

The Feminist Challenge to Bioethics

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From long nursing experience I became interested in feminist ethics and how it might transform medical ethics. Belonging to a religious order also fed my interest in theology and philosophy, the original home of ethics. For many years my interest was uncritical, as I tried to fit my experience into that of the rational, male norm. When it did not fit, I dismissed it, while remaining loyal to my “scientific” education.

I was fortunate in the 1980’s to be allowed a “second adolescence” (my original one had escaped me!), to go to university, and study English, my first love, and Psychology, as justification for this time out. English was a delight and a fascination with deconstruction made me consider difference, otherness, subjectivity and invisibility all of which *did* fit my experience to a remarkable degree!

Psychology (including a brush with philosophy) however, was more like work, although most sisters like myself, had long been exposed to group dynamics by then. At undergraduate level my love-hate relationship with Freud and psychoanalysis lost much of its energy and it seemed that ¹there was nothing in psychology of much use to my middle age, until I read Carol Gilligan’s book, *In a Different Voice*. “The inferiority of women’s moral voice has been documented for centuries. By interpreting these voices in a new way however, by defining them as valid and equal to the dominant moral voice, Carol Gilligan has revolutionised our understanding of morality and defined a new practice of ethics (Hekman, 84). I will return to the work of Carol Gilligan later, but first a short introduction to this nomadic, interdisciplinary, auto/biographical¹ project.

In the 1980’s a nursing colleague was doing research on women’s ways of coping with inner city life in Dublin. She discovered that, in the flats, women would tell each other where to go, in order to get a tubal ligation done and they also told each other what to say when they got there. Otherwise, if they approached it differently, they would be referred through the ethics committees in one of the other city hospitals and usually the response would be negative² (Clarke,)

These women were getting their information from each other and from friends and not from the public health nurse. They did not see the nurses as resources with information or knowledge which they needed. This, made me wonder afresh what was going on in relation to nurses, women and ethics. Was it possible that none of us were able to make moral decisions? Or were nurses seen to be in some sort of gatekeeping role; indeed was this how we perceived ourselves?

Philosophical knowledge has traditionally been almost entirely generated by white professional class men, who usually do not represent the people experiencing the moral dilemmas at first hand (Walker). How then do we discover a women’s

¹ See Liz Stanley,

² Since this time regulations have changed. If a consultant agrees to perform the operation on a clinic patient he (sic) applies to the Master (sic) of the hospital who will then not refuse permission.

understanding of some of the social realities of our world? Susan Sherwin argues that a feminist understanding is necessary, if we are to recognise and develop an adequate analysis of the ethical issues that arise in the context of health care (Sherwin, 1992). It is women who deliver most health care, whether this is inside or outside of hospitals, but too often they are not represented in the decision-making.

I propose here to look briefly at the principles traditionally used by bioethicists in decision-making and to affirm this approach (based on rights and justice) in many situations. Women, as well as men often need to appeal to human rights arguments, but we also have to question some of the limits of a rights-based approach. This involves a critique of purely rational thinking/deciding and a search for a more relational stance. We need to consider what medical ethics and feminist ethics hold in common, and to discuss other resources for doing ethics, ones which arise in women's experience and their praxis. This involves an examination of the role of community standards of morality (touching on the realist/relativist debate) and asking how we proceed in a way that eliminates all oppression - the aim of feminist ethics.

Initially I will define bioethics and follow with a case history, well known to Irish readers, the so-called "right-to-die" case of 1995. This will be followed by a reflection on the learnings from that traumatic case and some alternative ethical resources suggested by the work of Carol Gilligan.

Bioethics is a handier word than bio-medical ethics and is loosely defined here as the application of ethics to the biological sciences, medicine, health care and related areas, as well as public policies relating to these. It is interdisciplinary and involves scientists, doctors, nurses and others as well as theologians and philosophers. The term bioethics in the 1960's, when there was an explosion of interest at the time of the first heart transplant. Other scarce resources were also being more widely used also then, including kidney dialysis machines, raising the issue of priorities. ()

What are the traditional principles of medical ethics?

