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Why a Feminist Approach to Bioethics?

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Abstract. Many have asked how and why feminist theory makes a distinctive contribution to bioethics. In this essay, I outline two ways in which feminist reflection can enrich bioethical studies. First, feminist theory may expose certain themes of androcentric reasoning that can affect, in sometimes crude but often subtle ways, the substantive analysis of topics in bioethics; second, it can unearth the gendered nature of certain basic philosophical concepts that form the working tools of ethical theory.

Those who work in feminist bioethics are all too familiar with the question, "Why think that feminism offers a distinctive contribution to bioethics?" When asked respectfully, I take it to be a fair question. After all, even if we were to stipulate that the tenets of feminism are profound and wise, it would not guarantee that they offer substantial illumination in every subject matter. However, while it is a good question to ask, it also has a good answer. In this essay, I outline why it is, and how it is, that feminist insights provide such a valuable theoretical aid to the study of bioethics.

First, however, certain misunderstandings need to be addressed. Some individuals seem to understand feminist bioethics to be talk about women's issues in bioethics or, again, to be women talking about bioethics. But while the subject bears some relation to each, it is equivalent to neither. Feminist bioethics is the examination of all sorts of bioethical issues from the perspective of feminist *theory.* The question of feminism's contribution to bioethics can be understood, then, as a question about how and why bioethics might benefit from excursions into this sort of theory. And here the potential for dialogue is too often stunted by a tendency, on **[End Page 1]** the part of those who pose the question, to measure feminism's contribution solely in terms of any distinctive policy recommendations its advocates might give to familiar bioethical controversies. This tendency is often joined by frustration among those who have encountered the diversity within feminist thought, as they wonder how feminism's contribution to specific bioethical topics can be assessed until feminists resolve which camp--liberal, cultural, or radical, say--is correct. But this policy-oriented view of feminism, and of what would count as a "distinctive contribution," sets the stage for far too flat a conception of how feminist theory can enrich bioethics.

At its most general, feminist theory can be thought of as an attempt to uncover the ways in which conceptions of gender distort people's view of the world and to articulate the ways in which these distortions, which are hurtful to all, are particularly constraining to women. These efforts involve *theory*-- and not merely benign protestations of women's value or equality-- because the assumptions at issue are often so subtle or so familiar as to be invisible, and, crucially, because the assumptions about gender have shaped not only the ways in which we think about men and women, but also the contours of certain fundamental concepts-- from "motherhood" to "rationality"-- that constitute the working tools of theoretical analyses. According to feminist theory, that is, distorted and harmful conceptions of gender have come to affect the very ways in which we frame our vision of the world, affecting what we notice, what we value, and how we conceptualize what does come to attention.

If these claims are correct, then feminist theory will be useful to disciplines whose subject-matter or methods are appreciably affected by such distortions--and it will be useful in ways that far outstrip the particular policy recommendations that feminists might give to some standard checklist of topics. For one thing, feminist reflection may change the checklist--altering what questions people think to ask, what topics they regard as important, what strikes them as a puzzle in need of resolution. Or again, such reflection may change the analyses underlying policy recommendations--altering which assumptions are given uncontested status, which moves feel persuasive, what elements stand in need of explanation, and how substantive concepts are understood and deployed. If such reflections sometimes yield policies similar to those offered by nonfeminists, the differences in approach can still matter, and matter greatly, by influencing what precedent one takes oneself to have set, what **[End Page 2]** dangers one is alerted to watch for, what would later count as reason to abandon or re-think the policy. And if such reflections are sometimes followed by diverse policy recommendations, we should not be surprised, much less frustrated; for the diagnostic work that forms the core enterprise of feminist theory leads to policy recommendations only in combination with commitments on a variety of other fronts, from economic theory to the empirical facts of the case, about which feminists will understandably disagree.

This, however, is so far rather abstract. To give a more concrete sense of how feminist theory might contribute to bioethics, we need to dip into the theory itself. Accordingly, I want to outline two central themes common to virtually all feminist reflection and use them to illustrate two quite different ways in which attention to feminist insight offers illumination in health care ethics.

