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Feminism, Law, and Bioethics

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Rothenberg, Karen H., "Feminism, Law, and Bioethics" (1996). *Faculty Scholarship*. 179.
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Feminism, Law, and Bioethics

ABSTRACT. Feminist legal theory provides a healthy skepticism toward legal doctrine and insists that we reexamine even formally gender-neutral rules to uncover problematic assumptions behind them. The article first outlines feminist legal theory from the perspectives of liberal, cultural, and radical feminism. Examples of how each theory influences legal practice, case law, and legislation are highlighted. Each perspective is then applied to a contemporary bioethical issue, egg donation. Following a brief discussion of the common themes shared by feminist jurisprudence, the article incorporates a narrative reflecting on the integration of the common feminist themes in the context of the passage of the Maryland Health Care Decisions Act. The article concludes that gender does matter and that an understanding of feminist legal theory and practice will enrich the analysis of contemporary bioethical issues.

FEMINISM SEEKS TO UNDERSTAND AND TO VALUE the experiences, insights, and logic of women's lives. Feminist legal theory provides a healthy skepticism toward traditional legal doctrine and insists that we reexamine even formally gender-neutral rules to uncover the problematic assumptions behind them. It also challenges the traditional split between private and public spheres, as well as the way in which traditional conceptions of justice translate into public policy. Finally, feminist perspectives tend to value the importance of narrative, thereby challenging the traditionally "objective" approach to case law reporting. Stories put issues in context, just as case studies do for ethicists and health care providers, and hence help 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.¹ In this article, I outline the major feminist theories in order to

put the application of feminist jurisprudence in a broader analytical framework. Hopefully, this framework will help to clarify the societal implications of the legal rules, processes, and practices that shape our responses to bioethical challenges. I illustrate the differences among these theories by applying them to a contemporary bioethical issue, egg donation. I then reflect on the common themes shared by various feminist theories by providing a narrative describing how feminist thought influenced recent Maryland legislation on health care decision making.

FEMINIST THEORY, JURISPRUDENCE, AND PRACTICE

Liberal Feminism

Liberal feminism is based on a belief in formal gender equality, particularly in the economic and political arenas (see, e.g., Ginsburg 1971, 1975; Williams 1982). Since women possess the same capabilities as men, liberal feminists claim that women should be entitled to equal rights, equal employment opportunities, and equal pay. Under this equality model, gender classifications are to be challenged because they reflect and reinforce stereotypes that fail to treat men and women as individuals. Liberal feminism draws heavily on the notions of rationality, individual autonomy, and choice that are central to liberal political theory. Thus, liberal feminists have focused primarily on the goals of eliminating state-imposed gender distinctions and of preventing the state from limiting individual choice.

One significant source of law for liberal feminist theory is the Equal Protection Clause of the 14th Amendment to the U.S. Constitution, which provides that no state shall deny to any person, equal protection of the law. Simply put, similarly situated persons, namely men and women, should be treated equally. Advocates for women's equality first tried, unsuccessfully, to utilize the Equal Protection Clause almost 125 years ago when a woman was refused the right to practice law (*Bradwell v. Illinois*, 83 U.S. (16 Wall.) 130, 21 L.Ed. 442 (1872); *In re Goodell*, 39 Wis. 232 (1875)), and then again at the turn of the century to challenge "protective" labor laws that limited the number of hours women could work (*Muller v. Oregon*, 208 U.S. 412 (1908)). In both types of cases, the court justified treating women differently from men based on women's physical and mental attributes, their "nature," and their supposed need to be protected.

It was not until the early 1970s that tenets of liberal feminism began to take hold in the courts. The first case defending women's rights on liberal feminist grounds invalidated a statutory preference for men over women in the appointment of estate administrators (*Reed v. Reed*, 404 U.S. 71 (1971)). Many cases soon followed that challenged the constitutionality of laws that treated men and women differently and that advocated applying a higher standard of scrutiny to such cases. Ironically, many of the successful test cases were brought by men who claimed that various laws were unfair and unconstitutional—for instance, laws requiring men to meet more stringent tests of spousal dependency in order to claim government benefits (*Frontiero v. Richardson*, 411 U.S. 677 (1973)), laws establishing a higher legal drinking age for men (*Craig v. Boren*, 429 U.S. 190 (1976)), and laws rendering men ineligible for alimony (*Orr v. Orr*, 440 U.S. 268 (1979)).