The four main principles traditionally used in medical ethics are a bit strange-sounding. They are: nonmaleficence, beneficence, respect for autonomy and justice (Beauchamp and Childress, 1989). Nonmaleficence means that no harm shall be done to a patient by medical personnel. This also forbids negligence; the long-term interests and wellbeing of the patient are paramount¹. Beneficence implies a positive effort to do good and achieve the best results possible for the patient through the use of medical skills and ability. Both the above principles may come into conflict with the will of the patient, who has a right to information leading to free and informed choice about his/her treatment; this respect for autonomy is an important principle in medical ethics. Consent of the next of kin has to be obtained in the case of children, unconscious patients and those with severe learning disabilities. The fourth principle, justice, demands that people who need medical care be treated equally without ranking by race, gender, class, age or ability (Jantzen,).

These four principles constitute an approach which can be classed as rights-based, favouring a justice and rights approach in moral decision-making. They help to ensure the patients' interests and rights but at times they can be inadequate, especially when the best interests of the patient cannot be agreed as happened in the "right-to-die" case.

It is not difficult to envisage some of the problems which may arise when people are limited to this approach, in confronting concrete, moral dilemmas in health care. The principles can sometimes conflict with one another, or they cannot be easily ranked in importance. For example, how does one give maximum autonomy to a patient with advanced Alzheimer's Disease? Or who is best placed to decide what this patient would consider good in his/her own case? Or if someone with a painful terminal illness collapses, is it just to attempt to resuscitate him/her and who decides? Or if someone with dementia refuses to eat or drink, what is to be done?

These are some contextual situations where abstract principles are not much help. The average carer might perceive them as academic and somewhat removed. Linda Hogan argues that a justice and rights approach alone is not now usually seen as adequate in promoting human good (Hogan, 1992, 56). This is not to undermine the rights that people have, which are guaranteed under these principles, but to point to an approach which is more relational than adversarial. The principles alone can lead to adversarial problems as the case study demonstrates.

The story is told here by the mother of the 45-year old woman at the centre of the case. She had been in a sort of semi-coma for 23 years, after an anaesthetic mishap at the age of 22 years. She had been a bright and lively social science graduate, admitted to hospital for an overnight stay and a minor operation in 1972. One of the ironies of the case was that she hated hospitals and had not considered doing medical social work for that reason. She just wanted to get this investigation over, and, as she said, "get out of this place as fast as possible". She was to spend the next 23 years until her death in institutions and the family found it almost impossible to find out what exactly went wrong.

Her mother wrote this account of the case after her death. She had decided with her family, that her daughter should be allowed to die. But she found that this could not happen in an Irish hospital, even after the High Court and the Supreme Court had ruled in her favour. Here are some extracts from her story, beginning with a description of a meeting with the doctors, 2 years after the incident, when the family began a legal action, mainly to gain information about what had happened to their daughter.

"At that meeting in the Four Courts, a minimum of information was given to us. It was a hurriedly arranged meeting at the end of an exhausting day. We had no time to prepare for it and we left it no wiser than when we went into it. Our agony - and that is what it was - continued..... Two decades passed without another formal meeting with the hospital staff. Over the years I used

to meet the director doing his rounds, and all he would say apart from pleasantries was "she is holding her own". I never quite knew what that meant

In 23 years of constant and regular visiting, I got no response from her. For all that time she was fed through a nasogastric tube which, after two decades, seemed to cause her intense irritation. On occasions, the tube had to be replaced four or five times in one night. Over the years it was replaced thousands of times.

The doctors suggested that a gastrostomy tube be inserted....No alternatives were suggested by doctors and no one seemed to be prepared to look at the situation and say, "What are we doing here?" (After repeated replacement of the tube, sometimes under general anaesthetic, she appealed to her daughter's doctor).....I tracked him down. To my disbelief he could not understand why I was so upset nor could he understand that to me this was an opportunity to reassess the situation....We were unable to communicate with one another..." (*The Irish Times*, Saturday, February 24, 1996).

Over two decades the patient was given aggressive antibiotic treatment on several hundred occasions for repeated infections. While her mother protested, medical pressure left her no option, she felt, but to reluctantly assent. On two occasions her daughter was transferred to hospital, without her knowledge, for re-insertion of the gastrostomy tube -sometimes needing general anaesthetic.

She became increasingly convinced, with pastoral advice, that her daughter should be allowed to die and she felt that she was being put in an impossible situation each time she signed the consent form for an anaesthetic. Eventually the family decided to challenge the doctors' decision-making through the courts. The High Court ruled in favour of the family, but this was appealed by the hospital and Attorney General. The Supreme Court also ruled in their favour, but in order to allow the patient to die, the family had to remove her from the institution. Her mother received three letters reminding her of the urgency of this.

