Decentering Whiteness in Feminist Bioethics: Assisted Reproductive Technologies (ART) as an Illustrative Case

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Introduction

In a *New York Times* op-ed from May 2016 entitled "Is egg freezing only for white women?," Reniqua Allen reflected on whether to freeze her own eggs. Allen described herself as a professional woman in her 30s, unmarried, and African-American and explained she was considering freezing her eggs after a family friend nudged her to have children before it was too late, with or without a husband. In contemplating the option of egg freezing as a path to motherhood, Allen raised some questions about egg freezing that I had not seen directly addressed in the bioethics literature. Allen's biggest concern was that using egg freezing to have a child as a single black woman would mean becoming "a stereotype, a stigma." Her fear of being stigmatized constrained what she felt free to choose. In her words:

> Black women aren't given the luxury of having their nontraditional choices appear to be new and radical. When we make "unconventional" decisions around reproduction, we're stigmatized. Or labeled angry. Or lonely. Or difficult. We're robbed of our agency to do and be anything that's outside of the boundaries of whatever is perceived as normal. (Allen 2016)

Allen's self-examination represented a moment of clarity, a shift in consciousness, and a problematizing of the familiar parameters of the egg freezing debate. Rather than pondering whether egg freezing allows women to keep up with men in the workplace, as many feminist bioethicists have done, Allen asked whether women of color were even being informed of the option of egg freezing or, if given the option, whether they felt free to take it without experiencing stigmatizing repercussions based specifically on race. In other words, Allen's piece had the effect of illuminating what it might look like to "decenter" whiteness in a bioethical analysis of egg freezing.

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I begin this paper with a brief reference to Reniqua Allen's op-ed because I believe the moment is ripe for asking how much progress has been made in decentering whiteness in bioethics. Nearly 20 years ago, Susan Wolf, professor of law, medicine, and public policy at the University of Minnesota, diagnosed what was missing in bioethics: "[A] bioethics analysis that places race, ethnicity, and gender at the center" (Wolf 1999: 66). In her judgment, bioethics had, to its detriment, "held fast to its liberal roots, condemning discrimination and calling for equal treatment but failing to dig deeper into the…debates about difference" (66). Wolf felt the integrity of the field was at stake and specified the harms resulting from a failure to change course. She wrote: "[T]he damage done by a bioethics that erases difference occurs on a number of levels. Individual cases are wrongly construed, entire patterns of profound harm are left unchallenged, bioethics itself becomes complicit in those harms, and the field devolves into a bioethics by and for those who least need it—the already dominant. It is small wonder that the field has remained alarmingly white and nondiverse" (71).

Since Wolf wrote those words, significant strides have been made in placing gender at the center of bioethical analysis. However, one could easily argue that not enough work has been done to put race at the center of bioethical analysis, including feminist bioethical analysis. Scholars such as philosopher Camisha Russell (2016) and historian John Hoberman (2016) have assessed the degree to which the bioethics literature has focused on race. Hoberman, for example, surveyed the articles in major journals of bioethics that focused on race over the 15-year period from 2001 to 2016 and found only a few substantive examples. Russell's examination found that even when race was addressed, its presence did not have a fundamental impact on the theoretical work produced by philosophical bioethicists.

My intention here is not to reiterate the findings of Russell and Hoberman, or other general assessments of bioethics, but to focus my discussion more narrowly on the field of *feminist* bioethics. By using assisted reproductive technologies (ART) as an illustrative case, I hope to suggest what decentering whiteness might substantively look like and, by doing so, demonstrate why decentering whiteness is so critically important to the field of feminist bioethics. I argue that feminist bioethics needs to put race at the center of analysis, by which I mean it needs to embrace a shift in thinking that fundamentally alters what gets labeled as a problem and defined as a solution. This change cannot be superficial, self-serving, or transitory but should reach to the very core of what "feminism" is.

Identifying the Problem: Disparities in ART Use and Outcomes

What does it look like to consider assisted reproductive technologies (ART) with race at the center of analysis? One strategy is empirical: to look simply at who has access to ART. Surveys of ART usage show significant differences in access to ART by race and ethnicity (Quinn and Fujimoto 2016). Whites use a disproportionately large share of infertility services, given their overall population in the United States, while African-American and Hispanic women use a disproportionately small share of infertility services, given their numbers in the general US population.

