THE ROUTLEDGE HANDBOOK OF FEMINIST BIOETHICS

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Chapter 2

"HOW COULD ANYBODY THINK THAT THIS IS THE APPROPRIATE WAY TO DO BIOETHICS?" FEMINIST CHALLENGES FOR CONCEPTIONS OF JUSTICE IN BIOETHICS

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Carina Fourie

Feminist bioethics assumes that bioethics and the domains to which it applies – medicine, healthcare, health sciences research, and public health, for example – require assessment of gender injustices. In contrast, and oddly, discussions of justice, equity and equality in much of the bioethics literature seldom adopt a framework that is amenable to feminism. Why would one think that a conception of justice that is not amenable to feminism is appropriate? This question is a revision of Charles Mills's (2005: 169) provocative question posed about the relevance of much philosophical theory, ideal theory more specifically, to ethics: "*How in God's name could anybody think that this is the appropriate way to do ethics?*" Mills's particular emphasis is on racial injustice and how it is erased by many ethical theories. How, Mills is asking, can one do ethics while setting aside oppression, particularly the oppression of people of color? In a similar vein, I identify an odd mismatch in bioethics between conceptions of justice and feminist aims. Many bioethicists' response to my question would be to deny that there is a problem: the conceptions of justice we use, they are likely to claim, are indeed amenable to feminism. In part, I aim to demonstrate that such a response is mistaken.

In this chapter, I propose that conceptions of justice in bioethics must be feminist, meaning they must be able to capture how the domains of health, healthcare and medicine exacerbate the subordination of those perceived to be women and girls and how injustice impacts their health. After providing context in the first section, I identify three problems with conceptions of justice in the bioethics literature that interfere with their potential to be feminist. They tend to adopt the ahistoricism and distributivism characteristic of theories of justice that have been dominant in political philosophy, and they often rely on gendered conceptions of health that result in troubling comparisons of men and women's health. My argument is primarily "negative": it is a critique of generalist conceptions of justice in bioethics. However, in the final section I present characteristics of what a feminist conception of justice needs to look like and indicate how feminist bioethicists

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are using such a conception in assessing issues of injustice in bioethics. I emphasize the centrality of actual structural injustices, relational egalitarianism, and the assessment of values in conceptions of health and the health sciences. These characteristics are not, however, sufficient for a feminist conception of justice.

My comments are limited to bioethics as it is frequently theorized and taught in high-income, English-speaking countries such as the US and the UK. I do not believe, however, that my assessment is limited to these countries, particularly due to their considerable global influence.

Context: feminism, "ordinary" justice and bioethics

Justice, in ordinary language, is conceivably something like the following: all people should be treated fairly. Feminism, we can say, is at least in part motivated by promoting greater justice for those who suffer gender oppression, and more specifically, it often tends to focus on *sexist* oppression which subordinates those perceived to be women to men and those perceived to be girls to boys. Sexist oppression, my primary focus in this chapter, applies to many cisgender women and girls and also to some trans, genderqueer and intersex people, some of whom are not actually women and girls (because they do not identify as such). Another way to put this is that sexist oppression applies to women and girls, where gender is understood to be a form of class, rather than a form of identity (Haslanger 2000; Barnes 2020).

Gender oppression, however, is not limited to sexist oppression, and includes the oppression of gender-diverse people, that is, trans, genderqueer and intersex people.[1] Gender-diverse people are uniquely oppressed in ways that cisgender women and girls are not; however, there are important overlaps between sexist oppression and the oppression of gender-diverse people (trans oppression, for short; e.g. Catalano and Griffin 2016; Bettcher 2021). While my primary focus is sexist oppression, and for short I refer to the subjects of such oppression as women and girls, it is important to recognize that due to trans oppression, some women, usually transgender women, are frequently unfairly excluded from the category of "women" and some transgender men and genderqueer people are unfairly included (Bettcher 2021). I condemn these unfair exclusions and inclusions – however, the concerns of injustice I highlight here often reflect binary notions of gender that also unjustly exclude or include.

How is feminism applicable to bioethics? The health and medical sciences, and public health, healthcare and medical institutions, policies and practices manifest and exacerbate women and girls' subordination, whether intentionally or unintentionally. Additionally, women and girls' health are negatively impacted by this subordination and by gendered structural determinants of health and social norms. For example, medical research has often been conducted exclusively or primarily on men, leading to a lack of evidence on how medical conditions and their treatment affect women (e.g. Mehta et al. 2016). In turn, men's experiences are treated as the norm and misapplied to women; prescribed doses of drugs for heart disease are often the same whether for men or women, yet some research indicates that women fare better with half the standard dose (Santema et al. 2019). Gender binarism, namely the refusal to recognize genders beyond male/female or man/woman, adds a further dimension to this concern. In order for gender-diverse people to receive the correct dose, we would need information on the biological mechanisms, e.g. body weight, underlying the reason why "women" seem to fare better with half the standard dose.

