

APA Newsletters

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NEWSLETTER ON FEMINISM AND PHILOSOPHY

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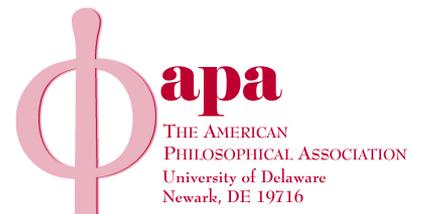
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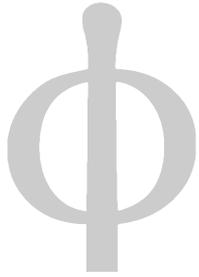
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FROM THE EDITOR

There can be little doubt that feminism has transformed the academy and, in turn, the development of feminist theory has in some ways transformed feminist activism. The authors of the articles in this issue attest to the impact of both of these transformations on their own lives as well as on their practice of philosophy by demonstrating some of the requirements of feminist health-care consulting. Jessica Prata Miller invited three other health-care consultants to reflect on their experience as consultants and academics. More importantly, she asked them to consider the project of feminist consulting. What, if anything, does the feminist consultant bring to health-care discussion and practical deliberations that is uniquely feminist? How does a feminist approach alter the nature and content of discussions within the organizational framework of medicine?

Although their focus is on health-care consulting, a feminist approach to consulting has numerous other applications. Advocates of every sort, social activists, business and engineering consultants, and others who apply philosophical reasoning to practical problems, will find something useful in this collection of articles. Miller's introduction delineates some of the convergences and variations found in the contributions by herself, Rosemarie Tong, Ana Smith Iltis, and Judith Andre.

In addition to the cluster of articles on health-care consulting, I have included a number of relevant book reviews. The first is a review of *Linking Visions*, edited by Rosemarie Tong, Anne Donchin, and Susan Dodds and reviewed by Toby Schonfeld. This collection of essays addresses the challenging questions raised by globalization; among them is the question of whether a universal approach to health care is appropriate given cultural and national differences. Next, Emily Crookston reviews *Natural Rights and the Right to Choose* by Hadley Arkes. Like the previous review, this timely review of a book aimed at a popular audience is a salient reminder of feminism's responsibility to address contemporary political problems. In a creative interpretation of that project, Penny Weiss's book, *Conversations with Feminism: Political Theory and Practice*, reviewed by Melissa A. Butler, engages political theory and practice employing dialogue. Although both Arkes's and Weiss's books were published a few years ago, reviewing them in today's political climate offers some interesting insights for feminist philosophers. The final review, by Andrea Hurst, evaluates *Imagine There's No Woman* by Joan Copjec. Copjec interweaves psychoanalysis with contemporary ethical and political theory issuing a unique challenge to how we understand the project of ethics. All four reviews complement the issue's articles by highlighting the interface between practical problems—ethical and political—with feminist philosophies' varied theoretical approaches to addressing them.

I think you will find this issue of the *Newsletter* to be a suggestive and valuable resource. As always, I welcome your suggestions and submissions for the *Newsletter*. The Fall 2006 issue will feature more book reviews as well as some articles and reflections on contemporary feminist activism. Please consider submitting something on the activism in which you participate. If you are interested in contributing to that issue or any other, please contact me.

About the *Newsletter on Feminism and Philosophy*

The *Newsletter on Feminism and Philosophy* is sponsored by the APA Committee on the Status of Women (CSW). The *Newsletter* is designed to provide an introduction to recent philosophical work that addresses issues of gender. None of the varied philosophical views presented by authors of *Newsletter* articles necessarily reflect the views of any or all of the members of the Committee on the Status of Women, including the editor(s) of the *Newsletter*, nor does the committee advocate any particular type of feminist philosophy. We advocate only that serious philosophical attention be given to issues of gender and that claims of gender bias in philosophy receive full and fair consideration.

Submission Guidelines and Information

- 1. Purpose:** The purpose of the *Newsletter* is to publish information about the status of women in philosophy and to make the resources of feminist philosophy more widely available. The *Newsletter* contains discussions of recent developments in feminist philosophy and related work in other disciplines, literature overviews and book reviews, suggestions for eliminating gender bias in the traditional philosophy curriculum, and reflections on feminist pedagogy. It also informs the profession about the work of the APA Committee on the Status of Women. Articles submitted to the *Newsletter* should be limited to ten (10) double-spaced pages and must follow the APA guidelines for gender-neutral language. Please submit four copies of essays, prepared for anonymous review. References should follow *The Chicago Manual of Style*.
- 2. Book Reviews and Reviewers:** If you have published a book that is appropriate for review in the *Newsletter*, please have your publisher send us a copy of your book. We are always in need of book reviewers. To volunteer to review books (or some particular book), please send the Editor a CV and letter of interest including mention of your areas of research and teaching.
- 3. Where to Send Things:** Please send all articles, comments, suggestions, books, and other communications to the Editor: Dr. Sally J. Scholz, Department of Philosophy, Villanova University, 800

Lancaster Avenue, Villanova, PA 19085-1699, sally.scholz@villanova.edu

- 4. Submission Deadlines:** Submissions for Spring issues are due by the preceding September 1st; submissions for Fall issues are due by the preceding February 1st.

NEWS FROM THE COMMITTEE ON THE STATUS OF WOMEN

Dear Colleagues:

I wish each and every one of you the best in 2006! As some of you might know by now, I was unable to attend the Eastern Division Meeting in New York. My husband was hospitalized with a life-threatening infection during our ill-fated Christmas festivities. I brought him home on New Year's Day, reminded that life is precious and that each of us is continually balancing complex personal and professional lives. Despite the fact that men are gradually shouldering an increased share of such family responsibilities as childcare, elder care, and sick care, it remains the case that women continue to carry heavier care burdens than men. To be sure, there is a measure of comfort and joy in knowing that one is a caring person, but there is also much in the way of exhaustion, lost and/or diminished opportunities, and one's own demons.

Please make a note of the panels that members of the CSW have organized. Just to list the titles of the 2005 Eastern Division panels ("Ontology of Race and Gender" and "Pornography Revisited"), the 2006 Pacific Division panels ("Women's Choices: Family Matters in the Profession Panel" and "Publishing as a Feminist"), and the 2006 Central Division panels ("Feminism and Disability" and "Teaching in a Climate of Conservatism") gives you an idea of the kind of topics that are of considerable interest to the CSW.

The *Newsletter* is a source of pride for women in the profession and is an excellent venue to publicize papers from panels held at one or another of the meetings we frequent. Sally Scholz, the *Newsletter* editor, encourages such submissions. She also would appreciate reports from you about conferences in which you played a major role. A detailed report is of great service to those who lack the time and/or funds to attend.

On the positive side, progress is being made on dependent care issues, but it continues to be a step-by-step process. The APA office's pilot program to help subsidize dependent care is posted at: <http://www.apa.udel.edu/apa/governance/committees/women/CSW%20Childcare%20proposal.pdf>

On the negative side, it remains relatively difficult for parents to actually secure needed childcare at APA meeting sites. However, the 2006 Pacific Division Program organizers believe they have organized a system this time around that will make things easy for parents who attend the Portland meeting.

Among the projects the CSW is committed to pursuing are the following: (1) developing a complete list of graduate programs and departments that are known as being particularly supportive of women in the profession and/or as being especially strong in the area of feminist philosophy; (2) developing a resource page on the CSW website that links together all the organizations, societies, and groups working to further the status of women in our profession; and (3) getting better data about women philosophers, a task made more difficult by the fact that not all women philosophers belong to the APA (a matter for discussion in and of itself).

As a result of some structural changes in the APA, I will remain chair of the CSW for an additional year together with my recently appointed co-chair, Erin McKenna. She and I have been in contact and look forward to some long discussions as we head into 2006-2007. Other new members of the CSW include Miriam Solomon, Robin Dillon, and Bat-Ami Bar On. Rotating off the CSW are Sharon Crasnow, Tracy Edwards, and Anita Superson. They have served the CSW with more of their time and energy than you might realize. Applaud them for their hard work on behalf of all of us.

Please feel free to contact me with your questions and ideas whenever you wish. I will try to be as helpful as possible.

Happy New Year,
Rosie

Rosemarie Tong,
Chair, Committee on the Status of Women
Distinguished Professor in Health Care Ethics
Director, Center for Professional and Applied Ethics
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The University of North Carolina at Charlotte

ARTICLES

Introduction to Special Cluster on Feminist Health-Care Ethics Consultation

Jessica Prata Miller, Guest Editor
University of Maine

Health-care ethics consultants may emerge from specialized training in bioethics, or from one of many feeder disciplines, including philosophy, law, medicine, nursing, counseling, and ministry, to name a few. There is as yet no certification or credentialing in this rapidly developing field where demand for practitioners has outpaced clear professional self-definition. For some, ethics consulting is a full-time job; for others, it is a highly lucrative extra-curricular activity, and for still others, it offers a way to provide a free service to the community. The definition of health-care ethics consulting is amorphous, and many diverse activities fall under its purview, from clinical case consultation, to committee work, to ethics education, to policy formulation. Each of these activities may occur in a wide range of settings. Education in bioethics may be targeted to pre-med or nursing students at the undergraduate level, medical students, post-graduate nursing students, medical residents, or practicing health-care professionals in a wide variety of fields and specialties. Policy formulation may refer to a specific hospital's policies, the policies of a professional association, or to policies promulgated by federal governments.

The relationship between traditional academic disciplines, especially philosophy, and bioethics is still contested, and the relationship between ethics consultation and bioethics is also relatively fluid. Bioethics is currently characterized by lively debates over method in ethics consultation, questions of accreditation, credentialing, and licensure for individuals and programs, and how and whether to develop, promulgate, and enforce a professional code of ethics for bioethicists. Making matters even more complicated is the fact that, unlike specialties in, say, philosophy, ethics consultation provides a pathway for a

select few to wide media exposure; a voice in state, national, and even international policy-making; and, perhaps even more influential in an era of globalization, a place at the table of major international corporations at the cutting edge of biotechnology. The high visibility of these few can influence the profession's self-understanding and public face in a way that affects even the most obscure practitioners.

All of the contributors to this issue have backgrounds in philosophy, have full-time academic appointments (although not necessarily in philosophy), and have experience with ethics consulting. As I explain in my autobiographical contribution, "Feminist Values and Bioethics Practice: Strangers at the Bedside?" I fell into ethics consulting gradually and mostly accidentally. The transition from a graduate program in philosophy to an academic appointment is challenging in its own way, but at least it is marked by a semblance of continuity. The medical environment is another world altogether, and as I entered it, I searched for other feminist accounts for guidance. There are already a few important articles in print, most of them written in just the last five years, to which the following essays make frequent reference. But the debate on the ethics of bioethics is so dominated by questions about conflicts of interest generated by prestige and pay, shot through with a strong proprietary interest in keeping out "charlatans," that the questions about social justice, equality, and power that feminists are used to foregrounding in ethics are seriously marginalized.

The essays that make up this issue begin to redress this paucity. Rosemarie Tong, in "Clinical Ethics Consultation: Bringing Gender into the Foreground of Case Discussion," takes at once a personal and a broad perspective on the question of feminist ethics consulting, integrating observations about the state of the field of bioethics and her own experiences educating health-care practitioners with theoretical work on the impact of gender on communication. Tong describes the case of Armando Dimas, an undocumented Mexican immigrant whose transfer from one hospital to another for suspicious reasons and subsequent abrupt discharge from the treating hospital raises important questions about gender, ethnicity, and class, as well as choice, control, and connection. Tong views the case through the lenses of liberal, radical, and cultural feminism in order to distinguish feminist from contextual or narrative perspectives on ethics consulting.

Ana Smith Iltis, in "Feminist Ethics Consultation: Clinical and Organizational Ethics," discerns key themes in feminist ethics that can and should inform the goals and the process of ethics consulting. Iltis re-describes a very well-known case in the bioethics literature, involving the refusal of Carlos to allow his physician to inform Consuela, his sister and future caretaker, of his HIV-positive status, as well as a second case involving sexual abuse and organ donation. Using these cases, Iltis demonstrates the difference a feminist approach to ethics consultation can make, from the initial call for a consult, to the perils of "curbside consultations," to the post-consult write-up and review.

Finally, Judith Andre, in "Remember the Nurses," focuses squarely on the tension between the commitment to equality and justice for women and bioethicists' failure to consider adequately the moral dimensions of nursing practice. Andre exhorts feminists to explore ways to mitigate moral distress in the most female of all the health-care professions—nursing—not just in ethics consultations but in the everyday experience of having responsibility without power that characterizes nurses who are "in the middle" between patients and physicians.

Taken together, these essays make the case not only for the possibility of feminist forms of ethics consultation but for

their urgent need. They provide some insight, along with some helpful references, to a scattered and still nascent literature for fellow practitioners, and perhaps they will inspire not-currently-identified feminist-ethics consultants to test their skills outside the academy. To the extent that all readers will also be engaged in one way or another with the sexist institutions that litter our social landscape, and to the extent that they have been, are, or will one day find themselves socially positioned as "patients," there are good grounds for interest in what some feminists engaged in ethics consulting take themselves to be doing, how they are doing it, and what they hope to accomplish in the process.

Feminist Values and Bioethics Practice: Strangers at the Bedside?

Jessica Prata Miller
University of Maine

Like many philosophers who find themselves frequenting conference rooms in hospitals, taking phone calls from physicians and chaplains at odd hours, attending grand rounds, poring over the American Medical Association (AMA) code of ethics with attorneys, and speaking with radio and television reporters on how the bioethics case *du jour* impacts the community, there is little in my academic background to suggest I would one day become—even part time—a health-care ethics consultant.¹ Neither my graduate training in analytic ethics nor my dissertation on conceptions of trust in feminist moral theory provided much in the way of preparation for the health-care ethics consulting that is now a significant part of my professional identity. However, due to the accidental convergence of several states of affairs, not least the growing recognition on the part of the health-care industry of the existence of a sphere of ethical dilemmas that are conceptually, if not practically, distinct from medical, legal, and religious ones, and the fact that, in central Maine, compared to black bear and moose, ethicists are a rare species, I find myself a hyphenate: professor-bioethicist.

As an academic, my situation is typical and settled, or at least as settled as it can be pre-tenure: I am, at this writing, the only woman and, not surprisingly, the only teacher of and researcher in feminist philosophy in my department. On campus, with other feminist academics, most of whom have long been so engaged, I do many of the things typical of feminist academics: I am active in the women's studies program, I try to redress the paucity of female philosophy majors, I work with other women faculty to initiate or enhance (or, at least, in these difficult fiscal times, *preserve*) family-friendly services, such as on-campus daycare, and policies, such as tenure clock extensions for dependent care. While I have lost some of the idealism that attended my discovery of philosophical feminism as a graduate student, I have, in general, found the university to be a place where feminism is spoken, if not always sincerely, and where the basic principles of equality and justice for women are understood, if not exactly given pride of place on the institutional agenda.

My experience at the community hospitals, clinics, and law firms where I have done the bulk of my ethics consulting has been rather different. I have had to learn how to do a kind of practical, provisional, contextual, immediate ethics deeply at odds with the methods and concerns of the moral theory—yes, even feminist moral theory—I had studied in graduate school² and, at the same time, figure out how to get my feminist bearings in an environment decidedly indifferent, not to say hostile, to the issues and concerns of gender justice. Others have written

of the power that attends the bioethicist as outsider,³ and I have certainly at times been surprised by the deference accorded me, even in the early stages of my deepest ignorance about how health care works, when I found myself nervously parroting acronyms, like DNR, IDD, and CCU without really knowing what they meant. No matter that this respect is misplaced, generated as it usually is from the long outmoded (in bioethics journals, anyway) notion that an ethicist is a kind of authoritarian figure, personally beyond moral reproach, who brings a substantive body of specialized knowledge, or at least unusually rigorous thinking and analytical skills, to the table: it often guarantees me a voice, perceived to be impartial and expert, with which I can, at least, say something and be heard.

This is not to say that I have not personally encountered the effects of a gendered society within the hospital's walls—far from it. To give just one example: after years of serving on panels for ethics grand rounds in which I was the only female—and often, not incidentally, the only panelist whose status as parent to two children was deemed important enough to be included in a very brief, title-free, introduction—the ethics curriculum committee happened to put together a panel with three women and one man. A physician approached me after the meeting to ask worriedly whether this panel was not “a little, uh, imbalanced.” I assured him that we gals, one of whom hosts a nationally syndicated radio program on mental health and the other of whom is a nationally recognized pediatric neurologist, would do our best not to let the team down. Nevertheless, I am accorded a certain authority on defining and working through moral questions arising in the practice of medicine.

The dominant model of ethics consulting is a kind of facilitation model, enshrined in the American Society for Bioethics and Humanities' (ASBH) *Core Competencies for Health Care Ethics Consultation*, in which the ethicist's role is “identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus,” while keeping in view the impact that laws, social mores, and institutional policies have on the issue or case at hand.⁴ The facilitator model dovetails with the notion of the ethics consultant as at least a semi-outsider, someone who can take “an ‘external point of view’, unburdened by routine, details, and departmental loyalties.”⁵ The facilitator is not necessarily value-free, for she has at least some conception of and interest in a good resolution, but, unlike her outmoded authoritarian counterpart, she is not the primary moral decision maker, either in terms of process or outcome, and her outsider status seems to give her an independence from the self-interested concerns or prejudices that might motivate an insider.