It became impossible however to find another nursing home, doctor, or nurse to take care of her, as they would risk censure by the Irish Medical Council and *An Bord Altranais* (Nursing Board) for any part they played in removing the feeding tube. Eventually a doctor and 8 nurses took this risk, and volunteered to look after her. As no nursing home could be found, the mother, who was now widowed, decided to,

"...bring my daughter home to die. All of this involved a huge amount of organisation -getting medical supplies, the nurses getting time off work and rearranging the house etc. My other children came home from the United States, Australia, England, Cavan and Cork. We rented and moved into another house to accommodate some of the family and my home became a temporary nursing home.....

We brought my daughter home amid secrecy and trauma for my whole family. Our great fear was that the media might get wind of her removal through a leak.... That in turn might lead to protests from the so-called “do-gooders”, something we could do without, given the strain we were under- a strain which is hard to exaggerate.

When the ambulance arrived at our house, the nurses were ready to receive her and from then on she had 24-hour nursing by a team of SRN’s, helpers and family members. Once we had my daughter in my house it seemed as though a great calm descended on us. There was great sadness too but it was accompanied by peace. We felt that at last, we were in control....

No praise is too high for her doctor and those eight nurses who voluntarily looked after her daily and risked censure by their various medical ethics bodies. On the morning of the eighth day, she simply stopped breathing. I can say without fear of contradiction, that her eight days of dying were more peaceful than the previous 23 years of so-called living” (*The Irish Times*, 24 Feb., 1996).

There were some features of this case which made the decisions particularly difficult; the patient was not clinically in Permanent Vegetative State (PVS). She could move her head from side to side and follow with her eyes, but could make no other response and was often in great distress. Arguments raged in the media at the time, as to whether tube-feeding was extraordinary medical treatment, or obligatory basic care. And could the State recognise someone’s right to die, or only create conditions which would allow them to die? ()

The “right-to-die” case provides examples of medical ethical principles being upheld, against the real interests of this woman, as her family assessed them and the quality of her life. The medical establishment felt that they had to uphold the principle of the sanctity of life, even while insisting that the patient be removed from the institution and causing great stress to the relatives by refusing to talk to them, except through solicitors. There were problems about handing over her medical notes (with the family wanting to protect the identity of her new medical carers). There were even instructions that none of the family could accompany the ambulance staff to the ward on the day of her discharge; all of this added to their distress and seemed to be inspired by litigation fears.

In this case the mother seemed best placed to decide what her daughter would have wanted, but this was not accepted. In private, various doctors agreed with her, but in public, the family had a lot of adverse publicity and some criticism. They were fortunate to have support from some moral theologians. For the medical profession, there has been no change in their guidelines. One hopes that there is now however, much more sensitivity and openness.

One would feel that there must be better ways of dealing with such painful situations and I suggest that feminist ethics offers resources for alternative practice.

The woman in this case seemed to discover this for herself at great cost. Her own experience and praxis, as well as that of her family, and what she knew intuitively, that her daughter would have wished, convinced her that she had made the right decision. She thus had the strength to confront great opposition, due to the prioritising of traditional principles, originally formulated by people who were not confronting the problems first hand. From feminist theology we gain other resources for doing ethics based on experience and praxis (Hogan

Carol Gilligan: the ethic of care and the ethic of justice

The question has been posed as to whether women are capable of making moral decisions. In the early 1980's Carol Gilligan wrote her book, *In a Different Voice*, which explored women's moral decision-making. From a background in developmental psychology, Gilligan raised the question about alternative ways of making moral decisions. Are there two different ethics, one of justice and one of care, and is the first associated with male morality and the second with that of females? Gilligan critiqued the conclusion reached by her colleague, Lawrence Kohlberg, who had proposed that moral development in females was deficient.

Kohlberg had concluded this from an experiment, in which he posed a hypothetical question to a male sample of 35 boys, about a man called Heinz. Heinz's wife was dying of cancer and he had no money to buy the drug which could cure her. Kohlberg asked the boys if Heinz would be justified in stealing it. Choosing the justice option uncritically, they argued that the right to life was paramount and that he was therefore justified in stealing the drug his wife needed, as he had no other way of obtaining it. This is a justice and rights based approach to morality, which Kohlberg defined as rational and morally mature.