So how does bioethics perform in representing injustices associated with the health of women and girls? Never mind any specific concerns with the applicability of conceptions of justice to feminism, justice generally has often been neglected in bioethics. Respect for autonomy is frequently prioritized as the foremost principle of medical ethics (Gillon 2003). Ethical conflicts in public health are often reduced to being about liberty or autonomy on the one hand, and the maximization of welfare (utilitarianism) on the other (Faden and Shebaya 2016). Feminist concerns are often

poorly represented when conflicts are reduced in this way. The systematic violation of respect for women's autonomy is a constitutive aspect of their oppression; thus, respect for autonomy is indeed important for feminism. However, the fact that women's autonomy *as a group* is undermined is an issue of justice/injustice and thus prioritizing autonomy over justice impedes a recognition of feminist concerns. If, for example, we focus on respect for the autonomy of individual patients on a case-by-case basis we will not recognize the systematic structural patterns of women's unfair treatment. Furthermore, feminists have taken issue with the androcentric way in which autonomy is frequently defined (e.g. Mackenzie and Stoljar 2000).

Additionally, justice, when it is acknowledged, is sometimes defined in a utilitarian way, ignoring issues of equity; for example, it has been described as being primarily about what benefits the greatest number of patients (and minimizes risks for healthcare workers; see Ruhl and Hohman 2020: 2689). But feminism is not well-represented by utilitarianism; while maximizing welfare may often overlap contingently with gender justice, it need not. Justice for women should be valued in and of itself, and not merely for its impact on average or total welfare. The predominance of debates about autonomy, liberty or utilitarianism, or the conflict between them, and a neglect of justice, remain concerns applicable to bioethics generally (see also Francis 2017), as well as specifically in application to women and girls.

However, there are signs of change. One, there is a growing interest in public and population health ethics, which will likely be further increased by discourse related to the COVID-19 pandemic. More than other kinds of bioethics, public health ethics frequently emphasizes the importance of justice or something that overlaps with justice, such as equity (Lee 2012). Social justice has even been described as the moral foundation of public health ethics (Powers and Faden 2006). Social injustice, such as gendered injustices or structural racism, has an immense detrimental impact on health. For example, residential segregation has led to Black people living in areas where there is greater pollution and diminished access to quality healthcare than in areas where white people tend to live (e.g. Morello-Frosch and Lopez 2006; Landrine and Corral 2009; Bailey et al. 2017). The emphasis on justice and equity in the public and population health literature makes it more of a natural friend to feminism. Two, justice is becoming of greater importance even in other bioethical debates beyond the realms of population health, including in clinical ethics (e.g. Gillon 2020). Three, feminist bioethicists continue to play a significant role in developing bioethics in ways that recognize the centrality of justice, for example by identifying how social inequalities impact the health of women, especially women of color (Roberts 1998), and how gendered power relations affect medicine as well as public health practice and policy (e.g. Wolf 1996; Rogers 2006; Marway and Widdows 2015).

The greater emphasis on justice in bioethics should be good news. Considering the substantial overlap between feminist aims and an ordinary language commitment to justice, conceptions of justice in bioethics should be developed, in part, by feminists to achieve, in part, feminist aims. "In part" because injustices applicable to women and girls are only one of the many forms of injustice that a conception of justice should be able to capture – others would include trans oppression, gender binarism, ableism, classism, racism, and the many intersections of these. However, conceptions of justice in the bioethics literature are frequently unhelpful to feminist bioethicists and have been resistant to critique from feminists, as well as critique from disability studies and critical race theory (see e.g. Danis, Wilson and White 2016), among other disciplines.

Feminist critiques of conceptions of justice in bioethics

In medical and research ethics, justice is often understood as one of a number of principles that should be applied to the particular ethical issues that arise in medical practice or research (Beauchamp and Childress 2019: 267–326; Vaughn 2019: 8–13). In healthcare ethics, and public

and population health ethics, justice is considered to overlap strongly with the notion of equity and is frequently seen as a supplement or alternative to a maximizing or utilitarian approach to healthcare and public health. "Justice" or "equity" or both are prominent principles in public health ethics frameworks designed to guide public health policy and practice (Kass 2001; Tannahill 2008). I focus on concerns with conceptions of justice, whether or not they are part of "principle-centered" approaches. To demonstrate how these conceptions of justice are lacking, I will judge them according to their relevance to feminism; their comprehensiveness in covering issues of injustice related to feminism; and their substantive acceptability for feminism (see Jaggar 2009).