In my view, we need to be careful about how we define facilitation, and we need to be especially careful not to confuse it with consensus. Consensus is all too easy to achieve when participants are tired, not fully informed, or done in by what Stephen Wear has called “muscular advocacy,” or “bioethics as exercise of institutional power.”⁶ Wear makes the point that clinical bioethics education and consulting is not as open-ended as classroom moral philosophy, and therefore not as theoretically well-grounded, but that there is a large and growing set of settled moral truths sufficiently legitimized by “a quarter century of intertwined debate, research and clinical expertise,” which has adequately established a “consensus with real depth” in bioethics, contributing significantly to its status as a legitimate discipline.⁷

But for feminists committed to large-scale social change, who identify health care as a major site of injustice for women, consensus may be more troubling than comforting. If one looks at the journals, at the popular press, and the scholarly conferences, for example, there seems to be consensus in bioethics that it

is really important to spend a lot of time talking about what we will do when the hounds of genetics and biotechnology are unleashed on an unsuspecting lay public, which suddenly has to decide whether to opt for immortality, germ-line gene therapy, or just plain old xenotransplantation. In a trenchant and bitingly funny commentary on the “celebrity bioethicist,”⁸ Leigh Turner suggests that bioethicists themselves feed the frenzy of speculation over improbably far off and practically inaccessible (except to the wealthiest few) treatments, further contributing to the utter invisibility of vast inequities in access to the sources of health, especially access to health care. I cannot help but note that it takes two devastating hurricanes, hundreds of deaths, and a news media that thrives on faux moral outrage to bring this into focus in the United States. Turner, and fellow critics such as Carl Elliott, worries that the conflicts of interest generated by the money that follows the high tech arenas will undermine the integrity of bioethics, especially of clinical bioethics.⁹ But the presumption of all of this worry about the erosion of legitimacy in clinical bioethics and bioethics consulting by a few bad apples is that consulting as regularly practiced is legitimate.¹⁰ This forecloses asking important questions about process, including what it means to be interested, or to be an insider, and about good outcomes, especially about the role of clinical bioethics in questions of social justice writ large.

While I read with interest and dismay about bioethicists who are implicated in the research frauds of the pharmaceutical or biotech corporations, I wonder if the focus on those imbroglions distorts the picture of the relations between money, insider status, bias, and good ethics consulting. Certainly it foregrounds the “big shots,” mostly men, and marginalizes the less glamorous work of the bulk of practicing bioethics consultants. In my case, a catered lobster-salad lunch is a big deal, and any payments are too small to be influential. The worry articulated by so many bioethicists about payment for ethics consultations is often couched in terms of loss of an outsider status, which confers at least the illusion of impartiality to ethics consulting, an illusion that is necessary for the ASBH model of facilitation to work. But the absence of fat paychecks for my work does not make me disinterested. As my teaching and research have moved more and more into the field of bioethics, I am undeniably interested in maintaining my access to the hospital, its employees, and its procedures.

This engagement is self-interested in both a broad and narrow sense. As I have come to know the physicians, nurses, social workers, chaplains, general counsel, and upper administration at various hospitals, I have become deeply interested in helping them do a better job. My interests now envelop theirs: I have an interest in helping them achieve *their* interest in providing the best health care. Indeed, this, as much as my Ph.D. in philosophy, or any appearance of my own moral goodness, is the ground of their trust in me. But my involvement is also more narrowly self-interested: without this access, I would not have case studies to stimulate my writing and enliven my courses. My departmental peer review committee now considers my consulting work to be part of my professional profile, and the administration at the public university where I work certainly is not opposed to friendly faculty engagement in the community.

To a certain extent, one must be an insider to serve as an effective consultant. Beyond that truism, “insider status” is hard to define, let alone measure. It might refer to involvement, knowledge, concern, and/or loyalty. It is not a threshold concept: one can be more or less of an insider. My own experience has involved a gradual increase in involvement and access, from sitting on the occasional ethics panel, to leading the regular bioethics reading group, serving as an *ex officio* member of the

on-call bioethics committee, and being a permanent presenter of the bi-monthly ethics grand round (a panel presentation of ethics cases for physicians, nurses, and hospital staff for which continuing medical education credits are earned). And insider status is relative. If access to administration and policymakers counts, then I am an insider. But because I am not a clinician, my knowledge of patients is mediated through the narratives of the providers, so I will always be an outsider relative to them. In fact, hospitals are, like any complex organization, rife with divisions, a couple of which are so sharp that to gain the confidence and trust of one group might automatically disqualify one from gaining the same status with another.

It is far from clear exactly how the insider-outsider continuum maps onto the interested-disinterested axis, or the biased-unbiased axis, and then again how that maps onto the authoritarian-facilitator axis. The notion that being an insider, being self-interested in the fruits of consulting, and being unethically biased follow from one another is too simplistic. A consultant might, for example, be an “outsider” simply in virtue of not taking the time to learn more than the bare facts about a health-care facility or a particular case, yet be deeply motivated by selfish interests.

My own feminist approach to ethical theory makes me attentive to the social context in which what counts as ethical and who counts as an ethical decision-maker are determined. In the last few decades, feminist ethicists have generated systematic criticisms of not just individual moral philosophers but also of the epistemological assumptions under girding a whole set of seemingly diverse moral theories.¹¹ In short, in one set of dominant—that is, Kantian, contractarian, or utilitarian—views, morality is viewed as an integrated set of knowledge claims, an impersonal, abstractly demonstrable code within a moral agent, meant to indicate the proper course of action in specific cases. In contrast, feminist ethicists have envisioned morality as interpersonal and collaborative, an ongoing project we build and carry forward together. Moral life is composed of overlapping networks of social accountability and responsibility that are continually re-negotiated. This view of morality as a progressive attempt at mutual acknowledgement presupposes that both moral thinking and moral resolutions require a much wider variety of skills than the traditional emphasis on principles would suggest, including skills in creating, reading, and wielding narratives, discursive skills, and virtues such as reasonable trust and empathy. Because this model takes seriously the idea that moral knowledge is generated and embodied in communities, questions about the credibility of people’s claims to moral knowledge can be answered only by understanding *who* it is that is claiming to know. This includes facts about particular individuals, their situations, and the larger cultural milieu in which both morality and moral philosophy are practiced.

In some ways, this feminist take on morality fits well with the tasks of ethics consultation, defined by the American Society for Bioethics and Humanities’ *Core Competencies for Health Care Ethics Consultation* as “a service provided by an individual or group to help patients, families, surrogates, health care providers, or other involved parties to address uncertainty or conflict regarding value-laden issues that emerge in health care.”¹² Certainly, the importance of narrative and empathy are well understood, at least implicitly, by most people I have encountered in health care, and one is not likely to be faulted for not beginning a discussion of a case with abstract principles when the subject’s life is hanging in the balance a few hundred yards away. But in other ways it does not. Indeed, the most discussed concerns about ethics consulting (the personal risks, laced with the promise of heroism’s glory, of whistle blowing on the one hand, and the corruption of paid consultants on

the other) presuppose and tacitly endorse a major trend in the field—the move from full committee models with wide participation to the use of a single expert who disinterestedly applies his or her skills to a single, discrete case. This move is premised upon a particular conception of moral theory and a certain understanding of what we do when we practice morality that feminist ethicists have questioned, revised, and in some cases rejected.¹³

Margaret Urban Walker, in a widely cited essay applying her own account of moral epistemology to bioethics, contends that a shift in one’s picture of moral theory leads to shifts in practical approach, or at least to new guiding metaphors for practice.¹⁴ Walker contends that in ethics consultation the so-called “moral engineers” who rotely plug in ethical theories to cases must give way to “architects” who creatively open up moral space. Laurie Zoloth and Susan B. Rubin have adopted Walker’s metaphor and have added their own: the ethicist as navigator, rather than captain. Navigators know the terrain, are informed by similar past voyages, can draw on their knowledge of the geography of wider debates, and can imaginatively route various courses.¹⁵

A recent article by Marian Verkerk, Hilde Lindemann, Else Maeckelberghe, Enne Feenstra, Rudolph Hartoungh, and Menno de Bree use these feminist metaphors to develop a flexible tool for ethics education in professional settings.¹⁶ Rather than a calculator to solve ethical dilemmas with appropriate inputs, this tool facilitates moral reflection by professionals in a way conducive to creating a new framework for understanding the moral aspects of their practice. As Verkerk et al. describe the three-step process:

The first step helps professionals attain a heightened moral sensitivity to the vulnerabilities, values, and responsibilities they encounter in their work—a sensitivity acquired by identifying and developing a point of view that can be used as a touchstone for decisions about the best way of proceeding. The second step helps them to understand that they are part of a practice that involves multiple perspectives and positions. This means that their beliefs need not be the only sources of moral reasoning: others may have different ideas with merit of their own. Finally, the third step helps them appreciate that they are participants in a socially shared practice that is partly constituted and re-created by their own collective actions.¹⁷

The idea is to facilitate moral competence, defined not as the ability to solve moral dilemmas but as “the ability to see what is morally relevant in a given situation, knowing the particular point of view from which one sees it, understanding that others who are involved may see it somewhat differently, and then, with those others, responding well to what one sees.”¹⁸

The authors do not describe this process as feminist, but much of the literature upon which they draw, including Lindemann’s own work, is self-consciously so, and it is clear that the authors hope that their approach will facilitate recognition of the social dimensions of one’s own and others’ moral agency. In one example, involving a noncooperative heroin addict in need of heart-valve replacement surgery, the instructor would ask the professionals to consider the impact of not just the standard values of the patient’s autonomy and well being but also the professionals’ own core beliefs and values (some of which may be infected with prejudice), as well as relevant hospital policies (for example, a policy against wasting resources) on this case, and what the consequences would be for this patient of adhering to the stated policy.¹⁹ Verkerk et al. suggest that salient social factors will spring to relevance and envision the

professional saying something like, “I’ve noticed that they’re much more concerned about wasting resources when the patient is poor, black, and a drug addict.”²⁰ This process thus allows for much fuller discussion of the social dimensions of ethical issues in health care and also brings to light the way that seemingly morally neutral policies and practices are in themselves shot through with moral beliefs and attitudes.

In my experience working in clinics and regional and community hospitals, ethics education takes the form of either a break in the action, where we might indulge in fanciful discussions about distant or purely fictional interventions like genetic enhancement or reproductive cloning with virtually no impact on daily practice, or of very concrete instruction in ethical aspects of medical care (for example, instruction on what ethical values the Do Not Resuscitate Order is meant to preserve, how to procure one, etc.). In either case, it is quite difficult to open up the space for the kind of reflection Walker, Verkerk et al., and Sherwin and Baylis recommend. Things are not much better in clinical setting, where very clear hierarchical lines of decision are drawn (literally, on flow charts), with major emphasis on avoidance, containment, or prompt resolution of ethical issues. Typically, a hospital will have something like a “Patient Team Conference Record,” with a section for “Applicable Ethical/Legal principles,” where one can check one of the following boxes: patient autonomy, informed consent, patient capacity, advanced directives, other. At many hospitals, only certain staff (typically physicians) may call ethics consults, and patients and patients’ families are restricted from requesting them or attending them.

I recently delivered a lecture on the Verkerk et al. article at a hospital where I am engaged in the ethics education program. I explained the relevant theories and methods and suggested ways we might implement them in our current practice. The audience for this session was typical: 90 percent female (primarily nurses and social workers), the rest physicians, chaplains, and administrators, mostly male. Throughout my presentation, I anticipated that these suggestions—which by their very nature implied that we were failing in unethical ways to empower nonelites, including not just nurses but patients and patients’ families—may have been too radical to spring all at once, and might provoke some indignation, or even outrage.

To my surprise, the end of the talk was greeted with the usual friendly applause. I noticed that the upper-level administrators who were present had huddled together, smiling and nodding. When I approached them, one said, “This is just what we already do!” He pointed out that first on the list of quality criteria for the medical ethics program is the question: “Do we have the right participants?” In his view, this was enough to ensure that the right kind of moral space is created for ethics consults. But as feminist professors who sit in a circle with their students know well, the hierarchical power structure in the hospital—graphically evidenced by the flow chart with “nurse” at the top and “executive v.p. and chief medical officer” at the bottom—does not evaporate at the conference table. And as poorly as the pseudo-prompt “any questions?” elicits genuine dialogue in the classroom, silence, or even quick assent, on the part of patients, patient advocates, or nurses at a patient team meeting may reflect not so much agreement but fear of the repercussions of disagreement.

I mention this example not to showcase my apparent inability get my point across to a room full of hospital employees but to buttress the claim made by Sherwin and Baylis that “those who engage in ethics consultation have a responsibility to take clear moral positions on matters of injustice and to work toward making health-care institutions, practices, and policies more just in their impact on individuals and groups.”²¹ In my experience,

this is a painstaking and very difficult process, characterized by very few of the kind of sudden realizations described by Verkerk et al. It requires a kind of immersion in the culture of the hospital or site of the ethics consult, an immersion that helps the consultant see what others are seeing.

Central and northern Maine are, in comparison to the city of Portland and the south coast, poor, and Maine is the whitest state, with most of the state’s 2 percent “diverse population” concentrated in Portland.²² Understanding this helped me to see that a staff member’s concern about a case in which a surgeon agreed to perform heart surgery on a child flown in from a developing country via a charity organization was not really about whether she had gone through the proper channels (it was labeled a “communication” problem) but about scarce resources and prejudiced beliefs. After a very long conversation, it became clear that the stated worries about the chain of communication were cover for the real concern that the hospital would become a magnet for “these black babies” whose aftercare could not be assured in their home countries. And it took even longer to clarify that while some of the concern for post-operative care was very genuine, uninformed opinions and beliefs about the ignorance and inability of the child’s parents to follow instructions were playing a significant but unstated role.

Thus, a focus on social context in ethics consultation, it seems to me, is not just a matter of personal moral integrity for feminist ethicists but absolutely necessary in order to achieve outcomes that can be considered ethical. Sherwin and Baylis distinguish the types of advocacy that are appropriate in different settings, noting (after Walker) that the metaphor of architect of private space works well for clinical cases, while the metaphor of advocates in the public sphere works well for public-policy consultation. In the middle ground of a hospital, an arena Sherwin and Baylis do not directly address, the smaller space of the clinical consultation is framed by the policies made at the highest administrative levels, creating a complicated intersection of these metaphors in practice.²³ But Sherwin and Baylis helpfully draw on feminist accounts of relational autonomy to suggest that feminist ethicists can use their typically privileged positions as ethicists to offer a kind of assist to members of oppressed groups, such that truly *feminist* ethics consultation requires “active effort on the part of the consultant to control for disproportionate power; for example, it is often necessary to privilege the needs and interests of the most vulnerable.”²⁴ In trying to enact this in specific cases, I have sometimes been able to use feminist ethical theory to argue—against other participants who fear that the discussion is “getting sidetracked”—that gendered, racial, ethnic, classed, and other social positions are indeed some of the “relevant facts” of the case.

There is a strong presumption in bioethics that the major ethical issues primarily involve physicians and that nurses do not have uniquely ethical or widely interesting moral concerns. Although nursing staff, mostly women, attend the bioethics meetings where educational priorities are set, it is the physicians, mostly men, who are the most vocal in determining what counts as an issue worthy of continuing medical education credit. When I have asked to speak separately with groups of nurses to see where their needs lie, I have been told that nurses tend to have “employee issues” rather than real ethical dilemmas and have been warned that any meeting or rounds devoted to moral dilemmas in nursing would surely devolve into a complaint session directed at the doctors. In contrast, ethics consultations are often initiated by nurses, not surprisingly, as they spend the most time in direct patient care. Unfortunately, nurse discomfort with some aspect of patient care is likely to be

cast not as genuine ethical concern but as miscommunication or ignorance about, for example, the actual level of well being of the patient.²⁵ In one case, the charge nurse called an ethics team conference when the husband of a forty-five-year-old female patient with a potentially reversible illness was allowed to suddenly rescind her carefully crafted Do Not Resuscitate order after the attending male hospitalist convinced him to “give her a few more days.” But the only “ethical issues” identified by the resident physician were “communication and documentation.”

In a case described by Benjamin Freedman in an edited collection of notes on ethics consultations in which he participated, a head nurse contacted him regarding unclear progress notes for a patient’s code status. In short, the physician failed to clearly and officially specify what steps should be taken in the event of an arrest. In his notes, Freedman treats the case as straightforward. He communicates the nurse’s concern to the physician, adding, “Please note that rather than asking you to reconsider the agreement reached or to reconvene a family conference, I am asking that you record that same agreement in an effective manner.”²⁶ Freedman did not reflect on why a nurse would ask him to intervene rather than communicate directly with the physician. As someone who has had the experience of being taken aside after a meeting or an ethics grand round by a nurse who had been completely quiet during the proceedings, only to have her expound at heated length in the elevator on her way back to the workstation, it is clear to me that more was worth commenting on in this case than the need for nurses to get comprehensible instruction.

A feminist approach to ethics consultation, informed by feminist ethical theory, identifies different worries about the practice than are currently dominant in the bioethics literature and shifts the focus from a narrowly defined ethical realm that one either inhabits or does not to the overlapping patterns of justice and injustice that can frame even the smallest bedside decisions. Feminist ethics consultants are as concerned with perceptions of conflict of interest as others but are also concerned to raise awareness about neglected dimensions of ethical decision-making in a way that helps consultation more closely mirror the complexity of moral life outside the conference room. There are many challenges ahead in the theorizing of feminist ethics consulting, including facing directly the varieties of feminisms, some of which cannot coexist, resolving conflicts in practice between autonomy and social justice, and distinguishing feminist interventions from other liberatory strategies. As these remain major research topics for feminism, there are still significant opportunities for the practices of ethics consultation and feminist theory to inform one another.

