against that background, it becomes clear that a broader range of topics warrants feminist attention. Women's lives intersect with health care, health policy, and health science in many ways. Women are patients; they are health care providers; they are scientists; they are research subjects.

As for bioethics methodology, feminists try to expand it, in two ways. First, simply by listening to what women say, in all these roles; second, by adding to the original foci on rights and justice, those of relationships and responsibilities. I will return to this topic later.

I should note that feminist bioethics, like all bioethics, is not just a matter of philosophical analysis. It demands close attention to the findings of social and biological science. Getting one's facts straight is absolutely basic.

Women as Patients: The Domain of Reproduction

Let me begin, then with women as patients. Topics here begin with the list of reproductive issues I mentioned earlier, and most prominently (in America) with the right to abortion. Feminist bioethicists defend the legal right strongly, and are also concerned with practical accessibility. In some regions so few health care providers perform abortion that in practical terms it is unavailable. Providers face social stigma and physical danger, and many doctors who in principle defend abortion rights choose not to perform them. But consistency to one's principles may demand taking risks to uphold them. We encourage medical students to think seriously about their willingness to perform abortions.

There is a related issue, that of prenatal testing. This is almost always done, and it is done − although this is not made explicit − because many women will choose to abort abnormal fetuses. Those doctors who believe abortion is always wrong face a dilemma: do they prescribe the prenatal tests, which are now a standard part of obstetrical practice? We argue that they must, and if they believe they cannot, they should not specialize in obstetrics.

Abortion is deeply controversial in the United States; many believe it presents serious moral challenges. Unfortunately these have been badly oversimplified in the public and especially political discussion: everyone seems to be either "pro-choice" or "pro-life," and each position is presented as absolute. In fact, however, most Americans have more nuanced positions, believing abortion is justified in some circumstances and not in others. The issue seems to be gaining attention in Korea, and to my dismay, the same simplistic slogans used in the United States (pro-life and pro-choice) are being used to frame the debate. I deeply hope that Asian countries in general, and Korea in particular, will find new approaches, new categories, new language. The moral issues here are deep, and no one should be happy with their oversimplification.

Nor, for that fact, with their being ignored. I must admit that although American feminist bioethicists speak strongly about the legal and policy issues, little is written about the personal moral dilemmas that face women with unwelcome pregnancies. In a sense this is no surprise, since bioethics in general has little to say to patients. Its central concerns are the behavior of health care professionals and the nature of public policy. Still, I think this is a loss. Perhaps here too Asia, Korea especially, can take the lead.

The current feminist literature does acknowledge several complications of special interest: in particular, recently, the fact that some fetuses that are aborted on account of disabilities, and the concern that this devalues those who are born with handicaps. There is a vigorous debate about this issue. There is also the fact that in some countries, particularly in Asia, the preference for sons leads to the abortion of female fetuses simply because they are female. (I am delighted to learn that the preference for sons has lessened or disappeared in Korea.)

Other issues related to reproduction also attract feminist attention. One is reproductive technologies: feminists usually argue that they should be available to women who want to use them, because they expand women's power over their own lives; on the other hand, surrogacy – in which one woman bears a child that will be raised by another – raise serious questions of exploitation. For similar reasons, so does the sale of ova.

Other feminist issues arise before pregnancy and at its end. Long-term contraceptives, done by injection or by implant, are difficult to reverse, and have at times been forced upon women (by judges, for instance). Research on male contraception seems perpetually to languish. Pregnant women often find their actions publicly controlled: in one famous case a waiter refused to serve a glass of wine to a visibly pregnant woman. Once labor begins, coercion can increase; judges have even ordered that cesarean sections be performed on women who have refused them.

Women as Patients: Beyond Reproduction

Women's bodies differ from men's, but for years the male body was taken as the standard human body; femaleness was taken as a variant on the norm. The ways in which women differ from men were sometimes understood as deficiencies and problems unique to women were little researched. That has changed in the last few decades as the women's movement has gained considerable social power. We now know, for instance, that the symptoms of a heart attack in women can differ from those in men. There are more complicated issues which need both empirical and analytical clarity. Why is it, for instance, that women are more frequently diagnosed with depression? Is it the attitude of doctors, women's social situation, women's biology, or some mixture of all three?

Issues of gender identity also arise. For instance, some babies are born with ambiguous genitalia; in other cases people become convinced as they grow up that their true selves do not correspond with their biological selves: men are sometimes convinced that they are in some essential way women, and vice versa. Hard questions about the appropriateness of surgical intervention arise.