Ahistoricism

Conceptions of justice are characterized by ahistoricism when they formulate principles, policies or practices of justice that set aside the history of actual injustice or they are developed for a society removed from history, or both. Where the injustices associated with patriarchy along with overlapping intersections of injustice such as those associated with race or sexuality are set aside, the conception of justice is likely to be irrelevant to feminism.

The exemplar of such an ahistorical conception of justice is John Rawls's theory of justice as fairness (1999; 2001). What I describe under the category of ahistoricism is often expressed as being a concern related to "ideal theory." Ideal theory can be understood in numerous ways and it is broader than what I describe here (e.g. O'Neill 1987; Mills 1999; 2005; Robeyns 2008; Valentini 2012), thus for the purposes of this paper, the more specific category is helpful.

Ahistoricism is reflected in at least two ways in Rawls's theory (1999; 2001). One, the principles of justice as fairness are justified, Rawls argues, because they would have been chosen, instead of utilitarian principles, under fair conditions – in "the original position" – and are thus a form of hypothetical social contract. A veil of ignorance, in part, aims to prevent the parties in the original position from choosing principles of justice that will favor them, because they cannot know what will favor them. The parties in the original position then determine principles of justice ahistorically – they lack knowledge of the particular injustices that may have affected their societies or themselves. Two, the principles of justice chosen in the original position function to regulate the basic structure of a "well-ordered society" meaning a society that may have some injustices, e.g. that is characterized by economic inequalities that do not favor the worst-off, but is primarily just. This reinforces the ahistorical nature of the theory – not only are principles of justice chosen without knowledge of past and current injustices, such as those associated with patriarchy, they are then meant to apply to a society that does not, or no longer, suffers from those injustices.

One might assume that Rawls's theory can be adapted to the nonideal. A number of feminists and philosophers of race have indeed tried to revise Rawls's theory to suit issues related to patriarchy and white supremacy (see e.g. Okin 1991; Shelby 2004). One can revise Rawls to rid the theory of some of its explicit *substantive unacceptability* in relation to feminist issues, e.g. we can rid it of its ambivalence about the inclusion of the family in the basic structure (Okin 1991). A problem of ahistoricism however is that it infuses the "Rawlsian apparatus" (Mills 2017: 161); it is baked into the principles via their justification and its methodology. Not only do we have principles of justice explicitly designed only to apply to a well-ordered society, and thus not a patriarchal society, but the method for demonstrating that these principles are legitimate, through the original position, purposefully excludes the injustices that feminism aims to identify and address. The principles themselves are not clearly relevant to gender injustice, and even if they are modified to be more clearly relevant, they will lack a sound normative justification as their design is agreed upon by agents in the original position with no knowledge of whether gendered injustice has occurred in their societies.[2]

What does this have to do with bioethics? Conceptions of justice in bioethics remain highly influenced by theories of justice in political philosophy and particularly Rawls's theory, despite Rawls infamously setting aside issues of health. Many theories of health justice are either directly derived from Rawls's theory (e.g. Daniels 1985; 2008), or they consider Rawlsians to be among their primary interlocutors, and they adopt similarly ahistorical approaches (e.g. Segall 2009). Additionally, scholarly works and frameworks in bioethics often primarily or *only* use Daniels' theory of health justice to describe "justice" in application to health and healthcare, or even refer to Rawlsian justice directly, or both (e.g. Kass 2001; Veatch, Haddad and English 2014; Vaughn 2019). The dominance of Rawlsian conceptions of justice applied to health means they tend to be irrelevant to feminism because they are not directed toward identifying and assessing strategies for combating how health, healthcare and medicine are influenced by or influence injustice as it relates to women and girls.