Endnotes

1. Some use the term “health-care ethics consultant” to refer only to clinical, i.e., “bedside” consultations. For the purposes of this essay, “health-care ethics consultant” includes all of the activities mentioned in this sentence as well as other activities such as the ethical education of health-care professionals, and health-policy setting in health-care facilities, professional organizations, other private sector settings, and government.
2. Would a graduate degree in bioethics have helped? Some are not so sure: “There is a serious lack of mentoring and clinical ethics practice in many graduate degree programs in bioethics. What is the meaning of such degrees if they produce students trained only in the most theoretical ways to address the realpolitik of the clinical arena?” Susan B. Rubin and Laurie Zoloth. “Clinical Ethics and the Road Less Taken: Mapping the Future by Tracking the Past,” *Journal of Law, Medicine & Ethics*, 32 (2004): 218-25, 223.
3. William Ruddick. “How Can Doctors and Philosophers Work Together?” *Hastings Center Report*, 11 (1981): 12-17.
4. American Society for Bioethics and Humanities. *Core Competencies for Health Care Ethics Consultation* (Glenview: American Society for Bioethics and Humanities, 1998). For detailed discussion of the ASBH model, see Rosemarie Tong, “Clinical Ethics Consultation: Bringing Gender Into the Foreground of Case Discussion,” this issue.
5. W. Finn and William Ruddick. “Objections to Hospital Philosophers,” *Journal of Medical Ethics*, 11 (1985): 72-76.
6. Stephen Wear. “Teaching Bioethics at (or Near) the Bedside,” *Journal of Medicine and Philosophy*, 27:4 (2002): 433-45, 441.
7. *Ibid.*, 442.
8. Leigh Turner. “Beware the Celebrity Bioethicist,” *Chronicle of Higher Education*, 50:35 (May 7, 2004).
9. See, for example, Carl Elliott, “Pharma Buys a Conscience,” *The American Prospect*, 12:17 (2001): 16-20.
10. Admittedly, some critics would welcome the utter demise of the medical ethicist. See, for example, Ruth Shalit, “When We Were Philosopher Kings,” *The New Republic*, (April 27, 1997): 24-28.
11. See, for example, Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (New York: Routledge), 1998.
12. ASBH. *Core Competencies in Health Care Ethics Consultation*.
13. The late Benjamin Freedman’s lament that “I don’t know of a single case of a bioethicist who has acted as a hero in that role,” when hero is defined as “seriously risking a job,” conjures this image of the solo practitioner, although I hasten to add that Freedman criticized the pure facilitation model of ethics consulting (Benjamin Freedman. “Where Are the Heroes of Bioethics?” *The Journal of Clinical Ethics*, 7:4 (1996): 297-99). For extended argument in favor of the full-committee model over the use of individuals or sub-committees, see Rubin and Zoloth, *op. cit.*
14. Margaret Urban Walker. “Keeping Moral Spaces Open: New Images of Ethics Consulting,” *Hastings Center Report*, 23 (1993): 33-40.
15. Laurie Zoloth-Dorfman and S. B. Rubin. “Navigators and Captains: Expertise in Clinical Ethics Consultation,” *Theoretical Medicine*, 18 (1997): 421-32.
16. Marian Verkerk, Hilde Lindemann, Els Maeckelberghe, Enne Feenstra, Rudolph Hartoungh, and Menno de Bree. “Enhancing Moral Reflection: An Interpersonal Exercise in Ethics Education,” *Hastings Center Report*, (November-December 2004): 31-38.
17. *Ibid.*, 32.
18. *Ibid.*, 38.
19. *Ibid.*, 34.
20. *Ibid.*
21. Susan Sherwin and Françoise Baylis. “The Feminist Health Care Ethics Consultant as Architect and Advocate,” *Public Affairs Quarterly*, 17 (2003): 141-58, 142.
22. I should add that there is, of course, a significant Native American presence in Maine, and that there is a lot of diversity in central and northern Maine if white ethnicity is taken into consideration, as it should be. For example, one-third of the state’s 1.3 million people is of French, French-Canadian, or Acadian origin, and of that number about 80,000 use French on a daily basis.
23. For more on this topic, see Ana Itlis Smith, “Feminist Ethics Consultation: Clinical and Organizational Ethics,” this issue.
24. Sherwin and Baylis, 149.
25. For more developed discussion of the marginalization of nurses in ethics consultation, see Judith Andre’s “Remember the Nurses,” this issue.

26. Benjamin Freedman. *The Roles and Responsibilities of the Ethics Consultant: A Retrospective Analysis of Cases*, edited by Françoise Baylis (Hagerstown, MD: University Publishing Group, 2000).

Clinical Ethics Consultation: Bringing Gender into the Foreground of Case Discussion

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In 1998 the American Society for Bioethics and Humanities Task Force on Standards for Bioethics Consultation issued a report entitled “Core Competencies for Health Care Ethics Consultation.”¹ The report is directed toward health-care ethicists who consult in clinical contexts, usually hospitals. It is both thorough and daunting. According to the authors of the report, clinical ethics consultation requires three categories of skills—“ethical assessment skills,” “process skills,” and “interpersonal skills.”² In addition, it requires mastery of nine knowledge areas: (1) “moral reasoning and ethical theory”; (2) “common bioethical issues and concepts”; (3) “health-care systems”; (4) “clinical context”; (5) “the local health-care institution”; (6) “the local health-care institution’s policies”; (7) “beliefs and perspectives of local patient and staff populations”; (8) “relevant codes of ethics and professional conduct and guidelines of accrediting organizations”; and (9) “relevant health law.”³ Lastly, and perhaps in the ideal, clinical ethics consultation requires “good character,” typically manifested in the possession of traits such as (1) “tolerance, patience, and compassion”; (2) “honesty, forthrightness, and self-knowledge”; (3) “courage”; (4) “prudence and humility”; and (5) “integrity.”⁴

Curiously, even though most health-care ethics consultants know that they cannot live up to the standards articulated in the “Core Competencies Report,” they have dutifully embraced it together with Tom Beauchamp and James Childress’s four principles of bioethics (autonomy, beneficence, non-maleficence, and justice).⁵ As a result of this state of affairs, clinical ethics consultation is no longer a hot topic at bioethics conferences. It has largely been replaced by heated debates about the business and politics of bioethics; that is, about whether health-care ethics consultants should sit on prestigious state and national commissions, express their views in sound bites to national media representatives, and, most controversially, accept handsome or even modest stipends/honoraria from private foundations and corporations.⁶

Although I find the relative disinterest in the topic of clinical ethics consultation understandable, I think that it may be unwise for feminists to neglect the subject. After all, many of us do serve as clinical ethics consultants, even though relatively few of us do so full time, let alone for fame or money. It is simply another item on our expanding list of volunteer services, work that is important and needs to be done but that does not factor into most institutions’ reward system. No doubt, this last fact partially explains why, when we do manage to carve out some research time, we focus on topics more likely to find their way into the journals or books our colleagues recognize as significant. Were it not for Jessica Miller’s urging, for instance, I would not be writing this article, trying to explain, for example, what makes an approach to clinical ethics consultation “feminist” and not simply “narrative” and/or “contextual.”

I. The Relationship between Clinical Ethics Consultation and Organizational Ethics Consultation

During the process of writing this exploratory article, I dusted off my copy of the “Core Competencies Report” and turned to the section on organizational ethics consultation. Although the authors of the report stress that the relationship between clinical ethics consultation and organizational ethics consultation is “important,”⁷ they seem reluctant to say much more than this. Not sure that they want to rekindle the flames that made the subject of organizational ethics consultation so controversial in the early and mid 1990s,⁸ the authors simply recommend that clinical ethics consultants educate themselves “in areas ranging from the health care organization’s business and administrative structures, the health care system’s current structure, the economics of health care (including financing mechanisms and cost-benefit analysis), and the variety of business arrangements in medicine.”⁹

Now, I may be naïve, but as a citizen of a country in which 44,000,000 people lack health-care insurance (a large number of them women and children), I think clinical ethics consultants should be vitally interested in organizational ethics. I suppose this conviction was the one that prompted me to co-edit with George Khushf a 2002 *HEC Forum* issue on organizational ethics. Interestingly, in our introduction to the issue, George and I pointedly asked, “[W]hy are we so slow to address organizational ethics in the practical arena?”¹⁰ Rather shamefacedly, I must admit that since formulating this question with George, I have not systematically sought to answer it from any perspective, let alone a feminist one. However, I am no less convinced today than I was in 2002 that it is the task of all clinical ethics consultants, and particularly we feminist clinical ethical consultants, to stress that the choices made at the bedside are often occasioned and/or constricted by decisions made in the boardroom.

Using what she identifies as a “contextual” approach to clinical ethics consultation, Patricia A. Marshall draws attention to the intersection of clinical and organizational ethics in a moving narrative of a twenty-eight-year-old patient with cystic fibrosis. The patient, whose condition was quite fragile, had two options. She could either enter a full-service hospice program or get a third lung transplant. The hospital transplant team thought another lung transplant for her would be “medically futile.”¹¹ They wanted her to enter the full-service hospice program where her physical, psychological, and spiritual needs could be addressed. But a talented physician, who was leaving the hospital to become the director of a transplant center at another hospital, disagreed. He told the patient that a third lung transplant might work and urged her to come with him to his new place of employment at which he would perform the transplant. At this point in the deliberations, the hospital transplant team requested an ethics consultation from Marshall. They told her they thought that family members, friends, and various health-care professionals (themselves included) were pressuring the patient to make a decision one way or another, and that she needed an “outsider”¹² to help her make an autonomous decision. Over a ten-day period Marshall, who did not view herself as an outsider, by the way, worked with the patient as the patient struggled to decide what to do. At one point in her decision-making process, the patient wrote a remarkable poem that captures what many feminists have described as the relational nature of autonomy. As hard as it is for someone to decide for themselves whether they want to continue living or instead give in to the forces of death, that decision is made so much harder, when, as the patient says:

You could stop right now

Put on your brakes, rest, or turn around and go

Down easy; haven't you done your best?
A lot of people say never give up. Others tell
You to do as...best as you can.
How do you learn to accept?
Or do you fight "till the absolute end"?¹³

In reflecting on the patient's poem, Marshall observes that, for the transplant team in particular but everyone in general, "respect for patient autonomy was an obvious way in which to frame the reason for the [ethics] consult."¹⁴ It was also a comfortable way for everyone to frame the patient's case because no one wanted to talk about the real "source of the patient's dilemma,"¹⁵ namely, the fact that a fairly ambitious physician, eager to add patients to the transplant list at his new place of employment, had offered a vulnerable patient a treatment option more likely to substantially harm than even marginally benefit her. Marshall comments that in the case of the patient "(f)undamental issues relat(ed) to power and the responsible exercise of power, and to the missions of biomedicine and the subjection of patients to those missions, were closeted,"¹⁶ thereby limiting the patient's ability to make a truly autonomous decision. Why, then, I wonder, did not Marshall blow the whistle, at least to the patient? Did she feel that her role as a clinical ethic consultant would be somehow compromised if she moved from serving merely as an ethics facilitator, a sympathetic listener, to looking the patient straight in the eye to say: "Ask yourself why Dr. X is offering you a third lung transplant. Is it to serve your best interests or his?" That Marshall did not pointedly ask this kind of question—or does not report herself as having asked it—troubles me. Did Marshall keep her opinions to herself because she did not want to pressure the patient in any way? Or did she keep quiet, as many of us clinical ethics consultants do, because she feared that her organizational status and credibility would be weakened? It is, after all, the rare health-care institution that wants its ethics consultants to raise tough organizational ethics questions about its practices, policies, and programs.

Another puzzling feature of Marshall's provocative article, which will serve as a transition to the next section of these reflections, is that although Marshall quotes feminist authors and has written articles such as "Boundary Crossings: Gender and Power in Clinical Ethics Consultations,"¹⁷ she does not identify her approach to clinical ethics consultation as "feminist." Is this because feminist approaches to ethics consultation are seen as somewhat limiting, alienating, or exclusionary? This last question is a very difficult one for me to raise because I fear that the answer to it may be "yes." On the table is the possibility that at least some feminists are deliberately describing their approaches to clinical ethics consultation as narrative and/or contextual in order to maximize their acceptability to others. In so doing, they/we are losing the opportunity to develop a robust feminist approach to clinical ethics consultation that insists on asking, when relevant, the woman question.

II. Feminist Approaches to Clinical Ethics Consultation

In one of the few explicitly feminist articles on clinical ethics consultation of which I am aware, Susan Rubin and Laurie Zoloth identify the factor that distinguishes a feminist approach to clinical ethics consultation from closely-related contextual and narrative approaches to clinical ethics consultation. Boiled down to a phrase, this factor is *a focus on issues related to gender*. In addition to identifying the factor that makes their brand of consultation "feminist," Rubin and Zoloth make four specific claims, each of which is worth highlighting. First, they observe that "of all the power relationships among health care professionals in the clinical setting, the gendered relationship is the most fundamental."¹⁸ They ask us to look closely at

our health-care institutions and to ask ourselves whether it is mostly men, mostly women, or an equal number of men and women who hold the major positions of power. Typically, the chief executive officers, the chiefs of staff, and the most highly paid physicians are mostly men, whereas the nurses, the lab technicians, and the social workers are mostly women. And even if an ever-growing number of women continue to enter medical school, say Rubin and Zoloth, it is unlikely that a larger number of men will start applying to schools of nursing and social work. Nurses (94 percent of whom are females) and social workers (85 percent of whom are females) simply do not have the prestige and status that physicians have; and although their salaries are better than they used to be, they are not nearly as good as the ones physicians receive.

Rubin and Zoloth's second claim—that "the engendering of discourse is critical in shaping both the ethical conversation and the science of medicine"¹⁹—follows directly from their first. Men and women do not speak the same language, or, if they do speak the same language, they speak it very differently. For example, boys in the United States are typically socialized to take center stage, to make their opinions known, and to win their arguments. By the time a boy enters a profession such as medicine, he has learned how to enjoy verbal sparring. Putting others down is his means to maintain a "one-up" position. Men play verbal games just like they play contact sports. They play to win. In contrast to boys in the United States, girls are socialized to make people feel comfortable in conversation and to let others take center stage. Indeed, many traditional hostesses consider a dinner party a great success if no voice is ever raised loudly and if no controversial topic is ever discussed. For this reason, many women find it difficult to engage in heated debates, let alone to enjoy them. They often censor themselves or apologize for their opinions, when neither censorship nor apology is necessary. What is even worse, in Rubin and Zoloth's opinion, is that there seems to be no way for women to win the "conversation game." For example, if a woman begins a conversation by asking for others' opinions, her attempt to be inclusive of others may be misinterpreted as evidence that she herself lacks a definite point of view. But if a woman instead begins a conversation by stating her position clearly and cogently, men (and often other women) may view her as a pushy individual whose views should be discounted or even dismissed.

Rubin and Zoloth's third claim—"when explicitly social and nurturant roles are named as female, such dynamics then shape the ethics consultation itself"²⁰—is one they make confidently. Automatically marked as relatively powerless on account of their gender, female ethics consultants are less likely to be viewed as experts and authorities than their male counterparts. They are pigeonholed as "touchy-feely" types (my choice of words) who are probably not as politically savvy, intellectually alert, and pragmatically inclined as their male counterparts.

The fourth and final claim Rubin and Zoloth make is a summary claim: "Gender shapes our perception of each variable in clinical practice, from diagnosis to the framing of what we understand and support as central truth claims, extending to how we hear the moral appeal of each in the ethics dilemma, and how we approach the ethics consultation process."²¹ Paradoxically, the very thing about women that reduces their institutional power—namely, their gender—simultaneously enables them to hear and see things that men are not likely to hear and see. But if serving patients' best interests is the end and aim of good medicine, should not more women be in positions of institutional power to help medicine stay on track by being maximally aware of patients' needs?

To be sure, Rubin and Zoloth's claims are salted and peppered with some essentialist claims about both women and men. But they are, I believe, correct to claim that even if gender is not the main issue in a case, it is always *an* issue because all of us bring our gender to our decisions. Now mind you, I do not do clinical ethics consults *directly*. Instead, I do them *indirectly*. I am a member of two hospital ethics committees and have been for about thirteen years. Both of these committees rely on a subset of their membership (a physician, a nurse, and a chaplain) to do the actual case consults. In most instances, the cases are resolved relatively quickly and to the satisfaction of the parties involved. All such cases are reported back to the entire ethics committee together with the occasional case that resists resolution. The latter cases are discussed by the entire committee, and I am expected to contribute to these discussions. During these deliberations, I am invited to raise gender, race, class, and other relevant issues as I see fit. In addition, over the years both committees have asked me to present actual or hypothetical cases for educational purposes. I have used these opportunities to make explicit the ways in which a feminist worldview informs my approach to "narrating" or "contextualizing" cases.

Among the cases I presented through feminist eyes is the Armando Dimas case reported in the *New York Times* by Lisa Belkin, a gifted reporter who specializes in issues related to health care.²² The case focused on a twenty-five-year-old survivor of a gunshot wound that left him paralyzed from the jaw down.²³ Using the lenses of liberal, radical, and cultural feminists, and focusing on issues of choice, control, and connection respectively, I aimed to convince my ethics committee colleagues that we could become more competent ethics consultants by focusing on *gender* issues as they intersected with issues related to race, class, and so forth.

According to Belkin, Armando Dimas may have been admitted to Houston's Hermann Hospital's crowded-to-capacity emergency room for ulterior reasons. Young victims of violent crimes are an excellent source of organs, and their number, though large, is certainly not large enough to serve all the patients lingering on our nation's transplant lists. Although the attending physician, David MacDougall, could not fathom how Dimas had managed to survive the assault on his body, Dimas had been resuscitated, returned to consciousness, and put on a ventilator for life support. Gathered around his bed were his loved ones: a fourteen-member family of undocumented Mexican immigrants petitioning for residency in the United States under a new amnesty law. His mother, Victoria Dimas, refused to let anyone tell her son that he would never walk again, for fear that he would give up on life. Although most of the hospital staff believed Victoria Dimas's son would want to die if he knew his actual condition, no one wanted to bear the brutal bad tidings to Dimas. Perceptively, Belkin observes that gridlock had set in—a gridlock that MacDougall finally broke because, frankly speaking, he wanted to end the Dimas case.

