Philosophical Feminist Bioethics

Past, Present, and Future

HERJEET MARWAY and HEATHER WIDDOWS

Abstract: The end of the last century was a particularly vibrant period for feminist bioethics. Almost two decades on, we reflect on the legacy of the feminist critique of bioethics and investigate the extent to which it has been successful and what requires more attention yet. We do this by examining the past, present, and future: we draw out three feminist concerns that emerged in this period—abstraction, individualism, and power—and consider three feminist responses—relationality, particularity, and justice—and we finish with some thoughts about the future.

Keywords: feminism; consent; paternalism; silencing; relational

Introduction

This article considers the contribution of feminist bioethics—its past and its current state—and finishes with some thought to the future. Feminist critiques of bioethics became particularly vibrant, influential, and prominent around two decades ago, when several scholars[1] developed a cluster of criticisms about the way bioethics was being conceptualized and practiced. Almost two decades on, we reflect on the legacy of these critiques, identify some core themes of feminist bioethics, and seek to explore the extent to which such critiques were successful in influencing mainstream bioethics. In order to do this, we take as our touchstone texts two of the many important works from this exciting period, namely, Susan Wolf's anthology and Rosemarie Tong's monograph, as they are characteristic of the concerns of feminist bioethics at this time.[2,3]

We aim to do three things. First, we outline three representative critiques that feminist thinkers made of bioethics: those of abstraction, individualism, and power. Second, we gauge the extent to which these criticisms have been influential and effective by looking at three broad responses: those of relationality, particularity, and justice. Finally, we, somewhat tentatively, look to a future opportunity and challenge that we think is continuous with the work of these earlier feminist bioethicists. On balance, our reflection of the progress (and sometimes lack of it) leads us to conclude that, unsurprisingly, the feminist analysis continues to be valuable. Moreover, we contend that, were bioethics to draw on it more, better bioethics would result.

The Past

We begin by presenting the feminist critique. Before we do so, two points of clarification are needed. First, though "bioethics" is a broad church, we take it to mean the ethics of medical, healthcare, or biological sciences that is Anglo-American in nature and practiced largely in the West, as these domains were the focus of the

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critiques. The second point is that "the" feminist critique is a misnomer, because there is no single critique but rather a cluster of concerns (documented in detail elsewhere)[4,5] that feminists—of varying persuasions—identified as problematic.[6] Drawing on Wolf and Tong in particular, we outline three worries that feminist bioethics had: those of abstraction, individualism, and power. Although not comprehensive, these reflect the key themes and give insight into the overall tone of the feminist critique of bioethics.

Abstraction

The first concern that these feminist bioethicists raised was that of abstraction, and the view that ethical decision-making was achieved by adhering to universal or impartial rules, principles, or norms. Wolf and Tong were not alone in highlighting this issue: Helen Holmes, for instance, argued that abstraction led to gaps in bioethics; Margrit Shildrick pointed to the trend of universality in poststructuralist and postmodern theory; and John Arras discussed the importance of cases and narratives in bioethics.[7,8,9] In Wolf's anthology, Susan Sherwin worried that patients were regarded with interchangeable sameness, and Mary Mahowald, that particular standpoints were being ignored.[10,11] Others in the collection also touched on the issue: Dorothy Roberts noted that the discipline assumed a generic physician and patient, served by generic ethical principles; Rebecca Dresser, that it opted for generality over particularity; Janet Farrell Smith, that the physician regarded the patient as a generalized other and abided by norms predetermined by rational abstract deduction; and Hilde and James Lindemann Nelson, that such generality did not allow for acute perception.[12,13,14,15] Taken together, the worry about abstraction in bioethics was significant.

The principlist method, which was prevalent in bioethics at the time, provides clear evidence of this inclination to abstraction and mirrors the approach of much post-Enlightenment moral philosophy (notably deontological and utilitarian thought).[16] The common feature here is an appeal to abstract rules or calculations to do ethics. In this regard, bioethics tends to be deductivist or top-down in approach.[17,18] The effort is in seeking out the right sort of universal principles to adopt, but, when this is achieved, all that remains is to apply that rule in each instance.[19] There has been much critique of this view, including from inductivists, who prefer a bottom-up model.[20,21] Some principlists too have expressed concern over a purely deductivist account, claiming that the principles were never intended to be so framed.[22]