Androcentrism

One of the central themes of feminist theory is that human society, to put it broadly, tends to be androcentric, or male-centered. Under androcentrism, man is treated as the tacit standard for human: he is the measuring stick, the unstated point of reference, for what is paradigmatic of or normal for humans. To start with an obvious example, man is used as the supposedly generic representative of humanity. That is, when we want to refer to humans independently of gender, it is man that is cast for the job: in language ("Man does not live by bread alone"), in examples (such as the classic illustration of syllogistic reasoning, "All men are mortal, Socrates is a man, therefore Socrates is mortal"); in pictorial representations (according to the familiar depiction of evolution--still used in current biology texts--the indeterminate primate, gradually rising to bipedalism, is inevitably revealed in the last frame to be a man).

This depiction of "human"arguably places man in an unfairly privileged position, since he is not only a constituent, but the representative, of all humanity. But much deeper problems than this are at issue, for these supposedly neutral uses of man are not actually neutral. They are *false generics*, as revealed in our tendency to drop the so-called gender-neutral "he" in favor of "she" when speaking of professions (such as nanny) that are held mostly by women, or again by our difficulty in imagining the logic professor saying, "All men are mortal, Sally is a man (woman?), therefore Sally is mortal." **[End Page 3]**

The first problem resulting from this hidden bias is that androcentrism has a disturbing cumulative effect on our understanding of "human": over time, our substantive conception of what is normal for humans has come to be filled in by what is normal for men (excellent discussions of this general theme can be found in Bem 1993, especially Chapters 3 and 6; Minow 1990; and MacKinnon 1987, Part I). Certain features of men--their experiences, their bodies, their values--have subconsciously come to be regarded as constituting the human norm. His psychology, for instance, tends to define the human mind. In a famous study (Broverman et al. 1970), when psychologists were canvassed and asked to describe the "healthy" man, the "healthy" woman, and the "healthy" human, the list for men and humans turned out to be virtually identical, the list for women divergent. His body tends to define the human body. A clear, if depressing, example can be found in the Supreme Court decision in *General Electric Co. v. Gilbert* (429 U.S. 125, 1976). In a decision finally superseded legislatively by the Pregnancy

Discrimination Act, the Court decided that businesses could permissibly exclude pregnancy disabilities from general insurance coverage. Their reasoning was that "pregnancy-related disabilities constitute an additional risk, unique to women, and the failure to compensate them for this risk does not destroy the presumed parity of the benefits that accrue to both men and women," even though (as the Court was aware) the list of traditionally protected benefits included all manner of medical procedures that were unique to men, such as prostate operations and circumcisions. As Sandra Bem (1993, p. 76) puts it:

> The Court is androcentrically defining the male body as the standard human body; hence it sees nothing unusual or inappropriate about giving that standard human body full insurance coverage for each and every condition that might befall it. Consistent with this androcentric perspective, the Court is also defining equal protection as the granting to women of every conceivable benefit that this standard human body might require--which, of course, does not include disability coverage for pregnancy.

In addition, man's biography tends to define norms of practice in the work place. We need go no further than the academic tenure system for an example. Presumably, the idea of evaluating faculty for tenure after **[End Page 4]** their first seven years of employment is premised on the supposition that job performance during those seven years provides some rough indication of performance over the remainder of academic life. But, while this may be true for men, the same cannot be said for women. Factoring in the average time spent at graduate school, those seven years precisely correspond to likely childbearing years for women faculty--years most likely to involve pregnancy, birth, and breast-feeding, and hence most likely to involve severe sleep deprivation and time pressure. Of all the years of her academic career, these will be the ones *least* likely to represent her overall potential.

Second, treating man as the human norm affects, in subtle but deep ways, our concept of "woman." Males and females obviously differ from one another in various ways. "Different from" is a relation, of course, and a symmetrical one at that: if x is different from y, it is just as true that y is different from x. Under androcentrism, however, we tend to anchor man as the reference point and view woman's nature as a departure from his. A subtle but powerful message is communicated when we always anchor one side of what is logically a symmetrical relation as the fixed point of reference: the anchored point gains the status of the center; the other receives the status of the margin. Because man has been fixed as the reference point for so long, part of our very conception of woman has become the conception of "other"--she is, as Simone de Beauvoir (1952) put it, the *second* sex. Instead of thinking that men differ from women who differ from men, a subtle conceptual shift occurs, and we begin to think of women as simply "different"--as though "different" were an intrinsic property that adheres to them, instead of a relational property men also instantiate (see Minow 1990, pp. 53-56). In the end, it is a short step to regarding aspects of woman's distinct nature as vaguely *deviant*.