Tired of catering to Victoria Dimas, MacDougall asked Cindy Walker, the social worker assigned to Dimas, to convene a meeting between his health-care team and family. Speaking through an interpreter, MacDougall told the Dimas family that Dimas would never walk again. For all practical purposes, he was nothing more than a "head in a bed."²⁴ There would be no miracles. Victoria Dimas responded angrily to MacDougall, exploding in Spanish that it was wrong to give up on her son and to leave him without hope. "He can walk, he will walk. He can breathe; he will not need that machine."²⁵

At the end of the disastrous meeting, reports Belkin, Walker knew something had to be done. Dimas, who had been excluded from the meeting (!!!), still did not know his

fate. Convinced that Dimas was being denied information he needed to determine his fate, Walker phoned the chair of the hospital ethics committee, who in turn called the hospital lawyer. The three of them then concluded that Dimas had a right to know his prognosis so that he could request a do-not-resuscitate (DNR) order or refuse further aggressive medical treatment. Norma McNair, a nurse, was selected to tell Dimas the awful truth about his condition, and to start preparing for Dimas's inevitable demise. But Dimas responded to the truth in a way no one had anticipated: he expressed no interest in being allowed to die. On the contrary, using two blinks of his eyes for a "yes" and one blink for a "no," he communicated his desire for life. He wanted it all: CPR, antibiotics, ventilators, feeding tubes, whatever. The staff was rendered speechless. Because "heads-in-beds" should not want to live, they did not know how to react to Dimas's decision to live. Things were not going according to the script they had written, the script that included Dimas throwing in the towel. Some major revisions were suddenly needed.

After Dimas communicated his wish to live, he became Hazel Mitchell's worry. A former nurse, Mitchell was now a hospital administrator. It was her job to get uninsured patients out of the hospital as quickly as possible and to make their stay as inexpensive as possible. According to Belkin, even after financially-troubled Hermann Hospital shaved its overhead padding off of Dimas's three-week bill of \$57,021.61, their actual cost remained \$29,830.00. Because Dimas's family could not pay even a fraction of the bill, the hospital had to absorb it in entirety as well as any subsequent bills.

In addition to being a financial worry for Mitchell, Belkin writes that Dimas was a major medical challenge for Mary Coffey, the occupational therapist assigned to his case. Coffey had never seen a patient worse off than Dimas, and she initially doubted that she could help him. But, contrary to expectations, Dimas proved to be an able learner. He learned how to speak and eat again. Yet Coffey knew that unless Dimas was provided with a wheelchair, custom-made to properly support his head, he would not be able to learn how to use a mouthstick device. Without this skill, Dimas would have no way to put his thoughts down on paper, so to speak, let alone get a job that requires computer skills only. She therefore requested Mitchell to order Dimas such a chair, pleading that he deserved a chance to be a productive human being. Initially, Mitchell denied Coffey's request on the grounds that Dimas had already cost the hospital more than it could afford, but she later relented only to transfer him nearly immediately to Hermina Bartkowski's Total Life Care Center ("Bart's" for short). There his bills would be \$300 a day instead of \$890 a day, the hospital's deliberately inflated rate. Bart's rates were low not because it provided poor care but because Bartkowski was a saint of sorts, and her staff was composed of Polish-immigrant physicians and nurses who were willing to work as low-salaried "nurses aides" rather than not work at all.

Despite the fact that Dimas arrived at Bart's without a custom-made wheelchair—the one that Mitchell ordered for him did not fit—Dimas did not seem to mind his lost opportunity for learning productive skills. Whenever someone at Bart's asked him whether he had changed his mind and now wanted a DNR order, Dimas always said "no." He liked life at Bart's, which, in his estimation, was better compared to the rough and tumble life he had had on the streets: "I see my family...my sister brings me food...It's nice here...In a lot of ways things are good...If I hadn't been shot, I would have died."²⁶

In a postscript to her report, Belkin notes that four-and-one-half years later, Hermann Hospital decided it would no longer pay for Dimas's care at Bart's or anywhere else. Because Bart's

could not care for Dimas for free either, his family would have to care for him at home. When they were told they had one month to learn how to care for the young man at home, the Dimas family panicked. Moreover, Dimas protested loudly: “Why don’t they just wheel me out to the sidewalk and let me die?”²⁷ Despite the family’s fears—Mrs. Dimas had to be hospitalized twice for shortness of breath—and Dimas’s protests, Dimas was sent home (once again without a custom-made wheelchair). To this day, Mrs. Dimas remains his primary caregiver. The rest of the family helps out when they can, but, now that they are documented, they have jobs to do and lives of their own to lead. As for Dimas, reports Belkin, he is no longer angry that both Hermann Hospital and Bart’s stopped paying for care. Indeed, he seems quite satisfied with his lot in life, stating matter-of-factly: “Things changed. This is the way it is. That’s all.”²⁸

But, wonder I, why did things change? Is this the way it should be? Is this all? Reflecting on Armando Dimas’s case, liberal feminists, as well as representatives of the principled tradition in bioethics, might find little of ethical interest. The principle of autonomy (liberalism’s major playing card) seemed to appropriately trump any misguided application of the principle of beneficence, according to which aggressive medical treatment for Dimas would have been deemed futile—that is, no favor to “a head in a bed” who would, in the judgment of others, be better off dead. Moreover, the principle of justice seemed to justifiably prevail over both the principle of beneficence and the principle of autonomy when Hermann Hospital and, subsequently, Bart’s decided they could not spend any more of their limited resources on Dimas. He would have to rely on the generosity of his family and/or charity for further care.

Those espousing radical feminist approaches to bioethics might not be so quick to proclaim Dimas’s case an ethical success, however. Sensitive to the myriad ways in which structures and systems of domination and subordination make “choice” largely beside the point, radical feminists might emphasize how authorities wield their power in cases like Dimas’s. Initially, Dimas was MacDougall’s medical problem. He assessed Dimas’s condition and pronounced his verdict—“This guy should be dead,” later revised to “There’s nothing that can be done for this guy.”²⁹ MacDougall was particularly annoyed by Mrs. Dimas’s demand that he or someone else at Hermann Hospital work a miracle for Dimas. As he saw it, Dimas was not material for a miracle. In fact, MacDougall saw Dimas simply as a body he could not fix, a good site for organ retrieval. He had to move on to bodies that he could repair. He had no more time to waste on Dimas. Someone else, like nurse McNair, whose work was less important, could tell Dimas the bad news and handle the requisite mop-up job that inevitably accompanies messy displays of human emotion. With reference to MacDougall, the expert in charge of the case, Dimas was always relatively powerless. Indeed, Belkin comments that one of the first things MacDougall noticed about Dimas was his body size: “small for a grown man, about 125 pounds.”³⁰ Dimas’s relative powerlessness became nearly absolute when MacDougall pronounced him “a head in a bed,” a *thing* to run from as quickly as possible.

When Dimas ceased to be MacDougall’s medical problem, he became Mitchell’s financial problem. Realizing that she could only go so far in a “man’s world” as a nurse, even a relatively well-paid head nurse, Mitchell retooled herself as a hospital administrator, quickly adopting a “male” psychology so that she could perform her job well. Radical feminists might speculate that Mitchell’s decision to send Dimas to Bart’s on the same day she decided to order his custom-made wheelchair was no coincidence. Fearing that she was regressing into “womanish”

modes of thinking, Mitchell may have elected to get Dimas out of sight so that she could continue crunching faceless numbers. Similarly, radical feminists might interpret social worker Walker’s initial shock that Dimas did not want to die as akin to the confusion that benevolent bosses feel when their workers want to do things their own way instead of the “right way”—that is, the benevolent bosses’ way. In this connection, Sarah Lucia Hoagland has written:

The relationship between women and men is considered in Anglo-European thought to be the foundation of civilization. I agree. And it normalizes that which is integral to Anglo-European civilization to such an extent that we cease to perceive dominance and subordination in any of their benevolent capacities as wrong or harmful: the ‘loving’ relationship between men and women, the ‘protective’ relationship between imperialists and the colonized, the ‘peace-keeping’ relationship between democracy (vs. capitalism) and threats to democracy.³¹

To this litany, Hoagland would probably add the “caring” relationship between health-caregivers and patients. So long as women and men—that is, human beings—structure their relationships in terms of patterns of domination and subordination, “there will,” she says, “always remain in social conscience concepts which validate oppression.”³²

Radical feminists might also express reservations about the way in which Hermann Hospital and, to a lesser extent, Bart’s ultimately resolved Dimas’s case. They convinced themselves that returning Dimas to his home, ventilator and all, would be in everyone’s best interests. Dimas would be closer to his loved ones, and the health-care system would be spared his expensive hospital and/or nursing home bills. However, Dimas and his family did not perceive his homecoming as all that wonderful. Home, after all, was a five-room trailer with an on-again, off-again electrical system, a dysfunctional heating system, and three times as many occupants as rooms. In fact, Dimas initially viewed his discharge from Hermann Hospital and Bart’s as a form of betrayal, of abandonment; and his family initially viewed caring for Dimas at home as yet another major disadvantage for them to bear: “We aren’t educated enough to run that machine. Something will happen to him, and we won’t know what to do. We aren’t educated, and it’s too late for us to become educated. This is all we are.”³³

To be sure, the Dimas family ultimately learned how to care for Dimas at home, minus the round-the-clock nurses they had, at one time, been promised. Yet radical feminists might underscore the fact that powerless people are quite good at settling for whatever the system gives them. The Dimas family adjusted to their particular reality because they had no other option—not if they wanted Dimas to live. Similarly, the Polish-immigrant “nurses’ aides” at Bart’s adjusted to their life in the “new world.” Faced with the choice of working at a fast-food establishment, or not at all, these highly-skilled professionals chose to work at Bart’s for low wages in an attempt to maintain their dignity. In the estimation of radical feminists, such “choices” are not so much choices as coping mechanisms: strategies to make the best out of a situation one has little or no power to change.

Interested in all the power plays at work in Dimas’s case, radical feminists would be particularly interested in those related to gender inequities. They would note, first, that the people with the least power in Dimas’s case—the nurses, the nurses’ aides, the occupational therapists, and the social workers—are members of one or another female-dominated professions; and, second, that the people doing the hard work

in Dimas's case—cleaning his body, sticking him with needles, teaching him how to eat and talk—are women. The men absent themselves from the scene of the “disaster.”

In their concern for women, radical feminists might even dare to ask some very troubling questions about Dimas himself. He may be powerless relative to white men, educated men, propertied men, men who are United States citizens, able-bodied men, and even so-called exceptional women—that is, women like Mitchell. Yet Dimas is not powerless relative to women in general or the women in his life. As soon as he learned how to speak again, he began to “boss”³⁴ the nurses around. He seemed to take it for granted that his family, but especially his mother, would make him the center of their attention and worry about his happiness day and night. Radical feminists might speculate that if not Dimas but Mrs. Dimas had been shot in the head, a very different series of events may have taken place. It is well documented that women typically sacrifice time, energy, leisure activities, and opportunities to care for their incapacitated relatives. In large measure, they find this work rewarding; but they also find it exhausting—especially if no one tends to their needs. Thus, Barbara Logue has commented:

Will women who have done all this for others—voluntarily or not—want another woman (their daughter or daughter-in-law, perhaps) to do the same for them? Will memories of their own negative or ambivalent feelings, role conflict, or even a sense of altruism, increase their desire not to be a burden to others? ...Will such considerations enhance willingness to choose death instead?³⁵

Worrying that her family members, but especially her daughters, would have to make her the focus of their already difficult lives, radical feminists might speculate that an injured Mrs. Dimas would be only too glad to say “yes” to a DNR order.

In contrast to radical feminists, and focusing not on matters of domination and subordination but on human beings' connections to each other, cultural feminists might stress how Dimas's condition affected his relationships, and how those relationships could have been better supported. In particular, they might lament the opportunities for connection that were lost in Dimas's case. Down deep, MacDougall might have wanted to view Dimas as more than “a head in a bed.” He seemed to recognize that Dimas was not a mere thing but a human consciousness with a unique personality. Still, MacDougall could not connect with Dimas man-to-man, for fear of showing his feelings perhaps. Nor could he communicate with the Dimas family in anything other than a confrontational manner, a manner he may have learned somewhere in the course of his education.

Similarly, cultural feminists might speculate that Mitchell wanted to be other than a numbers cruncher with no connections to humanity. She recognized that Dimas was, after all, like her, a human person with some very basic needs. Indeed, at one point, Mitchell even referred to the ancient Chinese saying: “If you save a life, you are responsible for it.”³⁶ In this reference, cultural feminists would probably hear Carol Gilligan's different moral voice—the voice of relationships and responsibilities. Specifically, they would probably hear Mitchell's desire to be responsible for Dimas as a unique person, and her regret at being unable to do so because her job required her to view him as a statistic, a number, a cost. An ethics of blind justice—of rules and regulations—was the only morality Mitchell's job permitted her, a morality that made it difficult for her to care for Dimas in the supportive way she might have cared for him had she still been a nurse.

As in Mitchell's person, in Walker's person, cultural feminists might see someone who appreciated Dimas's personhood at some level. Although Walker could not fathom his desire to go on living, she admired his “pure but misguided faith.”³⁷ Yet, she too could not fully connect with Dimas for fear that always looking at him as a person would make him that much more difficult to manage as a case. Assuring Mitchell and others that she was, after all, one of them, a professional, Walker may have bowed to the imperative of the bottom line—to the fact that Hermann Hospital could do only so much for any one patient. Recalling Walker's words to Coffey, “We can't just buy him a custom-made wheelchair...We have to face the fact that we can't afford him as it is,”³⁸ cultural feminists would probably suggest that a strict ethics of justice insulates people from the demands of care—indeed, justifies their lack of care as a virtue.

Viewing women's capacities for caring as strengths rather than weaknesses, as pluses rather than minuses in the struggle to be moral, cultural feminists would probably select Coffey, Bartkowski, and Victoria Dimas as paradigmatic moral agents, fighting to remain connected to Dimas as a person. They would note that Coffey, the occupational therapist, was well aware that Hermann Hospital's resources were limited. She tried to make do as long as she could. Yet she knew that if Dimas was ever going to be anything more than an eating and talking machine, he would need to develop his human capacities for connection. As she saw it, a custom-made wheelchair was Dimas's only real chance to interact meaningfully with the world. Confined to his own bed, Dimas's interactions would be limited to those involving his family. And even this mode of relationship would be fundamentally flawed: all unidirectional caring, pointed toward him. The situation of always being the one cared for and never the one caring could even deaden Dimas's potential for caring by leading him to take his family's actions for granted. If, on the other hand, he could get a proper chair and use a mouthstick, he might be able to develop skills useful in the workplace. A job could bring not only financial security and dignity but also the possibility to widen his network of relationships. He could also contribute the money he earned to his family, thus enacting the reciprocal nature of true caring.

In the case of Bartkowski as well as Coffey, cultural feminists would probably see not an oppressed woman but a woman delivering care on her own terms, proving to the larger community that if caregivers are not greedy, they can deliver quality health care at affordable rates. Moreover, they might add the point that even though the Polish-immigrant physicians and nurses at Bart's had to accept jobs for which they were over-qualified, they arrived at work upbeat and ready to follow Bartkowski's inspirational example. Because Bartkowski treated them as her equals, and made every effort to pay them the best she could, many of them felt that, on balance, the positives of their work far outweighed the negatives. Similarly, because Bartkowski insisted that her staff treat all the patients at Bart's, including the comatose and demented ones, like full human persons, the patients at Bart's were happier and, in many ways, healthier than the patients at more upscale facilities.

Finally, with respect to Victoria Dimas, cultural feminists would probably see not someone who is being exploited and “used up” by her family in general and her paralyzed son in particular, but someone who truly speaks the language of care, often to the deaf ears of the medical hierarchy's brand of justice. When it comes to deciding how to treat a son with catastrophic injuries, a mother is not likely to approach this intensely personal decision as she would approach an extremely difficult math problem. As she struggles to determine what is in her son's best interests, she will, as Nel Noddings has written, rely on

her “feelings, needs, impressions, and...sense of personal ideals”³⁹ rather than some set of moral axioms, theorems, or principles. Her goal will be to identify herself as closely as possible to her son so that she can speak for him when others are speaking not so much for him as for themselves. While the bulk of Dimas’s health-care providers are worried about getting things over with—obtaining a DNR order and closing a case history—Victoria Dimas is feeling what her son must be feeling—fear and anger. She clings to the hope to which Dimas must cling in order to want to live. She does not want to tell him his situation is hopeless and let him slip into premature despair. When MacDougall matter-of-factly informs her that “this is all there is” for any “head in a bed,” Victoria Dimas reacts with rage against this universalization. Here is a particular young man, her son, with particular needs. It never occurs to Victoria Dimas to think that her son is someone from whom she or others can be disconnected at will. Instead of viewing her as an irrational woman, making excessive demands on the health-care system, cultural feminists would probably see her as a woman who is obedient to the moral imperative of genuine human concern.

III. Conclusion

If Armando Dimas’s case is at all typical, feminist clinical ethics consultation has much to offer clinical health-care ethics in general by moving gender issues from the background of case framing and analysis into the foreground. That no one on Hermann Hospital’s Ethics Committee gave much thought to Dimas after he got to make his autonomous DNR decision is troubling. A better resolution to his case might have been found had, for example, the ethics committee become involved in the “organizational”/“business” decisions to get (not get) Dimas a custom-fit wheelchair (one that really fit), to transfer him to Bart’s, and, ultimately, to send him home. Perhaps a stronger feminist presence on the committee could have compelled its members to see that the Dimas case was just as much the Victoria Dimas case as the Dimas case. But such a presence was lacking, and because it as well as several other presences were lacking (for example, one attune to the needs of undocumented Mexican immigrants), Hermann Hospital’s Ethics Committee was only too glad to file the Armando Dimas case away and wait for its next chance to help a patient make an “autonomous” decision. Unreflectively and, I want to say, somewhat irresponsibly, they left Victoria Dimas and most of her family in their trailer to tend for Dimas for life. For them, the decisions had been made not so much by them as by the powers that be. Helping to change these decisions, or at least revisit them, is, I suggest, the task of feminist clinical ethics consultants.

Endnotes

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Feminist Ethics Consultation: Clinical and Organizational Ethics

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Bioethics consultation occurs primarily in health-care institutions (e.g., academic and non-academic medical centers, for-profit and not-for-profit hospitals); corporations (e.g., biotechnology firms); and government and other public

policy settings. This paper considers three hallmarks of feminist ethics and explores some ways in which these features can shape ethics consultation in the health-care setting. Feminist ethics encompasses a range of positions that share (at least) three features: the belief that (1) experience is important for understanding morality, that the context of decisions and actions is a relevant ethical consideration, and that there is no single moral point of view from which we have a full understanding and grasp of morality; (2) oppression, subordination, injustice, exploitation, and inequality create vulnerabilities, are morally wrong, and should be eliminated; and (3) the role of gender must be taken seriously in evaluating decisions, actions, relationships, and institutions. This list is not exhaustive of all that is common or central to feminist ethics, but these themes emerge in a wide range of feminist approaches to ethics and have immediate implications for the theory and practice of ethics consultation.