As feminist bioethics has become global, dramatic issues have arisen. In parts of Africa women are "circumcised" – that is, part or all of girls' external genitalia are removed, often without anesthetic and in unsterile conditions. In some parts of the world the virginity of young women is (thought to be) established by medical examination. In many parts of the world, women are denied basic medical care; Amartya Sen, economist and Nobel laureate, developed a tool for measuring the consequences. The tool is simple, really; there is a well known normal ratio between males and females in populations, when the two sexes have equal access to medical care (and food and shelter). That ratio is dramatically different in some

countries, and it can indicate a radical difference in health resources available to girls and women. It can also result from female infanticide, and from abortion for sex selection.

In many of those situations the ethically interesting question is not about the situations themselves, whose wrongness is generally assumed, but about what if anything people from the other countries should do. Ethically, how does respect for culture and for norms internalized by the women themselves limit appropriate outside intervention? And as a matter of empirical fact, what, if anything, done by outsiders would make a difference?

Women as Health Care Workers

Women are not only patients, they are also doctors, nurses, and therapists. Most of these fields follow a male model of professional life; i.e., they developed when doctors were virtually always men − men with wives at home. The wives managed the household and probably its finances, reared the children, and organized the family's social life; men could practice medicine and still have a personal life, arranged by their wives. Today women are as likely as men to enter medicine, but they will not have the luxury of a stay-at-home spouse. In addition they are more likely than men to want to spend significant amounts of time with their children. And, of course, women get pregnant. These differences are leading to some changes in the way medicine is practiced; they are, for instance, one of the reasons solo practice is becoming unusual. Medical education, too, is changing, so that students can stretch out the traditional four year program into five or six.

And now a predicable split is developing, as women are more likely to go into family practice and into pediatrics, and far less likely to enter fields like interventional cardiology and neurosurgery. Reasons for this include a desire to start a family rather than spend many additional years in training, but also the tendency of women to choose fields that include more human interaction. The results of the split, however, bear watching. One of the near universals in gender relationships is that fields dominated by women provide less prestige and less income than those dominated by men, and if gender imbalance in medical specialties persists and deepens, women's portion of social goods will continue to be less. The subspecialty fields will also suffer, as its members are drawn from only half of the talent pool available. (Imagine if half a group of teenagers were arbitrarily told "you cannot become a neurologist, or cardiologist, and so on.")

This leads to the situation of nurses, always a female dominated field. Recent severe shortages have led to higher pay for nurses, but this picture is worth a closer look. The shortages themselves have interesting roots. Nursing salaries have always been a large fraction of any hospital's budget. As hospitals tried to rein in their costs, the obvious move seemed to be to reduce the number of nurses on staff. This meant, of course, that the workload for nurses increased. Add to these pressures a usual fact about gender: decision makers can easily fail to appreciate the demands of work that is primarily done by women. The compassion that nursing embodies is always recognized, because compassion is a stereotypical female trait, but the technical complexity in the field is often underestimated. In addition the voices of nurses themselves can go unheard. About a decade ago I watched hospitals "restructure" their workforces. This meant peeling away some tasks traditionally done by nurses and assigning the work to "unlicensed personnel": workers with much less

training, earning much less money. Doing so saved the hospitals money, but demoralized nurses, whose jobs changed dramatically and became quite fragmented. Holistic patient care was much less possible. For this and other reasons (like the fact that many other fields had become open to women) women left nursing, especially hospital nursing, in increasing numbers. Hence today's shortage.

Feminist bioethicists have paid too little attention to the situation of nurses. There is rich material here for analysis, for empirical research, and for advocacy. At the moment purely economic forces are leading hospitals to take nursing more seriously, not only to raise salaries but also to improve working conditions and include nurses in decision-making roles. Feminist bioethics should be more involved in what is after all a paradigmatic women's issue.

As Research Subjects and as Researchers

When the second wave of feminism began women were often excluded from clinical trials of new pharmaceuticals. This was done for two reasons: first, the possibility that a woman could be pregnant, and the investigational drug damage her fetus; second, the assumption (mentioned above) that the male body was the standard human body. The result, however, was that drugs were used on women that had only been tested on men. After protests and pressure, those assumptions have been abandoned, and women are part of the pool of research subjects. In many areas, however, the gender balance among subjects is still uneven. This has implications not only for women as patients, but for men as well, since finding differences (or the lack of them) contribute to an understanding of

the disease process itself.

