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Colloquium - Gender, Law and Health Care: New Perspectives for Teaching and Scholarship: The Role of Gender in Law and Health Care

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Colloquium

GENDER, LAW AND HEALTH CARE

NEW PERSPECTIVES FOR TEACHING AND SCHOLARSHIP: THE ROLE OF GENDER IN LAW AND HEALTH CARE

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For the last two years, I have focused on gender issues in the seminar I teach on law and biomedical sciences. My primary goal in the seminar has been to combine a basic exploration of the major themes in law and biomedical sciences with an examination of related gender issues. Although I did not consider myself versed in feminist legal theory, I had been working on a number of women's health issues and found a lack of attention to gender in health care law. This introductory essay will discuss how and why I decided to teach this seminar and will review the pedagogical decisions I made in choosing topics and materials. Finally, it will introduce the four student-written Comments that follow and attempt to place them in the context of the themes and objectives of the seminar, as well as within an analytical framework informed by feminist legal perspectives.

It has been eleven years since I taught my first seminar on law and biomedical sciences. The seminar began as a survey of such issues as informed consent, medical experimentation, reproductive technologies, and death and dying. For guidance, I used a casebook,[1] but I quickly became frustrated by how limited I was by this approach and by how many "supplemental materials" were needed to make the course complete. The issues were so diverse and constantly changing as a result of new discoveries and technologies that it was difficult to get a handle on the priorities and most current developments. It also seemed that there were so many issues to cover that there was no time

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1. JUDITH AREEN ET AL., LAW, SCIENCE AND MEDICINE (1984 & SUPP.).

to delve into the connections among issues with any depth. After several years, I decided to focus on AIDS as a paradigm to explore issues in law and biomedical sciences. It was my hope that by narrowing the focus of the seminar to the study of AIDS, legal and policy issues could be studied in a context in which students could apply theory to "real world" issues. More specifically, the seminar examined the impact of AIDS on the rights and obligations of health care workers, including the obligation to treat, testing issues such as informed consent, and the rights and obligations of infected health care workers. To ensure interdisciplinary thinking, I invited students from the Schools of Nursing, Medicine, Dentistry, and Pharmacy to join the law students in developing policy papers on these issues, rather than requiring the traditional legal research and writings projects.[2]

Using the AIDS paradigm convinced me that concentrating on a particular focus was an effective way of teaching this course. Students were able to see the connections between such issues as informed consent for testing and informed consent for treatment; and between moral duties to treat and legal rights to practice. In each case, the connections had a context to ground their analysis. Thus, in developing my next seminar, I chose another lens through which students could consider the complex legal and ethical issues involved in health care—the lens of gender. Although I taught only law students in this seminar, I wanted to cultivate the same type of interdisciplinary thinking that I had seen in the AIDS seminar. Thus, I chose reading materials for the seminar from a broad array of sources including medical, scientific and psychological journals, newspapers, as well as the more traditional law review articles, cases, and regulations.[3]

The seminar was designed to progress from the general to the specific analysis of complex health care policy and gender issues. The seminar began with an introduction to gender discrimination in health care and to feminist bioethics.[4] Although I did not place labels

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2. *See* Comments, *The AIDS Project: Creating a Public Health Policy—Rights and Obligations of Health Care Workers*, 48 MD. L. REV. 95 (1989).

3. Because of the lack of attention to gender-related issues in law and medicine casebooks, the seminar required the development of course materials from a variety of sources. I would like to thank Leslie Bender for her inspiration and insights discussed in *Teaching Feminist Perspectives on Health Care Ethics and Law: A Review Essay*, 61 U. CIN. L. REV. 1251 (1993). I also wish to thank Vicki Michel, Pat Peppin, Susan Wolfe and Rebecca Dresser who shared with me their ideas and course materials.

4. Course materials included: Campaign for Women's Health, *A Challenge for the 1990's: Improving Health Care for American Women* (1991); Council on Ethical and Judicial Affairs, American Medical Association, *Gender Disparities in Clinical Decisionmaking*, 266 JAMA 559 (1991); NATIONAL INSTITUTES OF HEALTH, Executive Summary, REPORT OF THE NATIONAL INSTITUTES OF HEALTH: OPPORTUNITIES FOR RESEARCH ON WOMEN'S HEALTH 7

on approaches to feminist legal theory, I began to introduce the students to the diversity of feminist legal perspectives.[5] We discussed, for example, ways that the medical establishment has contributed to gender bias, and the need to evaluate ethical (and legal) dilemmas in a contextualized way, looking at the particular details and relationships involved in a problem situation rather than mechanically applying abstract principles.[6] As Susan Sherwin argues in *No Longer Patient*, "An important task of feminist ethics is to reshape the problem and offer alternative models for medical relationships that neither replace patient authority with technical expertise nor abandon patients to their 'rights,' where that amounts to granting them the opportunity to assert their independent authority in a hostile, frightening environment."[7] Throughout the seminar, we tried to meet Sherwin's challenge to develop a "richer, nondichotomous account of proper decision-making in health care,"[8] not limited to the choice between paternalism and autonomy.