For example, blacks were 12.9% of US general population in the year 2000, while whites were 75.1% of US general population (Seifer et al. 2008: 1707). However, only 3666 or 4.6% of ART cycles were undertaken by black women, while 68,607 or 85.4% of ART cycles were undertaken by white women (Seifer: 1707). Notably, white women with higher levels of education and socioeconomic status are the most likely to access infertility care, even in states where insurance coverage for infertility treatment is mandated and theoretically more widely available. The state of Massachusetts, for example, which mandates insurance coverage for infertility treatment, provides a particularly stark set of contrasts:

> [I]n Massachusetts, only 3.9% of infertility patients were Hispanic/Latino, compared with 6.8% of the state population being Hispanic/Latino. Furthermore, none of the infertility patients had less than a high school diploma, compared with 15.1% of the state population, and 49.6% of infertility patients had advanced degrees, compared with 12.4% in the state. Finally more than 60% of infertility patients had an annual household income above $100,000 compared with only 17.7% of the state's population. (Quinn and Fujimoto 2016: 1121)

Clearly, infertility services, including ART, represent an elite medical consumer item that is not broadly or equally accessible.

One of the most widely cited studies in recent years examined the utilization of ART in the "equal access setting" of a military base—in this case the Walter Reed Army Medical Center—where ability to pay was a nonissue. Remarkably, "African-American women utilized ART services at a fourfold greater rate than [they did] in the U.S. ART population" (Feinberg et al. 2006: 893). Overall, black and white utilization rates of ART were proportional to the actual population of these groups in the US military. Specifically, whites were 64.2% of the total military population and 66.9% of the users of ART at Walter Reed Army Medical Center; blacks were 19.1% of the total military population and 17.4% of the users of ART at Walter Reed Army Medical Center (Feinberg: 890). Interestingly, Hispanics still underutilized ART at Walter Reed compared to their total population in the US military, but researchers did not offer an explanation for this disparity. Although limited in scope, this study suggests that removing the factor of socioeconomic inequality would partly reduce the inequality of access to ART.

In addition to charting the phenomenon of disparate access, this study and several others have also pursued the question of disparate outcomes: why there appears to be a racial disparity in how well women do with ART when they use it. The most obvious indicator of success with an ART cycle is whether it results in a live birth, but outcomes are also measured and compared according to clinical pregnancy rates, implantation rates, and spontaneous abortion rates. Data about disparate outcomes according to race are not conclusive. Not all studies agree that racial differences in outcomes are statistically significant. However, where differences are noted, nonwhite women seem to fare worse. For example, studies have found that leiomyomas (uterine fibroids) are linked with lower live birth rates after ART and that African-American women seeking infertility treatment tend to have more uterine fibroids (Seifer et al. 2008; Quinn and Fujimoto 2016). Data show that African-American women tend to endure more months of infertility compared with whites before seeking treatment (Seifer: 1706). Delays in seeking treatment may decrease the probability of success. A separate study found that premature progesterone elevation on the last day of ART stimulation is linked with lower live birth rates after ART and that nonwhite women seeking infertility treatment are more likely to have premature progesterone elevation (Hill et al. 2017: 159). Unfortunately, these studies do not address the causes of these underlying health issues or why certain groups of women are more likely to have them, leaving many questions unanswered.

Looking for an explanation for racial disparities in ART outcomes is complicated. The search begins on shaky ground because the initial categorization of patients by race is not firm. Many clinics actually do not report the race/ethnicity of their patients undergoing IVF cycles (Wellons et al. 2012). A systematic review of Society for Assisted Reproductive Technology (SART) Clinic Outcome Reporting System (CORS) data from 1999 to 2007 found that "more than 35% of cycles could not be used for comparisons of racial/ethnic groups and reproductive outcomes because the data on race/ethnicity were indeterminate" (Wellons: 407). Thus, incomplete information undermines the reliability of claims of racial disparity.

In addition to the indeterminacy of how clinics categorize their patients, there is a more fundamental question about the ambiguity of race itself. Legal scholar Dorothy Roberts's claim that it is counterproductive to seek "biological explanations for social problems" is relevant here (Roberts 2014: 1779). Race is not a natural or biological category but rather a socially constructed one. As such, it might be more accurate to talk about "health inequities" rather than "health disparities," to use Roberts's preferred wording, because differences in a health are so often the "result of unjust distribution of social, economic, political, and environmental conditions" (Roberts 2012: 333). For Roberts, the point of highlighting racial disparities in medical outcomes is not to point back to race itself as a cause but to raise our awareness about social inequality as the root cause of poorer health outcomes. Indeed, some studies even suggest that racial disparities in health may be the product of racism itself. For example, "[F]oreign-born non-whites [in the United States] have better health outcomes than their U.S.-born counterparts—outcomes that decline the longer the non-white person lives in the U.S." (Russell: 48).[1]