Further, woman becomes closely defined by the *content* of her departure from man. The fundamental ways in which women and men differ are, of course, in certain biological features. But when man's body is regarded as the neutral "human" body, woman's biological sex becomes highlighted in such a way that, in the end, awareness of woman very often is awareness of her sex. The phenomenon is akin to one that occurs with race. In white-dominated societies, being white gets anchored as the tacit reference point; over time, the fact that whites have a race tends to fade from consciousness, while people of color are seen as somehow more intrinsically raced (think of how many Americans use the phrase **[End Page 5]** "ethnic restaurants" to refer to non-European cuisine, as though Europeans had no ethnicity, or of how Western history books use the phrase "Ethnic Hoards" to refer, say, to the Mongolian invaders of Europe, but not, say, to the United States' invasion of Okinawa). In a similar way, woman's sex comes to be seen as more essential to her nature than man's sex is to his. We are more likely to see woman as ruled by the whims of her reproductive system than man is by his; more subtly, if no less dangerously, we are simply more likely to think of and be concerned with reproductive issues when thinking of women than of men. [1]

Finally, under androcentrism, woman is more easily viewed in instrumental terms--in terms, that is, of her relation to others and the functions she can serve them. We tend, for instance, to specify a woman's identity in relation to the identity of some man (think of how traditional titles of respect for women indicate her marital status while those for men do not). Or again, the norms of a good woman, unlike those of a good man, tend to value her function for others: an excellent man is one who is self-directive and creative; an excellent woman is one who is nurturing of others and beautiful for them to behold. More concretely, women's legal status often reflects an instrumentalist interpretation of her being. In certain countries, indeed, the interpretation is still as stark as it was in early English common law's doctrine of coverture, which declared, as the legalist William Blackstone ([1765-1769] 1979, Vol. 1, p. 430) wrote:

> By marriage, the husband and wife are one person in law: that is, the very being or legal existence of the woman is suspended during the marriage, or at least incorporated and consolidated into that of the husband; under whose wing, protection, and cover, she performs everything.

Awareness of these general androcentric themes will give new food for thought on any number of topics in bioethics. The medicalization of childbirth, for instance--too often packaged as a tiresome debate between those generically loyal to and those generically suspicious of technology--takes on more suggestive tones when we consider it in light of the historical tendency to regard women as "other" or deviant and hence in need of control (see, e.g., Rothman 1982). Certain patterns of research on women and AIDS emerge with greater clarity when viewed **[End Page 6]** against our proclivity to view women instrumentally: until very recently such research focused almost entirely on women as transmitters of the disease to their fetuses, rather than on how the disease manifests itself, and might be treated, in the women themselves (Faden, Kass, and McGraw, in press). Let me develop in slightly more detail, though, an example that brings to bear the full range of androcentric themes outlined above.

Many people were taken by surprise when a 1990 U.S. Government Accounting Office report (GAO 1990) indicated that women seemed to be underrepresented in clinical trials. To give a few now-famous examples, the Physicians Health Study, which concluded in 1988 that an aspirin a day may help decrease the risk of heart disease, studied 22,000 men and no women; the Baltimore Longitudinal Study, one of the largest projects ever to study the natural processes of aging, included no women at its inception in 1958 and still had no data on women by 1984, although women constitute 60 percent of the population over age 65 in the United States (see Laurence and Weinhouse 1994, p. 61). It is difficult to be precise about women's overall representation in medical research because information on participants' sex often is not gathered; but there does seem to be legitimate cause for concern. For one thing, U.S. Food and Drug Administration (FDA) guidelines from 1977 to 1993 barred all women of childbearing potential from early clinical trials, which seems to have discouraged their representation in later stages of drug research (Merton 1994). More broadly, a review of medical studies published in JAMA in 1990 and 1992 revealed that, in studies on non-gender-specific diseases, women were underrepresented in 2.7 times as many studies than were men (Bird 1994; see also Laurence and Weinhouse 1994, pp. 64-67).