Furthermore, the concern is not with Rawls's theory specifically, but with ahistoricism generally, and the accompanying tendencies toward idealization and abstraction from gender injustice in ethical theory (O'Neill 1987; Young 2011; Schwartzman 2006). Many debates about justice in bioethics are troublingly ahistorical, whether or not they are explicitly influenced by Rawls (see also Wolf 1996; Tong 1997; Lindemann, Verkerk and Walker 2008). An example: much of the debate about whether or not scarce healthcare resources should be prioritized for younger people over older people can be framed in an oddly ahistorical way. Scholars have argued that as a matter of *egalitarian justice* certain kinds of healthcare resources should be prioritized for younger people over older people (e.g. Daniels 1990; 2008; Persad et al. 2009). One version of this argument is that older people have had more life-years than younger people, and in order to achieve greater equality of opportunity for life-years, lifesaving treatment, such as heart transplants, should be prioritized for younger people. Note, this is not the same as the claim that treatment for younger people should be prioritized because those who are younger are more likely to benefit in terms of prognosis; it is the claim that we should prioritize on the basis of *age* itself (Bognar and Hirose 2014: 94–95). Advocates argue that this prioritization is not an example of interpersonal discrimination in the same way it would be if we prioritized healthcare according to race or gender as each person has the potential to benefit from this form of prioritization over a complete life (Daniels 1990; 2008).

The debate seems somewhat irrelevant to justice when we consider the real world of aging within a social and historical context. One, while an analytic distinction can be drawn between age groups and birth cohorts (Daniels 1990, 2008), in reality it is hard to see when there will exist a time in which birth cohorts are treated similarly enough via health policy and practice that this kind of age-based rationing would truly be a form of prioritization for one person over a complete life. As Marcoci and Popescu (2020) have argued, for example, prioritizing ventilators or ICU beds for younger people over older people during the COVID-19 pandemic is unfair, among other reasons because of changes in UK healthcare policy and advances in technology. People who are older lacked access when they were younger to the quality of healthcare resources relative to what younger people have now. Two, issues of injustice such as those associated with gender and race seem to be set aside in many of these discussions despite their relevance to the ethics of differential treatment by age. As Nancy Jecker (1991) has emphasized, considering that women live longer than men, the brunt of the burden of this form of prioritization will be borne by women. Additionally, in terms of structural racism, it is hard to see why African-Americans who have been egregiously disadvantaged and mistreated in comparison with whites in numerous ways across their lifetimes including through the healthcare system (see e.g. Roberts 1998; Gilbert et al. 2016) and who in spite of the unfair social odds now find themselves in their eighties, should be given any less priority than younger people, at least on the basis of what is intended to be an egalitarian argument that assumes that they were given priority for healthcare when they were younger.

While abstracting from some of the complexities of reality is necessary in ethics, including specifically feminist ethics (Schwartzman 2006), it seems odd how many debates about justice in bioethics abstract from egregious real-life injustices that are especially relevant to that very debate.

Distributivism

A further concern with the influence of dominant modes of analytic political philosophy on conceptions of justice in bioethics is its distributivism. Justice is often described as primarily or exclusively about the distribution of benefits and burdens within a society (Kass 2001; Beauchamp and Childress 2019). A primary assumption is that a society has certain social goods to be distributed, and determining whether or not society is more or less just has to do with how fairly these goods are distributed or redistributed. Much of the debate in the last few decades after the publication of Rawls's theory of justice as fairness, originally in 1971, has centered on two issues of just distributions. First, philosophers debate the metric or currency of justice. For example, should principles of justice regulate the distribution of expectations of primary social goods, such as income (Rawls 1999), or the distribution of central capabilities such as health, bodily integrity and control over one's environment (Nussbaum 2001)? This debate is characterized well by one of Amartya Sen's papers "Equality of *What*?" (Sen 1980). The title of Sen's paper assumes the answer to the other primary debate: what should be the pattern of distribution? A just society is one that distributes the metric of justice equally, say, or according to a sufficiency threshold, or by giving priority to the worst-off (see e.g. Crisp 2003; Olsaretti 2018).

In bioethics, justice is frequently assumed to be or is explicitly identified as distributive (e.g. Steinbock 2009: 6–7; Arras, Fenton and Kukla 2015: 1–2; Fourie and Rid 2017). Furthermore, theories of health justice tend to present justice as distributive. Shlomi Segall's (2009) luck egalitarian theory, for example, determines when distributions relevant to health and healthcare are unjust and Madison Powers and Ruth Faden's (2006) approach requires sufficiency in health as one aspect of social justice, as much as this is socially possible to achieve. Often the relevance of justice to the domain of health and healthcare is expressed as being primarily about the distribution of *healthcare* (Daniels 1985), however a greater emphasis has been placed more recently on the distribution of other social determinants of health (Daniels 2008; Venkatapuram 2011).