Women are not only research subjects, they are researchers. When they are, they face the same sorts of pressures that face women in medicine: a template for the professional life that is hard to meld with a determination to spend significant time with one's children. The result is a significant underrepresentation of women among biological scientists. Again the loss is not only to the women whose careers are diverted, but also to the field itself. Part of the talent pool is not being tapped. But in addition to the purely numerical way of putting the loss, note as well that in some fields women tend to bring up different questions for research. This has been obvious in the humanities, as women historians and social scientists are often aware of, and investigate, different issues than do men. I do not want to essentialize: the interests and approaches of the two sexes overlap for the most part; but there is some difference, and the degree of it varies from field to field.

Feminist Methodology

This brings me to my final topic. Feminists hope to change methodology in bioethics, as they do in many other fields. In general the criticisms are that standard approaches are too individualistic, too concentrated on rights, too abstracted from context, and too focused on dramatic issues rather than on what might be called "housekeeping" issues. Feminists also hope to challenge basic assumptions that can go unnoticed. Sometimes this last challenge is phrased as a disagreement between liberal feminists and radical ones: liberal feminists are described as wanting "a piece of the pie," i.e., a share in the good things of which men have a disproportionate

share: professional positions, good salaries, access to health care, and so on. Radical feminists are more likely to propose changing our "recipe" for that pie. Radical feminist political theory often espouses some form of socialism, or proffers other radical possibilities for the way economics and politics are structured.

In ethics, the challenge is not to the way society is structured, but to basic ethical theory. Two books here have been particularly influential. One was Carol Gilligan's *A Different Voice*. Published almost thirty years ago, the book has been both hailed and reviled. Gilligan is a psychologist; she believed that she had found a different way of thinking about ethical dilemmas, one more common in women and girls than in boys and men. This "different voice" treated ethical problems not as a mathematical balancing of rights, but as matters of conflicting responsibilities and as threats to relationships. Over the years, naturally, her findings have been challenged, and she has refined them. In addition her work has at times been viewed as dangerous to feminist concerns, because they can be interpreted as claiming that differences between men and women justify unequal (and almost always lesser) positions for women.

The other important early work was Nel Noddings' *Caring*. A philosopher, Noddings argued that the fundamental ethical good was neither the happiness of utilitarianism nor the rational dignity of Kant, but relations of caring between persons. Like Gilligan's, Noddings' analysis has been subject to serious criticism both by feminists and non-feminists alike. Yet both books, I believe, have been influential and some of the insights of each have gradually been incorporated into philosophical ethics.

In feminist bioethics in particular, however, there has been no parallel attempt. The lack may be because bioethics itself is both pragmatic and polyglot, primarily concerned not with abstractions but with practicalities, and drawing from many different disciplines. There is no single "voice" to challenge. But various insights from feminist ethics and political theory do play a role. I would suggest that the most theoretically interesting work in feminist bioethics arises in the related areas with which it is concerned: race theory, disability studies, and "queer theory," i.e., gay and lesbian ethics. The relationships and overlap between these and feminist bioethics are fertile ground; but they are the subject of a different paper.

Feminist bioethics, then, persistently calls attention to women's issues, not just in our lives as patients, although that's essential; not just in our reproductive lives, although that is also essential. It also looks at our lives as health care providers, as research subjects, and as biomedical scientists. It tries, with some difficulty, to "do bioethics differently": to talk less about rights and more about relationships, and to ask deeper questions about what kind of life, and what kind of society, is good.

In all of this work many of us hope that the new voices and perspectives from Asia will become important. We hope that you will provide new concepts, new issues, and new vocabularies. I have expanded on that idea in a short piece called "Fusion Bioethics," listed in the bibliography below.

Together let us work toward a better world for women and for men. Bioethics requires both thinking and action; each informs the other. In the globalizing world before us, what is thought and done in Korea can have

an impact far away. We all need to work, patiently, respectfully, and together.

Further Reading

Books:
Feminism & Bioethics, Susan M. Wolf
Patient No Longer, Susan Sherwin
Linking Visions: Feminist Bioethics, Human Rights, and the Developing World, Tong, Donchin, and Dodds
Feminine and Feminist Ethics, Rosemarie Tong

Networks:
FAB: Feminist Approaches to Bioethics http://www.fabnet.org/
FEAST: Feminist Ethics and Social Theory www.afeast.org

Journals:
Hypatia (a journal of feminist philosophy)
International Journal of Feminist Approaches to Bioethics

Article:
"Fusion Bioethics," Judith Andre. *Medical Humanities Report*, Michigan State University, Vol. 32, No. 1. Fall 2010. http://www.bioethics.msu.edu/index.php?option=com_content&view=article&id=79&Itemid=77