The possibility of significant underrepresentation has raised concerns that women are being denied equal opportunity to participate in something they may regard as valuable and that women may face compromised safety or efficacy in the drugs and procedures they receive (for instance, the difference in the average weights of women and men raises questions about the effects on women of drugs that are highly dosage-sensitive). Now, determining what policy we should advocate with respect to women's inclusion in medical research is a complicated matter--if only because adding sex as a variable in research protocols can significantly increase the cost of research. [2] What is clear, though, is that awareness of various androcentric motifs can highlight important issues **[End Page 7]** that might otherwise remain hidden or camouflaged. Without the perspective of feminist theory, that is, certain concerns are likely not even to make it to the table to be factored in when policy questions arise (for a related discussion, see DeBruin

1994). Let me give some examples.

One argument against the inclusion of women commonly offered by those running clinical trials is that women's hormones represent a "complication": the cyclicity of women's hormonal patterns introduces a variable that can make it harder to discern the effects of the drug or procedure being studied. Now this is an interesting argument, for acknowledging the causal power of women's hormonal cyclicity might also suggest the very reason that it might be important to include women in studies, namely, the possibility that the cyclicity affects the underlying action of the drug or procedure. Medicine has only begun to consider and study this possibility in earnest (see Cotton 1990; Hamilton and Parry 1983). Early results include preliminary evidence that surgical treatment for breast cancer is more effective if done in the second, rather than the first, half of a woman's menstrual cycle, and that the effectiveness of antidepressants varies across a woman's menstrual cycle, suggesting that women currently receive too much for one half of the month and too little for the other (see Laurence and Weinhouse 1994, p. 71). Trust in all-male studies seems to reflect a broad confidence in the neutrality of treating the male body as the human norm and a familiar tendency to regard that which is distinct to woman as a distortion--in this case, by regarding women's hormonal pattern as merely distorting the evidence concerning the true effect of a drug or procedure, and hence as something that is best ignored, rather than regarding it as an important factor in its own right, one influencing the actual effect of the object studied.

Another reason often given for the underrepresentation of women by those running clinical trials is that women are harder to find and to keep in studies. There is an important element of truth here: questionnaires reveal that women report greater problems navigating the logistics of participating in drug trials--they find it more difficult, for instance, to arrange for transportation and child care (Cotton 1993; Laurence and Weinhouse 1994, pp. 70-71). But if it is currently harder for women to participate than for men, it is not because of some natural or neutral ordering of things; it is in large part because drug trials are currently organized to accommodate the logistical structure and hassles of men's lives. Organizers routinely locate trials where men are, such as the military, for instance, and to organize activities around work schedules in **[End Page 8]** the public economy. Again, there is a tendency to anchor what is normal for "participants" to features that are more typical of men. If women's distinctive needs show up on the radar screen at all, they appear as needs that would require "special" accommodation--and hence accommodation one may decline to make--as though accommodations for men have not already been made.

A different concern lay behind the now-defunct FDA guidelines barring women of childbearing potential from early clinical trials. Here the explicit rationale was fetal protection: the drugs women would be exposed to might harm fetuses they knowingly or unknowingly carried. A closer look, however, once again reveals the subtle presence of androcentrism: granting society's interest in fetal health, protective measures are applied quite differently to men and women. The guidelines in essence barred all fertile women from early trials--including single women not planning to have intercourse, women using reliable birth control, and women whose partners had had vasectomies (Merton 1994). In contrast, when trials were conducted on drugs suspected of increasing birth defects by affecting men's sperm (a possibility often forgotten), fertile men were simply required to sign a form promising to wear condoms during the trial (Laurence and Weinhouse 1994, pp. 72-73). The regulation was able to think of men under guises separate from their reproductive capacities, but, as Vanessa Merton (1994, p. 66) says, it "envisions all women as constantly poised for reproductive activity." Further, and again granting that fetal protection is important, one might argue that respect for parental autonomy argues in favor of allowing the individual to decide whether participation is worth the risk. But when respect for parental autonomy conflicts with protection for fetuses or children, society is much more willing to intrude on the autonomy if it belongs to a woman than to a man. Courts, for instance, have forced women to undergo cesarean sections in attempts to gain slight increases in a fetus's chance for survival, while they routinely deny requests to force fathers to donate organs--or even blood--to save the life of their children (see Daniels 1993).

