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On Feminist Engagements with Bioethics

Abstract: *The article explores two questions: what is feminist bioethics, and how different it is from standard bioethics. Development of feminist bioethics, it is argued, began as a response to standard bioethics, challenging its background values, and philosophical perspectives. The most important contribution of feminist bioethics has been its re-examination of the basic conceptual underpinnings of mainstream bioethics, including the concepts of “universality”, “autonomy”, and “trust”. Particularly important for feminists has been the concept of autonomy. They challenge the old liberal notion of autonomy that treats individuals as separate social units and argue that autonomy is established through relations. Relational autonomy assumes that identities and values are developed through relationships with others and that the choices one makes are shaped by specific social and historical contexts. Neither relational autonomy, nor feminist bioethics, however, represents a single, unified perspective. There are, actually, as many feminist bioethics as there are feminisms—liberal, cultural, radical, postmodern etc. Their different ontological, epistemological and political underpinnings shape their respective approaches to bioethical issues at hand. Still what they all have in common is interest in social justice—feminists explore mainstream bioethics and reproductive technologies in order to establish whether they support or impede gender and overall social justice and equality. Feminist bioethics thus brings a significant improvement to standard bioethics.*

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Key words: *feminism, bioethics, social justice, autonomy, reproductive technology.*

Marginalized for a long time, feminist bioethics today is recognized as an influential approach in bioethics even though its contributions are not always acknowledged. This article outlines some major developments in feminist bioethics since its inception in the late 20th century.¹

Already in the 1970s, and early 1980s when the field of bioethics began to grow rapidly, some feminist work was published commenting mainly on new reproductive technologies. By the late 1980s and early 1990s feminists developed a sustained critique of the health care system and of the field of bioethics. This work was widely circulated in feminist publications. *Hypatia*, one of the leading journals in

¹ This paper was realized as a part of the projects “Bioethical Aspects: Morally Acceptable Within the Biotechnologically and Socially Possible (41004) and “Studying climate change and its influence on the environment: impacts, adaptation and mitigation” (43007) financed by the Ministry of Education and Science of the Republic of Serbia within the framework of integrated and interdisciplinary research for the period 2011-2014.

feminist philosophy, for example, published two special issues on bioethics (Fall and Summer of 1989), later revised and reprinted as a collection (Holmes and Purdy, 1992). In 1992 the International Network on Feminist Approaches to Bioethics (FAB) was established at the congress of International Association for Bioethics.² As a result of all these activities, by the late 1990s, feminists had created a rich body of work covering a wide range of topics pertinent to bioethics.

20 Feminist bioethics, as already mentioned, began as a critique of “standard” bioethics’ focus on reproductive issues such as abortion and contraception, woman-fetal relations and reproductive technologies. Initially, less attention was given to interconnections between these issues and other bioethical concerns such as the limits of physician authority, conflicts between commercial interests and patient well being. Later on, however, these issues entered feminist bioethics as well. Feminists challenged the structures, background values, and philosophical perspectives in standard bioethics; and questioned why certain issues were prioritized over others. One of the central issues in feminist bioethics was the issue of social justice—feminists explored whether mainstream bioethics supports or impedes overall equality in the realms of health and health care (Donchin 2001, 2008; Inhorn, 2007; Nykövaara, 2011; Tong, 2001).

It has been argued that the “dominant ways of doing bioethics are *fundamentally* gendered contributing thus to culturally inscribed oppressive practices” (J. Leach et.al, , 2010). According to Leach et.al., within standard bioethics, gender oppression is reinforced in two ways. First, by focusing on questions that reflect masculine experiences and priorities—for example, health research until recently did not pay sufficient attention, if at all, to ways in which women and men suffer differently from the same diseases thus requiring different treatments;³ or to the fact that women throughout their lives suffer from more illnesses and disabilities. Second, ontological and epistemological foundations of the standard bioethics tend to privilege masculine ways of knowing while devaluing those ways of knowing that are culturally designated as feminine. Namely, the modern western science is mostly based in rationalism and positivism, in separation between the subject and object of knowledge, in duality between reason and emotion, designating gender characteristics to those notions while excluding emotions and intuitions from the process of discovery. “Western science and technology have evolved based upon the concept of predicting and controlling nature, and nature has been assigned the female gender by Western philosophers” (K. Zuga, 1999). Thus, both nature and women are designated as objects of knowledge.