With this brief introduction in place, we examined the patient/provider relationship.[9] The study of this relationship laid the founda-

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(1991); SUSAN SHERWIN, *Toward a Feminist Ethics of Health Care, in* NO LONGER PATIENT (1992); Virginia L. Warren, *Feminist Directions in Medical Ethics*, 4 HYPATIA 73 (1989).

5. *See also infra* notes 20-28 and accompanying text for discussion of feminist legal perspectives. *See generally* FEMINIST LEGAL THEORY: FOUNDATIONS (D. Kelly Weisberg ed., 1993); FEMINIST LEGAL THEORY: READINGS IN LAW AND GENDER (Katharine T. Bartlett & Rosanne Kennedy eds., 1991); Katharine T. Bartlett, *Gender Law*, 1 DUKE J. GENDER L. & POL'Y 1 (1994); Patricia Cain, *Feminist Jurisprudence: Grounding the Theories*, 4 BERKELEY WOMEN'S L.J. 199 (1989); Patricia Cain, *Feminism and the Limits of Equality*, 24 GA. L. REV. 803 (1990).

6. SHERWIN, *supra* note 4, at 77.

7. *Id.* at 140.

8. *Id.*

9. Course materials included: Truman v. Thomas, 611 P.2d 902 (Cal. 1980); Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977); SUSAN SHERWIN, *Paternalism, in* NO LONGER PATIENT 137 (1992); Alexandra Dundas Todd, *The Diseasing of Reproduction: When the Patient is a Woman, in* INTIMATE ADVERSARIES: CULTURAL CONFLICT BETWEEN DOCTORS AND WOMEN PATIENTS (1989); Dorothy C. Wertz & John C. Fletcher, *Ethical Decision Making in Medical Genetics: Women as Patients and Practitioners in Eighteen Nations, in* HEALING TECHNOLOGY: FEMINIST PERSPECTIVES 221 (Kathryn Ratcliff ed., 1989); E.J. Emanuel & L.L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221 (1992); Peter Franks & Carolyn M. Clancy, *Physician Gender Bias in Clinical Decisionmaking: Screening For Cancer in Primary Care*, 31 MEDICAL CARE 213 (1993); Bernadine Healy, *The Yentl Syndrome*, 325 NEW ENG. J. MED. 274 (1991). Recommended readings included: Crosscutting Science Working Group, *Cardiovascular Function and Disease*, REPORT OF THE NATIONAL INSTITUTES OF HEALTH: OPPORTUNITIES FOR RESEARCH ON WOMEN'S HEALTH (1991); Emily Martin, *Medical Metaphors of Women's Bodies: Menstruation and Menopause*, in THE WOMAN IN THE BODY 27 (1991); SUSAN SHERWIN, *Ascriptions of Illness, in* NO LONGER PATIENT 179 (1992); Alfredo Morabia et al., *The Influence of Patient and Physician Gender on Prescription of Psychotropic Drugs*, 45 J. CLINICAL EPIDEMIOLOGY 111 (1992); Richard M. Steingart et al., *Sex Differences in the Management of Coronary Artery Disease*, 325 NEW ENG. J. MED. 226 (1991).

tion for the more specific applications of theory to practice in the weeks to come. We first considered the effect of the long tradition of paternalism, and the issues raised by the apparent alternative—a "masculine version" of patient autonomy and informed consent.[10] Following a discussion of different models of informed consent and empirical data on gender differences in physician/patient communication, we examined case law that raised the "real life" applications of informed consent theory. Hopefully, students were now sensitized to the difficulty of generalizing roles and behaviors for both patients and providers.

We next examined death and dying issues as an extension of our informed consent analysis.[11] We first studied the landmark *Cruzan* case[12] and the Supreme Court's lack of commitment to family decision-making. We also considered research by Miles and August[13] on gender bias in right-to-die cases indicating that courts are less likely to respect a woman's choice regarding her death than a man's choice, even when her decisions have been clearly expressed. The undervaluing of women's needs and gender difference was then considered in the context of clinical research.[14] We were able to evaluate the trend

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10. SHERWIN, *supra* note 4, at 140 ("After all, patients often are at a disadvantage in medical contexts: when they are ill, they are likely to be frightened of abandonment, and they may not be confident about their own judgment; hence, they may not be eager to insist on their rights to independent judgment. Individual authority is not necessarily their preferred alternative under such circumstances.").

11. Course materials included: Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990); MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -618 (1994); Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 TENN. L. REV. 519 (1992); G.E. Dickinson & R.E. Tournier, *A Longitudinal Study of Sex Differences in How Physicians Relate to Dying Patients*, 48 J. AM. MED. WOMEN'S ASS'N 19 (1993); B.J. Logue, *Taking Charge: Death Control as an Emergent Women's Issue*, 17 WOMEN & HEALTH 97 (1991); Stephen H. Miles & Allison August, *Courts, Gender and the Right to Die*, 18 LAW MED. & HEALTH CARE 85 (1990); Susan M. Wolf, *Nancy Beth Cruzan: In No Voice at All*, HASTINGS CENTER REP. 38 (1990); Abigail Trafford, *Assisted Suicide's Apparent Gender Gap*, WASH. POST, Mar. 2, 1993, at 26.