The feminist critique joins its voice to these concerns, proposing that abstraction obscures factors that are relevant to moral judgment. Wolf, for instance, argues, "Universal moral rules or principles posited for the abstract, generic person erase that person's gender (not to mention race, class, and other characteristics)."[23] She goes on to contend, "It is only when a situation is appreciated in its particulars that the full moral problem and plausible tools for its resolution appear."[24] Similarly, Tong argues that truth and knowledge are not views from nowhere but are situated and partial.[25] She submits, "What I see is a function of who I am—a white, middle-class, well-educated, post-menopausal, Catholic, heterosexual, married academic and mother of two boys."[26] Such features, feminists argue, are fundamental to accurate moral reasoning and should not be abstracted away. These, for instance, may affect a patient's medical experiences or a doctor's perception

of a problem. Avoiding such detail (as the general approach does) suggests a reduced understanding or less appropriate solution in bioethics. This was an important element of the feminist critique.

Individualism

The second concern that feminist bioethicists raised was about over-individualism. Again, others—such as Renee Fox and Judith Swazey, Hyakudi Sakamoto, and Sherwin—also broached this issue.[27,28,29,30] In Wolf's collection too it was a recurring theme: Laura Purdy implied that taking the individual to be isolated from her context was a non-feminist approach to health; Farrell Smith expressed worries that decision-making in medicine was understood to be one person reflecting alone; Adrienne Asch and Gail Geller highlighted problems with the assumed autonomous, self-focused individual in genetics; and the Lindemann Nelsons argued that theories of justice for distributing healthcare viewed the individual in an atomistic way.[31,32,33,34] Taken together, these works make clear that individualism was a common concern of feminism at the time.

This propensity for individualism emerged post-Nuremberg, with a growing emphasis on autonomy, and developed most rapidly in the United States, such that a liberal commitment to individual rights and freedoms became part of its fabric.[35] Autonomy, perhaps understandably given its historical origins, came to take precedence over the other principles,[36] promoting the individual's capacity to choose and rejecting paternalism.

Though the desire to safeguard the individual is clearly well motivated and although various feminists hold differing ontologies, many feminist bioethicists were concerned with the type of agent and autonomy that emerged. They broadly critiqued the overly detached and self-sufficient construction of the individual, claiming that this was an unrealistic picture.[37,38] Wolf, for example, argues, "Bioethics has embraced a liberal individualism with more vigor than it has embraced anything else," and points out that this is unsettling because it depicts "the moral community as a set of atomistic and self-serving individuals."[39] Consequently the default agent of bioethics is detached and self-regarding. Likewise, Tong contends, "Lurking within the deep structure of traditional ethics (and, I would add, traditional bioethics) is a creature known as the autonomous self, generally pictured as a biological male, intent on maximising his self-interest."[40] Such a "self is entirely separable from others" and excessively self-focussed.[41] Further, the concept of autonomy itself has become intertwined with this kind of self, and "there has been a gradual alignment of *autonomy* with *individualism*."[42] Autonomy has become synonymous with substantive detachment and independence. Both the agent and autonomy, then, are criticized for being highly individualistic notions. Although some feminist bioethicists wish to retain understandings of autonomy—as we shall discuss—concern about individualism was a primary theme of the critique.

Power

The third feminist concern that Wolf and Tong discussed was about privilege and power. This thread ran through most, if not all, of the chapters in Wolf's anthology: Sherwin bemoaned the lack of focus on the oppressive aspects of the medical

structure; Mahowald argued that women were subjugated in the medical establishment; Roberts emphasized the racial and social inequalities in the doctor-patient relationship; Dresser highlighted women's frustration with the attitudes of medical professionals; Purdy drew attention to underlying biases in the judgment of women's bodies; Farrell Smith noted the commanding nature of doctors' speech; Vanessa Merton argued that women were unfairly excluded from research; Ruth Faden, Nancy Kass, and Deven McGraw contended that women's healthcare needs often went unnoticed; and the Lindemann Nelsons noted the white, middle-class, male bias in healthcare distribution.[43,44,45,46,47,48,49,50,51]

The establishment—doctors, researchers, clergy, review boards, professional societies, and governmental bodies, for instance, all of whom are authority figures or institutions—have traditionally driven and shaped the agenda in bioethics.[52] The discipline, that is, has typically focused on issues raised by experts: "concerns presented not by patients and families but by professionals."[53]