Distributive justice *is relevant to feminism*, and more specifically to feminist bioethics. For example, a lack of access to contraception and to safe abortions has a detrimental impact on the health of women and girls as well as on the distribution of opportunities for jobs and education. The allocation of access to these medical interventions (one kind of distribution) has an important influence on the social basis of the distribution of health and other opportunities (another kind of distribution). Which distribution is ultimately relevant to social justice depends on what the currency of justice should be; e.g. the former might be included as examples of resources required for justice, whereas the latter may be associated with opportunities or capabilities.

The trouble is that justice is often reduced to distributivism (Young 2011). This reduction is a problem for feminism because such a conception of justice lacks comprehensiveness, and, because of its lack of comprehensiveness, it may also be substantively unacceptable.

Theories of distributive justice often neglect certain aspects of injustice that are difficult to capture as goods to be distributed or as end-states to be achieved, and often these neglected aspects are particularly important to feminism. Often neglected are *attitudes* toward women – a concern about recognition or respect rather than distribution (Fraser 1996; Wolff 1998) – and the social values that underlie those attitudes, values that, for example, subordinate women to men and treat women as if they are inferior. For example, injustice in terms of how people are treated as bearers of knowledge has often been ignored (see Collins 2008; Fricker 2009), including the lack of epistemic credibility

frequently afforded women, and Black women especially, as they negotiate the healthcare system (e.g. Freeman 2015; Del Pozo and Rich 2021). Also consider the stigmatization that women frequently experience if they do not live up to the social norms of womanhood. We could have an adequately just allocation of contraceptives and access to safe abortions, but have a lack of uptake from women and adolescent girls due to stigmatization and its internalization:

> Gender norms often stigmatize girls who seek contraceptives, become pregnant, or are sexually abused. Hence, gender norms are increasingly recognized as an important influence in shaping health, particularly adolescent sexual and reproductive health.
>
> *(George et al. 2020: 20)*

Distributivists often respond by translating these concerns into ones about distributable goods. Stigmatization is translated as a maldistribution of the social basis of respect. We could thus assess health policies and practices both according to their effect on health *and* their effect on other dimensions of wellbeing such as respect (e.g. Nussbaum 2001; Powers and Faden 2006). While this is an analytically neat solution and fares better than many distributive solutions at recognizing the impact of relational factors (Fourie 2017), such as stigmatization, it cannot be sufficient for capturing the concerns related to stigmatization and disrespect because a distributive framework cannot identify the gendered nature of the social norms that influence the distribution of the social basis of respect. The problem is not merely that women receive less respect than men for the same actions, but that how behavior, and indeed "respect," is defined and judged occurs against the backdrop of pervasive and systematic gendered norms that play a role in maintaining a patriarchal system (e.g. hooks 1984; 2014; Butler 2006; Young 2011). Put it this way: men may be ridiculed and stigmatized for acting in so-called feminine ways, such as crying and paying attention to their appearance, but the primary problem with this is not a maldistribution of respect for men but the system of gender norms underlying it. "Redistributing" respect can leave those norms intact, even reinforce them, and thus the lack of comprehensiveness of distributivism can also lead to substantively unacceptable solutions.

Gendered health outcomes

The final feminist concern has to do with the often-unacknowledged gendered assumptions underlying comparisons of health outcomes between men and women. I am not against drawing comparisons between men and women per se. However, in the political philosophy and bioethics literature, as well as in public discourse, conceptions of health and the social determinants of health on which many comparisons contingently draw may be less relevant to women and girls, and to gender-diverse people, than they are to men, with the potential for substantive unacceptability in terms of their normative implications.

When it comes to health outcomes, comparing the experiences of oppressed and privileged groups can show us one of the significant ways in which oppression harms those who are oppressed. The COVID-19 pandemic, and its impact on health, caregiving, jobs and income, is a prominent example of the social determinants of vast inequalities in health between racial, national and ethnic groups. For example, American Indian, Alaskan Native, African-American and Latinx people have much higher rates of hospitalization and deaths associated with COVID-19 than white, non-Hispanic people (CDC 2020). The reasons for these disparities are social, as opposed to biological. More specifically the disparities occur due to social *injustices*, e.g. having diminished opportunities to live in non-polluted neighborhoods, and inadequate access to reliable transport and quality healthcare (CDC 2020), stemming in turn from the broader social injustices of structural racism and colonialism, among other primary political and social determinants of health (e.g. Williams

and Mohammed 2013). Achieving health equity requires the reduction of unjust health disparities (Whitehead 1992) such as these, and is a morally urgent goal of public policy.