12. *Cruzan*, 497 U.S. at 261.

13. Miles & August, *supra* note 11, at 85.

14. Course materials included: The National Institutes of Health Revitalization Act of 1993, 42 U.S.C. § 289a-2 (Supp. V 1993); SUSAN SHERWIN, *Research, in* NO LONGER PATIENT 158 (1992); Marcia Angell, *Caring for Women's Health—What is the Problem?*, 329 NEW ENG. J. MED. 271 (1993); Board of Health Sciences Policy of the Institute of Medicine, *Inclusion of Women in Clinical Trials—Policies for Population Subgroups*, 329 NEW ENG. J. MED. 288 (1993); L. Elizabeth Bowles, *The Disenfranchisement of Fertile Women in Clinical Studies: The Legal Ramifications of and Solutions for Rectifying the Knowledge Gap*, 45 VAND. L. REV. 877 (1992); Rebecca Dresser, *Wanted: Single, White Male for Medical Research*, HASTINGS CENTER REP. 24 (1992); Ruth B. Merkatz et al., *Women in Clinical Trials of New Drugs*, 329 NEW ENG. J. MED. 292 (1993); Tracey L. Johnson & Elizabeth Fee, *Women's Participation in Clinical Research: From Protectionism to Access* (June 30, 1993) (background paper for the Institute of Medicine Committee on the Legal and Ethical Issues Relating to the Inclusion of Women in Clinical

from excluding "vulnerable" women from research based on protectionism, to including women based on the view that both the quality of the research and women themselves stand to benefit from inclusion.

The seminar then turned its attention to reproductive technologies[15] and pregnancy control[16] to further develop a specific context for examining the evolution of health care policy and its impact on women. We noted that on the surface, these issues illustrate the diversity of feminists' perspectives, including whether to promote the au-

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Studies, on file with the author). Recommended readings included: J.H. Gurwitz et al., *The Exclusion of the Elderly and Women From Clinical Trials in Acute Myocardial Infarction*, 268 JAMA 1417 (1992); Sandra D. Cassard, *Health Consequences of Exclusion or Underrepresentation of Women in Clinical Studies* (May 10, 1993) (paper prepared for the Institute of Medicine Committee on the Legal and Ethical Issues Relating to the Inclusion of Women in Clinical Studies, on file with the author).

The Institute of Medicine Committee on the Legal and Ethical Issues Relating to the Inclusion of Women in Clinical Studies completed its project and published a book on women and clinical research that could be substituted for many of the materials listed above. 1 INSTITUTE OF MEDICINE, WOMEN AND HEALTH RESEARCH (Anna Mastroianni et al. eds., 1994). The *Executive Summary* and *Legal Considerations* chapters may be especially useful.

15. Course materials included: *In re* Baby M, 537 A.2d 1227 (N.J. 1988); Johnson v. Calvert, 871 P.2d 776 (Cal. 1993); Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992); SUSAN SHERWIN, *New Reproductive Technologies, in* NO LONGER PATIENT 117 (1992); Ellen Wright Clayton, *A Ray of Light About Frozen Embryos*, 2 KENNEDY INST. ETHICS J. 347 (1993); Paul Lauritzen, *What Price Parenthood?*, HASTINGS CENTER REP. 38 (1990); Janice G. Raymond, *Reproductive Gifts and Gift Giving: The Altruistic Woman*, HASTINGS CENTER REP. 7 (1990); Karen H. Rothenberg, *Gestational Surrogacy and the Health Care Provider: Put Part of the 'IVF' Genie Back into the Bottle*, 18 LAW, MED. & HEALTH CARE 345 (1990); Marjorie Maguire Shultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 WIS. L. REV. 297-316, 372-98 (1990). Recommended readings included: J.C. Shattuck & K.K. Schwartz, *Walking the Line Between Feminism and Infertility: Implications for Nursing, Medicine, and Patient Care*, 12 HEALTH CARE FOR WOMEN INT'L 331 (1991); Ellen Hopkins, *Tales from the Baby Factory*, N.Y. TIMES, Mar. 15, 1992, § 6 (Magazine) at 40.