Feminists have been critical of this establishment-led approach, not because such groups do not raise significant ethical questions but because this perspective has obscured the power dynamics involved. The worry, as Wolf argues, is that in attending to the concerns of the establishment, "bioethics has stopped asking the big questions; instead of debating whether a technology . . . should be used at all, we end up debating merely how it should be used."[54] As such, "bioethics may have lost its critical capacity" by becoming part of the problem, not only by failing to champion the kinds of issues that affect laypersons but, more importantly, by sidestepping harder discussions of structural change.[55] To address this, Tong contends that feminist bioethicists ask the "so called woman question" to uncover ways in which women, as a marginalized group, are systematically underserved in bioethics.[56] They ask, for example, why women's specific health concerns are not taken seriously and explore the latent, perhaps even blatant, gender biases of those who diagnose them. Likewise, they question why authorities medicalize reproduction by focusing on discrete stages or components, thereby disengaging from the overall process, and how the social institution of motherhood silences women's conflicted lived experiences.[57,58] Such examples suggest that there are power imbalances within bioethics that are often unrecognized and seldom resisted or challenged. The feminist critique, then, is that bioethics regulates the present system but fails to tackle its wider flaws. It serves the interests of those in power because it responds to their concerns, while it fails to protect the most vulnerable because it stops short of the more pressing task of structural critique.

In Sum

These three criticisms provide a taste of some of the problems identified by feminist bioethics almost two decades ago. For those making them, these critiques were often seen as revolutionary, in that they demanded a wholesale overhaul or "reconstruction" of many of the underlying ideas in bioethics.[59] Although such radical change has not (yet) happened, some of these critiques have influenced the theory and practice of mainstream bioethics, though perhaps not quite in the way, or to the extent, these theorists hoped, as we shall see.

The Present

We outline three ways in which feminist bioethicists have developed alternative readings and have responded to the critiques of individualism, abstraction, and power.

The Relational Self

First, we consider the feminist claim that the self should be regarded as social. Drawing on advances in feminist ethics more broadly, many feminist bioethicists have placed greater significance on our connectedness and have argued for relational selves.[60]

In so doing, such bioethicists have directly challenged some of the gold standards of bioethics. Though important, practices like consent and confidentiality, for example, have been critiqued for being individualistic concepts, and so too has the principle of autonomy.[61] Rather than autonomy (Greek for "self" and "rule"), which is associated with separate and independent selves, feminist bioethicists, building on the work of feminist philosophers, have promoted "autokoenomy" (Greek for "self" and "community"), which recognizes selves in perpetual relation to others.[62,63,64]

Many contemporary bioethicists have adopted such approaches. Indeed, the language of a relational self and autokoenomy is explicit in several recent works: for instance, in discussions of intergenerational interdependence and justice;[65,66] vulnerability in research,[67] disability,[68] and bio-ethics;[69] and constrained agency in psychiatry.[70,71] In all these areas, the relational model recognizes—as the norm—the patient's interconnections with others: that patients are rarely in the position of the highly rational decision-maker, that single treatment decisions cannot be isolated from the patient's life and context, and that patients are seldom fully autonomous or not autonomous.

In such ways, the relational self and autokoenomy have been developed and applied extensively, if not always dominantly, in key bioethics debates. They can be seen as attempts to address the problem of individualism, and also of abstraction, in bioethics as identified by earlier feminist scholars.

Particularity

A second area in which feminist critiques have had some effect is in particularity. Feminists have advocated seeking detail and actual experience by, for example, recognizing context-specific vulnerability,[72,73] discerning differences in situations, and advocating circumstance-appropriate protections.[74]

Perhaps the clearest evidence of the move to particularity can be seen in nursing ethics.[75,76] Rather than the general patient, it is the particular patient, in all her specificity, that is the focus. Achieving this shift in emphasis is difficult work: it requires being receptive to the patient's unique and holistic physical, psychological, and emotional needs, and it necessitates that the patient receive care appropriately too.[77] These insights are already part of nursing ethics to some degree, but, as the spate of recent high-profile scandals shows,[78] there is some way to go yet in turning feminist bioethics theory into practice. Still, the hope is that, where concrete detail, good judgment, and compassion are valued, care is likely to be better practiced, and as such nursing ethics can be regarded as a particular

embodiment of the concerns of feminist bioethicists to reject abstraction. There is, however, as we explore in the final section, some tension between this type of particularism and decisive feminist intervention in debates.