However, Gilligan found that when girls were presented with the same problem the findings were different; they made alternative suggestions. They suggested that Heinz might talk to the pharmacist about credit, or try to find work, or otherwise raise the money for the drug. These girls' judgements, Kohlberg would have said, were only at "the third stage of his six-stage sequence of moral development. At this earlier stage of development, morality is conceived in interpersonal terms and goodness is equated with helping and pleasing others" (Gilligan, 1982, 18).

Are women then less capable of making difficult moral decisions, as Kohlberg thought? This suggestion disturbed Carol Gilligan, and from further research, talking to women about the issue of abortion, she concluded that these women used what she called an ethic of care, in contrast to the ethic of justice described above. They considered the consequences for everyone and examined other aspects of the situation, unlike the straightforward justice approach. Gilligan's research confirmed her idea, that these women had a different, a more relational approach, which was not a morally inferior or immature one. This relational approach was what made the woman in the "right-to-die" case, unable to watch her daughter undergoing any further treatment, which she saw as futile, distressing and undignified.

Gilligan's argument, that there are two distinctive modes of moral judgement and her classification of a 'care voice' and a 'justice voice' have led to the new school of feminist ethics but have also caused some controversy. As a result of her methodology, the two ethics have been interpreted as gender-related, with all women favouring the care ethic while all men tend towards a justice and rights approach. Gilligan denies that she made a gender connection and argues that: "The association is not absolute, and the contrast between male and female voices are presented here to highlight a distinction between two modes of thought and to focus a problem of interpretation, rather than to present a generalisation about either sex" (Gilligan, 1982, 2).

Gilligan was not arguing that an ethic of care is a superior one. Beverley Harrison does argue in favour of this ethic, which affirms and celebrates embodiment and aims to overcome the dualistic split between mind and body still dominant in the Western ethical tradition. Harrison encourages us to "recognise that all our knowledge, including our moral knowledge is body-mediated ..." (Harrison 1985, 13). Their way of perceiving the world through their senses and being aware of their feelings, Harrison argues, is what makes women effective moral agents, "In the absence of feeling, there is no rational ability to evaluate what is happening. Failure to live deeply in 'our bodies ourselves' destroys the possibility of moral relations between us" (Harrison, 1985,13). Being out of touch with the body and operating in a cerebral fashion, makes people lose moral sensitivity and regress into moralism. This urge to control, destroys the human sense of connectedness, which is integral to women's feelings and consequent moral activity according to Harrison.

Feminism therefore wants to examine traditional assumptions and investigate which questions get asked and which are ignored. In the above case history the mother complained that on-one was prepared to even listen to her question: "What are we doing here?" Similar questions need to be raised about whose interests are affected by the decisions that are being made and who has the power to control the agenda. (Sherwin, 1992, 4). The scientific community needs to learn from feminism, that it is possible to live creatively with diversity.

Diversity is central to the feminist perspective and leads us to challenge general policies and protocols being universally applied which may not be in the best interests of particular individuals in concrete situations. Such a critique was addressed at an obstetric regimen, the *Active Management of Labour*, at the National Maternity Hospital in Dublin in the 1980's. Feminists were questioning the routine use of what they considered to be unnecessary technology, during labour and childbirth. At times this technology was very helpful to women and to babies, but often it seemed largely to promote the convenience, status and authority of the doctors. They defended the policy, on the grounds that it was helping women to avoid prolonged labours, which might damage them psychologically. This seemed to imply that women's emotional frailty, associated with their tricky biology, made them dependent on obstetrical rescue ().

Here again is this troublesome weakness of women, seen in medical eyes as needing special help and protection. But has medical solicitude always been helpful to women? Traditionally many more women than men were diagnosed as depressive and treated with tranquillisers or even referred for corrective frontal lobotomy. Their mental health, pregnancy and childbirth have become heavily medicalised. The stereotype of the hysterical, unstable and untrustworthy female psyche is reinforced in psychiatry. Clearly women are not considered as qualified to make responsible, moral decisions and because of this misperception, on the part of medicine and theology, women lost faith in themselves, and in their own moral agency.