Women's health, prima facie, seems to follow a different pattern. Women are often presented as having better health than men, and in certain dimensions of health, this is true. The most obvious example is that globally, all other things being equal, women tend to live longer than men. Part of this greater longevity appears to be social, and part of it biological, although the biological mechanisms are poorly understood (e.g. Ostan et al. 2016). This can be described as an inequality in health between men and women. Some political philosophers have described the inequality as a potential injustice with the implication that we may need to compensate men for it (e.g. Segall 2009; Van Parijs 2015). Prima facie, this kind of argument seems to match our attitudes to health equity as it applies to other social groups – we should achieve equity by reducing the gap in health between those who are better off in terms of health outcomes and those who are worse off, particularly by improving the health of those who are worse off. Applied then to the case of men and longevity, it might seem that we should focus our moral attention on men's health, at least in terms of promoting their average life expectancies.

There are numerous concerns with this kind of argument (see Paula Casal's (2015) astute assessment), but I will focus on one: comparisons between the health of men and women are often based on unacknowledged gendered conceptions of health and its determinants (see also Fourie 2019). The dimensions of health on which we focus in order to make comparisons are already gendered, often in troublingly androcentric and binary ways. Furthermore, focusing on men and women can make invisible the impact of other axes of oppression such as those associated with race and gender diversity.

While men have lower life expectancies (one dimension of health) than women, generally women's morbidity (another dimension of health) is worse than that of men's, all other things being equal, especially during the last few years of women's lives (e.g. Austad and Bartke 2015; Ostan et al. 2016). Indeed, it has been claimed that women's morbidity during the final years of life is so poor it is unlikely that their longevity should be viewed as an advantage (Van Oyen et al. 2013; Ostan et al. 2016: 1714). Choosing thus to focus on one dimension of health, and particularly the one that is not in men's favor – longevity – means adopting, whether intentionally or not, an androcentric notion of health. This conception of health not only has less relevance to women's health than it does to men's, but it may also lead us to draw substantively unacceptable conclusions by assuming that in terms of health, men are clearly worse off than women and need to be compensated.

Another example of gendered conceptions of health underlying comparisons of men and women's health is the impact of COVID-19. This impact is often measured in terms of "ICU admissions" and "deaths." When it comes to these measures of ill health, women on average are better off than men, even though infection rates are similar (e.g. Jin et al. 2020; Wolfe et al. 2021). This has led to headlines such as "Why Does COVID-19 Affect Men More Than Women?" (Sanchez-Carrion 2020). Focusing on other dimensions of health paints a different picture, however, e.g. research shows that women are more likely to experience the long-term, chronic effects known as "long COVID" (Sudre et al. 2021). Furthermore, focusing on men and women, all other things being equal, has made invisible the impact of race: Black women in states such as Georgia and Michigan, for example, have higher mortality rates for COVID-19 than white men do (Rushovich et al. 2021).

A focus on "health outcomes" may also make unacknowledged gendered assumptions about what should be included in our assessments of health equity or justice. If we exclude the *determinants* of health, we will be missing relevant gendered differences in terms of how women and girls' health and wellbeing is affected. Even if women's health is relatively better than men's along a number of dimensions – thus, the health outcome implies that women are better off – their health

is often not what it should be due to gendered structural determinants. Gendered determinants of health include the unequal power relations that often subordinate women and girls, resulting, for example, in girls "in some contexts, [being] fed less, educated less, and more physically restricted" while "women are typically employed and segregated in lower-paid, less secure, and 'informal' occupations" (Sen and Östlin 2008: 4). While in extreme cases, women's health may be worse than men's due to these determinants, it need not be; in either case, however, recognition needs to be given that women's health is being restricted by unfair treatment. A comparison of outcomes in health between men and women, understood for example according to mortality or infection rates, could miss the ways in which social determinants of health affect women.

Comparisons of "health outcomes," unless interrogated according to sex and gender, may also obscure the ways in which women and girls' wellbeing or subordination is exacerbated by health policies and practices themselves. "Stay-at-home" orders in response to COVID-19, for example, have had the effect of confining those experiencing domestic violence with the perpetrators of violence (Chandan et al. 2020), and of substantially increasing caregiving burdens (CDC 2021). The headline mentioned above, "Why Does COVID-19 Affect Men More Than Women?" (Sanchez-Carrion 2020), only seems applicable, even all other things being equal, if one ignores the impact of the pandemic beyond the effect of the disease on the body, and then only on certain ways of measuring the disease's effects on the body, e.g. acute infection rather than chronic effects (see also Fourie and Ganguli-Mitra 2020).