16. Course materials included: *In re* A.C., 573 A.2d 1235 (D.C. 1990); Elaine W. v. Joint Diseases N. Gen. Hosp., 613 N.E.2d 523 (N.Y. 1993); Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987); Thomas B. MacKenzie & Theodore C. Nagel, and Barbara Katz Rothman, *When a Pregnant Woman Endangers Her Fetus*, HASTINGS CENTER REP. 24 (Feb. 1986) (commentaries); Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991); Elyse R. Rosenblum, *The Irony of Norplant*, 1 TEX. J. WOMEN & L. 275 (1992); Michael Dorris, *A Desperate Crack Legacy*, NEWSWEEK, June 25, 1990, at 8; Tamar Lewin, *Implanted Birth Control Device Renews Debate Over Forced Contraception*, N.Y. TIMES, Jan. 10, 1991, at A20; Baltimore Norplant Policy materials (1993); Policy on Decision-Making with Pregnant Patients at the George Washington University Hospital (1990). Recommended materials included: Andrea Goetze, *Court-Ordered Caesarean Sections: Probing the Wound*, 1 TEX. J. WOMEN & L. 59 (1992); Abby Lippman, *Prenatal Genetic Testing and Screening: Constructing Needs and Enforcing Inequities (The Human Genome Initiative and the Impact of Genetic Testing and Screening Technologies)* 17 AM. J.L. & MED. 15 (1991); Dorothy C. Wertz & John C. Fletcher, *Sex Selection Through Prenatal Diagnosis: A Feminist Critique, in* FEMINIST PERSPECTIVES IN MEDICAL ETHICS 240 (Helen B. Holmes & Laura M. Purdy eds., 1992).

tonomy of women or to seek to protect women from exploitation. It soon became clear, however, that this purported dichotomy did not fully capture the complex issues, and a more flexible approach to feminist positions was needed. Following our general study of pregnancy control, we considered these issues in the context of women and AIDS, focusing on the limits to reproductive choice.[17] We also considered how current public health strategies have focused on a male model, in that the threat of domestic violence, for example, may limit a woman's participation in partner notification and in condom negotiation, the two major public health strategies currently employed in the fight against AIDS.

Finally, we applied the major themes developed in the seminar in the context of breast cancer and breast implants.[18] This context al-

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17. Course materials included: Doe v. Jamaica Hosp., 608 N.Y.S.2d 518 (1994); CENTERS FOR DISEASE CONTROL AND PREVENTION, *Facts About Women & HIV/AIDS*, HIV/AIDS PREVENTION 1 (Feb. 1993); CENTERS FOR DISEASE CONTROL AND PREVENTION, *Female Adult/Adolescent AIDS Cases by Exposure Category and Race/Ethnicity*, HIV/AIDS SURVEILLANCE REPORT (May 1993); UNITED NATIONS DEVELOPMENT PROGRAMME, YOUNG WOMEN: SILENCE, SUSCEPTIBILITY AND THE HIV EPIDEMIC (Summer 1993); John D. Arras, *AIDS and Reproductive Decisions: Having Children in Fear and Trembling*, 68 MILBANK Q. 353 (1990); Centers for Disease Control and Prevention, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MORBIDITY & MORTALITY WKLY. REP. 1 (1992); Cecilia Leonardo & Joan C. Chrisler, *Women and Sexually Transmitted Diseases*, 18 WOMEN & HEALTH 1 (1992); Carol Levine, *Women & HIV/AIDS Research: The Barriers to Equity* 13 IRB, 18 (Jan.-Apr. 1991); Carol Levine et al., *Building a New Consensus: Ethical Principles and Policies for Clinical Research on HIV/AIDS*, 13 IRB, 1 (Jan.-Apr. 1991); Carol Levine & Nancy Neveloff Dubler, *Uncertain Risks and Bitter Realities: The Reproductive Choices of HIV-Infected Women*, 68 MILBANK Q. 321 (1990); Karen H. Rothenberg & Richard L. North, *The Duty to Warn 'Dilemma' and Women with AIDS*, 2 COURTS, HEALTH SCIENCE & THE LAW 90 (1991); Ellie E. Schoenbaum & Mayris P. Webber, *The Underrecognition of HIV Infection in Women in an Inner-City Emergency Room*, 83 AM. J. PUB. HEALTH 363 (1993). Recommended readings included: Kathryn Carovono, *More Than Mothers and Whores: Redefining the AIDS Prevention Needs of Women*, 21 INT'L J. HEALTH SERVICES 131 (1991).