Concurrently, activists and the courts began to discover additional protections in the Equal Pay Act of 1963 (29 U.S.C.A. §§206(d), 216-217), which mandated that employers pay women the same wages as men holding the same jobs, and in Title VII of the Civil Rights Act of 1964 (42 U.S.C.A. §2000e et seq.), which banned sex discrimination in employment and labor organizations. By 1971, the Supreme Court upheld a finding of sex discrimination under Title VII when an employer refused to hire mothers but not fathers with preschool children (*Phillips v. Martin Marietta Corp.*, 400 U.S. 542 (1971)).

Perhaps the biggest challenge for liberal feminists has involved issues that relate to pregnancy and childbearing. In 1974, the Supreme Court upheld the constitutionality of a comprehensive state disability insurance plan that excluded benefits for pregnancy (*Geduldig v. Aiello*, 417 U.S. 484 (1974)) and, in 1976, held that an employer was not in violation of Title VII when medical benefits did not include costs associated with pregnancy (*General Electric Co. v. Gilbert*, 429 U.S. 125 (1976)). Following these two rulings, feminists lobbied Congress to pass the Pregnancy Discrimination Act of 1978 (42 U.S.C.A. §2000e(k)), which specifically states that sex discrimination under Title VII includes distinctions based on pregnancy, childbirth, or related medical conditions. The Supreme Court has since held that an employer's fetal-protection policy that excluded fertile women from certain jobs constituted sex discrimination under Title VII (*International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991)), but it has not issued any similar rulings based on a constitutional analysis.

Although 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 to the extent that they act like men. In fact, some critics of "formal equality" argue that affirmative action and certain "special" accommodations to women, such as childrearing leave, special child custody standards, and comparable worth schemes for job classifications, are necessary to counteract unfairness that results from what appear to be gender-neutral rules (see, e.g., Littleton 1987; Law 1984). Many liberal feminists continue to maintain, however, that women will not ultimately benefit from strategies that promote special treatment and reinforce gender differences (see, e.g., Williams 1982).

Cultural Feminism

While liberal feminism basically emphasizes the essential sameness of men and women, cultural or relational feminism focuses on their differences (see, e.g., Bender 1990; West 1988). Cultural feminism is grounded in the work of Carol Gilligan (1982) and other contemporary psychologists who suggest that men and women speak in a "different voice." 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.

Cultural feminists argue that many traditional legal doctrines and practices are based on "masculine" values of autonomy and abstraction and fail to value the positive "feminine" concerns of responsibility, relationship, and essential connectedness experienced, for example, in the mother-child relationship. They have sought to balance the traditional legal emphasis on male values by promoting a jurisprudential theory that espouses a female ethic of care rather than a morality of rights. For example, cultural feminists have suggested that the law look for mechanisms to resolve disputes that would provide alternatives to the traditional adversary paradigm (Menkel-Meadow 1983). Feminist models of mediation have also been proposed to address bioethical disputes about medical decision making among family members and health care professionals. It is believed, for example, that ethics committees are better

equipped than the adversarial court system to foster and maintain family and physician-patient relationships. Similarly, cultural feminists have suggested that courts apply a feminist ethic of care when determining standards of negligence in order to recognize a duty to rescue strangers where none currently exists (Bender 1988). In order to promote and support a caring society, they argue, why should health care professionals not have a legal duty to stop by the side of the road and provide medical assistance to a person injured in an automobile accident? Cultural feminists also have challenged the categorization of physician-assisted suicide as “a criminal act of murder,” rather than as “an act of caring” that would alleviate pain and suffering (Bender 1992).

Cultural feminism may also question current standards of proper informed consent. Currently, standards of informed consent require the disclosure of information that a “reasonable person” would want to know in order to make an informed decision. However, if men and women think and speak in “different voices,” there may be no one common conception of a reasonable person. Indeed, current conceptions of such a person tend to reflect a masculine notion of reasonability, and cultural feminists urge that we expand this notion to include women’s values.

Radical Feminism

Radical or dominance feminism, like cultural feminism, arose in large part as a response to the perceived inadequacies in liberal feminist theory. Catherine MacKinnon, the major proponent of dominance theory, argues with cultural feminists that men and women are different; however, unlike cultural feminists, she argues that these differences largely reflect the fact that in society women are subordinate and men are dominant (MacKinnon 1987; see also Littleton 1989). 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. Radical 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 the abusive power of men in the private sphere. These arguments have produced concrete changes in some state laws that have made it easier for the

police to intervene in domestic violence disputes and for criminal law to recognize that rape is a violent act that can occur within the marital relationship.