2 In 2008, FAB has established *International Journal of Feminist Approaches to Bioethics*.

3 Because women have been underrepresented in clinical trials of new drugs their safety and efficacy may be compromised when used by women.

Other feminist objections to standard bioethics include: its emphasis on deduction from abstract ethical principles rather than induction from concrete cases because such approach privileges the perspective of elite groups and legitimates the status quo within and between societies; a tendency to view ethical problems as problems between individuals, or as problems for the entire society, but rarely at an intermediate level to take into account the moral significance of various groups; privileged status of expert opinions and disregard for input that could be given by social movements like, for example, feminism, environmentalism, and working-class organizations; finally, standard bioethics usually does not reflect upon whom the field serves and how (Donchin 2001, 2008; Inhorn, 2007; Nyrövaara, 2011; Tong, 2001).

Feminist bioethics, however, is not a unified perspective and it could be argued that there are at least as many feminist bioethics as there are feminisms: liberal, cultural, radical, postmodern, to name just a few best known streams. Still, even though there are diverse and sometimes conflicting versions of feminism, they all focus on equality or justice between men and women. Laura Purdy calls it “core feminism,” and argues that commitment to gender justice is the only necessary and sufficient condition for being a feminist. Different versions of feminism, no doubt, rely on different theories of justice or equality—but gender injustice and ways to achieve equality are central issues for all of them (Mahowald, 2001). Since gender justice is simply a subset of justice, Mahowald argues that as long as it is committed to justice, all bioethics is feminist (Mahowald, 2001), and that one day *feminist* should become a superfluous designation in front of bioethics. But that day has not come yet because sex, gender and other marginalized issues have not become the standard categories of analysis in bioethics. Feminists argue that, standard bioethics is actually unable to analyze structural injustices related to gender, class, race, sexuality, and other, because of its espousal of a liberal paradigm, its individualism, and its decontextualized and ahistorical approach.

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The most important contribution of feminist bioethics has been its re-examination of the basic conceptual underpinnings of mainstream bioethics, including the concepts of “universality”, “autonomy”, and “trust”.

It is argued that the concept of autonomy in standard bioethics understood as “maximal choice” neglects the effects of power relations on individual choices, opportunities, and capacities, while the concept of universality obscures masculine and western biases behind a façade of neutral equality (Leach et.al, 2010). An example of such conception of autonomy can be found in the UNESCO’s *Universal Declaration on Bioethics and Human Rights*, adopted by the General Conference in 2005. According to Rawlinson and Donchin the Declaration “sets well-meaning universal standards that nonetheless obscure historical links between abstract rights discourses and practical inequalities” (Rawlinson and Donchin, 2005).

They find the Declaration's two underlying assumptions problematic—universality and disregard of power relations. According to Rawlinson and Donchin, universal principles should rely on shared values as well as on differences in ethical values across cultures; and the Declaration should explicitly recognize disparities of power and wealth that deny equal dignity and rights to many.

Feminists have also engaged in an examination of various specific issues and practical applications of feminist bioethics such as contraception, sterilization and abortion, novel reproduction enhancing technologies, reprobogenic and, to a somewhat lesser degree, non reproductive high-tech medicine, like organ transplants, xeno-medicine, etc. Given that it was one of the first issues addressed and has remained one of the central topics in feminist bioethics, the next section of this paper focuses on the concept of autonomy. It shows how this concept has been redefined and applied in examining implications of new reproductive technologies.