I am claiming neither that we should only care about the dimensions of health that women experience, nor that women are necessarily worse off than men when it comes to health or its determinants. What I am emphasizing here, however, is that conceptions of health can be androcentric; they can center on dimensions of health or on health outcomes rather than their determinants that are more relevant to men than they are to women and thus what may seem to be neutral understandings of health are already gendered. Using androcentric norms such as these is likely to confound comparisons between men and women's health.

Furthermore, comparisons of health are often binary, made between the health of men and women or males and females. In and of itself this makes invisible the health of gender-diverse people. While data collection on gender-diverse people is slowly improving in the US, there are still many omissions (Stotzer 2017; Grasso et al. 2019; Streed et al. 2020). Gender-diverse people suffer a range of structural injustices, such as misrecognition and discrimination, including in the domains of health and healthcare (Liszewski et al. 2018). The failure to consider gender diversity in many comparisons of men and women represents a misrecognition of gender-diverse people and the "erasure" of their identities (Bauer et al. 2009), and leads to a lack of information for understanding and improving their health outcomes. Such binary comparisons also obscure the effects of biology, e.g. whether or not you have a uterus, and the effects of gender, e.g. whether or not you are treated as a woman.

How should we conceive of justice in bioethics?

In the introduction, I claimed that conceptions of justice in bioethics must be feminist.[3] I have not argued for this claim directly; however, it is hard to understand how one could have a plausible conception of justice that is not feminist. As I have argued directly, many conceptions of justice used in the bioethics literature are not feminist, or at least are not sufficient for feminism. While many working in public health are aware of the gendered determinants of health and the ways in which women, girls and gender-diverse people are affected by health policies and practices, my concern is that we do not have the *theoretical resources* to capture the problem, at least as conceptions of justice, equality and equity are often employed in political philosophy and bioethics.

What would a feminist conception of justice for bioethics look like? One, in contrast to ahistoricism, conceptions of justice should provide means to identify and explicitly address real-life contemporary forms of structural injustice, and how they impact health and its determinants, as well as how the policies and practices of health and healthcare create or exacerbate those forms of oppression and domination. This means we need to centralize *actual* injustices (Anderson 1999; Mills 2005; Young 2011), especially those most prominent in the particular societies about which we are theorizing. Additionally, we need to ensure that some of the most pervasive and morally urgent injustices are centralized, and this will mean taking account of *structural* injustice. Structural injustice has to do with the ways in which social arrangements, including informal social norms and practices, and formal laws and institutions, can be unfair, specifically in terms of how they treat or impact members of identifiable social groups (Young 2011; Powers and Faden 2019). Women and girls experience structural injustice through unfair social arrangements, for example, policies and laws related to parental leave, childcare, equal pay and domestic violence, as well as social expectations that they conform to the various stereotypes of "femininities"; directly or indirectly these unfair social arrangements impact their health and wellbeing. In terms of finding theoretical underpinnings in the philosophical literature, it would be better to turn to theories of oppression, at least in part (Jaggar 2009), as opposed to the ahistoricism of much theory underlying bioethics, as discussed in the previous section. Feminist bioethicists often prioritize the importance of structural oppression and domination to explain what is morally troubling about bioethical issues that are particular to women and girls (e.g. Sherwin 1996; Rogers 2006; Ganguli-Mitra 2021).

Furthermore, work on the intermeshing of structural injustices should be centralized. While many feminist bioethicists have highlighted multiple and intermeshing injustices, for example, injustice in relation to disabilities (e.g. Scully 2008; 2018; Kittay 2008; Goering 2008), there are also troubling silences. Structural racism in the US, despite its impact on health and healthcare, is often neglected by bioethicists generally (Ayeh 2015; Danis, Wilson and White 2016), and as a number of feminists have frequently centralized the experiences of white women (see, e.g. Lorde 1984; Crenshaw 1989; hooks 2014), feminist bioethics must ensure that it takes account of the intermeshing of racial and gender oppression. Indeed, the question in the title of this paper can be turned toward feminism itself: "How could anybody think that this is the appropriate way to do feminism?" is, in spirit, a question that has been asked of many feminist theories with regards to their exclusion of women of color, lesbians, transgender women – and many others. Building a conceptual framework for intersectionality as it applies to health and healthcare, which will recognize the unique nature of intermeshing oppressions such as those experienced by Black women, is of urgent importance (Wilson et al. 2019).