Justice

The third response is justice. Feminist bioethics, as Tong argues, attempts to grapple with issues of justice that arise in the microcosmic (the ethics of care) and the macrocosmic (the ethics of power).[79] It recognizes that there are likely to be all sorts of power imbalances: for example, between a particular man and woman and in a context of wider gender-subordinating norms, respectively. Activities in bioethics cannot be divorced from these structural frameworks of power.

Examples of uncovering and addressing injustice can be identified in some recent literature. There has been work on using reproductive technology to help women made infertile by inadequate sexual health provision,[80] efforts to champion abortion rights when such rights are in danger of being surreptitiously overridden,[81] explorations into medicalization,[82,83] discussions on mental health prejudice within the medical system,[84,85] and calls to consider the absolutely, not just relatively, vulnerable.[86,87]

This trend is also evident in the field of public health ethics, in which the focus is less on fixing the health of individuals and more on securing the health of the collective.[88] This includes proactively preventing or mitigating the threat of infectious diseases, promoting healthy lifestyles in populations, and protecting the health of the most marginalized groups.[89,90] It illustrates the connectedness and vulnerability not just of persons but of the human species and highlights systemic problems that impede healthy societies across the globe. This approach, then, has links with the ethos of feminist bioethics as interested in structural injustice wherever it occurs. However, a population focus also stands somewhat in tension with the rejection of abstraction, because the emphasis is on the general public rather than particular relationships.

In Sum

Taken together, whether directly or indirectly, advances in these three areas—developing the relational self and relational autonomy, focusing on particularity, and insisting that context and structure are relevant to justice—take seriously the feminist critique of bioethics. In various ways, these shifts interconnect: regarding persons as relational suggests understanding the social conditions in which relationships are immersed, and discerning particularity implies looking at the specific detail of the relationship, while human vulnerability indicates our interdependencies and fragility in light of oppressive systems and structures. They also potentially conflict: too much particularity can obscure matters of justice and can collapse back into individualism. Balancing these insights is an ongoing concern for feminist bioethicists.

The Future

In the final section, we finish by highlighting one challenge that besets feminist thinking in general, and especially feminist bioethics, given the continuing focus on consent and the propensity for abstraction in bioethics.

Despite attempts to include a more relational and less individual understanding of persons, securing informed consent (which is presumed to protect autonomy) continues to be the dominant ethical practice in bioethics. Although it is motivated by good historical reasons (as noted above), the primacy of consent suggests a failure to develop alternatives to individualism, at least in practice. For instance, in genetics (in which families and consanguineous relations are, by the very nature of genetics, involved), individual consent remains paramount. In an era of biobanks (in which genetic data that does not belong solely to the consenting individual is stored and shared over long periods), risks to others with that genetic makeup may arise from information misuse (or just—but unknown and unpredicted—use).[91] Such potential injustices make the need for relational practices, which (because of their philosophical underpinnings) can take into account such connection and effects on others more readily, even more pressing.

Given their long critique of individualism and wish to recognize relationality, feminists are perhaps best placed to lead on non-individual approaches. Yet, and paradoxically, developing non-individual practices might be a challenge that is especially hard for feminist bioethics to rise to. There are pragmatic reasons for this, such as the simplicity of using individual informed consent, but it is not these reasons we wish to consider. Rather, and this is the point we want to finish on, it is the fear of being labeled paternalistic that may be obstructing feminist progress.

Paternalism is a particularly cutting criticism for feminists to be subjected to, as the last thing we want is to ignore the agency of women, whom we are seeking to empower. Bioethicists too are worried about the accusation—as Graeme Laurie puts it, "Paternalism has come to be seen as the very antithesis of autonomy and self-determination because implicit in its operation is a disregard for the wishes of the subject towards whom the paternalism is directed."[92] However, so potent has the fear of paternalism become that it serves to forestall criticisms of exploitative and harmful practices.[93] This view of paternalism arises from the promotion of individual autonomy above all other values (something feminism does not endorse) and the wish to respect patient views (which feminism does endorse). However, these two positions have become (wrongly) entwined, making it difficult for feminists to reject individualist practices (such as the individual consent model) without (wrongly) believing that they have criticized the individual women who have "consented to" or "chosen" some act. These two claims are separate. To criticize a practice is not automatically to critique individuals. Nor is it paternalistic, unless paternalism means simply to criticize anything at all that any individual could possibly choose. Ironically, rather than liberating women, anxiety about paternalism may have silenced feminists, disempowered women collectively, and resulted in the privatization of the feminist critique.