22 **Autonomy and Choice in Feminist Bioethics**

The concept of autonomy defined by earlier liberal feminists as the “right to choose”—whether, when and how many children to have—in other words to have access to fertility limiting technologies, turned problematic when applied to fertility enhancing technologies and reprobogenics. In this context the “right to choose” has been transformed into “consumer rights” (Aengst, 2011, internet). Consequently, new technology has been praised not only for enabling infertile women to become mothers, but also for making it possible for all women to have as many children as they want, when they want, and of the kind they like. The consumer rights approach, however, neglects economic disparities among women, namely, the fact that these still rather expensive technologies are out of reach for many women. Thus, as is argued by radical and cultural feminists, the consumer rights approach cannot be an adequate strategy for access to reproductive rights (Aengst, 2011, internet).

For them, this essentially neoliberal perspective suffers from several problematic underlining assumptions: the assumption of equal access to existing options; of unlimited autonomy and choice; and of unrestrained individual agency. Cultural and radical feminists argue convincingly that the autonomy thus envisaged is unattainable. They insist on the importance of context in determining the real effects and consequences of the new reproductive technologies. Context, here, refers to taking personal characteristics into account, as well as the social, legal, and cultural circumstances of a given ethical issue.

In Serbia, for example, the legal framework together with the overall economic conditions in society determine that access to some of the most sophisticated

reproduction enhancing technologies is limited to a small number of affluent women (i.e. couples) and potentially may result in a rather inefficient application of this type of technology.

To begin with, The Law on Infertility Treatment by Biomedically Assisted Fertilization passed in late 2009, grants access to invitro fertilization only to heterosexual couples. According to this Law, state owned health insurance covers all the costs of the procedure but only for two cycles. Since, statistically, it takes between five and six cycles for conception to take place, it is fair to argue that such a policy is ineffective, inefficient and economically imprudent from a societal perspective—this costly procedure is, in other words, wasted in all cases in which conception does not occur within the two cycles. Not to mention emotional, psychological, physical and many other costs that women and couples endure during this arduous procedure, only to be left without the desired outcome halfway through. These couples (who probably constitute the majority) could, of course, continue the treatment in several private clinics. However, the rates charged by private clinics exceed economic capabilities of the majority in Serbia. The current rates range from 2500-4000 euros per cycle (depending on the procedure), and are affordable to only a tiny minority in a society where the average monthly income is between 300 and 400 euros.

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A further limiting element in the Law is the stipulation that single women can qualify for invitro fertilization “only in exceptional cases” that are not specified by the Law. The procedure is not available to women above the “age appropriate for reproduction”, again not specified by the Law; and to women who can conceive naturally, which potentially puts homosexual women in a disadvantaged position (see Law on Infertility Treatment by Biometrically Assisted Fertilization, art. 27).

It is, thus, more than obvious that the “right to choose” invitro fertilization in Serbia is determined (and significantly limited) by principles of heteronormativity and traditional marriage rules that inform the Legal framework which regulates access to this procedure. Poor economic conditions in the society at large and the lack of resources represent another limiting factor. Because health insurance covers the expenses for only two cycles of invitro fertilization, only a small number of the most affluent couples is in a position to undergo the procedure as many times as needed to conceive.⁴

Contextuality in feminist bioethics has various applications—it refers also to people’s embeddedness within social networks, and the fact that their decisions

4 Belgrade residents are in a somewhat better position since the city government covers their expenses for a third cycle of IVF. Currently one hundred couples are enrolled in this program—twenty of whom have conceived thus far (see, www.beograd.rs/cms/view.php?id=1529317).

are made within the context of those relationships with others. This implies taking into account the obligations and responsibilities that one has within those interconnections.

The idea of contextuality, connectedness and interdependence of people has given birth to feminist relational ethics. Particularly important for feminist relational ethics is the concept of *relational autonomy*—that is autonomy through relationships rather than independence. Individuals, according to this view, cannot be treated as separate social units because their identities and values are built through relationships with others.

[O]ur self is constituted to an important degree by relations with and responsibilities towards our intimates, and these relations and the welfare of our loved ones may be more significant than the interests of any individual self in isolation (Keller, 1997).