Citizenship, moral agency and authority

Moral agency is a corollary of citizenship which also eludes women at times. They are given the duties of citizenship in rearing future citizens, but their moral competence as citizens, is still in question in many places. Issues of violence against women and of women's reproduction make society's ambivalence about women's moral autonomy clear. Lorraine Code discusses three areas of traditional male authority: the law, the family and the state and argues that in all three, "women's vulnerability increased with their rhetorically-induced willingness to trust in the authority of scientific expertise,...(to trust their own intuition would break)...a fundamental epistemic imperative" (Code, 1991, p. 207-210). Even in the female area of childbirth and midwifery women's abdication of their authority in favour of that of modern "experts", is well documented. (Ann Oakley).

Feminist ethics addresses the issue of authority as central. Authority is seen, not as an issue solely for the individual, but also for the community. Letty Russell calls for "a paradigm shift in authority to one in which authority involves authorising the inclusion of all persons as partners, and power is understood as empowerment for self-actualisation". (Russell, In Pears, *FT 9*, 115). These tools from theology are appropriate for achieving a partnership approach in delivering health care.

Feminist ethics goes beyond the analysis of patriarchal oppression. It encourages agency where this has not been allowed. While medical ethics concentrates on the responsibilities of health professionals, feminist ethics examines the options of non professionals and patients also. The system for delivering health care must make health accessible to patients through information, access, support and participative practices. Too often however, the role of medicine has been experienced by patients and carers as a powerful mystique (Sherwin, 1992, 87). The choices as presented, can at times leave people feeling that they have very few options, as we saw above.

Is feminist ethics relativist?

At times feminist ethicists are accused of being relativist. While they may at times defend a relativist stance, they also at other times critique this. Moral relativism suggests that moral judgements must be made relative to the existing moral standards of a community. However this thinking would, in theory, approve for instance, female genital mutilation which is widely accepted and practised in many

societies. Feminists argue that sexist practices are objectively wrong, even where they have wide acceptance in the community, relativism is not adequate in dealing with patterns of patriarchal oppression which need to be challenged (Sherwin, 1992, 60). Feminist moral relativism concerns itself with the process of moral decision-making as well as its outcome.

It is argued that both positions, the realist or absolute and the relativist, hinder women rather than promote their efforts to enquire into, and theorise about, their experiences. (Heldke in Sherwin 16). Women do not expect a single way of making decisions. Different dilemmas can be appropriately resolved using different analysis. There is one important constant however: **"we must always decide these questions within the wider political context of considering how this analysis affects our general objectives of eliminating oppression in all its forms (Sherwin, 1992, 95).** Benhabib calls for a feminist universalism which is interactive and where "our differences complement rather than exclude one another" (Benhabib, 159, S the S). Relationality is central for Benhabib.

Agreement and divergence between feminist and bioethics

Bioethics, as a relatively modern discipline does avoid some of the misogyny of the past. Medical ethics also shares with feminist ethics, an awareness of the importance of context in ethical decision-making. Both biomedical and feminist ethicists are concerned about the situation in which people find themselves. But medical ethics lacks the perspective of feminist ethics which is committed to challenging oppression. Indeed Sherwin argues, that "the practice of medicine serves as an important instrument in the continuing disempowerment of women (and members of other oppressed groups) in society. It thrives on hierarchical power structures, which maintain interactions characterised by domination and subordination" (Sherwin, 1992, 84).

Bioethics has not considered the wider implications of the burden of care especially for women, or looked at implications of this for social policy, and where women's voice is heard or silenced in the system. The ethic of care has historically been devalued and associated with the inferior role of women. Many feminists claim that women have the caring role imposed on them throughout their socialisation and perpetuated by the continuing expectations of society and institutions. It is "natural" for women to do all the caring.

Bioethicists do not often comment on the political role of medicine or challenge its injustice. Market-led reforms causing cuts in services to those most dependent on them, are regularly taken as given. The bioethics agenda is often confined to issues about truthfulness, consent and confidentiality. Practice continues to be assessed in the light of traditional principles alone. "(T)he whole framework of medical research and practice, including the ethical principles themselves is masculinist. Not only are people at the top of the medical hierarchy predominantly male but the practices and even the moral framework on which the practices rest are inherently patriarchal" (Jantzen, 1996, 131). Sherwin argues that men also need to address this

imbalance and share the feminist agenda of bringing about an end to women's oppression.