First, I consider the ways in which feminist ethics can shape our vision of the purpose, goals, and scope of ethics consultation. I argue that clinical consultations informed by feminist ethics (a) must hold as an immediate goal identifying and advocating for vulnerable, oppressed, or unjustly treated parties and (b) must have as a long-term goal advocating for change in structures that create or perpetuate injustice or oppression. Feminist ethics involves not merely noticing oppression and injustice but a commitment to eliminating these features of our (im)moral experience. Eliminating oppression and injustice may involve assessing and changing the institutional and societal structures that permit, create, or perpetuate oppression and injustice. Discussions of ethics consultation in the health-care setting often either intentionally set aside or for other reasons do not consider the organizational ethics aspects of particular cases or of clinical ethics issues in general. This will not be permissible for consultants working from a feminist perspective. Ethics consultants are uniquely situated to identify structures within health-care organizations that create or perpetuate the injustice or oppression. As a result, a feminist perspective commits consultants to addressing issues typically classified as organizational ethics concerns. The connection between feminism, feminist ethics, and politics has long been recognized and is captured in the widely used phrase, "The personal is political." But the connection between feminist ethics and what we might call mid-level social organizations that are not explicitly political, health-care organizations, has been less explored.

Second, I examine some of the ways in which feminist concerns can inform the consultation process. Feminist ethics consultation processes will share features recommended in some of the ethics consultation literature that is not written explicitly from a feminist perspective. For example, many consultants believe it is important to identify the facts relevant to a case and the opinions of various parties. Even where there is common ground, however, important differences may emerge between feminist approaches to ethics consultation and other approaches. For example, the feminist and non-feminist consultant may see different facts or circumstances as relevant, even as central, to a case. The feminist consultant will focus on specific features of a case, such as the role of gender in shaping experiences, conversation structures, and decision-making practices; will raise these issues as part of the consultation; and will resist attempts to ignore them. Thus there may be agreement on the importance of identifying all the facts and positions relevant to a case, and there may be differences among consultants concerning what the facts truly are and which ones matter. Moreover, the feminist consultant will be committed not merely (1) to creating notice of oppression, vulnerability, injustice, and (2) to creating a space for the

oppressed, vulnerable, or unjustly treated to speak, but (3) to ensuring that the vulnerable, oppressed, and unjustly treated in fact are heard, and (4) to eliminating oppression and injustice. Thus the feminist consultant will be committed to a particular result rather than merely to a thorough exploration of issues and opinions. This commitment to particular conclusions generally is not evident in the literature on bioethics consultation, much of which focuses on facilitation of dialogue, the development of consensus, and an exploration of moral issues. In short, feminist ethics commits individuals to a certain general position on the theoretical question of what are the appropriate goals and roles of clinical consultations and on the connection between clinical and organizational ethics as well as to particular consultation methods.

I. The Purpose, Goals, and Scope of Ethics Consultation

One fundamental question we may ask regarding ethics consultation is: What is the purpose, goal, or scope of ethics consultation? While the issue has been discussed in the literature, there is no consensus in the field.¹ Much of what has been written about the purpose or goals of ethics consultation calls for consultants to facilitate discussion; to facilitate consensus on a morally acceptable course of action; to help physicians in identifying, analyzing, and resolving ethical issues in health care; or to explore and identify moral issues and to give parties new ways to think about a situation. Some of the ethics consultation literature shifts the focus of consultation toward advocating for particular positions or results. Benjamin Freedman appeared to hold that ethics consultants have a responsibility to stand up for what is morally right and to conduct consultations in a way that yields particular conclusions.² Susan Sherwin and Françoise Baylis, writing from an explicitly feminist perspective, call on consultants to be, first and foremost, architects who design "collaborative, fair and inclusive sites for moral deliberations and [build] good ethical processes."³ When the effort to create spaces within which individual autonomy is fostered and respected fails, they argue, consultants should become advocates, speaking for the vulnerable, oppressed, or unjustly treated. They note that the role of advocate is complex and wrought with implications contrary to feminist commitments but that advocacy sometimes is appropriate and necessary.⁴ I argue that someone who adopts a feminist perspective necessarily will see the role of the consultant as advocate for the vulnerable, oppressed, or unjustly treated, though I accept a broader conception of what constitutes advocacy that includes what Sherwin and Baylis refer to as being an architect. That is, insofar as Sherwin and Baylis's architect designs an open moral space for the purpose of allowing the disenfranchised to have a voice and attempts to ensure that the space is effective, then the architect is engaged in advocacy. Feminist commitments make it morally unacceptable for persons who can defend the vulnerable, eliminate oppression, and neutralize injustice not to attempt to do so. From a feminist perspective, then, ethics consultants should advocate for particular parties in specific cases and for organizational (and societal) changes to eliminate the patterns and structures that create or perpetuate the injustice or oppression observed.

This advocacy may take three forms, though it will not always be necessary or appropriate to employ all three forms. The first is advocating for vulnerable or oppressed parties in a specific case by intentionally creating a space within which they can find a voice and have it heard. This is what Sherwin and Baylis refer to as being an architect. While they distinguish this activity from advocacy, I hold that it is a form of advocacy because it is an attempt to shape a process that will serve the interests of those the consultant sees as vulnerable

or oppressed. This form of advocacy involves structuring the conversation in a way that enables the otherwise voiceless to be heard and that brings forth consideration of particular issues, including issues of gender and power. The second form of advocacy involves ensuring that the created space is functional and that the vulnerable or oppressed are in fact heard. If the voices of vulnerable parties are not respectfully engaged, then the consultant will act on their behalf and ensure that their interests are voiced by, for example, speaking on their behalf. This is what Sherwin and Baylis refer to as advocacy.⁵ The third form of advocacy—being an activist for change at an organizational level—almost always is overlooked by both mainstream and feminist analyses but, in my view, is vital to feminist aims in ethics consultation. Because organizational structures, policies, and practices may create or perpetuate vulnerability, oppression, or injustice, health-care organizations may play vital roles in clinical cases. Hence feminist ethics consultants may not participate in clinical ethic consultation without attending to organizational ethics and promoting change at the organizational level. (Consultants may participate in a fourth level of advocacy by being political activists. This form of advocacy is not considered here.)

Addressing organizational ethics will be an important aspect of consultation from a feminist perspective for multiple reasons. Organizational ethics concerns the overall conduct of a health-care organization, including its policies and procedures related to business, finance, management, employment, and the general ethical climate. Feminist approaches to ethics call on us to appreciate the context of decisions and actions, and insofar as ethics cases arise in the context of health-care organizations, it will be essential to evaluate and consider the organizational features relevant to the case. Moreover, ethical issues that arise within organizations cannot be categorized as strictly clinical or strictly organizational ethics because of the nature of organizational agency. Organizations are moral agents—bearers of moral obligations and responsibilities—but they depend on the individuals associated with them to identify and execute their responsibilities. Therefore, ethics consultants ought to attend to the ways in which individuals affiliated with health-care organizations shape organizational behavior and the extent to which organizational policies, procedures, practices, or structures are relevant to a consultation. Consider the following case:

David is a twenty-five-year-old who was diagnosed with leukemia five years ago. He wrote an advance directive at that time stating that when his doctors deemed he would die within six months, he wanted all medical interventions, other than comfort care, withheld. At the time, he discussed his decision with his parents, and they expressed disapproval. David recently reached the point at which he was declared terminal. While still conscious, he decided to forgo all further aggressive interventions and voluntarily stopped eating and drinking. David became less coherent and, when he could no longer make decisions, his parents began demanding that he be given artificial nutrition and hydration (ANH). They argued that ANH was not a medical intervention, that David was depressed and in shock over his diagnosis when he completed his advance directive, and that they had the right to make decisions for him now that he no longer could formulate and communicate preferences. David's physician resisted their request on the basis of the advance directive and the fact that David voluntarily stopped eating and drinking while still conscious. The parents' attorney contacted the physician and the

hospital threatening the hospital and physician with a lawsuit. A hospital administrator informed David's physician that the parents' threat is real and that the physician should write an order for ANH for David. The physician, uncomfortable with this request, contacted the ethics committee for a consultation.

On one level, this case is about patients' rights and the decision-making authority of adults. Couched within broader concerns about how a voiceless patient who attempted to make his wishes known is having those wishes ignored in the name of protecting a physician and an institution from liability, one sees this case as concerning not only patients' rights but also organizational practices that threaten the weak. I suspect that most ethics consultants would respond to this case by seeking to help the parents understand the nature of their son's condition and the importance of respecting their son's wishes. However, this case also should alert the consultant to the possibility of an organizational pattern in which patients' and families' power, as a function of their likelihood of suing, is assessed. Patients may be treated differently based on how likely it seems that they or their families are to sue. A consultant concerned with oppression and injustice will want to know the extent to which this risk-management approach to patient care influences other types of decisions. For example, the consultant may be concerned that patients deemed unlikely to sue may receive lower-quality care than those deemed likely to sue. Identifying and changing systematic practices that may further marginalize those who already are relatively powerless will be of concern to the feminist consultant.⁶ Other clinical ethics cases involving organizational components are discussed below.

II. Feminist Ethics and the Practice of Clinical Consultation

In the literature on ethics consultation, one finds a number of analyses of how to conduct a consultation, whom to involve, which questions to ask and so on. I suggest here some of the ways in which feminist ethics may shape the practice of clinical consultation. Before I address these points in particular, I note that even consultants who do not identify themselves as feminists and who do not specifically adopt feminist objectives and concerns can benefit from understanding the implications of feminist approaches to ethics consultation. Some approaches to ethics consultation hold that an important purpose of ethics consultation is facilitating dialogue and creating an opportunity for all stakeholders to be heard. One who has this goal and genuinely seeks open conversation may learn from feminists that there are ways in which gender and power may affect conversations and the ability of some persons to participate meaningfully in a conversation. Similarly, many approaches to ethics consultation hold as a goal of consultation identifying all the aspects of a case that may influence people's understanding and opinion as well as shape their understanding of what solutions are ethical. Insofar as a consultant is concerned with helping the parties identify, understand, and consider all the issues that are at stake, a consultant may ask whether gender or some other power relationship could be affecting the case. Thus even one who does not share the broader concerns of feminism but has some general concern with inclusion or with understanding all the relevant ethical issues in a case may benefit from understanding feminist approaches to ethics consultation. Ethics consultants may better meet their defined consultation goals if they take into account some contributions of the feminist ethics or feminist bioethics literature. This essay speaks to ethics consultants who do not identify themselves as feminists or consciously adopt a feminist approach but whose approach to ethics consultation may benefit from feminist insights.

To illustrate some of the ways feminist ethics can shape the practice of clinical ethics consultation and the relevance of organizational ethics to clinical ethics consultation, I consider four elements of the case consultation process.

1. Case Descriptions: Structuring Cases for Oneself and Others. Case descriptions reflect how the consultant understands the issues, and they can shape how others see them. Case descriptions are important, Susan Rubin has argued, because “there is no one single ‘real’ story of any case.”⁷ When one asks different parties for their story, one may find that a single case is described in very different ways. She recommends the use of narrative methods in constructing case descriptions because they “can help ensure that information is gathered and interpreted in an appropriate and competent fashion.”⁸

There are a number of points during the consultation process at which the consultant describes the case. First, at the initial request for consultations, consultants describe cases to themselves. Consultants’ descriptions are informed by the descriptions offered by those requesting the consultation. (These persons will be referred to as “callers” for convenience, even though initial contact may not be by phone.) However, consultants have the opportunity to re-describe cases, either consciously or unconsciously. Part of the re-description may include resisting the initial description and identifying unanswered questions—including perhaps questions or concerns ignored by callers or issues callers may perceive as irrelevant. In this initial process of describing cases to themselves, feminist consultants will ask specific questions about power relationships and other sources of vulnerability as well as about the possibility of oppression or injustice. Feminist consultants will seek to understand the circumstances that led to a case, identify the parties whose views must be sought, and begin to imagine the multiple interpretations and points of view that may cast the facts in a different light or even that may identify different facts as central to the case. This is an important process because those who request consultations may not see or describe the case in a way that represents alternative points of view. I am not suggesting that non-feminist consultants will not seek more information than callers provide, ask about alternative points of view, or attempt to understand the contexts within which cases arise. Feminist consultants, however, will do this in light of particular concerns and with the goal of identifying the vulnerable parties and ensuring that their voices are heard. Such concerns, which include attention to the role of gender and power as well as to the social context within which cases arise may receive less notice from non-feminist consultants throughout the consultation process. Consider the case discussed by Angell, Fleck, and Walker:

Carlos, a young man who is HIV-positive, is to be discharged from the hospital to complete his convalescence from a gunshot wound under the care of his twenty-two year old sister, Consuela. Medicaid will not pay for nursing because a caregiver is available in the home. Consuela is willing but is ignorant of Carlos’s HIV status; Carlos refuses to inform her, fearing that she—and worse, his father—will learn of his homosexual orientation.⁹

Different lenses may yield different descriptions and, ultimately, different recommendations. The description offered here is fairly neutral. However, one can imagine that one person might request an ethics consultation and describe the case as one in which a patient may be forced to disclose confidential information against his wishes. Another may request a consultation because of the injustice he sees being done to the sister. Both lenses are plausible in light of Fleck’s and Angell’s competing analyses. Fleck sees the case as one

requiring a risk-benefit comparison of the duty to maintain confidentiality and the duty to warn. He concludes that the risks associated with breaching confidentiality outweigh the risks of failing to warn Consuela—the physician has a duty to maintain confidentiality. Angell, on the other hand, sees this as a case about a woman in a vulnerable social position. She focuses more on the relationship between Carlos and Consuela, the social circumstances that put Consuela in the caregiver role, the way Consuela would be treated if she were a paid caregiver rather than an “available” family member, and the assumption (by the hospital and the Medicaid system) that a woman living in the household is an available caregiver. Angell concludes that Carlos has a right to confidentiality and that the physician should not breach it, but that if Carlos refuses to disclose his HIV status to his sister, then he should not have access to Consuela as a caregiver. She argues that the physician and health-care organization should not perpetuate the oppression created by a system that assumes Consuela’s availability and dismisses her interests. It is not difficult to imagine that a caller who shares Fleck’s perspective, that what matters are the risks and benefits of disclosure, will offer a different description from one who sees Consuela as a victim of injustice.

Second, as the consultation proceeds, the consultant describes the situation to others, such as members of an ethics committee with whom the case may be discussed and the other parties involved in the case. Here the consultant has the opportunity to shape the lens through which others see the case and determine the issues others hear about and are told are important. Consider the following case:

Miss D is an 18 year old woman who suffered a serious injury and may be brain dead. She left home three years ago and has had no contact with her family. In the past, she has alleged that her father sexually abused her. She was living with a boyfriend at the time of the injury. Her father is on dialysis and in need of a kidney transplant. The hospital located her parents to inform them of her condition. They arrived twelve hours later, after her father’s dialysis appointment. During his dialysis appointment, the father had asked his nephrologist if he might be able to use one of his daughter’s kidneys. The nephrologist immediately contacted Miss D’s physician and testing began to determine whether the patient is a suitable donor for the father. The boyfriend realized what was happening and insisted that the patient never would have wanted to donate a kidney to her father. A nurse, concerned by the allegations, alerted the transplant team to the conflict. The transplant team insisted that the parents have decision-making authority.¹⁰

Imagine that the ethics committee is called to participate in this case. Some might place great emphasis on the boyfriend’s opinion, insist that the allegation of sexual abuse is important and should be investigated (perhaps by talking with the patient’s younger sisters who are in the room), and suggest that the parents may not be appropriate decision-makers in this case. In describing the case to others, such consultants might emphasize these aspects and the importance of determining what the patient would want. Others would emphasize the importance of saving lives, the authority of parents, the unsubstantiated nature of the sexual abuse allegation, or some other feature, in describing the case. How consultants describe cases can shape how others see them. If others do not identify the potential gaps in the descriptions they are given or the alternative understandings of particular cases, then consultants’ descriptions stand as valid and serve as the baseline from which all discussions proceed. Yet no description of a case,

even one formulated by a trained ethics consultant, can be objective in a strong sense.¹¹ Descriptions may be influenced by one's background, beliefs, and other factors that shape the lens through which one sees the world. In this case, one can imagine very different reactions to a description that minimizes the sexual abuse allegation and one that emphasizes it.

Third, after the consultation, the consultant may describe the case (a) in an ethics committee meeting for the purpose of case review or (b) in other venues for educational purposes. Here again there is an opportunity to include and exclude specific aspects, to emphasize some elements over others, and to shed a particular light on a case.

In all of these instances, the consultant has the opportunity to describe what is happening, to identify agents and objects of others' actions, to include and exclude particular elements, and to note where more information or input is needed, to suggest or imply causality, and to identify injustice or oppression. The case description is a powerful lens. One who holds or accepts the basic hallmarks of feminism will attend to specific issues in describing a case, such as the ways in which a particular party may be the victim of injustice, vulnerability, oppression, or for some other reason may be voiceless. Some observations about, for example, the role of gender and power may be left out of a case description or de-emphasized by a non-feminist consultant. Some of these questions and observations probably would be included or considered by many ethics consultants, whether or not they had specific feminist inclinations. Nevertheless, a feminist approach to consultation will intentionally address these issues, raise certain questions, and look at cases from what some might consider radically different points of view.

The importance of case descriptions as elements of consultation can be understood in light of the feminist concern that we recognize our own myopia and that of others. Consultants must realize that all case descriptions are perspectival, including their own. In an effort to take into account the importance of context and lived experience for understanding ethical issues; to give voice to the vulnerable, the oppressed, exploited, or unjustly treated; and to take seriously the role of gender, consultants must be attentive to the power of case descriptions.