For their part, scientific researchers who seek explanations for racial disparities in ART outcomes generally seem open to the possibility that these disparities could be the result of "biologic differences":

> Although access to care differs for whites and racial minorities, it is unclear if IVF outcomes vary as a result of biologic differences with a host of other contributing factors, or if these outcomes truly represent a disparity in medical care. Of course, any study of racial and ethnic variation is complicated by social, cultural, nutritional, environmental, physical, metabolic, and genetic confounders. (Quinn and Fujimoto 2016: 1122–23)

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[1] Russell is citing the work of Thomas LaVeist. 2005. *Minority Populations and Health: An Introduction to Health Disparities in the United States*. San Francisco: Jossey-Bass.

Identifying confounding variables and getting to the bottom of true causes seem exceedingly complex. However, as Roberts suggests, the search for biological explanations may not be as helpful as a more thorough-going investigation of the social context surrounding ART use, including the "unjust distribution of social, economic, political, and environmental conditions" (333).

To be clear, the Walther Reed Army Medical Center study provides an encouraging example of what can happen when one factor of inequality—the inability to pay—is removed from the equation. It is not surprising to learn that reducing economic barriers would lead African-American women to use ART in equally proportionate numbers to whites. However, other types of barriers yet to be explored must still be in play if not all ethnic groups began using ART at Walter Reed in numbers proportional to their population. In addition, research that seeks to identify racial disparities in ART outcomes and pinpoint their causes is commendable insofar as its underlying motivation is to enable better ART outcomes for everyone. However, such research may be limited in what it truly illuminates.

Merely pointing out disparities in ART access and outcomes may not go far enough toward decentering whiteness in bioethical analysis in this case. Calling for equal treatment may not go far enough in interrogating the assumption that the white experience is the normative experience while everything else is a deviation from that norm. As Camisha Russell writes, "It is not simply a matter of applying bioethical analysis to the problems of marginalized people (to 'help them out' or 'be more fair'). Rather it is a matter of making bioethics more genuinely universal in its scope by gathering more perspectives…as a means of obtaining a more comprehensive (and more just) view of the world" (Russel: 49).

Problematizing the Center: "Lean-In" Feminism and the Unified Sisterhood Fantasy

How else could we look at assisted reproductive technologies in a way that would decenter whiteness? In an article entitled, "Differences from Somewhere: The Normativity of Whiteness in Bioethics in the United States," bioethicist Catherine Myser argues that:

> The dominant white center must be problematized, displaced, and relocated for diversity work to make a difference in determining what counts as an ethical issue and to adjust or revise dominant bioethics values (e.g., hyper individualism and truthtelling) and concepts (e.g. autonomy) (Myser 2013: 7).

Bioethics has been rightly criticized for mistaking the white experience as the universal experience (Wolf 1999: 71). For its part, feminism has also been rightly criticized for mistaking the white experience as universal (Hull et al. 1982; Crenshaw 1991; Harding 2004). In Sandra Harding's words, "Feminism has a long history of association with bourgeois Liberal rights movements, racially and ethnically discriminatory projects, heteronormative understandings, and other theoretical luxuries available to women from the dominant groups" (9). But white experience is as particular, biased, and subjective as any other. A white perspective is not a neutral, objective perspective. White cultural values have their own normative content (DiAngelo 2017).

Given their disproportionate use by white women, assisted reproductive technologies (ART) in general—and perhaps social egg freezing most pointedly—provide an opportunity to discuss the particularity of these white values and problematize this dominant white center. I single out social egg freezing for closer examination in this paper largely because it is a special case of ART, one done for "elective" rather than "medical" reasons and one aimed at preempting or circumventing age-related fertility decline rather than actually treating infertility in the moment. Social egg freezing is an "extreme" case of ART in that epitomizes in a dramatic way some of the most common assumptions about the values that motivate its use. The decline of women's fertility after age 35 is a biological reality. Delayed childbearing is a social reality. How will women who want to have children in today's world make it work? Although data on who uses egg freezing are much more limited than data about ART generally, the marketing for social egg freezing in the United States is explicit, enterprising, and revealing. The targeted consumer is almost always white and affluent. Likewise, the abundant popular media discussion of social egg freezing reveals some of the assumptions at work.