18. Course materials included: Chudson v. Ratra, 76 Md. App. 753, 548 A.2d 172 (1988); Butler v. Mentor, Breast Implant Litig. Rep. (Andrews Publications) 1795 (June 11, 1993) (complaint); Marcia Angell, *Breast Implants—Protection or Paternalism?*, 326 NEW ENG. J. MED. 1695 (1992); Jack C. Fisher, *The Silicone Controversy—When Will Science Prevail?*, 326 NEW ENG. J. MED. 1696 (1992); Marcia F. Goldsmith, *Image of Perfection Once the Goal—Now Some Women Just Seek Damages*, 267 JAMA 2439 (1992); David A. Kessler, *The Basis of the FDA's Decision on Breast Implants*, 326 NEW ENG. J. MED. 1713 (1992); H.M. Thornton, *Breast Cancer Trials: A Patient's Viewpoint*, 339 LANCET 44 (1992); Sandra G. Boodman, *Fear of Breast Cancer*, WASH. POST, Jan. 5, 1993, at Z10; Susan Ferraro, *The Anguished Politics of Breast Cancer*, N.Y. TIMES, Aug. 15, 1993, § 6 (Magazine) at 25; Ellen Joan Pollock, *Breast-Cancer Diagnosis Suits are Increasing*, WALL ST. J., July 22, 1993, at B1; Elizabeth Rosenthal, *Study Questions Breast Removal*, N.Y. TIMES, June 3, 1993, at A18; ONCOLOGIC DRUGS ADVISORY COMMITTEE, FOOD AND DRUG ADMINISTRATION, NATIONAL WOMEN'S HEALTH NETWORK, *Tamoxifen Prevention Trial* (1993). Recommended materials included: Marianne H. Whatley & Nancy Worcester, *The Role of Technology in the Co-optation of the Women's Health*

lowed us to examine the role of body image in our society and its manifestations in the law, as well as the diversity of feminist perspectives to policy approaches in the area. We reviewed the historical failure of the research community to investigate the cause and cure for breast cancer. We also considered both the tort system's failure to adequately address damages for women injured both physically and emotionally by breast implants, and regulatory approaches which permit, for example, silicone breast implants for reconstructive, post-mastectomy surgery but not for cosmetic purposes.

Throughout the seminar, I relied heavily on student participation and required significant, original research on a paper topic. By the ninth week of class, the students had completed a first draft of their seminar paper. For the remainder of the semester, students with similar topics were grouped together to develop their class presentations and design supporting reading materials. Students were asked to design presentations that were not mere outlines of the written paper, but instead pedagogical exercises that would force the rest of the class to focus on a significant legal, ethical, or policy issue raised by the presenter. For example, students developed ethics committee case studies regarding reproductive choices for women with HIV, administered questionnaires on the use of egg donation, and videotaped interviews of women of different generations talking about their life choices and decisions about death. Other students shared draft legislation on issues such as surrogacy and advance directives. These exercises were not only instructive for the rest of the class, but also for the presenting student who was able to gain some feedback and integrate the experience into her or his paper. This approach also provided an opportunity to expand significantly the number of topics studied in the seminar.[19]

Movement: The Cases of Osteoporosis and Breast Cancer Screening, in HEALING TECHNOLOGY: FEMINIST PERSPECTIVES 199 (Kathryn Strother Ratcliff ed., 1989); Phillip J. Camponella, *Breast Cancer, Staging, Treatment, and the Duty to Inform*, 35 MEDICAL TRIAL TECHNIQUE Q. 17 (1988); Bernard Fisher et al., *Lumpectomy Compared With Lumpectomy and Radiation Therapy for the Treatment of Intraductal Breast Cancer*, 328 NEW ENG. J. MED. 1581 (1993).

19. Paper topics included the following: gender bias in the evolution of the Maryland Health Care Decision Act; pregnancy clauses in living wills and advance health directives; elderly women and medical decision making; surrogacy legislation; legal and ethical issues regarding the sale of human ova; fetal tissue research; sexual harassment in medical schools; Norplant use in public schools; linking entitlements to behavior of mother/women/parents; sterilization of the mentally retarded; legal implications of classifying PMS as a mental disorder; analysis of state laws addressing genetic defects; prenatal genetic testing & provider liability; liability of pharmaceutical companies for inclusion/exclusion of women in clinical trials; bone marrow therapy as a treatment for breast cancer; breast implant litigation and regulation; and breast cancer litigation.

Since first teaching the seminar in 1993, I have updated the readings in bioethics, medical literature, and the law. I have added a week on women and genetics, focusing on the impact of genetic testing not only in pregnancy but also on diseases that specifically affect women such as breast and ovarian cancer. I continue to refine this seminar, shifting some of the topics covered and integrating more feminist legal theory. It is my hope that this introductory essay and the Comments that follow will stimulate new ideas and concerns for both teaching and scholarship in this area. All four Comments are examples of the excellent hard work and commitment of my seminar students at the University of Maryland.

All four Comments reflect a number of important feminist themes which we discussed throughout the seminar. Perhaps most importantly, *gender does matter* in the context of both law and biomedical sciences. Feminist approaches seek to understand and to value the experiences, insights, and logic of women's lives. Feminist legal theory provides us with a healthy skepticism toward traditional legal doctrine and insists that we re-examine even formally gender neutral rules to uncover the assumptions behind them. Feminist theories also challenge our traditional split between private and public spheres, as well as the impact of public policy and reform on our sense of justice. Finally, feminist perspectives value the importance of narrative, thereby challenging the traditional "objectivity" of legal reporting of case law. Stories put issues in context, just as case studies do for ethicists and health care providers. Narratives allow us to challenge the assumptions we make about individuals and the role of the law in their lives.