Gendered Concepts

A second core theme of feminist theory maintains that assumptions about gender have, in subtle but important ways, distorted some of the broad conceptual tools that philosophers use. Certain key philosophical **[End Page 9]** concepts, such as reason and emotion or mind and body, seem in part to be *gendered* concepts--that is, concepts whose interpretations have been substantively shaped by their rich historical associations with certain narrow conceptions of male and female.

One such distortion stems from the fact that, historically, that which is tightly and consistently associated with woman tends to become devalued. Throughout history, woman has been regarded as a deficient human: as a group, at least, she does not measure up to the standard set by man. (Indeed, it would be surprising if there were not some such evaluation lurking behind the scenes of androcentrism, for it would otherwise be puzzling why it is man who is ubiquitously cast as the human norm.) Aristotle *defined* woman as "a mutilated male," placing her just above slaves in the natural hierarchy (*Generation of Animals*, Books I and II; *Politics*, Book I). In post-Darwinian Victorian society, when a theory emerged according to which "lower forms" of human remained closer to embryonic type, a flurry of studies claimed to demonstrate the child-like aspects of woman's anatomy. She was, as one chapter heading called her, "Undeveloped Man;" in the words of James Allan, a famous and particularly succinct anthropologist, "Physically, mentally, and morally, woman is a kind of adult child . . . Man is the head of creation" (both cited in Russett 1989, pp. 74, 55). Against this background, those things associated with woman can gradually inherit a depreciated status. "Womanly" attributes, or aspects of the world regarded as somehow "feminine," become devalued (which, of course, only serves to reinforce the poor judgment of women, as they are now associated with things of little value). To give just one illustration, think of the associations we carry about voice types and authority. A resonant baritone carries a psychological authority missing in a high squeaky voice. This is often cited as a reason women have trouble being viewed as authority figures; but it is also worth asking why authority came to be associated with a baritone rather than a soprano in the first place. Clearly, the association both reflects a prior conception of man as naturally more authoritative and reinforces that commitment, as women's voices then stand in the way of their meeting the "neutral" standard of authority.

Another common distortion stems from the fact that pairs of concepts whose members are associated with man and woman, respectively, tend to become interpreted in particularly dualistic ways. For much of Western history, but especially since the Scientific Revolution, men and women have been understood as having different appropriate spheres of **[End Page 10]** function (see, e.g., Gatens 1991, Pateman 1989, Bordo 1986, Lloyd 1983, Okin 1979). [3] Man's central role was in the public sphere--economics, politics, religion, culture; woman's central role was in the private sphere--the domestic realm of care taking for the most natural, embodied, and personal aspects of humans. This separation of spheres was understood to constitute a complementary system in which each contributed something of value that, when combined, made an ideal whole--the marriage unit. Of course, given the devaluation of that which is associated with woman, it is not surprising that woman's sphere was regarded as less intrinsically valuable: it is man, and what is accomplished in the public sphere, that represents the human ideal (a view reflected in history books, which are histories of wars and political upheavals, not of hearth and home). In any event, because the division was understood as grounded in the natures of man and woman, the separation was a rigid one; the idea that either side of the division could offer something useful to the other's realm would simply not emerge as a possibility. This dualistic picture of the nature and function of women and men, with its subtle devaluing of women, can bleed over to concepts that have been tightly associated with the sexes. When abstract concepts, such as, say, mind and body, come to be paired with the concepts of male and female consistently enough, their substantive interpretations often become tainted with the dualism that characterizes the understanding of those latter concepts. The nature of each comes to be understood largely in opposition to the other, and, while the pair is understood as forming a complementary whole, the functions of the components are regarded as rigidly separated, and the one that is regarded as "male"--here, mind--is held in higher

philosophical esteem.