What are some of the values that seem to drive egg freezing? In one interpretation, social egg freezing assumes a time-limited "race" for marriage, parenthood, education, career, and social status. The legitimacy of all facets of this race is presumed; egg freezing provides a way for women to stay in the game. Egg freezing assumes life plans are driven by consumer preferences and individual choices. Egg freezing does not require a restructuring of society to make it easier to combine employment with childbearing. It does not seek fundamental change. It enables privileged women to access more privilege. It assumes financial plenitude rather than scarcity. It assumes that biogenetic ties (and racially homogeneous ties) are valuable and worth the considerable expense. To follow this interpretation to its logical conclusion, egg freezing is an application of the "lean in" advice Sheryl Sandberg offers to the ambitious and talented (Sandberg 2013). More specifically, it is the application of a "lean in" model of feminism to the problem of the biological clock: be proactive, preempt age-related fertility decline, keep your options open, and stay at the table.

In addition, the attention given to the elite experience of egg freezing reveals how "what counts" as an important issue of reproductive healthcare may be skewed by the dominant white center. Inadequate access to basic health services like preventative screenings, prenatal care, birth control, and abortion and political threats to these basic services arguably deserve more attention than egg freezing. These issues certainly affect more people. However, the feminist bioethical analysis of egg freezing has not generally conceptualized or critiqued it in ways that have traveled very far outside this individualistic frame. White bioethicists/white feminists have asked: will egg freezing provide greater autonomy or not (Harwood 2009)? Will it be a form of affirmative action in the workplace or not (Goold and Savulescu 2009)?

These questions assume that the ultimate goal of gender equality is equality with (white) men in the (white) workplace. The goal of healthy (white) babies is perhaps also assumed, if unstated.

But as black feminists have been arguing for decades, and as should be abundantly clear after the 2016 US presidential election, whiteness is not representative of all experience. As aptly stated in this post-mortem of the 2016 election: "For many women of color, white feminism feels less like a unified fight for the liberation of all women, and more like a campaign to ensure white women have the same status, rights and privileges as white men, and thus the corresponding power to oppress black and brown people" (Lasha 2016). Ninety-four percent of black women voted for the female candidate for president, Hillary Clinton. The majority of white women voted for now President Trump (Rogers 2016). One of the lessons of that historical moment was the thorough debunking of the myth that white women would vote for women's interests generally. What we saw instead, in the case of white women, was race and class interests trumping gender.

Here I would pause to emphasize the obvious: that the myth of a unified sisterhood has been a problem for feminism for a very long time, at least since the days of the American suffrage movement, if not before. Simone de Beauvoir's observation in 1949 remains just as true today: "As bourgeois women, they are in solidarity with bourgeois men and not with women proletarians; as white women, they are in solidarity with white men and not with black women" (de Beauvoir 2011: 8). The stereotypical white woman's experience of infertility, ART, and egg freezing, as sketched above, is just that: a stereotype. It does not represent all women's experiences. It is not the basis of a unified solidarity of women's interests. It is not the basis for universal pronouncements from bioethicists about "generic" patients.

All of this brings me back to the perspective of one particular person of color: Reniqua Allen, the op-ed author quoted at the outset who was considering freezing her eggs. Allen worries about her decision in ways that would not burden a "typical" white woman. She writes:

> Considering this procedure opens up the possibility that I could become a single mom as a black woman. I worried about becoming a stereotype, a stigma, despite coming from a loving, stable, middle-class single-parent home myself. (Allen 2016)

Notably, a recent study of women who froze their eggs for nonmedical reasons found that the top reason for not using frozen eggs to become pregnant was not wanting to become a single parent (Hammarberg et al. 2017: 579). In fact, 41% of the women surveyed chose "do not want to be a single parent" as the reason for not using stored eggs (more than any other reason). The study, conducted in Australia, did not indicate the racial or ethnic identity of the respondents. Demographic data were collected for the respondents' age, relationship status, level of education, occupation, and private insurance status, but not race. Are we to assume that race is irrelevant and/or that the respondents were all white? It would be a false equivalence to say that Allen's fear of being a stigmatized black mother in the United States is the same as these women's aversion to becoming single parents in Australia. There is no generic patient-consumer of egg freezing, only the situated experience of particular individuals.

Reniqua Allen sees herself as an individual choosing and at the same time identifies as a member of a group whose choices have been curtailed and criticized. She writes:

> It felt like my community had been left behind in this new path to maternal “empowerment” that centers on elite white women, who have long been thought of as the model of femininity and motherhood (Allen 2016).