Two, conceiving of justice according to a relational egalitarian framework is also recommended. Such a framework will help to combat an over-emphasis on distributivism, although it has not yet received much uptake from feminist bioethicists, despite its feminist credentials in political philosophy (Anderson 1999; Young 2011). Relational egalitarianism emphasizes that a primary form of injustice, and one that often determines the unjust distributions of social goods, is when people are unable "to stand in relations of equality to others" (Anderson 1999: 289; see also Fourie et al. 2015). This form of egalitarianism can provide the background needed to identify the primary inequality underlying structural injustice – social arrangements that are structurally unjust are so because they do not allow, whether intentionally or unintentionally, members of social groups such as women and people of color to stand with men and with whites in relations of equals. Furthermore, among the advantages of relational egalitarianism is its ability to account for the expressive dimensions of injustice (Voigt and Wester 2015) – attitudes of disrespect and misrecognition expressed interpersonally or through medical practice and policy, and the problematic norms on which they are

based, come under the purview of justice. For example, while breastfeeding has health benefits for infants, stigmatizing people who do not breastfeed their babies can be criticized because the stigmatization expresses disrespect. This disrespect, however, is not well-understood as merely a maldistribution of the social basis of respect – it is part of a system of patriarchal norms that often over-rides women's choices with regards to their bodies, only exacerbating the ways in which women are prevented from being part of a community of equals. This example also highlights the potential for disrespect to gender-diverse people based on entrenched gendered norms and trans oppression; if we consider breastfeeding and the stigmatization around it to be solely a concern for women, we make invisible the experiences of transgender men and other gender-diverse people who are able to breastfeed.

Last, considering the gendered assumptions underlying many comparisons of men and women's health, how health is conceived as part of health equity, needs to be considered in the context of structural injustice and feminist philosophy of science. When we compare the health of social groups as part of an assessment of justice, we must consider how conceptions of health are already gendered, often in androcentric and binary ways. Structural injustice means that the centering of men's experiences and of gender as binary is pervasive; we should assume that even seemingly "neutral" conceptions of health, and comparisons of health are influenced by these injustices. Feminist philosophy of science demonstrates how scientific studies and their methodologies can, for example, exclude women and reproduce troubling gender norms (e.g. Harding 1991), and help us to assess the relevance of health sciences research to women's wellbeing (e.g. Rogers 2004). Even research aimed at exposing and reducing health inequity can reinforce gender stereotypes and stigmatization. For example, models that present the ways in which discrimination can affect emotions and health may reinforce the over-valuation of masculinist or middle-class norms, such as being in control of one's emotions (Fourie 2018).

Conclusion

The title of this chapter, "How could anybody think that this is the appropriate way to do bioethics?" reflects the rhetorical spirit of Mills's question. It asks how it could be that conceptions of justice in bioethics often do not align with feminist aims. I myself used to have more faith in dominant theories of justice in terms of their amenability to feminism, and thus I was one of those "anybodies" referred to in Mills's question.

While my version of the question is hyperbolic in this paper (after all, distributive justice and comparisons between the health of men and women are still needed), I have elaborated on some of the reasons why we should question the appropriateness of many conceptions of justice in the bioethics literature and demonstrated in part what such conceptions should look like in order to be, as they should, feminist. Turning the question back on feminism, however and asking "how can anybody think that this is the appropriate way to do feminism?" can remind us of the many axes of oppression that also need to be considered to develop a conception of justice relevant to the egregious, multi-faceted and intermeshing forms of real-life injustice that infuse health, healthcare and medicine.

Notes

1 Gender oppression can also include the oppression of men, e.g. Asian-American and African-American men (Arisaka 2000; Gilbert et al. 2016; Curry 2017).
2 See, in contrast, Schouten (2019) on justifying a gender egalitarian agenda via Rawls's political liberalism. I thank Simone Gubler for emphasizing this point.
3 I thank Sara Protasi for encouraging me to be explicit about this point.

Further reading

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Marway, H. and Widdows, H. (2015) "Philosophical Feminist Bioethics: Past, Present, and Future," *Cambridge Quarterly of Healthcare Ethics 24*: 165–174. (For detail on the major criticisms and contributions of feminists to bioethics)

Rogers, W.A. (2006) "Feminism and Public Health Ethics," *Journal of Medical Ethics 32*: 351–354. (For an explicitly feminist assessment of public health ethics)

Wolf, S.M. (ed.) (1996) *Feminism and Bioethics: Beyond Reproduction*, New York: Oxford University Press. (For a particularly influential edited volume on feminist bioethics with emphasis on how structural power relations influence health and healthcare)

Young, I.M. (2011) *Justice and the Politics of Difference*, Revised edition, Princeton: Princeton University Press (One of the most influential nonideal delineations of structural injustice, although not specifically framed in terms of bioethics)

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