These themes are mirrored in the interpretation of certain central philosophical concepts. An important instance is the traditional conception of reason and emotion, which plays a large role in moral philosophy. For all the hotly disputed debates in the history of ideas, one theme that emerges with remarkable consistency is an association of women with emotion and men with reason (see Tuana 1992, Chapters 2-4; Lloyd 1984). According to Aristotle (*Politics*, 1260a15), women have rationality "but without authority;" Rousseau (1979, p. 386) gives Sophie a different education from Emile because "the search for abstract and speculative truths, principles and axioms in the sciences, for everything that tends to general ideas, is not within the competence of women;" and according to Kant (1960, p. 79), "women's philosophy is **[End Page 11]** not to reason but to sense." Science has contributed its support--for example, tracing woman's supposedly greater proclivity towards volatile emotions to disorders of the womb (hence "uterus" as the root of "hysteria") and her restricted intellect to the "hormonal hurricanes" of her menstrual cycle (see Smith-Rosenberg 1972; Russett 1989, especially Chapter 4; and Fausto-Sterling 1992, Chapter 4). As James Allan wrote, "In intellectual labor, man has surpassed, does now, and always will surpass woman for the obvious reason that nature does not periodically interrupt his thought in application" (cited in Russett 1989, p. 30). (Apparently Allan suffered no concern that man's rather more constant hormonal activity might be rather more constantly interrupting his thought!)

The conception of reason and emotion found in much of traditional ethical theory bears the mark of these entrenched associations (see Jaggar 1989, Lloyd 1983). There is a tendency to regard reason and emotion as having completely separate functions and to regard emotion, at best, as irrelevant to the moral enterprise and, at worst, as something that infects, renders impure, and constantly threatens to disrupt moral efforts. Emotion is conceptualized as something more to do with the body we have as animals than the mind we have as humans; it is viewed as a faculty of blind urges, akin to pains and tickles, rather than as responses that reflect evaluations of the world, and that hence can be "tutored" or developed into mature stances.

Thus, most traditional moral epistemology stresses that the stance appropriate to moral wisdom is a dispassionate one. To make considered, sound moral judgments, we are told to abstract from our emotions, feelings, and sentiments. Emotions are not part of the equipment needed to discern moral answers; indeed, only trouble can come of their intrusion into deliberations about what to do, for they "cloud" our judgment and "bias" our reasoning. To be objective is to be detached; to be clear-sighted is to achieve distance; to be careful in deliberation is to be cool and calm. Further, the tradition tends to discount the idea that experiencing appropriate emotion is an integral part of being moral. Moral theory tends to focus exclusively on questions about what actions are obligated or prohibited, or perhaps on what intention or motive one should have in acting, not on what emotional stance a moral agent should be feeling. Indeed, much of traditional moral theory has a positive suspicion of emotion as a basis for moral action. Emotions such as love or indignation, as opposed to some cerebral "respect for duty," are **[End Page 12]** deemed fickle and unreliable (metaphors, of course, for the female); they "incite" and "provoke" us, rather than moving us by way of their reasonability. Finally, traditional moral theory vastly underplays the importance of the "emotional work" of life--of nurturing children, offering sympathetic support to colleagues, or displaying felt concern for patients. To the extent that the value of such work is recognized at all--as, for example, in treatises on "mother love"--it is often accorded a lesser status, regarded as reflective of instinct rather than skill, and hence not qualifying as moral work at all, or as relevant only in limited spheres of life, such as nursing or parenting, that are accorded lower value than other more impersonal enterprises.

Feminists argue that these presuppositions may not survive their gendered origins. Possession of appropriate emotion, for instance, arguably forms an indispensable component of a wise person's epistemic repertoire (see Little 1995). While our passions and inclinations can mislead us and distort our perceptions, they can also guide them. To give just one example, if one is deprived of felt concern for a patient, it is unlikely that one will be attuned to the subtle and unique nuances of his situation. Instead of discerning the contours of his particular needs, one is likely to see his

case as an instance of one's current favorite generality. Distance, that is, does not always clarify. Sometimes truth is better revealed, the landscape most clearly seen, from a position that has been called "loving perception" or "sympathetic thinking" (Lugones 1987, Jaggar 1989, Walker 1992b). And again, emotion arguably forms an integral part of being moral. Simply to perform a required action--while certainly better than nothing--is often not enough. Being moral frequently involves feeling appropriate emotions, including anger, indignation, and especially caring. The friend who only ever helps one out of a sense of duty rather than a feeling of generous reciprocity is not in the end a good friend; the citizen who gives money to the poor, but is devoid of any empathy, is not as moral as the one whose help flows from felt concern. This is not to say that we owe personal love to all who walk the earth--proper caring comes in different forms for different relationships. Nor is proper caring to be conflated with self-abnegation. Suspicions about the moral imperative to care often tacitly rely on self-sacrificial models of care, in which the boundary between self and other is overly blurred. From a feminist perspective, it is not surprising that this is the model of care we have inherited, for caring has usually been regarded as women's work, and traditional norms for women have stressed a denial of self. **[End Page 13]** Feminist reflection, acutely aware of the limitations of these norms, precisely invites us to develop a healthier and more robust conception of proper caring (for further discussion, see Carse and Nelson 1996).