The “lean in” empowerment message is not lost on Allen, but she recognizes it does not apply to her. The advertisements she sees feature white women and white babies. The clientele of the clinic is almost entirely white.

In addition, Allen perceives racial discrimination as transcending class boundaries. Whether poor or middle class, black women’s reproductive choices are not respected, including the choice to subordinate having a baby to other life goals:

> Poor black women are criticized for having too many babies they “can’t afford” and professional middle-class black women are criticized for being too picky and not finding a man. But when professional white women follow these same patterns, it’s often labeled a trend or brave or empowering (Allen 2016).

Allen is writing here about personal experiences and perception, but she is also referencing the power of cultural approval or condemnation. “Who gets to be a ‘legitimate’ mother in the United States?” (Ross and Solinger 2017: 3). Interestingly, contrary to the common narrative, recent studies suggest that delayed childbearing may not actually be due to the prioritization of professional goals but simply the lack of a suitable partner. According to the authors of the study from Australia:

> Although the increasing age of childbearing observed in most high-income countries is often framed as a result of women electing to pursue other life goals before having children, evidence suggests that the main reason for women having children later in life is the lack of a partner willing to commit to parenthood (Hammarberg et al. 2017: 579).

This news—this superficial commonality among unpartnered women—might be cold comfort to Allen, who experiences a racially specific inhibition and anticipates a racially specific stigma.

Allen describes her visit to a New York fertility clinic and shares her thoughts upon seeing only one other black woman in the crowded waiting room. She wonders to herself, “Did [this woman] have concerns about stigma? Lingering worry about the history of black women and forced sterility treatments…? Fear that she would be seen, negatively, as a ‘baby mama?’” (Allen 2016). She makes no assumptions about the experiences and perception of this other woman, and even refrains from speaking to her, writing, “[R]acial solidarity today can be a tricky thing, valuable to some and a disdainful reminder of the past to others” (Allen 2016).

Allen’s self-examination demonstrates there is no neutral space from which to consider using egg freezing. Individual acts of reproductive autonomy are not unfettered acts of the will but take place within a complicated social context. Her concluding thoughts express hope for the possibility of true freedom of choice and a thorough revision of norms: “I want black women to feel like egg freezing isn’t just for their rich, white peers and to know that we, too, can make unconventional decisions the norm” (Allen 2016).

This extended examination of one woman's perspective helps to problematize the dominant white center because it brings specificity and particularity to the discussion of ART. This one individual author is asking for specific changes: better information about reproductive options, inclusion in the marketing for egg freezing, inclusion in physician's consideration of who counts as a legitimate candidate for egg freezing, more freedom in decision-making, freedom from stigma, and more. Her experiences and perceptions help to displace the white experience as the normative experience, they displace the idea that there is generic patient in bioethical analysis, and they "make a difference in determining what counts as an ethical issue" (Myser 2013: 7).

Decentering Whiteness as an Ongoing Responsibility of Feminist Bioethics

I would like to make three points about what I see as the ongoing responsibility of feminist bioethics to decenter whiteness in its analysis, following up on my earlier claim that not enough work has been done. First, decentering whiteness requires a consideration of epistemic limits and privilege, including the epistemic advantage of what has been called "insider-outsider" status. Second, decentering whiteness in feminist bioethical analysis requires a questioning and broadening of the goals of feminism itself, including questioning the conceptualization of equality as equality with white men and advocating for reproductive justice that ends oppression for all. And finally, decentering whiteness calls for an embrace of empathy in service of a more responsive and flexible worldview.

The Epistemic Advantage of "Insider-Outsider" Status

Moving race from margin to center, in the famous words of Bell Hooks (1984), and thus perceiving reality more clearly, requires a consideration of epistemic limits and privilege. Decades of controversy have dogged feminist standpoint theory because critics fear that it implies both essentialism (i.e., that all members occupying a certain "standpoint" or social location see and know in exactly the same way) and automatic epistemic privilege (i.e., by virtue of one's social location or membership in a particular disadvantaged group, one automatically has superior knowledge) (Wylie 2003: 28). But the project of decentering whiteness need not fall victim to these critiques of standpoint theory, in part because the critiques have been answered with refinements of the theory.