"Feminist philosophers have observed that among the neglected 'female-associated' elements in many of traditional philosophy's canonical texts are the concrete, particular, and subjective, which are viewed as the enemies of the abstract, universal and objective; the emotions and the body, which are set in opposition to reason and the mind; the human need for co-operation and community, which is viewed as less urgent than the human desire to compete and assert one's individuality; and, finally, the judgment that the lines between the disciplines, as well as between theory and practice and value and fact, should be blurred hazy and permeable as opposed to clear, distinct and impenetrable" (Tuana and Tong, p 2)

A narrow orientation legitimises existing health care institutions, and leaves general structures and patterns unchallenged. The allocation of resources, for instance present cutbacks in staffing levels and in community care, are not always considered as ethical problems. And market-led constraints on health care provision are often accepted by the medical profession as given. But I suggest that it is not ethical to so restrict the time allocation of home helps, knowing that, in the goodness of their hearts, they will give of their own time and energy, rather than rush an elderly person, or see them deprived of the help they need.

While bioethicists may be concerned with justice in service provision to minority groups, such as those with disability, for feminist ethicists however, "disability" itself is a socially constructed response to a biological condition. Society demands 'perfect' people. Medicine tends to reinforce a sense of imperfection, failure and abnormality. Perhaps this is one cause of the great interest in the human genome project (Scully). I suggest that we need to continually ask "What are we doing here?" When a medical point of view predominates, the concerns of nurses, health care workers and women generally are often subsumed.

In the medical world feminist ethics therefore offers a challenge to medical ethics. By introducing a gender perspective feminist scholars have demonstrated inequalities in the traditional manner of doing ethics. Medical ethics has heretofore been taught, using only male interpretations from philosophy and science and proceeding as if women shared the same visibility as men. The role of feminist ethics is radical as described by Scaltsa: "(T)he project of criticising, analysing and when necessary replacing the traditional categories of moral philosophy in order to eradicate the misrepresentation, distortion and oppression resulting from the historically male perspective is, broadly speaking, the project of feminist ethics" (Scaltsas, 1992, 16).

The contribution of feminist ethics is becoming clearer in everyday medical practice. It is largely due to consciousness raising in women's groups, that it has become unacceptable, when there is a case of domestic violence in casualty to stitch up the

victim, put her fractures in plaster and discharge her home with her attacker. Neither is it acceptable for religious ministers, when they are consulted about the same problem, just to recommend prayer and wifely submission.

A critique of scientism does not dismiss scientific research, but "simply insists that science does not provide the primary or most significant access to a sense of ourselves and the world" (Critchley, p 359). "We need to consider an epistemology which is not only more satisfactory in its understanding of women's concerns, but also more adequate as a rendering of the logic of moral reasoning..."(Parsons, 1990,92)

Braidotti argues that "The effective presence of female scholars has caused basic alterations in the practice as well as the discourse of the sciences" (Nomadic, 220). Feminists have analysed moral epistemology imaginatively (Lovibond, '83 Parsons, 1990). But I suggest that their potential contribution to new thinking is less pronounced in health sciences than in single tier disciplines where gender neutrality has had to be addressed more vigorously. The influence of nurse academics to affect change in medical culture is still diluted by their subordinate role as the caring, not the curing people within the medical world.

Universalisability

In the West especially where disciplinary boundaries have remained almost impermeable, these same boundaries are being breached by feminist critiques within all disciplines, revealing many patriarchal connections. As in philosophical and religious traditions so also in bioethics and other areas, women's marginalisation, exclusion and even subjugation serve as the basis for challenging the authenticity and validity of those traditions (Pears, 114).

Within moral theology, until the 1960's a universalist stance was taken in the making of moral rules which would apply to everyone, regardless of the context in which they found themselves. However in the 60's, this thinking was challenged from different quarters. Liberation theology began in the shanty towns of South America, black and feminist theologies originated in the US and the political theology of Metz and Moltman was appearing in Europe. It became clear that the universal approach was not adequate for particular people, for instance people of colour in a white church, or women in a man's church. The concrete situation where people were, became acknowledged as important and the categories of experience and praxis were seen as central to feminist theology and ethics.