MacKinnon (1979) was also instrumental in persuading lawmakers to recognize that sexual harassment in the work place is sex discrimination, and not just a private matter between individuals. Within the last decade, the evolution of sexual harassment as a legal claim has significantly changed the problematic dynamics of many historically male-dominated professions, including law and medicine. (Of course, the nursing profession has, for a long time, been all too aware of the negative dynamics that result from male domination.)

Whereas liberal feminists have concentrated primarily on expanding women's choices and cultural feminists have concentrated on reforming legal rules to reflect women's real experiences and to 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

Postmodern feminism is a more recent addition to feminist discourse. This perspective rejects the assumptions and generalizations at the core of the preceding feminist theories. According to postmodern feminists, no objective reality can describe the "essential" woman; consequently, such 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 (see Frug 1992; Bartlett 1994, pp. 13-18; Cain 1990, pp. 838-41). 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 (see, e.g., Rhode 1990; Radin 1990).

APPLYING DIFFERENT FEMINIST PERSPECTIVES: EGG DONATION²

How might the three major feminist theories enrich the debate over contemporary issues in bioethics and public policy? Here I shall consider the issue of egg "donation," a process more accurately described as the harvesting of eggs from one woman, usually with compensation, by

an IVF clinic for use by a contracting woman and/or couple who desires the birth of a baby. How might each feminist theory help us to frame and answer the questions raised by the process?

The liberal feminist would frame the issue in terms of the similarities and differences in the roles men and women face in such situations. For instance, although men do not donate or sell eggs, they do donate and sell sperm; since men can sell sperm and liberal feminists want to promote choice, perhaps women should be able to sell their reproductive material as well. If we allow a market for sperm, why not allow a market for eggs? On the other hand, liberal feminists will call our attention to the extent to which egg and sperm donation are not truly analogous. For example, egg retrieval is much more complex, risky, and time-consuming than is sperm donation. Thus, proper compensation would be greater for the sale of eggs, but not so great as to preclude economic arrangements between the infertile and those who want to sell their eggs. As part of promoting "procreative liberty," however, the liberal feminist will argue that it is important to have an informed consent process in place that clearly spells out the benefits and risks of the procedure both to the woman supplying the eggs and to the woman receiving them, as well as the intent of all parties. For example, the woman who agrees to have her eggs extracted should have no expectation of maternal rights and, absent a prior relationship, no involvement with the intended mother or any future child. Such policies would closely parallel those currently in place for sperm donation. Given full disclosure and a fair and reasonable compensation scheme, liberal feminists would support a public policy that recognizes egg donation as a choice for women.

In contrast, cultural feminists might frame the issue by asking what impact egg donation would have on family relationships, future connections, and the role of motherhood. If egg donation is viewed as a paradigm in which altruistic women help infertile women to become mothers, the cultural feminist might support it in the context of a noncommercial arrangement. Egg donation would be characterized as a caring gesture, involving an open arrangement in which the relationship among both women and any offspring could continue to grow. On the other hand, cultural feminists are not likely to support a market for women's eggs by IVF clinics. Such a scheme might be viewed as commodifying motherhood and undermining caring relationships.

Radical feminists, finally, would be very suspicious of egg donation. Whereas artificial insemination can be done with a turkey baster, egg

donation and IVF procedures require a high level of reproductive technology. Radical feminists argue that this technology, which is controlled by the male-dominated medical establishment, has historically tended to manipulate women's reproductive lives. Thus, women who participate in these procedures will be subject to the subordination of male power and the medical hierarchy. Furthermore, radical feminists worry about the potential for exploitation that such arrangements bring with them. First, poor women will be vulnerable to exploitation, undergoing invasive procedures and selling their eggs because they need the money. Second, infertile women seeking eggs, while they tend to be wealthier, will be exploited by society's pressure to reproduce. At the same time, the male-dominated medical establishment and any middlemen, including lawyers, will financially profit from the arrangement. Finally, even in the noncommercial setting, radical feminists might argue that egg donation requires women to use other women to perpetuate a sex stereotype that only values women in the context of reproductive capacities. Thus, egg donation in any context may result in the exploitation of women.