- 24 The concept of relational autonomy is embedded in feminist theory of care. Feminists argue for a concept of autonomy that is sensitive to relations of care, interdependence, and mutual support that, while centrally important for social life, has traditionally been designated primarily within a women's domain. This does not mean that relational autonomy approach endorses the self-sacrifice and subordination of women. On the contrary, it considers the unequal burden that women carry due to their reproductive and care-taking roles. Thus, a relational autonomy approach includes a struggle for more equitable distribution of care-taking and views it as a precondition for achieving gender justice and equality. The theory of care insists that relation is ontologically basic and the caring relation morally basic. *Caring* as it is described in care ethics cannot be equated with caregiving; it is a moral way of life. We are individuals only within relations. We are recognizable individuals as separate physical entities, but the attributes that we exhibit as individuals are products of the relations into which we are cast (Noddings, 2001, internet).

The proponents of the relational autonomy approach also emphasize that in addition to their rational capacities, the characteristics of autonomous agents include their emotional, embodied, desiring, creative and feeling abilities, within complex social and historical contexts (Campbell, 2002).

Relational autonomy, however, far from being a "single unified conception", refers to various theoretical positions that put emphasis on social embeddedness of individuals, and on social structures and relations that make autonomy possible (Christman, 2004; Dickenson, 2001; Scherwin, 2008; Shirdlick, 2008).

Feminist relational theory is particularly sensitive to ways in which options and opportunities are shaped by power arrangements, and to the fact that social structures enable some choices while limiting others. They distinguish between

autonomy-enhancing and autonomy-undermining influences within particular historical and social contexts.

For example, feminists point to the numerous ways in which reproduction enhancing technologies and reprogenetics may actually be oppressive and limit reproductive choices for some women (Dickenson 2001; Parks 2009).

In some societies the new reproductive technologies may increase pressure on women to opt for motherhood, especially where men are expected to be breadwinners (Gupta, Richters, 2008). The availability of assisted reproductive technology can weaken the women's struggle against potential negative consequences of infertility. Research and state funds could be disproportionately directed to the development of reproduction enhancing technologies, neglecting the research that could lead to the elimination of certain types of the most widespread causes of infertility. As a consequence, limited resources that should be dedicated to the health care of all women are disproportionately directed to assisted reproduction of some women (Rajani, 1999).

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New technologies could also revive the idea of the universal maternal "instinct", while the possibilities offered by repro-genetics and prenatal diagnosis have turned choice "into a eugenic obligation which women cannot forego without being termed irresponsible towards themselves and towards society" (Dickenson, 2009, internet) if they do not bring a "perfect baby" into the world.

According to Sarah Franklin, assisted reproduction technology, has brought about a change in the perception of nature—women and their reproductive functions are now treated as inferior to technology and also submitted to it:

ART "de-naturalizes" reproduction and "naturalizes" ART simultaneously. It reduces infertility and natural conception to the same level of insufficiency. Infertile women's nature is insufficient because of their limitation to conceive; natural conception is insufficient because it cannot guarantee the aspired outcome, which is the birth of a (fit) child. In both cases, nature needs "the helping hand" of medical and technical assistance to overcome its deficiency. This does not only legitimize ART, but it "naturalizes" it (Franklin 1995a:334).

The application of the feminist concept of relational autonomy to specific situations has shown some weaknesses, summarized by Christman in three points: the abstract and fluid quality that limits its applicability to concrete situations; overemphasis put on interrelationships at the expense of the private self and self-determination; and the relational autonomy approach could override individual rights and interests in the name of family, group, or community rights (Christman, 2004).

Christman, however, does not reject the relational approach. He only insists that it be applied cautiously, with these limitations in mind. He actually identifies six important themes in relational autonomy: since relational life is inevitable, our decisions are to some extent constrained by the responsibilities and relationships within which we are embedded; trust, responsibility and care are as important as autonomy; emotions, attitudes, desires, creativity, feelings, memory are all important parts of autonomy alongside rationality; social structures fundamentally shape our identities, desires, beliefs and emotional attitudes—hence, the skills needed to exercise autonomy are learned and developed “in and through relationships”; finally, while “relational life is ‘good’, and beneficial relationships are vital for genuine autonomy to flourish, relationships and social structures can also be oppressive or abusive. A core part of relational autonomy therefore emphasizes protecting people from harmful relationships and their consequences” (Christman, 2004:157).