These important themes are reflected in a diversity of feminist legal theories.[20] It is useful to outline briefly these feminist theories in order to put the papers that follow in a broader analytical framework. Although these legal perspectives were not explicitly labeled as such throughout the seminar, they are clearly reflected, to varying degrees, in each of the student's papers.

Liberal feminism is based on a belief in formal gender equality, particularly in the economic and political arenas.[21] Since women possess the same capabilities as men, women should be entitled to equal

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20. I have crafted the analytical framework for describing the major feminist theories in part from the outstanding work of authors cited *supra* note 5.

21. *See, e.g.*, Ruth Bader Ginsburg, *Sex and Unequal Protection: Men & Women as Victims*, 11 J. FAM. L. 347 (1971); Ruth Bader Ginsburg, *Gender & the Constitution*, 44 U. CIN. L. REV. 1 (1975); Wendy Williams, *The Equality Crisis: Some Reflections on Culture, Courts, and Feminism*, 7 WOMEN'S RTS. L. REP. 175 (1982).

rights, equal employment opportunities, and equal pay. Under this equality model, gender classifications are highly suspect because they reflect and reinforce stereotypes that fail to treat men and women as individuals, without regard to gender. Liberal feminism draws heavily on the notions of rationality, individual autonomy and choice that are central to liberal political theory. Liberal feminists have focused primarily on eliminating state imposed gender distinctions and on preventing the state from limiting individual choice. While liberal feminism has been quite successful in expanding political and economic opportunities available to white, middle class, women, it has been criticized for ignoring the constraints of race and class and for adopting an assimilation model that benefits women only if they acted like men.

While liberal feminism emphasizes the essential sameness of men and women, cultural or relational feminism focuses on their differences.[22] Cultural feminism is grounded in the work of Carol Gilligan and other contemporary psychologists who suggest that men and women speak in a "different voice."[23] These theorists argue that men on average tend to analyze problems in terms of abstract rules and competing rights and to emphasize the importance of autonomy. Women, by contrast, tend to be more contextual in their analysis of problems and to place more emphasis on preserving personal relationships and on maintaining connections between and among individuals. Cultural feminists argue that many traditional legal doctrines and practices aré based on male values of autonomy and abstraction and fail to value the positive "feminine" concerns of responsibility, relationship, and essential connectedness experienced in the mother-child relationship. Many cultural feminists have sought to promote a positive vision of a female ethic of care, rather than a morality of rights. For example, cultural feminists have suggested that the law look for alternatives to the traditional adversary paradigm including alternative dispute resolution mechanisms. In a similar view, they suggest that courts apply a feminist ethic of care in negligence law.[24]

Dominance or radical feminism also arose in large part in response to the perceived inadequacies in liberal feminist theory. Like

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22. *See, e.g.*, Leslie Bender, *From Gender Difference to Feminist Solidarity: Using Carol Gilligan and an Ethic of Care in the Law*, 15 VT. L. REV. 1 (1990); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. (1988).

23. CAROL GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT (1982).

24. Leslie Bender, *A Lawyer's Primer on Feminist Theory and Tort*, 38 J. LEGAL EDUC. 3 (1988).

cultural feminists, Catherine MacKinnon, the major proponent of dominance theory, argues that men and women are different, but that these differences largely reflect the societal fact that women are subordinate and men are dominant.[25] According to dominance theorists, it is this inequality in power to which the law must respond. Moreover, since the primary source of women's oppression is private power, particularly the threat of sexual violence, the solution is not—as the liberal feminists often claim—less state intervention, but more. Dominance feminists argue, for example, that the legal system should abandon its traditional "hands-off" attitude toward violence in the family and move more aggressively to protect women from abusive power of men in the private sphere. These arguments have produced some concrete legal changes. MacKinnon was instrumental in persuading law-makers to recognize workplace sexual harassment as prohibited sex-discrimination, not as just a private matter between individuals.[26] Thus, whereas liberal feminists have argued primarily on expanding women's choices, and cultural feminists attempted to reform legal rules to reflect women's real experiences and affirm women's values, radical feminists have argued that law should address the harms to women that arise from conduct of other private actors, particularly men, and particularly with respect to sex and violence.

Postmodern feminism rejects the assumptions and generalizations at the core of the other feminist theories. Since no objective reality can describe the "essential" woman, postmodern feminists embrace the particular "situated" realities of all individual women. Postmodernists encourage feminists to consider real life experiences influenced by each woman's race, class, age, and sexual orientation.[27] Critical legal feminist scholars have incorporated themes of postmodernism by rejecting abstract universal theory and embracing the need for a social policy that provides practical and just solutions to real life problems.[28]

Abby Brandel's Comment considers the tensions among these various feminist theories in the context of surrogacy.[29] Supporters ar-

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25. CATHERINE MACKINNON, FEMINISM UNMODIFIED: DISCUSSIONS ON LIFE AND LAW (1987); *see also* Christine A. Littleton, *Feminist Jurisprudence: The Difference Method Makes*, 41 STAN. L. REV. 751 (1989).