Within medicine both patriarchy and racism need to be analysed as medicine has a political role of medicine. This will be further discussed under the heading of international medicine below. Feminist scholars question the assumptions that govern the treatment of different groups of people. Sherwin argues that bioethicists regard many reproductive techniques as not violating moral rules; surrogacy is seen as a voluntary legal contract similar to other legal contracts. Feminism is not satisfied with the case study approach, but asks about the value given by society to women's

biological role and how this might impact on poor and disadvantaged women, or those with disability (Sherwin, 1992, 90). There is now an on-going debate on whether or not a woman should be allowed payment for giving ova for use in IVF.

There has been a surprising agreement in many different disciplines in relation to the status of women in all disciplines. It is not simply that the missing feminist perspective needs to be fitted into mainstream thinking as a kind of adjustment or afterthought. This perspective needs to be "mainstreamed" in all areas, in line with the guidelines from the Fourth UN Conference on Women at Beijing (1995). This process will radically alter all disciplines.

An ethic of trust?

Lynda Baier calls for an ethics of trust which can include justice and also care. The ethics of care, love and loyalty is clearly included in an ethics of trust as also, she suggests, is the ethics of justice and obligation. Trust is necessary and the conditions for it need to be built in before mechanisms of enforcement can be established. Trust involves risk and vulnerability, but is not the same as reliance. Baier considers a society unhealthy in which there is an over-reliance on contracts, and trust is almost non-existent. A wise mistrust will not allow us to trust someone whose interests are contrary to our own (Baier, 12).

In the medical world trust is often between people who have unequal power and "scientific" knowledge. At times moral philosophers or bioethicists can add weight to medical decision-making processes, so that *two* sets of experts are involved. But are their decisions gender-neutral as science would think itself to be? Sherwin argues that there is a sexist ethics, "characterised by its use of male perspectives to frame moral questions and propose solutions, ...(with a)... habit of cloaking itself in a commitment to gender neutrality...." (Sherwin, 1992, 91).

Moral and political philosophy are not gender-neutral. It is not neutral to exclude from philosophical discussion structures and institutions that benefit one group at the expense of the other (Frazer et al, 1992, 4). Pears argues that in philosophical and religious traditions, so also in other areas, women's marginalisation, exclusion and even subjugation serve as the basis for challenging the authenticity and validity of those traditions (Pears, 114).

An international perspective in ethics

On a global level, Mary Midgely argues that many people today are caught in moral isolationism because of a reluctance to look critically at other cultures. This well-intentioned respect and tolerance, due to a lack of understanding and fear of hypocrisy is misguided. Midgely argues that we can and do know enough about other cultures to form some favourable judgments and also take a critical stance. The standards we use help us to be critical in assessing the shortcomings within our own culture. Otherwise moral isolationism leads to immorality, a vacuum where we lose the capacity to decide what is bad or good and to learn from the insights of others. (Midgely,).

In Western philosophy there has been an inordinate concern about the preservation of interdisciplinary boundaries (Critchley,). This preoccupation is also critiqued by feminism for disguising an oppressive thought system. We need to be aware that as medical and other science has developed, new ethical dilemmas have multiplied in different parts of the world; problems of inequality remain and can even be worsened by technological progress. Medical technology and scanning equipment is now portable and is being widely used in rural China and the Far East to discriminate against the girl child, - technology which was initially developed to benefit women in childbearing.

We in the West also tend to export advanced obstetrical techniques to developing countries where, what is urgently needed, are primary health care provision, nutrition and a safe water supply. Jantzen argues that, "Standard textbooks in medical ethics discuss issues as though ethical problems and resources had national boundaries, and rarely ask what moral obligations arise because of the international inequalities of needs, resources and facilities. Yet as the trafficking in human organs, or the AIDS epidemic makes obvious the idea that any country need concern itself only with its internal health problems and policies is one of the greatest ethical and prudential follies imaginable" (Jantzen, , 133).

Male morality has tended to be disembodied, relating only to the male half of the population and it is therefore not universal. "The female half of human experience is privatised and excluded from the moral viewpoint, or if thought of as moral is defined as 'personal', that is the domain of nurture, reproduction and care. (Benhabib, *S the S*, 152). The sexual division of labour helps to ensure the perpetuation of women's oppression in all cultures while insisting that, "...that women's moral voice is distinctive, that it is inferior to that of men because it lacks objectivity, and that it is only marginally 'moral'" (Hekman, 26). Hekman argues that in challenging this thinking, women insist that their experience with all its difference, must be incorporated and the well-being of all women be included in the ethical agenda for the future.

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