2. Determining the Extent of a Consultation: The Decision to Conduct a Formal Consultation. In the ethics consultation literature, one finds mention of "curbside consultations." These are situations in which someone, often a physician, asks an ethics consultant to render a quick opinion on a matter or answer a question. The person requesting the consult believes that this "consultation" is sufficient to resolve the initial question. Bioethicists have questioned the appropriateness of "curbside" consultations, in part because such consultations may be used to end discussion prematurely. Even if one holds that such consultations are appropriate in some circumstances, a consultant informed by feminist concerns will seek to ensure that such a consultation does not undermine any parties in the case, especially any vulnerable parties. A consultant must ensure that he or she has sufficient information to determine that important issues have been identified by the person requesting the consultation or that they can be satisfactorily identified in the brief consultation. It is possible that the person requesting the consultation does not have all the relevant information or sees the information only in a particular way and thus diminishes other points of view. If a consultant offers a quick response to a question, important information may be missed, a perspective that was being marginalized in the process may be further marginalized as a result, and the interests or needs of a relevant party may be ignored. Thus consultants must make decisions about how extensive or formal a consultation is necessary and who should be included.

Consider the kidney transplant case discussed above. One can imagine that when the boyfriend protested the testing, someone from the transplant team called a member of the ethics committee to confirm that the parents have decision-making authority for this unmarried, incapacitated patient who has no adult children and no durable power of attorney for health care. (This is a legal matter, though most non-lawyer ethicists are familiar with and answer such questions.) Answering the question without asking why it arose, why it matters, whether there is disagreement that should be taken seriously, and so on could leave important issues unexplored. The nurse who was concerned by the boyfriend's allegations also would have no opportunity to speak to the issues, and organizational power structures that disenfranchise the less powerful would continue. One also can imagine a case in which the person who has legal decision-making authority has had relatively little to do with the patient because the patient has strong religious beliefs that the legal surrogate does not share. Such a surrogate might not understand a patient's moral views sufficiently well to represent them and make decisions based on them as the patient would make. That surrogate also may attempt to dismiss or ignore the patient's beliefs. In such a case, it may be important to work with the legal surrogate to help the surrogate understand his responsibilities as a surrogate for a patient whose values and wishes are known. In extreme cases it may be appropriate to try to have a different surrogate legally appointed. But if the consultant merely confirms what the caller initially sought to confirm, the patient's wishes and values may be lost—the voiceless patient may be deprived of having his preferences respected.

Ensuring that consultations are sufficiently extensive, that they include the perspective of all who should have a voice in the case, and that the parties have an opportunity to consider the full range of issues relevant to a case is important from the feminist perspective. Allowing persons who request "curbside consultations" to control the information available to the consultant can leave some persons further marginalized.

A separate issue related to determining the extent of a consultation concerns the involvement of a consultant in a case into which her participation has not been requested.¹² Consider again the kidney transplant case. Suppose that no one calls the ethics committee but that members of the committee become aware of the case. Would a consultant be justified in contacting some of the parties involved and suggesting that no further decisions be made until there is an opportunity to discuss the case? Because ethics consultants and ethics committees typically play advisory roles, it is unlikely that such an ethics committee member would have the authority to stop the transplant team from proceeding, but such a person might attempt to become involved. Ought such a person to try to become involved? Would it be permissible for a consultant to do so? The issues associated with what we might call proactive consultation are too complex to analyze in detail here. I suggest, however, that a person who (1) is aware of the ways in which power relationships marginalize some persons and (2) is concerned with eliminating injustice, oppression, and subordination will be inclined to become involved in cases of this type. Doing so may be necessary to help empower the disempowered and to ensure that the vulnerable are not further marginalized. Despite the fact that in most institutions everyone is permitted to contact the ethics committee and request a consultation, in reality many individuals may not know this or may be too afraid to utilize that authority. Becoming involved in a case in which some parties are actively hostile to the idea of ethics consultation may be useless or impossible. But a consultant concerned with the vulnerable, oppressed, or unjustly treated may recognize a responsibility to be

proactive, to investigate situations in which there are serious allegations that a vulnerable person's wishes are being violated, and to determine whether certain points of view are being inappropriately ignored, regardless of whether her presence is welcomed by all or even sought. It will be insufficient to wait until others identify a case to become involved because those who truly possess the power to call for an ethics consult may be the very parties that have no interest in helping the vulnerable or oppressed speak out. Alternatively, they may not even recognize that a party has been marginalized and has a valid, relevant perspective. Finally, there may be organizational policies or practices that make it difficult or impossible for some to voice concerns and be taken seriously. If there are sufficient grounds for believing that the vulnerable, oppressed, or unjustly treated are being denied a voice, a consultant working from a feminist perspective may see herself as having a responsibility to become involved in a case.

3. Consultation Methods and Process. Several authors who write from a feminist perspective have contributed to the ethics consultation literature recommendations or observations about the process of consultation. Laurie Zoloth and Susan Rubin have written extensively on the process of consultation and the use of full committees, and DeRenzo and Strauss have offered a feminist approach to ethics consultation.¹³ Here I mention only some global procedural issues that will be important for an ethics consultant from a feminist perspective.¹⁴ Some important issues for establishing consultation procedures and conducting consultations from the feminist perspective are: (a) ensuring that the appropriate parties have access to consultants, are invited to participate in consultations, and are provided an appropriate environment for participating meaningfully; (b) determining how to encourage parties that may hesitate to participate actively to contribute and finding ways to help individuals communicate their perspectives (this is the architect role Sherwin and Baylis discuss); (c) determining what role the consultant plays during the consultation or at various moments in the consultation, and determining when the consultant should shift from one role to another (e.g., in raising issues others may not see or mention, asking questions, advocating for the vulnerable, unjustly treated, or oppressed); and (d) maintaining an awareness of the goals of consultation throughout.

4. Post-Consultation Duties and Practices. Much of the literature on ethics consultation calls for documentation of consults and review of cases after consultations have concluded. Case review presents an opportunity to ask questions about consultation procedures and to make judgments and recommendations for improving consultation practices. The feminist consultant will pay special attention to how well the consultation procedures engaged the vulnerable or the oppressed and enabled them to be heard. Case review also is an opportunity to identify or discuss further organizational issues relevant to the case. A case or a collection of cases may reveal systematic ways in which particular categories of persons are marginalized, treated unjustly, or in some other ways disempowered. Identifying such circumstances and then working to change them will be of concern to the feminist ethics consultant. For a consultant committed not only to facilitating the resolution of particular cases but to eliminating oppression, injustice, and the powerlessness of the vulnerable, the case review process will provide a forum for examining a case in the broader context of organizational and societal structures. Understanding the source or cause of oppression or injustice and understanding the ways in which the vulnerable may be silenced gives the feminist consultant a focus for change. Recall that the feminist ethicist is committed not merely to noticing but to changing the circumstances that create and perpetuate

injustice, oppression, and weakness of the vulnerable. This may require action at the organizational level. There is no doubt that engaging these sorts of issues and attempting to change organizational behavior or organizational structures can place a consultant's job in jeopardy. Nevertheless, this is an important responsibility for anyone working from a feminist perspective. Feminist ethics consultants will see clinical ethics as a gateway to organizational ethics, and in organizational ethics rest substantive issues that must be addressed in the long-term effort to eliminate oppression and injustice.

Endnotes

1. See, for example, K. Danner Clouser, "Medical Ethics: Some Uses, Abuses and Limitations." In *Bioethics: An Introduction to the History, Methods and Practice*, edited by Nancy S. Jecker, Albert R. Jonsen, and Robert A. Pearlman (Boston: Jones and Bartlett Publishers, 1997); Susan Sherwin and Françoise Baylis, "The Feminist Health Care Ethics Consultant as Architect and Advocate," *Public Affairs Quarterly*, 17 (2003); Lisa M. Rasmussen. *Clinical Ethics Consultation: Analysis of a Practice* (Rice University, Ph.D. Dissertation – Philosophy, 2003); Jonathan Moreno. *Deciding Together: Bioethics and Moral Consensus* (New York: Oxford University Press, 1995); and Terrence F. Ackerman, "The Role of an Ethicist in Health Care." In *Health Care Ethics: A Guide for Decision Makers*, edited by Gary R. Anderson and Valerie A. Glesnes-Anderson (Rockville: Aspen Publishers, 1987).
2. Benjamin Freedman. *Duty & Healing: Foundations of a Jewish Bioethic* (London: Routledge, 1999).
3. Sherwin and Baylis, 141-58, 145.
4. *Ibid.*, 151. Because feminism calls for changes that promote justice and the elimination of oppression, it involves advocacy. However, Sherwin and Baylis are concerned that consultants who assume the position of advocate may undermine the autonomy of those on whose behalf they speak.
5. These claims regarding the importance of advocacy must be distinguished from any claim that an ethics consultant should be a patient advocate. The feminist consultant whose goal is to ensure that the vulnerable or oppressed are heard sometimes may act as an advocate for patients, but the consultant will advocate for all parties that are vulnerable, oppressed, or the victims of injustice. Sometimes this will mean advocating for nurses, for family members, and even for physicians, depending on the nature of the case and the parties involved. This broader advocacy role can be understood better in light of the case of Carlos and Consuela discussed below. To say that feminist concerns commit ethics consultants to advocacy is not to say that feminist ethics consultation is patient advocacy.
6. Given this article's focus on feminist ethics consultation, it is reasonable to ask whether this case involves any gender issues and, if not, whether it should be subject to feminist analysis. If the patient were female, it clearly would be of concern from a feminist perspective. Even with a male patient, however, one could argue that the case should be subject to feminist analysis because all relationships are affected by gender. Others might hold that the case requires feminist analysis because the patient is vulnerable, and, although feminism was born out of concern for women's oppression, feminists hold that all forms of oppression or injustice are immoral. Yet others might hold that, insofar as no clearly vulnerable woman is identified in this case, there may be no work for feminist analysis here. Only if, for example, the physician or hospital administrator involved were female, or if the patient's mother was found to be in a vulnerable or oppressed position, would feminist ethical analysis be relevant to the case. Assessing these different perspectives is beyond the scope of this paper.
7. Susan B. Rubin. "Beyond the Authoritative Voice: Casting a Wide Net in Ethics Consultation." In *Stories Matter: The Role of Narrative in Medical Ethics*, edited by Rita Charon and Martha Montello (New York: Routledge, 2002), 109-18, 111.

8. *Ibid.*, 109.
9. Margaret Urban Walker, "Keeping Moral Spaces Open," *Hastings Center Report*, 23 (1993): 33-40, 35. See also Marcia Angell, "Commentary," *Hastings Center Report*, 21(6) (1991): 40; and Leonard Fleck, "Please Don't Tell," *Hastings Center Report*, 21(6) (1991): 39-40.
10. This is an abbreviated version of a case presented at the Notre Dame Medical Ethics Conference, March 19-21, 2004. I am grateful to the person who presented this case for permission to use it. The contributor's name is withheld to protect confidentiality. This case could be the subject of a rich analysis, but space does not permit me to undertake such an analysis here.
11. What it means to be a trained ethicist or a bioethics expert is a matter of debate. The American Society for Bioethics and Humanities (ASBH, 1998) published a document delineating the core competencies individuals must possess to engage in bioethics consultation, but there is no consensus on what level and type of education should be required for ethics consultants. The ASBH published a survey of bioethics training programs in North America, which gives some insight into the range of educational opportunities for ethics consultants (2001). However, not all persons who engage in ethics consultation have graduated from a formal training program. See American Society for Bioethics and Humanities, *Core Competencies for Health Care Ethics Consultation* (Glenview: American Society for Bioethics and Humanities, 1998) and American Society for Bioethics and Humanities, *North American Graduate Bioethics and Humanities Training Survey* (Glenview: American Society for Bioethics and Humanities, 1998).
12. One might be tempted here to suggest that this is likely to be a matter of hospital policy and that the consultant will have to adhere to that policy—it is not a matter for individual consultants to decide. That suggestion raises the question of what the policy ought to be. It does not resolve the question.
13. Susan Rubin and Laurie Zoloth-Dorfman. "She Said/He Said: Ethics Consultation and the Gendered Discourse," *The Journal of Clinical Ethics*, 7:4 (1996): 321-22; Susan B. Rubin and Laurie Zoloth, "Clinical Ethics and the Road Less Taken: Mapping the Future By Tracking the Past," *Journal of Law, Medicine & Ethics*, 32 (2004): 218-25; Evan G. DeRenzo and Misha Strauss, "A Feminist Model for Clinical Ethics Consultation: Increasing Attention to Context and Narrative," *HEC Forum*, 9:3 (1997): 212-27.
14. Some recommendations for case consultation procedures do include concerns relevant to feminist ethics even though they are not written explicitly from a feminist perspective. Others may be less responsive to feminist concerns. For example, John LaPuma and D. Schiedermayer, authors of *Ethics Consultation: A Practical Guide* (Boston: Jones and Bartlett Publishers, 1994), hold that a consultant should become involved in a case only when the attending physician offers a formal invitation. They compare the request for an ethics consult to any other request for an expert opinion. LaPuma and Schiedermayer note that "patients and families often directly (and appropriately) ask the attending for expert opinions from medical consultants in other fields...[T]he attending nearly always agrees to a consultation" (5). Once invited, the ethics consultant meets with the attending to determine what the attending physician's goals are for the consultation. While they offer a number of reasons for these claims, they do not acknowledge what surely is important from a feminist perspective: patients, nurses, family members, or others who have concerns with ethical issues may be afraid to suggest to the attending physician that an ethics consultation be requested, or they may be unable to convince a physician who rejects such a request that a consultation is needed; an attending physician's goals for a consultation may be very different from and may not serve the interests of others (for example, an attending may

have as a goal leading a family to agree with the physician's recommended course of treatment even though it violates the patient's religious beliefs); patients sometimes have little or no control over who their attending physician is, and to limit patients' access to outside opinions and help by requiring that all consultation requests be channeled through the physician further disempowers patients. LaPuma and Schiedermayer's recommendations regarding ethics consultation processes perpetuate a hierarchical power structure that feminists are likely to find problematic.

Remember the Nurses

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Feminism used to be about women. Feminist activists set out to improve the situation of women; theorists set out to understand it.

Those basic commitments still hold, of course, but as our understanding grew in sophistication, so did our commitments. Sometimes I am bemused by the present shape of feminism; as I write, for instance, the listserv for FEAST (Feminist Ethics and Social Theory) hosts a passionate debate about whether "Duh!" is insulting to the cognitively disabled. Susan Sherwin and Françoise Baylis's article on feminist ethics consulting¹ mentions women (separately from men) only rarely, and the only woman-specific issue they mention is contract pregnancy. Knowledgeable readers, of course, recognize the authors' fundamental principles as growing out of decades of work in feminist theory. When the situation of women is well understood, it is obvious that the same basic understandings apply to anyone living under oppression, and the practical commitment to work on behalf of women entails, morally, the same commitment to everyone similarly situated. So FEAST members take seriously issues about the cognitively disabled, as they do issues about refugees, gays and lesbians, and others. For the same reasons, Sherwin and Baylis take issues of power (and its abuse) as central concerns for a feminist ethics consultant.

These broader commitments, however, have paradoxical consequences and even dangers. Sherwin and Baylis, for example, recommend that people invited to participate in a consultation should include the "health professionals with the most continuous, committed and trusting relationship with the patient."² The authors do not make the obvious point that those health professionals are usually nurses.

In general, feminist bioethics pays relatively little attention to nurses, and I am sometimes puzzled as to why. Roughly 95 percent of nurses are women, a proportion highly likely to continue. Men generally avoid occupations identified as female, just as they generally avoid names and clothes thought of as belonging to women. The taint of inferiority and contamination appears to be psychodynamically powerful. When men do take up female-coded occupations, in my experience, they are likely to be impressive human beings, comfortable in their own identities, unthreatened by ordinary irrational fears. But there is no reason to think that their attitudes will ever be the norm.

Nursing has been an overwhelmingly female occupation for most of its history and bears all the marks of that fact. The field is idealized by the general public ("angels in white," "the lady with the lamp") but also understood simply as a handmaiden to medicine. It is nurses that make a hospital into what it is, a place offering round-the-clock care. Doctors diagnose and plan the management of disease, obviously

essential activities, but the role of doctor does not include providing continuous observation and care. A collection of doctors and their patients is a clinic, not a hospital. Yet hospital administrators can ignore the input of nurses—highly skilled professionals—on how their own jobs are best managed. This is a standard gendered story: women seen as noble and warm hearted, their technical skills unnoticed and unhonored. Work done by women receives at best sentimental appreciation; rarely is it genuinely respected.

There's another reason nurses deserve more attention from bioethics (and not just feminist bioethics): they are gatekeepers. Again there are analogs everywhere: in poor countries where children are sick or starving, the best way to improve their situation is to help their mothers. Mothers spend what aid they receive on children far more dependably than fathers do. And so in health care: good patient care in hospitals depends on nurses. A good nurse can often compensate for a poor physician; a good doctor cannot compensate for a poor nurse. Something similar holds true in research: the protection of human subjects depends on the nurses to whom the protocol is entrusted.

Let us take it, then, that feminist bioethics should pay more attention to nurses. How would such attention figure into a feminist discussion of ethics consultation? As Sherwin and Baylis point out, "ethics consultation" refers to a complex variety of activities; they themselves focus on two domains, the care of individual patients and input into public policy. In what it omits, this is a telling decision about the commitments of philosophy and the reach of its tools. As I have argued at length elsewhere, the tools of philosophy provide almost no insight, let alone practical guidance, into the moral character of organizations.³ A philosopher myself, I was fortunate to have learned from social scientists something about hospital culture and policy. (I want to emphasize, however, that this inadequacy in philosophy is *not* the result of unreflective individualism, contrary to the usual, itself unreflective, charge.)