26. CATHERINE A. MACKINNON, THE SEXUAL HARASSMENT OF WORKING WOMEN (1979).

27. *See generally* MARY JOE FRUG, POSTMODERN LEGAL FEMINISM (1992). *See also* Bartlett, *supra* note 5, at 13-18; Cain, *Feminism and the Limits of Equality*, *supra* note 5, at 838-41.

28. *See, e.g.*, Deborah Rhode, *Feminist Critical Theories*, 42 STAN. L. REV. 617 (1990); Margaret Radin, *The Pragmatist and the Feminist*, 63 S. CAL. L. REV. 1699 (1990).

29. Abby Brandel, Comment, *Legislating Surrogacy: A Partial Answer to Feminist Criticism*, 54 MD. L. REV. 488 (1995).

gue that surrogacy is a reproductive choice that the state should not limit, while critics contend that the state should prohibit surrogacy because it is exploitative and degrading to women and society as a whole. Brandel adopts primarily a liberal feminist position although she is clearly influenced by the other feminist perspectives as well. She argues that carefully drafted legislation would minimize the potentially exploitative aspects of surrogacy and preserve access to surrogacy as a reproductive choice. She also asserts that although surrogacy poses serious potential problems, it is and will continue to be used, and it is therefore wiser to attempt to minimize those problems and provide for the best interests of children born of surrogacy.

After describing the uncertain state of surrogacy law in Maryland, Brandel proposes legislation as a partial solution, recognizing that no legislation can prevent or resolve every situation, especially in an area as complex and emotionally charged as surrogacy. She proposes that surrogacy be available only to people with infertility, and that legislation abandon the "previous birth" requirement for surrogates adopted by many states. Brandel argues for increased regulation of surrogacy clinics, particularly in the way they report their "success" rates, to address the widespread statistical manipulation and deception that has occurred. Brandel proposes mandatory judicial pre-approval of surrogacy contracts, and compensation for surrogates, within certain guidelines. She argues that surrogates should be responsible for all clinical decision-making during the pregnancy, and that they be allowed a short "grace period" after the birth to rescind their decision to renounce parental rights.

Brandel recognizes, however, that some of the issues raised by surrogacy simply cannot be resolved satisfactorily by legislation; she proposes non-legislative ways to minimize the potential harms in surrogacy. She suggests that preventing infertility should be a higher priority in medicine. She urges us to combat the cultural notion that reproduction is a "biological imperative"[30] and that children are the symbols of a "successful" union. Brandel also contends that we should attempt to change the medical profession's focus on the technology of medicine toward a more patient-centered ethic of care, particularly in the context of female reproduction, which has historically been "overmedicalized" to the detriment of many women. Finally, she suggests that we should revise the language of surrogacy, which includes terms

30. JANICE G. RAYMOND, WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM xviii (1993).

like egg "harvesting" that tend to depersonalize and objectify both the process and the participants.

Some of the same issues raised by the surrogacy debate are also considered in Timothy Burch's Comment dealing with pregnancy clauses in living will and advance health care directive statutes.[31] Burch argues that pregnancy clauses, as presently written in most jurisdictions, limit an incompetent pregnant woman's right to terminate life support in violation of her common law and constitutional rights. He also argues that these laws are bad policy and often make the state of the law unclear.

Burch then argues for what he believes is a more realistic and humane way of legislating in this area. He adopts primarily a cultural or relational feminist position. He proposes legislation based upon a "caring substituted judgment" paradigm. This approach would allow a woman to decide, when drafting her directive, what should occur if she were pregnant and incompetent by recognizing that her decision is made in context, and allowing for that context to be legally recognized. For instance, a woman may not consider her individual rights versus State power in such a situation, but may consider whether or not she wants a child brought into the world without her and whether or not her surviving family can cope with such a situation. As it now stands, such considerations are often ignored by the law.

Burch sets up his paradigm by arguing that the traditional clash between autonomy and beneficence is insufficient to evaluate the real life circumstances and concerns of most people in our society. He argues that the ethic of care enhances autonomy better then the justice paradigm because it recognizes that people are not equally empowered and that many relationships contain codependencies between differentially empowered people. Furthermore, almost all decisions are made with other people or effects in mind; Burch's approach allows for these considerations and people to be a part of any final decision.

In fact, the ethic of care dovetails nicely with the doctrine of substituted judgment in allowing a woman's family and friends to be a part of the decision-making process. Burch argues that throughout life we seek the counsel of others and often make decisions based upon their concerns. He then asks why, at the time of death, do we try to isolate the individual from those support systems that they have

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31. Timothy J. Burch, Comment, *Incubator or Individual? The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes*, 54 MD. L. REV. 528 (1995).

relied on throughout life. In response, Burch's model legislation adopts a "caring substituted judgment" standard as the means to effectuate the interests of those involved without the state ordaining what should occur, as it now does in most jurisdictions.