26 Some feminists, however, believe that the concept of relational autonomy does not go far enough in challenging and deconstructing the liberal concept of the free, independent self.

The concept of autonomy, which is central to liberal humanism in its masculinist formulations, gets kicked around a bit, only to reappear in revised forms that extend agency to previously oppressed groups—women, patients and global others. The feminist turn to relationality... [however] fails to radically disengage from the image of the bounded liberal humanist subject, who acts, consents, and makes moral choices as an individual” (Shildrick, 2008:31-32; see also Campbell, 2002).

Shildrick suggests that the notion of interconnectedness should be expanded to include intercorporeality and concorporeality (particularly significant in the domain of organ transplants). It should also recognize that “the boundaries of the human body are part of a cultural, and indeed, biomedical imaginary, not a representation of how things really are” (Shildrick, 2008:34).

Similarly, Meyers, warns that an emphasis on integration that is inherent to the notion of autonomy may run counter to some of the most important insights of feminism and postmodernism regarding non-integrated, conflictual, and pluralistic selves.

Feminist vs. Standard Bioethics

Feminists have participated in scholarly discussion of virtually all the major topics in bioethics (sex selection techniques, genetic ties to children, disabilities, genetic testing and screening, abortion, discrimination in health insurance and employment, stem cell research, human cloning, etc.), and their writings now appear reg-

ularly in bioethics journals and anthologies. Despite this, the specific health care concerns of women and other marginalized groups still receive disproportionately little attention in mainstream bioethics.

Within feminist bioethics, on the other hand, reproduction remains the central topic, due to, among other reasons, the fast development of new reproductive technologies, with ever more complex social and ethical implications and with unequal burdens they put on women and men. For example—there is pressure put on women to produce only “perfect” children using prenatal techniques. This is accompanied by the increased stigma imposed on those children who happen to be born with disabilities. Feminist authors warn that development of genetic enhancement techniques could expand these tendencies and thus pose even greater threats to social equality. The main feminist objection to standard bioethics is its neglect of issues of power and social justice. In order to amend this, feminists focus on power and justice in their approach to reproductive technologies and rerogenetics. Their most important conclusion is that these technologies (for example superovulation, egg extraction and prenatal and preimplantation diagnosis) are not gender-neutral because they put greater physical, psychological emotional and even moral burden on women, since it is women who are expected to assume responsibility not only for their own health but also for the health of their families. Reprogenetics and new reproductive technologies thus pose problems when they ignore or, worse still, exacerbate the difference in burden between men and women (Dickenson, 2009, internet).

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According to Dickenson, feminism makes three separate, but equally important contributions to the field of human genetics and the new reproductive technologies. First, feminism explores ways in which these new technologies have the potential to exploit women while seeming to offer them greater reproductive freedom. Second, feminism stresses the fact that genetic testing and reproductive choice takes place in the context of relationships, and investigates ways in which this happens. Finally, feminists were the first to point out the commodification and commercialization in genetic research and application, issues which often affect women disproportionately. (Dickenson, 2009, internet).

Anne Donchin (2008) identifies three goals that have been central in feminist bioethics: extension of bioethics theory to integrate concerns of race, class, ethnicity and gender; reexamination of the principles of bioethics; and creation of new strategies and methodologies that include the standpoints of those who are socially marginalized. In pursuing these goals, feminist bioethics has made a significant theoretical and methodological contribution in understanding the meaning and applications of new reproductive technologies and repro-genetics. Moreover, feminist bioethics has suggested possible ways to minimize the threat of intensified inequalities—for example including representatives of affected groups

within policy-making bodies (e.g. women, people living with disabilities). Thus it could be argued that feminist bioethics gives an important contribution and a necessary correction to standard bioethics.