In another important instance, that which is associated with the private or domestic sphere is given short shrift in moral theory. Relations in the private sphere, such as parent-child relations, are marked by intimacies and dependencies, appropriate kinds of partiality, and positive but unchosen obligations that cannot be modelled as "contracts between equals." Furthermore, few would imagine that deliberations about how to handle such relations could be settled by some list of codified rules--wisdom here requires skills of discernment and judgment, not the internalization of set principles. But traditional moral theory tends to concentrate on moral questions that adjudicate relations between equal and self-sufficient strangers, to stress impartiality, to acknowledge obligations beyond duties of noninterference only when they are incurred by voluntary contract, and to emphasize a search for algorithmic moral principles or "policies" that one could apply to any situation to derive right action (Walker 1992a, Baier 1987).

This tendency to subsume all moral questions under a public "juridical" model tends, for one thing, to restrict the issues that will be acknowledged as important to those cast in terms of rights. "The" moral question about abortion, for instance, is often automatically cast as a battle between maternal and fetal rights, to the exclusion of, say, difficult and nuanced questions about whether and what distinctly maternal responsibilities might accompany pregnancy. And it often does violence to our considered sensibilities about the morality of relations involving dependencies and involuntary positive obligations. For instance, in considering what it is to respect patient autonomy, many seem to feel forced into a narrow consumer-provider model of the issue, in which the alternative to simply informing and then carrying out the patient's wishes must be regarded as paternalism. While such a model may be appropriate to, say, business relations between self-sufficient equals, it seems highly impoverished as a model for relations marked by the unequal vulnerabilities inherent in physician-patient relations. In these sorts of relations, all of the rich moral possibilities lie in between the two poles of merely providing information, on the one hand, and wresting the decision from the patient, on the other. For example, a proper moral stance might involve proactively helping a patient to sift through options, or **[End Page 14]** proactively fostering the patient's independence by, say, discussing sensitive questions outside the presence of overly interfering family members.

Finally, when ethical approaches more characteristic of the private sphere do make it onto the radar screen, there is still a tendency to segregate these approaches from those we take to the public sphere. That is, in stark contrast to the tendency to subsume the morality of intimates into the morality of strangers, rarely do we ask how the moral lessons garnered from reflecting on private relations might shed light on moral issues that arise outside of the purely domestic context. To give just one example, patients often feel a deep sense of abandonment when their surgeons do not personally display a caring attitude toward them: the caring they may receive from other health care professionals, welcome as it may be, seems unable to compensate for

this loss. This phenomenon will seem less puzzling if, borrowing a concept from the private realm, we realize that surgery involves a special kind of *intimacy*, as the surgeon dips into the patient's body. Seen under this guise, the patient's need becomes more understandable--and the surgeon's nontransferable duty to care clearer--for reflection on more familiar, domestic intimacies, such as those involved in sexual interactions, reminds us that intimacy followed by a vacuum of care can constitute a kind of abandonment.

In summary, then, reflection in feminist theory is important to bioethics in at least two distinct ways. First, it can reveal androcentric reasoning present in analyses of substantive bioethical issues--reasoning that can bias not only which policies are adopted, but what gets counted as an important question or persuasive argument. Second, it can help bioethicists to rethink the very conceptual tools used in bioethics--specifically, helping to identify where assumptions about gender have distorted the concepts commonly invoked in moral theory and, in doing so, clearing the way for the development of what might best be called "feminist-inspired" moral theory.

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Notes

1. For excellent discussions of this theme in the history of science, see Russett (1989), Fausto-Sterling (1992, Chapter 4), and Rosenberg (1976, Chapter 2).

2. For extensive analysis of issues relating to public policy, see the essays in Institute of Medicine (1994, vol. 1).

3. Portions of this and the next few paragraphs are taken from my article, "Seeing and Caring: The Role of Affect in Feminist Moral Epistemology" (Little 1995).

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