Ethics consultation at the level of patient care can be very useful to nurses. Their occupational hazard is moral distress, defined in contrast to moral dilemmas: dilemmas are situations in which one does not know the right thing to do, while moral distress occurs when someone (believes that she) knows the right thing to do but cannot do it. Moral distress is a chronic experience in nursing and typical of any work where responsibility exceeds authority—which is to say, much of women's work.⁴

Ethics consultation can be useful for nurses caught in such a bind, but the usefulness depends on several factors: nurses must have the authority to request consultations, and, once convened, they must have a chance to be heard. A number of people, including Sherwin and Baylis, write helpfully about ways to be sure that the disempowered have a voice around the table. But few writers take up the question of who has the authority to request an ethics consultation. There have been situations, for instance, where only physicians are allowed to call for a consult—no one else on the caregiving team, and no patient or family member. Questions about why this happens, and what to do about it, belong to the neglected subjects of hospital culture and policy, which is to say to the fledgling arena of organizational ethics.

What I have learned from my own ventures into this arena is how very hard it is to work effectively in it. Addressing this one element of policy—giving authority to nurses to request a consultation—could be done straightforwardly when a consultation service is first being set up. Yet for hospitals with established consultation services that cannot be requested by nurses, resistance by medical staff can probably be assumed and would not easily be breached. Doing so would require

understanding not only of the formal chain of command but also of the informal one, almost always the more efficient. Working effectively within it requires all sorts of different skills. Most readers of this essay are employed by universities and can understand by analogy what it is to work in other complex institutions. But only by analogy; the specifics will be quite different, not only because of particular histories and personalities but also because businesses are not at all democratic and job security does not exist. Working to change hospital policy requires immersion and sensitive observation. The work will reveal that the custom and culture of particular units is just as important as official policy. Whatever official authority nurses possess, a unit can be run in such a way that they cannot exercise that right. (The same is true for dietitians, chaplains, social workers, and so on, also primarily female occupations.)

So ethics consultations about the care of individual patients can be useful to nurses: the ability to request them and to be heard during them are levers of power, and by changing what is done, or changing the nurses' understanding of what should be done, consultations may alleviate their moral distress. Consultations also help resolve conflicts between doctors and nurses.

Yet the moral distress of nurses occurs most often in areas beyond the purview of traditional consultation. Far more than physicians, nurses work in teams and within institutions. Decisions about the structure of their work have a major impact on nurses' professional lives. Bioethicists tend to know quite a bit about the moral distress faced by physicians, about the way, for instance, that cost-containment interferes with a doctor's ability to give patients appropriate care. Nurses have experienced this same conflict for decades.

The most recent surge arose from "patient-care redesign" during the 1990s. Typically work that seemed to be menial, not requiring the expensive expertise of a nurse, was assigned to unskilled workers, to housekeepers and orderlies. Nurses could then be assigned more patients than they were before. The new arrangement was thought to be a "win-win" solution: the hospital would save money, and housekeepers and orderlies would have more rewarding jobs. (Previously they might have been ordered not even to speak to patients, much less to get them a glass of water.) Nurses could spend their time on the technical jobs that only they could do.

The trouble is that for the most part these ideas came from management, not from practicing nurses. It was the old story of cognitive authority: nurses' convictions about how their own jobs could best be done did not count. Their resistance was dismissed: "Nurses don't like to change; they want to keep doing what they were trained to do." But, in fact, nurses change and change and keep on changing. Their resistance was to workloads that were dangerously high and to work being done by people not qualified to do it. Changing a urine bag, for instance, seems purely menial. But, in fact, noting the color of the urine is critical: if it is tea colored or blood-streaked, the patient is in trouble, trouble which if spotted early could prevent more serious complications. Bathing a patient also seems menial, and nurses stopped doing it long ago, for the usual reasons of cost containment. But during a bath, a skilled nurse was assessing the integrity of the patient's skin, his degree of pain and mobility, and his mental status; she was also educating him about his changed body and supporting him emotionally as he adjusted to it.

Furthermore, this redesign of patient care put nurses in charge of less-skilled workers (the former housekeepers and orderlies). Again the intention was good: more holistic care, more unity within a team of workers, and more flexibility. Yet

nurses were not trained in the supervision of lower-skilled workers. Not only were the new team members less skilled, they were unlicensed and (understandably) had less professional commitment. Nurses are trained to do whatever needs to be done, however menial, if it is necessary for the welfare of the patient. The emesis basin is not emptied? Then the nurse does it. She is not just an employee, she is a professional. Creating a professional relationship with unlicensed personnel is an ongoing, but totally overlooked, challenge.

Spurred by stories such as these, David Kallen and I have done qualitative research into the issue. We identified three major categories of moral distress. (1) The first, and the heart of the matter, was feeling forced to provide care that was inadequate and even unsafe. Most of our participants reported anguish, a feeling of being professionally compromised. Over and over again we heard, "This is not why I went into nursing." But there were two other common sources of moral suffering. (2) Often nurses felt forced to work against one another rather than together. Various budgeting and goal-setting strategies can force units to compete rather than to cooperate. As individuals, too, nurses watched one another stagger under their workloads and found themselves resenting anyone who so much as took a coffee break, let alone lunch—or a vacation. Nurse managers felt this particularly acutely as they watched for ways to motivate subordinates into still more overtime. (3) Too often nurses felt caught within forces they could not endorse and could not change. A simple example is hospital advertising promising what nurses cannot in fact provide. Another is discharging patients before they are ready.

The question, then, is what ethics consultation could do to help with such issues. As consultations are commonly constituted, almost nothing. The situations I have just described are not classic dilemmas; yet for those of us convinced, like Sherwin and Baylis, that serving in the arena of public policy counts as ethics consultation, then this intermediate realm of hospital policy also counts. Sherwin and Baylis speak of architecture, of creating space in which people can be heard. Let me extend the metaphor and talk about carpentry. On issues of institutionally-caused moral distress, providing a place at the table first requires building the table; it requires building institutional structures that encourage or require conversation. Creating a situation in which administrators really want to listen to nurses—and vice versa—is extraordinarily difficult. I know of no one who has managed to do it. Yet if feminist bioethicists are to be true to their calling, they must take on this goal.

Taking it on would mean reinventing "ethics consultation." Whatever is invented might not even be called "consultation." No matter. Its implications, as always with good feminist work, would be profound. Building this kind of table would help everyone in the hospital, every employee and every patient. Paying attention to women, creating structures that empower them, by its very nature means paying a new kind of attention to many others: to men (since there could not be one sex without the other); to others who are disempowered (because if the oppression of women matters, so does every other sort of oppression); to the assumptions of the workplace (so often inflected by gender); and to the very categories we use to talk about all this (transgender, sexual harassment, and date rape had no names thirty years ago). This is why the FEAST listserv is so interested in whether "duh!" is a term of derogation and why Sherwin and Baylis could write an article rarely mentioning women explicitly. The ramification of feminist concerns is a sign of its great strength and fecundity. But let us not forget to pay explicit attention to real women in gendered lives. Let us not forget the nurses.

Endnotes

1. Susan Sherwin and Francoise Baylis. "The Feminist Health Care Ethics Consultant as Architect and Advocate," *Public Affairs Quarterly*, 17:2 (April 2003): 141-58.
2. *Ibid.*, 146.
3. Judith Andre. *Bioethics As Practice* (Chapel Hill: University of North Carolina Press, 2002).
4. See, for example, Andrew Jameton, "Dilemmas of Moral Distress: Moral Responsibility and Nursing Practice," *Clinical Issues in Perinatal and Women's Health Nursing*, 4:4 (1993): 542-51; Judith M. Wilkinson, "Moral Distress in Nursing Practice: Experience and Effect," *Nursing Forum*, XXIII:1 (1987-88): 16-29; D. R. Hanna, "Moral Distress: The State of the Science," *Research and Theory for Nursing Practice*, 18:1 (2004): 73-93; Mary C. Corley, "Nurse Moral Distress: A Proposed Theory and Research Agenda," *Nursing Ethics*, 9:6 (2002): 636-50.

BOOK REVIEWS

Linking Visions: Feminist Bioethics, Human Rights, and the Developing World

Edited by Rosemarie Tong, Anne Donchin, and Susan Dodds (Lanham, MD: Rowman and Littlefield Publishers, Inc., 2004). 272 pages. \$27.95. ISBN: 0-7425-3279-8

Reviewed by Toby Schonfeld

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Traditional feminist scholarship in bioethics has drawn attention to the inequality and oppression of women in contemporary society. Such oppression takes the form of inadequate access to health-care resources, an inappropriate focus on individual autonomy at the expense of relational considerations, and on value systems that force women into traditional roles while, at the same time, marginalizing those positions in society.

At the 2002 Conference of the International Network on Feminist Approaches to Bioethics (FAB), participants considered a different dimension of the problem of women's oppression in health care: that of women in the Global South. In these societies, the struggle for adequate health care requires a reconceptualization of the political, social, and economic structures to effect change. Scholars at the conference considered the ways in which the language and concepts of human rights can assist feminists' struggle to achieve an adequate level of health as part of the needs of women in developing societies.

Linking Visions compiles some of the papers presented at this conference, as well as several others solicited specifically for this volume. The book is divided into four parts, although there is clearly some overlap in the topics. The first, and longest, section of the text does the major conceptual work, as it focuses on the ways in which human rights discourse can assist the work of feminist bioethics. One major theme that runs throughout the selections of this section is the tension between universalist and particularist notions of ethics. As Donna L. Dickenson argues, universalism is necessary in a world where the global economic structures directly affect the fate of women and the provision of health care. While cultural competence and sensitivity to context is to be commended, an unexamined focus

on diversity in lieu of commonalities runs the risk of miring us in the quagmire of inaction: support of relativism robs a moral agent of the power to act across political and social boundaries to affect positive change. This is one lesson, Dickenson argues, feminism can teach global ethics. The recognition that “woman” constitutes a category of need that spans geographic borders enables individuals and groups to work to improve the conditions of women everywhere (23). To do this, Dickenson asserts we must integrate particularism with universality and not fall into the trap of tolerance rhetoric.

One way to achieve this goal, Arleen L. F. Salles argues, is to encourage and respect cultural diversity but at the same time recognize that cultures are not homogenous and should not be stereotyped. Salles is critical of the lack of reflective work in bioethics regarding the identification of “culture” and suggests we use a relational conception of ethnicity as an alternative to current conceptions (64). Generalization is possible without reducing to essentialism (65). Jing-Bao Nie agrees with this argument from the perspective of the heterogenous Chinese culture. At the same time, Nie argues that many comparisons of Chinese and Western cultures rest on “exaggerated assessments” of the differences between the traditions (76). A closer analysis reveals that the considerations of women in Western cultures are similar in kind to those in the Chinese culture, and such feminist perspectives will enable the citizenry to critically assess the role of women in traditional and contemporary society.

Where the authors in this section differ is on whether or not human rights language can offer the sort of universalism that seems required for a global feminist bioethic. Both Salles and Nie reject the notion that human rights cannot transcend national borders. Nie argues that insofar as human rights can be conceived of as a global ideal of human dignity, they are an important vehicle for the empowerment of Chinese women (76). Yet these ideals must be embraced by the Chinese themselves, by combining academic bioethics with grassroots efforts by Chinese women to improve their status (81). Human rights discourse is not imperialist when the citizens internalize the tenets for themselves (78).

Anne Donchin, however, offers some caveats to an uncritical acceptance of human rights discourse. She worries that a focus on human rights further compartmentalizes the plight of women and fails to give us the grounds to effect moral change. Stringent focus on individual rights obscures more relational aspects of the moral life, including sexual equality and the child-rearing environment (34). Donchin argues that what is required for a truly global bioethic is a recognition that the problem is not simply one of a scarcity of resources, but rather of social and political structures that preclude access to resources by certain groups (36-37).

Rosemarie Tong and Carol Quinn both argue for a combination of human rights talk and traditional feminist morality to formulate a global bioethic. Combining an ethic of care with human rights discourse will account for the relational aspect of the moral life and provide for the cared-for based on her articulation of what she needs. Quinn argues for a concept of relational dignity as a way of bridging political and economic differences and affecting positive moral change.

The remainder of *Linking Visions* looks at the ways in which combinations of traditional feminist bioethics and human rights discourse would apply to specific problems. Part II focuses on reproductive technologies, which, as K. Shanthi argues, are “neither morally neutral nor value free” (119). Sex-selection, fetal monitoring, and abortion practices in India and, as Julia Tao Lai Po-Wah argues, surrogacy arrangements in China, are all influenced by traditional value systems as well as political

and economic forces. Solutions to these problems cannot merely come from making resources more available to the population but, rather, must come from a recognition that many of these cultures’ traditional values are in direct conflict with basic human rights.

Karen L. Baird and Julie M. Zilberberg discuss how the United States’s position on reproduction affects the larger community. Baird describes the ways in which U.S. politics, represented by the Global Gag Rule, has negatively impacted the health of women and children in countries that receive U.S. funding. Furthermore, these policies support values that are not held in the United States proper—an obvious double standard. Zilberberg’s discussion of sex selection in the United States and India further demonstrates that the concept of relational autonomy is necessary for the maintenance of the rights of women (152-53).

Part III of *Linking Visions* focuses on genetics. Maria Julia Bertomeu and Susana E. Sommer argue that genetic material belongs to the universal human community, and that common Lockean defenses of human labor as patentable fall short in the case of genetic material. Attaching property rights to genetic material may continue the alarming trend of the rich getting richer (196). In their discussion of DNA and biological parentage, Michele Harvey-Blankenship and Barbara Ann Hocking argue that the decision regarding the reunification of biological parents and children cannot be considered apart from the context in which the separation occurred—a traditionally feminist argument. Human rights offers to this problem an analysis of this context, as the authors describe cases in Argentinian and Australian Aboriginal culture where children were kidnapped and raised within the oppressors’ families.

Part IV looks at ways in which global health rules impact women and their families. In the first selection, Eileen O’Keefe and Martha Chinouya discuss the struggles of Black-African immigrants in the United Kingdom and how their social and political situation influences the health care they receive. O’Keefe and Chinouya argue that the question of women’s sexual health must be considered in the broader context in which they live their lives. This can be seen both in the case of the Black-African immigrants and the traditional Zimbabwean value system from which many of them hail.

In the final selection, Laura Duhan Kaplan gives an account of contemporary practical statements of human rights and their foundations. These statements are grounded either in human reason or on social/cultural patterns of conduct. Kaplan argues that both are necessary for a true foundation of a global human ethic.

Linking Visions offers a unique and important discussion of the global condition of women and the challenges to creating a true global ethic. Rejection of relativism is fundamental to this effort, as is a recognition of diversity within each culture. Calling attention to the ways in which the social, political, and economic structures of society influence the health of women is a necessary first step in taking action to affect positive moral change. Yet only by convincing those in power of the long-term effects of policy decisions will we make real changes in the status of women’s health globally.

Natural Rights and the Right to Choose.

Hadley Arkes (Cambridge: Cambridge University Press, 2002). 302 pp. \$28.99. ISBN: 0-5218-1218-6.

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With President Bush's recent nomination of Samuel Alito, Jr., to the Supreme Court as the replacement for Sandra Day O'Connor, Hadley Arkes's *Natural Rights and the Right to Choose* is even more pertinent today than it was at the time of its publication in 2002. Although the explosive issue of abortion has never been far below the surface in American politics, since September 11th and the beginning of the war on terrorism it has resided out of the limelight. But now the issue is showing signs of rising to a fever pitch once again. This is precisely what Hadley Arkes invites in his deeply sincere, powerful, and even suspenseful account of the "crisis" threatening democracy in America.

According to Arkes, the crisis that Americans face today is not a new one. Abraham Lincoln courageously faced the same crisis, though in a different form, regarding the issue of slavery. The important question concerns what it means to be a human person. For Lincoln, the answer depends upon principles of natural law: human beings are endowed with reason, which is the ability to know right from wrong; this unique capacity for moral reason commands respect and is the basis of the concept of human rights. By contrast, entrenched in the modern culture of "soft" relativism and legal positivism, judges today do not presume to know the meaning of terms such as "nature" and "human." Arkes offers a story of this shift away from the premises of natural law and toward premises that, he says, are incompatible with jurisprudence itself. He argues that without objective moral truths, there can be no moral reasons and no set of "rights" that apply to all people at all times. But beyond this, without natural law there is no justification for positive law either. It is natural law that provides the reasons that one ought to obey those laws established by convention. Thus, Arkes takes the burden upon himself to prove that in order to secure the "right to abortion," judges have created jurisprudence with the form of law but without moral substance, what he calls "antijural jurisprudence," and have converted the regime into one that is democratic in name only.

Elections take place and power continues to change hands according to a democratic process but, Arkes argues, in accepting the "right to abortion," Americans accept one or both of the following nondemocratic propositions: (1) I have a "right" to kill another human being in my womb if the life of that being would adversely affect my interests, disrupt my plans, or cause me embarrassment. Of course, most people recoil from this characterization of the "right to choose" and frame it in a different way, but in so doing, they back into a second proposition: (2) the being I would kill is not a human being; evidence from embryology is beside the point, for it is up to me to decide whether I myself regard the being as human. I may not have the right to kill another human being, but I do have the right to decide who is human, as that suits my interests (171-72). Here I think that Arkes is remiss. Proposition (2) is an uncharitable interpretation of the pro-choice position, and although an unreflective defender of abortion might implicitly accept it, it certainly does not represent key arguments presented by prominent philosophers. In fact, Arkes disappointingly fails to engage with any of the recent literature in either biomedical ethics or feminist philosophy. Indeed, minus acknowledgment of Mary Anne Warren's distinction between moral personhood and

biological humanness, philosophers could easily label Arkes's book dead on arrival. However, Arkes's target audience is not philosophers, but politicians and the American public, most of whom have not read the philosophical literature. Additionally, Arkes is correct to point out that the idea that one's status as a human person depends upon whether someone else "wants" her would undermine the basis of democracy itself.