APPLYING COMMON FEMINIST THEMES:
THE MARYLAND HEALTH CARE DECISIONS ACT

In spite of these different perspectives, there are a number of themes, as noted earlier, that unite feminist theory. First, gender does matter. All feminists ask what impact a rule, practice, or policy will have on gender and, more specifically, on the lives of women from diverse backgrounds and experiences. Second, all feminist legal theory questions the objectivity of legal doctrine and its seeming gender neutrality, since laws and policies that are gender neutral on their face may not be so in result or application. Third, it reevaluates the traditional distinction between public and private spheres and the view that the law should respond only to public issues. To make these various considerations come to life, feminists value the importance of the narrative to give voice and context to the personal experiences of women.

The themes shared by feminist theories may be integrated to enrich the analysis of important bioethical and public policy issues. Let me share my narrative and perspective on how this integration, quite undeliberately, enhanced the development of a major piece of recent health care legislation, the Maryland Health Care Decisions Act of 1993 (*Md. Code Ann., Health-Gen.* §§5-601 to 618 (1994)).³

By the early 1990s, the *Cruzan* decision (*Cruzan v. Director, Mo. Dep't. of Health*, 497 U.S. 261 (1990)) caused many states, including Maryland, to recognize the need for a comprehensive legislative approach to the termination of life-sustaining medical treatment. Prior to this time, Maryland had very little judicial guidance in the area—only advisory opinions from the Attorney General's Office and a narrowly drafted living will statute that was limited to those with a terminal condition. In addition, Maryland had no durable power of attorney statute that extended to health care decisions, and its surrogate consent statute did not specifically address the termination of life-sustaining medical treatment.

By March 1992, a drafting committee was formed under the auspices of the Maryland Conference of Circuit Judges to consider comprehensive legislation that would address medical decision making for competent and incompetent persons, advanced directives, surrogate/family decision making, emergency treatment and other health care decisions by physicians, and judicial standards under Maryland guardianship law. The committee was chaired by Judge John Carroll Byrnes, Circuit Court of Baltimore City, and included four additional members from the Office of the Attorney General, the Health Law section of the Maryland Bar, the Maryland Disability Law Center, and the University of Maryland School of Medicine. It is worth noting that this five-member committee was all white and all male.

Within a few months the committee circulated drafts of its proposed legislation for public comment to a limited number of "interested parties." My first reaction was that while the committee did attempt to address a number of issues, the result was a very lengthy, detailed, and complex document. It seemed to cover every possible situation, and for every grant of authority, there seemed to be a caveat, and then an exception to each caveat (Hoffmann 1994, p. 1086). In addition to my concern with the legalistic nature of the proposal, I noticed certain obvious problems that had disturbing gender implications. First, the living will provisions of the proposal still maintained the pregnancy clause from Maryland's 1985 living will statute, which stipulated that a living will would not be honored during a woman's pregnancy. Thus, a pregnant woman, regardless of the viability of the fetus she carried, would have fewer rights to terminate life support than similarly situated men and nonpregnant women. Such a view is problematic from the perspective of

each of the feminist theories. Liberal feminists would argue that such a pregnancy clause would violate the constitutional rights of pregnant women and would make bad public policy. Cultural feminists might argue that the state should not impose its judgment on that of the pregnant woman who is the one best equipped to evaluate her needs in the context of her relationships. Radical feminists would object to a law that subordinates pregnant women to the state in the determination of what is best for her and her fetus. In spite of such concerns, members of the drafting committee believed that maintaining the pregnancy clause might prove to be a nonnegotiable issue with the Catholic Conference and ultimately with the Maryland Legislature.

A second problem with the proposal was its inclusion of provisions that appeared gender neutral on their face but proved not to be on closer inspection. The proposal declared that the state has an interest in ensuring that the welfare of minor children not be impaired as a result of a competent individual's decision to withhold or withdraw life-sustaining procedures (Hoffmann 1994, pp. 1074-75). Thus, although the proposal declared that a competent individual has a right to refuse life-sustaining medical treatment, it stated that if the individual was the sole provider of a minor child and life-sustaining treatment would allow the individual to continue to care for the child, that individual would have to seek court approval before being permitted to refuse life support. The provision considered neither the nature of the proposed treatment nor the religious conviction of the individual (Hoffmann 1994, pp. 1070-71, n. 19). Although the term "individual" includes both men and women, in fact the large majority of sole providers of minor children are women—often women who are suffering from HIV/AIDS. Thus, this provision had an unfair and disparate impact on women. This reality was brought to the attention of the committee by a number of public interest lawyers, almost all of whom were women.