28 What, according to Rosemary Tong, all feminist approaches to bioethics have in common, despite the differences in politics, ontology, epistemology, and ethics, is posing questions, raising consciousness, and action-oriented methodology. According to her, they all ask the so-called woman or gender question, pointing to the subordinate status of women in society, and they work towards eliminating gaps between feminist theory and feminist practice. She is hopeful that one day these approaches might also share a “philosophical framework flexible enough to accommodate a very wide range of feminist politics, ontologies, epistemologies and ethics—that would constitute the foundation of an eclectic, positional and relational feminist bioethics” (Tong, 1997:93). She envisions eclectic politics as a combination of socialist, Marxist and radical approaches to inequality—for example, a combination of an emphasis on equality with a feminine approach to health care. Positional epistemology, according to her, assumes that there is truth to be known, but knowledge of it is always positional and partial—it emerges from roles and relationships and no one (individual or group) possesses it entirely. Finally, relational ontology, deconstructs the concept of self as discrete and self-sufficient (Tong, 1997:96).

A similar position is put forward by Susan Sherwin (2008). Instead of aiming for a single grand theory, moral theories, she argues, should be preconceived as multiple perspectives that provide partial and overlapping resources to address difficult moral issues. Within such a preconception, various, at present competing approaches, would, as she puts it, offer overlapping and interlocking “lenses” to illuminate dimensions of moral problems obscured when approached from a single overarching theoretical matrix.

Such a framework, she continues, would be best suited to reveal structural injustices that are masked by currently prevailing approaches; it would enable reshaping social conditions in a way that promotes the autonomy, health, and well-being of subordinated groups across diverse cultures and traditions. In this way, feminist bioethics would come close to achieving one of its most important goals—equality and social justice for all.

Primljeno: 15. decembar 2012.

Prihvaćeno: 4. januar 2013.

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Rada Drezgjić

O susretu feminizma i bioetike

Apstrakt

Tekst pokušava da pruži odgovor na dva pitanja: šta je feministička bioetika i po čemu se ona razlikuje od standardne bioetike. Počeci feminističke bioetike vezuju se za prve feminističke kritike „standardne“ bioetike, a njen dalji razvoj i najznačajniji doprinos povezani su s redefinisanjem centralnih kategorija glavnog toka bioetike. To su, pre svega, „opštost“, „autonomija“ i „poverenje“. Za feminizam je od posebnog značaja koncept autonomije, te se njemu u tekstu poklanja nešto više pažnje. Feminizam kritikuje stari liberalni pristup autonomiji u kome se pojedinci posmatraju kao zasebne, izolovane jedinice, smatrajući da se autonomija ostvaruje kroz društvene odnose. Koncept relacione autonomije polazi od pretpostavke da se identiteti razvijaju i vrednosti usvajaju kroz odnose s drugima, kao i da su izbori koje pojedinci prave u velikoj meri određeni konkretnim društvenim kontekstom. Ni relaciona autonomija kao ni feministička bioetika, međutim, ne predstavljaju jedinstveno, unisono, stanovište. Može se reći da ima onoliko feminističkih bioetika koliko i feminizama—liberalni, radikalni, kulturni, postmoderni... Oni se između sebe razlikuju po ontološkim, epistemološkim i političkim premisama koje nadalje određuju i njihov pristup bioetičkim pitanjima. Ipak, svi ovi različiti feminizmi i feminističke bioetike bave se pitanjem socijalne pravde. U okviru feminizma bioetika i reproduktivne tehnologije i reprogenetika se proučavaju da bi se utvrdilo da li i u kojoj meri podupiru ili pak ograničavaju rodnu ravnopravnost i opštu pravdu u društvu. Stoga se može reći da feministička bioetika donosi značajno poboljšanje i dopunu „standardnoj“ bioetici.

Ključne reči feminizam, bioetika, socijalna pravda, autonomija, reproduktivne tehnologije.