But leaving such methodological questions aside, the author further argues that the acceptance of proposition (2) above and the denial that human beings have an objective nature paves the way for an unqualified and unrestricted "right to abortion." According to Arkes, this is exactly what the Supreme Court has sought with its creation of the "right" in *Roe v. Wade* (1973), its interpretation of the "right" in *Floyd v. Anders* (1977), and its enforcement of the "right" in striking down bans on partial-birth abortions passed by legislators in individual states (1998). The problem is that regular Americans, including many who consider themselves pro-choice, believe that abortion should be restricted in some way or another. For example, a 1991 Gallop poll showed that 73 percent favor prohibiting abortions after the first three months of pregnancy, except in cases of grave danger to the health of the mother. As Arkes says, it is telling that abortion has remained an issue entirely controlled by unelected judges on the Supreme Court; in fact, in recounting his experiences working in public policy on the "Born-Alive Infants Protection Act," Arkes shows that politicians on both sides of the aisle flatly refuse to sign legislation on the issue. But what is most worrisome to Arkes, and on this point I think philosophers can agree, is the unwillingness of the public at large to engage in debate and reason about the issue at all. The remedy for all of this, says Arkes, is to end the monopoly of the courts and judges and return the question of abortion to the arena of legislatures and arguments of citizens in ordinary discourse about rights and wrongs (182). This book is but one of the ways that Arkes has sought to lobby for this remedy.

Additionally, in the realm of public policy, Arkes has argued that the most logical place to begin restricting abortion rights is where abortion merges with infanticide, by protecting the life of the child surviving the abortion. This is what he calls the "modest first step." (If you are wondering whether this happens, Arkes offers the example of Christ Hospital in Illinois where doctors regularly use a procedure called "live birth abortions." The doctor induces a woman to deliver her child and afterwards, the child is left to die (248).) With the courts upholding partial-birth abortion as legitimate, but ruling out infanticide, one wonders where legal protection for the child begins. The implicit answer given in the 1977 case, *Floyd v. Anders*, is that surviving an abortion does not entitle one to the right to life. In that case the courts predictably ruled that women have the right to an effective abortion. Consequently, defenders of abortion cannot protect the life of the abortion survivor because that would be to deny proposition (2): to acknowledge that the "fetus" is a real entity with standing under the law; to recognize that her injuries count in the eyes of the law and that the claim to protection of the law cannot depend upon whether anyone wants her. None of these premises are acceptable to the abortion defender. So that first step turns out to be anything but modest because the "right to abortion" cannot stand together with any recognition that there is a separate human being suffering lethal injuries. However, Arkes further argues, even if we grant the right to an effective abortion, it is the right to terminate a pregnancy, the right of a woman to be separated from the child that she does not want, but neither of these rights entails the right to destroy a child if the pregnancy can be ended without the death of the child (123). The fact is that it is easier to kill a fetus than to give up a child of one's own, and that is the driving force behind rulings such as *Floyd v. Anders*.

But make no mistake, Arkes does not support sweeping legislation that would make all abortions illegal. He understands that we have gotten to this point through gradual stages and that realistically restoring democracy in America requires the retracing of those steps. Thus, Hadley Arkes seeks only legal protection for survivors of abortion. In fact, that step was almost taken by Congress in 2001, attaching the Born-Alive Act as a rider to the Patients' Bill of Rights, but the bill was put off until September and after September Congress suddenly found itself dealing with another important issue. Arkes recounts the history of that act in suspenseful detail in the final chapter of the book.

In *Natural Rights and the Right to Choose*, Hadley Arkes presents the most plausible and complete account of the pro-life position to date. He does so using a style that is extremely accessible and appropriate for a popular audience but lacks the vigor and metaphysical precision that would make it more appealing to philosophers interested in the issue. Nonetheless, Arkes admirably merges his experiences in public policy with his philosophical defense of natural rights. For that reason, I especially recommend Arkes's book for courses in philosophy of law and social/political philosophy, but it would also be a unique addition to a biomedical ethics course or to any ethics course specifically dealing with the issue of abortion.

Conversations with Feminism: Political Theory and Practice.

Penny A. Weiss (Lanham, MD: Rowman & Littlefield Publishers, Inc., 1998). 240 pp. \$22.95. ISBN # 0-8476-8412-7

Reviewed by Melissa A. Butler
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In this collection of essays written over a period of several years, Penny Weiss shows us the genesis of political theory—as a temporal event, as a process, and as an approach to life. By constructing the work as a series of conversations, Weiss inevitably summons up Plato's ghost. Through dialogues, Plato began the tradition of theorizing about politics. Now Weiss goes back to the roots of political theory, picks up that tradition, and brings it into conversation with feminism. In doing so, she reminds us why people bother with political theory at all—it is a way of coming to grips with really important life questions. Yet, as a feminist, she has found yawning gaps in traditional political theory—areas where theory has failed to recognize, acknowledge, or understand questions central to the lives of women—and she aims to broaden political theory's "exclusionary discourse."

As in Plato's work, students and professors, questioning and answering, are constant features here. A veteran teacher, Weiss's interactions with her students raise new questions and concerns that stimulate her thought. Plato brings political theory into the agora, and Weiss takes it into the living room (or dorm room?). The lively, conversational style of the text gives the work immediacy and accessibility and suggests to readers that political theorizing is not a dull enterprise. Plato's dialogues are teeming with everyday life—real people, real things, and real human activities abound. The dialogues are filled with physicians, pastry cooks, shepherds, flute players, ship's captains, hunters, cobblers, (child-minders?) as well as play, athletic competition, meals, food, and drink. Weiss argues in "Plato's Republic as Male Dialogue" that these slices of life, far

from universal, are slices of male lives and not representative of women's everyday lives. Her book not only points to the lapse but also imagines what Plato (and the subsequent tradition of political theorizing) missed out on—what he *should* have asked about but did not, and what is lost as a result.

The work carries with it a sense of playfulness, activity, and openness (see especially "Reversals"), while also acknowledging frustration, pain, and loss (especially "(S)mothering/Profess(oring)"). Her chapter on "Asking Questions about Women" makes for a fine introduction to the process of theorizing about politics by laying bare its beginnings in acts of questioning, envisioning, and revisioning. Weiss realizes that "without asking certain questions, certain answers can look right that are brought into question through other questions."

Weiss's essays themselves often grow out of her own real-life experience as student, professor, citizen, partner, and mother. She often begins with questions asked by her teachers, students, children, and as she grapples with these, she unites Socrates' dictum, an "unexamined life not worth living" with the feminist rallying cry that "the personal is political." The conversations and questions that follow become broader. "Are you a feminist?" What power do I have? Where did I get it? How can I get rid of it? Weiss engages feminists, anti-feminists, and non-feminists; feminists, communitarians, liberals. Hers is a strategy of engagement. She works hard to understand and critique anti-feminist positions, arguing (in a way reminiscent of J.S. Mill) that "continuing discourse with opponents of feminism can add theoretical strength to our position...and uncover common ground where it exists." At about the time that Hillary Clinton was inventing late night discussions with Eleanor Roosevelt, Weiss was initiating her own correspondence with Abigail Adams ("Remembering the Lady"). As Abigail Adams argued against men's tyranny over women, Weiss asks, "Why does that argument so often fail? Why can we not move people committed in one place to ending tyranny and supporting liberty to ally with the women's movement? Is it that they cannot see the similarity? How can it be missed?" In another essay, she allows Rousseau and Wollstonecraft to face off directly in a conversation that was once performed by Weiss and Virginia Sapiro at an American Political Science Association conference, much to the delight of the attendees at the session. The exercise allowed Weiss to explore the uniqueness and originality of Wollstonecraft's critique of Rousseau and to show what political theory had lost by silencing people like her. In her chapter "Comparing Feminist and Non-feminist Political Theorists" she offers answers as she compares Aristotle, Machiavelli, and Rousseau with Christine de Pisan, Mary Astell, and Mary Wollstonecraft.

Weiss brings the political theorists' perspective to practical questions in American politics as she analyzes Congressional and Judicial defenses of sexual differentiation and confronts the tricky interplay of gender and race in the Clarence Thomas/Anita Hill confrontation. Unfortunately, through no fault of Weiss's, a long time has passed between the writing of these essays and this review. While the good thing in writing about "classic" political theory is that such works tend to have a long shelf life, the Hill/Thomas controversy may seem rather stale to readers today. On the other hand, it would be refreshing to have Weiss begin a conversation on the current issues of balance in the Supreme Court.

This book is especially valuable from a pedagogical perspective. It would be very useful in either introductory courses in political theory or in feminist theory. Alternatively, graduate students about to begin their teaching careers would be well served by reading it.

Imagine There's No Woman: Ethics and Sublimation.

Joan Copjec (Cambridge, MA: The MIT Press, 2002). 269 pages. \$18.95 paper. ISBN 0-262-53270-0

Reviewed by Andrea Hurst

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Given the link in psychoanalytic theory between “Woman” (“Mother”) and the dream of “Being,” Copjec’s Lacanian invitation to “imagine there’s no Woman” questions Hegel’s claim that the truth of being is the whole. But, one may ask, would the negation of universals simply promote a nominalistic, particularistic relativism that makes ethics impossible? This question is improperly posed, for Copjec argues that ethical action first becomes *possible* on shattering the dream of becoming whole. Further, while such transgression is a necessary, negative condition for ethical action, it remains insufficient, for it indeed risks relativism. Ethical action, then, requires a further, positive moment of inventive sublimation.

This important argument is supported by a close interweave of subtle theoretical argumentation and analysis of artistic texts. Unable to do justice to this richness, however, I have (violently) extracted the main argumentative threads and re-ordered them into three parts. Copjec, admittedly, divides her book in half, first analyzing the acts of four women, which exemplify feminine sublimation, and then addressing its underside, the masculine superego. This division, however, may raise eyebrows, since it leaves intact what she expressly debunks, namely, that the revisable, structural distinction between masculine and feminine matches a division according to biological sex. Instead, given patriarchal dominance in the symbolic, she argues, traditionally masculine values understandably characterize “convention,” while transgressive “invention” is called “feminine.” But women and men may adopt either stance; indeed, Lacan’s own intellectual style is feminine. Further, this division could suggest that Copjec views masculine over-generalization as the source of all evil, leaving feminine particularity or singularity free from its taint, for no structural space is given to feminine transgression’s “hysterical” underside. Her argument, however, is more nuanced than this suggests. Acknowledging patriarchy’s factual dominance and the metaphorical fecundity of the correlative castration threat, she argues that the intrinsic “lack” in being is “imaginable” in opposing masculine and feminine ways, yielding competing problematics of “the All.”

The masculine imagination rejects “original castration” (the insight that “being is not-all”) and construes “Woman’s” absence as a loss (4-6). Literally, the supposedly once possessed “Mother” is lost through prohibition. Metaphorically, the gap between ideals (absolute knowledge, goodness, etc.) and their “unsatisfied actual state” reflects a lost plenum calling for restitution. Accordingly, masculine consciousness strives to actualize a “universal” adequate to “the All.” Pretending to an immanent “species-immortality” (a progressive accumulation of acquisitions enduring beyond particular contributions), individuals aim to guarantee their own interests through selfless work in pursuit of this universal (21-24).

Psychoanalysis casts such self-annihilation through identification as the masculine oedipal drama, whereby an internalized superego becomes the cruel critic who fosters dissatisfied distaste “for mundane, compromised pleasures” and demands “more sacrifice, more work,” in the name of an unattainable ideal, derived from “a loss that the subject is

unable to put behind him” (46). Inadequate to the ideal, the perpetually guilty ego is relentlessly driven to match demand with achievement through “sublimation,” ill-defined as the exchange of “earthly passions” for a nobility of soul, the approximation of which measures human progress. This drive negates what is; for no worldly object is found to have enough value.

Copjec defines radical evil as the aggression correlative to fixation upon an ego-ideal. Whether manifest as war between nations or *Schadenfreude* between friends, such aggression is a noncontingent effect of “progress,” for any projected ideal is constituted by separating the accredited inside from the rejected outside. Even the “just causes” (human rights, the sanctity of life, democracy) ironically “demand the torture and execution of those who oppose them” (137). Since the ideal is structurally inadequate to “the All,” ultimate satisfaction (*jouissance*) is unwittingly given up in constructing the “universal” intended to secure it. Further, the “anomalies,” rejected to the “outside,” inevitably return in the form of disruptive symptomatic inconsistencies.

A turn to the feminine, Copjec argues, whose initiation rite is Nietzschean radical nihilism, avoids the suppressive masculine terror and opens a path for ethical action. Accepting “original castration” and being’s intrinsic fragmentation, feminine consciousness sees that “the All” must include every part without limit. But precisely because there is no limit to the aggregation of fragments, no ideal whole can take shape: there is no legitimate ideal that could ground, unify, and organize all particulars (46-7; 115-17). The world becomes intrinsically inauthentic, made up of facades with no underlying support, for nothing has pre-given value, and no object is the measure for any other. Feminine consciousness, then, indicts existing laws and standards as unfounded, and relishes the negative shattering that reveals the “real” as being-split. Yet, it remains dissatisfied and desires a constitutionally unavailable *jouissance* (117-18). Since the feminine drive aims at a non-place on the outside of an unsatisfying reality, its satisfaction twists into the sacrifice of worldly satisfactions, such that *jouissance* entails total exclusion from the living world. Fixation to the feminine death-drive, then, which aims to force “the impossible real” to appear, would bring about another terror: the disaffection with the world whose correlate is the will to chaotic dissolution.

Universalistic illusion and transgressive particularism are related according to Lacan’s Hegelian “veil of alienation,” which he characterizes, darkly, as “the mugger’s choice: your money or your life.” Because the terms are interdependent, Copjec notes: “Once the choice is offered, you’re done for—no matter which alternative you take” (17). However, following Lacan, she argues that ethical action escapes this lose/lose pseudo-choice, for it is structured, in contrast, by the revolutionary’s slogan, “freedom or death.” Here, the outcome is lose/win, but only if death is understood not biologically, but as the paradoxical death-drive, which strives for immortality. Again, this requires qualification, since the death-drive in its masculine and feminine versions reflects endemic dissatisfaction with devalued worldly objects and engenders heartless aggression toward them.

Both extremisms forget, however, that the death-drive is always aim-inhibited (38-40; 42-45). As masculine, it is inherently inhibited because it aims at a retrospectively constituted illusion that necessarily cannot be realized. As feminine it is stopped temporarily, but continuously, by an unending stream of partially satisfying objects. This infinity of partial satisfactions is the key to a characteristically feminine “sublimation” whose ethical import should not be distorted by confusing it with the above-described notion of “sublimation” (42-43). If Lacan’s prescribed turn to the feminine demands recognition that nothing has

intrinsic value, this does not imply that nothing is of any value. Rather, Copjec notes, one may surpass hysterical fixation through transformative, inventive sublimation.

The sublime immortality of everyday objects, she argues, is guaranteed precisely because they cannot extinguish desire (38-43). Reflecting the same paradoxical logic of excess by which reflection “posits and gives birth to the difference of objects from themselves,” my desire adds a “supplement” that allows me to “repeat” a worldly object as just what it is, but always with the inestimable difference made by this “supplement.” Each “repetition,” then, due to this excess, will never coincide with all of its being, allowing me to re-invent it as I go along. The immeasurable value of an object, then, derives from desire’s restless insatiability, which is both satisfied by it and circulates endlessly around it. Reflecting Kant’s articulation of genius and taste, Copjec notes that inventive sublimation grants the immanent sublimity of worldly objects and creates a singular place for them, which, since it affects the weave of the worldly fabric in massive or minor ways (after which it cannot assume its old shape), promises them immortality. We mortals relate not only to each other but to these places, which are woven into history and bind the world together (22-23).

Such immortalization of the object through feminine sublimation is connected with ethical action defined in terms of the revolutionary’s choice by the fact that my own ego is precisely a symbolic object whose singular value must similarly be invented. In fact, Copjec construes the ego’s ethical task as precisely such “inventive sublimation.” Returning to the revolutionary’s choice: the election of freedom is a choice for the power of self-invention and, with it, power of ethical action. The willingness to persevere to the last in this demand for power does not carry a lose/lose outcome, for ethical freedom is not lost in death for its sake and may gain for the agent a singular immortality. Does this suggest that one has to be a revolutionary to act ethically? Bluntly, yes. Famous revolutionaries act on a grander scale than many minor revolutionaries of everyday life, but the structure of the act remains the same.

Since Copjec insists that the ethics of psychoanalysis concerns the subject rather than the other (44), one may wonder if she allows for assessment of the subject’s singular self-invention in terms of good or evil. Perhaps one cannot here leave the other altogether out of account. Presumably, acts of self-invention are only recognized as singular against the weave of convention that they reconfigure to create the immortal places in relation to which others orient their actions. Moreover, in its realization through action singular self-invention is automatically exposed to the risk of publicity and to the intersubjective test of the good, whereby its status is decided, and periodically subjected to context-specific revisions. This is, admittedly, hardly a satisfactory measure, but, as Copjec demonstrates, the alternatives (the rigid law and order of conventional moralities or the chaotic disorder of hysterical transgression) risk far greater terrors.

All in all, Copjec not only contributes uniquely to feminism in a way that moves far beyond any narrow critique of psychoanalysis for its residual patriarchy but also brings the vigor of psychoanalytic theory into highly intelligent conversation with contemporary ethical and political discourses, successfully challenging stereotypical criticism that equates psychoanalysis with the supposed ethical and political impotence of individualism. Through its powerful interweave of theory and analysis, the book invents for itself a singular space in intellectual life that holds the promise of immortality.

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ANNOUNCEMENTS

Call for Papers: Feminist Activism

Papers, Testimonials, Reflections, and Calls to Action for a Special Issue of the *Newsletter* on contemporary Feminist Activism. This special issue aims to identify the myriad forms of feminist activism and to offer philosophical reflections on the life and times of the activist and the feminist movement. Submissions that address intersections and conjunctions between social movements are encouraged and welcomed. Submissions should be in Chicago style and range from 250 words to 3,000 words. Please send all materials to the Editor: sally.scholz@villanova.edu. Deadline: May 1, 2006.

Publishing Notes in the *Newsletter*

Please send information about conferences, workshops, lecture series, and other events of interest to be held in 2006 to the Editor at sally.scholz@villanova.edu. The *Newsletter* happily will publicize news that might interest our readers. Also, please note that the CSW and the *Newsletter* are committed to publishing conference notes on feminist conferences in the *Newsletter*. If there is a conference you attend that you think might interest others who work in feminism and philosophy, please contact the Editor.