Third, and more generally, many of the proposal's provisions appeared to excessively burden the family in the decision-making process by requiring a legalistic rather than a supportive approach to family relationships. The approach taken reflected a presumption that the state needs to protect the individual from harm in every possible situation: for example, family members would have to go to court under delineated conditions to prove that their ill relative would have wanted to discontinue life support or that doing so would be in the relative's best

interests (Hoffmann 1994, p. 1101). The proposal required written certification and justifications of actions by clear and convincing evidence. In an early draft, even artificial feeding and hydration could not be withheld or withdrawn from an incapacitated person unless the patient had previously stated in writing or orally the desire not to be kept alive specifically by these means (Hoffmann 1994, p. 1104). Such restrictive language gave little or no voice to the family to act in good faith on behalf of a loved one.

By December 1992, the committee decided to present the proposal to a broader audience, and the University of Maryland's Law and Health Care Program agreed to organize a conference that would include public comment on the committee's proposal. I agreed to critique the proposal at the conference. I did not ground my critique in any one particular feminist theory; in fact, my approach integrated several feminist perspectives.

To put the issues in context, I started my critique with a true story. A week prior to the conference, a friend of mine had called me to ask for some advice. Her mother had suffered a massive stroke and was no longer able to speak. My friend could not care for her and had her admitted into a nursing home in Maryland. A few years previously, her mother had signed a standard living will form, which failed to specify many details, such as whether she would want artificial nutrition and hydration withheld or withdrawn. Neither my friend nor her mother knew that the form only applied to a terminal condition. Her mother had not gone to a lawyer to seek advice on how to fill out the form—in fact, her mother had never been to a lawyer in her life. My friend was upset because her mother had told her many times that she would not want to be kept alive on feeding tubes and that she did not want to be a burden to the family if she could no longer care for herself. Of course, her mother had never written any of this down. The nursing home was claiming that they had no choice but to insert a feeding tube and that these conversations and the living will form were of no relevance.

With this narrative as a frame of reference, I was able to ask whether the committee's proposal addressed concerns such as those of my friend. Obviously, many of the provider and consumer groups attending the conference had similar stories and frustrations, and many expressed concern that the proposal was too restrictive of both individual and family/surrogate decision making. I argued that any proposal to legislate med-

ical decision making should establish the presumption that family and friends with close relationships to the patient are best able to give voice to a family member or friend with limited decision-making capacity. As we all agreed, most individuals do not sign advanced directives or write their wishes down, but that does not mean that only a court can protect their interests. Not having filled out a form should not mean that your family has no voice to act on your behalf. Rather, when a health care provider, institution, or the state wants to challenge the decision of a surrogate, they should have the burden to petition the court, not the other way around. Obviously, there may be times when an individual needs the court's protection, but these circumstances should be regarded as the exception rather than the rule. In addition, I urged that the patient care advisory committee may serve as an alternative to the judicial process to mediate such matters. Clearly, the perspectives of cultural feminism helped to frame the deference to family decision making and the shift from a presumption of distrust and protectionism to one of trust and support of caring relationships.

Following this analysis, I focused more specifically on the gender implications of the proposal and its distrust of women. Not only were families not to be trusted, but pregnant women would not be able to exercise their right to have a living will respected and sole care givers of minor children, the majority of whom are women, would not be able to terminate life-sustaining treatment without the court's approval. As a result, the proposal treated these women differently from all other competent individuals.

Many other participants at the conference expressed significant problems with the content and approach of the committee proposal. As a result, a coalition was formed to draft an alternative. The coalition included representatives of the elderly, women's groups, an Alzheimer's association, and a number of medical, hospital, and legal organizations. As I would later testify at a hearing on the issue, the original proposal had ignored reality because it failed to recognize that not all feelings and contingencies can be codified (Hoffmann 1994, p. 1104); the alternative proposal was much shorter, simpler, and less legalistic. Further, the coalition's alternative shifted the presumption to trusting the family, not the state, to make decisions. To the extent that safeguards were included, it was felt that they should not overly burden care givers making decisions for incapacitated patients. Even though some recent empirical data suggest that surrogates may not make the same decisions that patients

would make for themselves, many individuals still prefer that their family members, rather than physicians and judges, make these decisions (Hoffmann 1994, p. 1102, n. 151, 152).