With the concerns of paternalism, the debate has become confused and polarized, unhelpfully presented as either accusing women of false consciousness or supporting expressed "choices," no matter how oppressive, context driven, and desperate.[94] Given genuine feminist worries about denying women's agency, we as feminists have tended to be steered toward the latter of these binaries and in the process have become afraid to speak up against harmful practices, lest we be charged with being anti-choice. The charge of paternalism idealizes consent and choice (as proxies for autonomy) but suppresses other ethical values. The result, we suggest, is the silencing of all criticism.

To resolve this impasse, we propose that feminists should reject the claim that to critique a practice is to critique all individuals who have "chosen" it, and the implication that any critique is therefore unjustified. A first step is to remind ourselves of the critiques of feminist bioethics: to be relational, particular, and concerned with justice. If we reject individualism and focus on the context and structure, which includes elements of particularism—particularism understood as paying attention to difference rather than respecting all "chosen" practices—then a critical voice can be reclaimed. If this is not done, then feminists will continue to struggle to speak out against unethical practices that harm women.[95]

Conclusion

We have reflected on the past of feminist bioethics by identifying three key concerns that feminists interrogated nearly two decades ago: abstraction, individualism, and power. We have tracked responses in the form of relationality, particularity, and justice and have used these to say something about the present of feminist bioethics. Finally, we have considered a significant challenge for future feminist bioethics.

In mapping these stages, at least two things are revealed. First, there is considerable continuity between the early feminist thinkers we looked at and today's pressing concerns. In this regard, the critiques offered almost two decades ago by feminist bioethicists remain valuable ones. Second, the need for *philosophical* bioethics is clear. The critiques we have traced are profoundly philosophical and yet are crucial to understanding activity on the ground and to seeing why aspects of current policies and practices might not be as ethical as they appear. Without theoretical critique one cannot understand—and then change—what is bad practice.

Notes

1. For a useful list of feminist bioethics work, see Donchin A. Feminist bioethics. *The Stanford Encyclopedia of Philosophy*; 2012 Sept (cited 2014 July 5); available at http://plato.stanford.edu/archives/fall2012/entries/feminist-bioethics/ (last accessed 13 Aug 2014).
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3. Tong R. *Feminist Approaches to Bioethics: Theoretical Reflections and Practical Applications*. Boulder, CO: Westview Press; 1997.
4. See note 1, Donchin 2012.
5. Wolf SM. Introduction: Gender and feminism in bioethics. In: Wolf 1996 (see note 2):3–44; and note 3, Tong 1997, at 75–98.
6. Though defining "a" feminist approach is problematic given the notorious complexities of the movement, we take "feminist" to mean a minimal commitment to combating oppression and respecting agency. Likewise, though difficult to define, we take "feminist bioethics" to include the insights of various feminisms, such as being politically eclectic, ontologically autokoenomous, epistemologically positional, and ethically relational (see note 3, Tong 1997, at 93), and with an aim of actively opposing harm to women (see note 5, Wolf 1996, at 21).
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18. For more on deductivism, see Gert B. *The Moral Rules*. New York: Harper and Row; 1973.
19. See note 3, Tong 1997, at 59.
20. See note 5, Wolf 1996, at 15.
21. For more on inductivism, see Jonsen AR, Toumlin S. *The Abuse of Casuistry*. Berkeley: University of California Press; 1988.
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23. See note 5, Wolf 1996, at 15.
24. See note 5, Wolf 1996, at 15.
25. See note 3, Tong 1997, at 95.
26. See note 3, Tong 1997, at 244.
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34. See note 15, Lindemann Nelson, Lindemann Nelson 1996, at 354.
35. For more, see Toulmin S. Medical ethics in its American context. In: Callahan D, Dunstan GR, eds. *Biomedical Ethics*. New York Academy of Sciences; 1988; and Jonsen AR. The birth of bioethics. *Hastings Centre Report* 1993;23 Suppl 6:S1–15.
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37. See note 3, Tong 1997, at 81, 84.
38. See note 5, Wolf 1996, at 16.
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44. See note 11, Mahowald 1996, at 101.
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56. See note 3, Tong 1997, at 90.
57. See Rich AC. *Of Woman Born*. London: Virago; 1977.
58. See note 3, Tong 1997, at 92.
59. See note 5, Wolf 1996, at 6.
60. For more, see, e.g., Gilligan C. *In a Different Voice*. Cambridge, MA: Harvard University Press; 1982; and Noddings N. *Caring*. Berkeley, London: University of California Press; 1984.
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