Lee Solomon's Comment shifts our attention to premenstrual syndrome (PMS).[32] Nonetheless, her Comment is analogous to the others in that it captures the diversity raised by feminist perspectives and their impact on legal analysis. The official classification by the American Psychiatric Association in its DSM-IV manual of a severe form of premenstrual syndrome (called premenstrual dysphoric disorder (PMDD)) has caused controversy among feminists and women's health activists because of the legal and societal implications of this "disorder." The PMS defense used in various criminal trials, for example, will have a more solid foundation now that the syndrome is a recognized illness in the field of psychiatry. Critics fear that this development will be the proverbial "double-edged sword": The classification lends credibility to symptoms which have long been ignored or disbelieved by society and medical professionals, yet may also serve to reinforce the cultural belief that menstruation is a disability and makes women less fit for positions of power and responsibility.

Solomon initially discusses the myths, questions, and taboos which have surrounded the menstrual cycle in all societies, cultures, and religions, and the medical theories which have provided sexist rationalizations for women's inferior social status. She then highlights the many facets of the debate surrounding PMDD. Critics of the classification allege that there is insufficient empirical evidence to support the classification, and that without better evidence no woman should be labeled as mentally ill. Furthermore, critics contend that the classification is often subjective and leads to inconsistent diagnoses. Critics are also skeptical about establishing a psychiatric illness related exclusively to hormonally linked symptoms found only in women, particularly since there is no parallel category for men.

Solomon then examines the implications of using PMS or PMDD as a criminal defense strategy. She stresses that the classification of PMDD as a recognized disorder in the DMS-IV will lessen the evidentiary and definitional problems that have been associated with this defense, and consequently lead to its increased usage, particularly in the United States. Solomon cautions that the potential benefits of the defense must be weighed against its possible negative implications in em-

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32. Lee Solomon, Comment, *Premenstrual Syndrome: The Debate Surrounding Criminal Defense*, 54 MD. L. REV. 571 (1995).

ployment discrimination and custody cases. Thus, she struggles with the tensions raised by adoption of liberal, cultural and radical feminism in different contexts of women's lives. Whereas she rejects liberal feminism in the criminal law context, she recognizes the negative consequences of treating women differently in other areas of law.

Sex discrimination in another context is at issue in Kim Limbrick's Comment on the sexual harassment of female medical students.[33] Due to the long history of male dominance and female subservience in the field of medicine, women in medical school are at an especially high risk of being harassed by their superiors and their peers. This risk and the potential harm of harassment is especially great in this arena because medical education and training for medical students is largely controlled by a few professors and supervising physicians. Students are therefore unwilling to challenge persons who wield so much control over their future careers, or believe that they are incapable of stopping the harassment and accept it as an unfortunate consequence of choosing a career in medicine. Others simply do not recognize the harassment as such because the male dominance is so pervasive and institutionalized in the profession. Limbrick points out that unreported harassment reinforces the perception that it does not occur or that it is harmless, thereby creating a vicious cycle of discrimination that not only robs women of the opportunity to enjoy an educational experience equal to that of their male counterparts, but also reinforces disrespect for women in the profession. Her attention to the effect of power imbalance in the medical profession reflects the perspective of dominance feminism.

The author proposes a two-part change in the analytical framework used by courts in evaluating Title IX claims for sexual harassment. Limbrick relies primarily on the insights of cultural feminism to craft her recommendations. First, she argues that courts should evaluate the abusiveness of an environment from the perspective of a reasonable *woman* rather than a reasonable person. This change would force courts to recognize that men and women react differently to harassing conduct. Second, she asserts that the abusiveness inquiry should require no more than a finding that the harassment made the student's studies more difficult, instead of the more onerous standard currently required.

Limbrick also discusses a mechanism by which the medical school could be held liable for students' harassment of their peers. Instead

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33. Kimberly L. Limbrick, Comment, *Developing a Viable Cause of Action for Student Victims of Sexual Harassment: A Look at Medical Schools*, 54 MD. L. REV. 601 (1995).

of requiring proof of intentional discrimination on the part of the institution, she argues that courts should evaluate the notoriety and pervasiveness of peer harassment and should examine institutional efforts to curtail it. If the institution knew of or should have known of the peer harassment and did not take sufficient action to stop it, it should be held liable for neglecting its duty to prevent sex discrimination in violation of Title IX. Limbrick disagrees with the notion that pursuing sexual harassment claims in court reinforces the stereotype of the weak woman unable to fight her own battles, noting that making a harassment claim is in fact a courageous act. While acknowledging that the courtroom is not the ideal environment in which to iron out any kind of discrimination issue, Limbrick contends that the cycle of sexism in medicine will continue until a viable cause of action against sexual harassment is available as one way of forcing change.

All four Comments address significant gender issues in health care that are informed by the diversity of feminist perspectives. They demonstrate that fruitful legal and policy analysis incorporate empirical research, feminist theory, and interdisciplinary approaches. Hopefully, this strategy for teaching and scholarship will increase our understanding of the complexity of law and biomedical sciences in our society.