This shift in presumption to one of trust in caring relationships permeated the coalition proposal. The coalition proposal extended the conditions under which a surrogate could make decisions to withhold or withdraw life support and gave a clear decision-making priority to those most likely to be closest to the patient (Hoffmann 1994, p. 1093). It recognized that a close friend, and not just family members, might have the authority to make decisions for an incompetent patient. It expanded the use of an oral advanced directive to include appointment of a health care proxy. The coalition proposal also prohibited a health care provider from overriding the instructions of a surrogate without first going to court and proving that the surrogate was not following statutory guidelines for decision making (Hoffmann 1994). The proposal modified the guardianship law to allow a guardian to authorize the withholding or withdrawal of life support without court approval if the patient had executed an advanced directive, and it treated artificial feeding and hydration like other forms of life-sustaining treatment. Further, both the coalition proposal and the committee's final proposal eliminated the provision that required competent individuals who were the sole care givers of minor children to seek court approval for termination of life-support decisions. Finally, and significantly, the coalition proposal did not include a clause restricting the right of pregnant women to have their advance directives followed.

Ultimately, the Maryland Legislature considered modifications of both proposals. Political compromise resulted in the passage of the Maryland Health Care Decisions Act on May 12, 1993. The statute incorporated advanced directive forms that do include a section allowing women to write additional instructions concerning pregnancy. If the section is left blank, it is presumed that her choice of treatment will be the same independent of whether she is pregnant. More generally, the legislation adopted the approach of the coalition proposal to presume trust of care givers rather than courts with a few additional safeguards (Hoffmann 1994, pp. 1108-30).

This legislative approach, which shifts reliance from the court to the family, may have significant gender implications. An analysis of "right-to-die" cases by Miles and August (1990) found asymmetric gender patterned reasoning in which judges were less likely to consider evidence of

women's preferences with regard to life-sustaining treatment. The authors concluded that "the arbitrariness of gender patterned reasoning and its effect of these cases amply illustrates the vicissitudes of institutional reasoning" (Miles and August 1990, p. 286). Thus, they suggested that courts not attempt to construct a person's preferences, but rather empower care givers to make decisions on behalf of an incompetent family member or friend.

Just as significantly, the legislation rejects an approach that presumes that laws need to be crafted to protect us from "bad actors" rather than to support care givers. As Leslie Bender, a cultural feminist, has observed, "The social and ethical price of designing our laws and rules for the bad actors is significant suffering and indignity to innocent, humane people because of unnecessary restraints on their freedom to act out of care in a manner responsive to particularized circumstances of need" (Bender 1992, p. 532; Hoffmann 1994, p. 1102-3, n. 28).

On reflection, I believe that the Maryland Health Care Decisions Act was enriched by the integration of feminist perspectives. Although gender issues were not always front and center, feminist legal theory did, in fact, contribute to the challenging of legal rules and presumptions. Obviously, the bioethical and public policy debate over the new reproductive technologies, including egg donation, will also be enriched by the diversity of feminist legal theory. Hopefully, both lawyers and bioethicists will recognize that gender matters and will insist that "women's experiences, varied as they are, be taken into account" (Carbone 1994, p. 183). In the end this is what feminism is all about.

I wish to thank my colleagues Jana Singer and Diane Hoffmann for their insights and expertise, Maggie Little for her thoughtful comments and suggestions, and the other faculty and participants at the Kennedy Institute's Feminist Perspectives on Bioethics course for their collaborative spirit.

NOTES

1. See Rothenberg (1995). The analytical framework for describing the major feminist theories was crafted in part from the following outstanding works: *Feminist Legal Theory: Foundations* (Weisberg 1993); *Feminist Legal Theory: Readings in Law and Gender* (Bartlett and Kennedy 1991); "Gender Law" (Bartlett 1994), "Feminist Jurisprudence: Grounding the Theories" (Cain 1989); and "Feminism and the Limits of Equality" (Cain 1990).

2. This analysis was inspired in part by an outstanding presentation by Rosemarie Tong at "Bioethics, Feminism and Reproductive Technology," AALS Annual Meeting, New Orleans, 8 January 1995.
3. For an outstanding discussion of the evolution of the legislation, see Diane Hoffmann (1994).

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