For example, the insights of feminist standpoint theory have been refined by the insights of intersectionality (Crenshaw 1991). All of us stand at the intersection of multiple identities, to summarize the most basic starting point of intersectional feminism. Greater awareness of the multifaceted nature of our identities decreases the temptation to "essentialize"—because we know to look only at someone's gender, or only at someone's race or class, will ignore the points of intersection of gender, race, and class. This greater awareness encourages us to value the perspective of an individual person like Reniqua Allen without "essentializing" her experience or making it stand in for the experiences of all African-American women. Allen's story has complexity and meaning, and it is her story to tell.

Although claims of automatic and all-encompassing epistemic privilege may be indefensible, feminist philosophers have satisfactorily defended the idea that some epistemic advantage is possible. One of the most basic premises of feminist standpoint theory is that "the social identity and position of inquirers themselves can be relevant to inquiry produced" (Roth 2016: 29). That is not to say that one's social identity is wholly determinative, only relevant. Amanda Roth, drawing on Alison Wylie (2003), has argued that having an "insider-outsider" status can be especially illuminating. "Insider-outsider" status refers to the ability to travel back and forth between center and margin, to perceive and understand both the cultural cues of a dominant group and those of marginalized group. Somebody like Reniqua Allen, who is both a professional woman and also a member of racial minority, experiences both margin and center, both inside and outside the dominant culture, and therefore sees more and sees differently than the person who is only one or the other. Some call this epistemic superiority. I am happy to call it epistemic advantage.

To let the call for decentering whiteness be sidetracked or sidelined by concerns about essentialism is already to discredit the call for decentering before one has done any of the work. To let the call for decentering whiteness be defeated by objections that some people are claiming better insight and knowledge by virtue of the complexity of the social worlds they inhabit is similarly to abandon the effort without adequate justification. It is to forfeit, out of fear and prejudice, the opportunity to recognize and respond fully to the unbalancing, the refocusing, the revising, and the disorienting changes that *necessarily* must accompany a displacement of the dominant center. In other words, the critiques of feminist standpoint theory are overblown and ultimately distract from the work of decentering whiteness.

As should be increasingly clear, the benefits of engaging in the project of decentering are significant, and the costs of not doing so are even greater. There is a great deal of intersectional work already being done by a number of well-established activist organizations like SisterSong, Fertility for Colored Girls, Black Women's Health Imperative, New Voices for Reproductive Justice (New Voices Pittsburgh), Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR), and Native Youth Sexual Health Network, to name a few. These groups are defining for themselves what count as the most important priorities in women's reproductive health, and they are a source of advocacy and empowerment for many women of color.

Avoiding Conceptual Tokenism

Second, the project of decentering whiteness is not merely a reordering of priorities or treating race as an "add-on" to generic patients who are analyzed by generic principles. It is instead a more fundamental reconceptualization of how problems are defined and solved. To return to Camisha Russell:

> In the case of bioethics… I would argue that philosophers of race must insist upon not only the necessity, but also the *centrality*, of discussions of race to the broader field. They must show that there are vital lessons to be drawn from the experiences of racial minorities for bioethics *as a whole*. (Russell, 49)

This position is shared by African-American philosopher Charles Mills, who speaks more generally about the discipline of philosophy (not the sub-field of bioethics) in his work "Philosophy Raced, Philosophy Erased" (2012).[2] Mills emphatically rejects "conceptual tokenism," which he describes as a half-hearted effort to bring race into the core of one's analysis. Conceptual tokenism occurs when:

> [A] black perspective is included, but in a ghettoized way that makes no difference to the overall discursive logic of the discipline…in question: [including] the framing assumptions, dominant narratives, prototypical scenarios. (Mills 2012: 54)

His critique of conceptual tokenism is tied directly to his criticisms of philosophy:

> [T]he conception of the discipline [of philosophy] itself is inimical to the recognition of race. Philosophy is supposed to be abstracting away from the contingent, the corporeal, the temporal, the material, to get at necessary, spiritual, eternal, ideal truths. Because race as a topic is manifestly not one of those eternal truths… it is necessarily handicapped from the start… Philosophy aspires to the universal, whereas race is necessarily local, so that the unraced (whites) become the norm. (Mills, 60)

Susan Wolf made very similar arguments about bioethics as a field: that it has "strained for universals, ignoring the significance of groups and the importance of context," and in so doing has failed to interrogate racist assumptions (Wolf: 70).

I agree. Conceptual tokenism should be consciously avoided in bioethics. Feminist bioethics should redouble its efforts to put race at the center. But what does this mean for how ART or egg freezing should be fundamentally reconceptualized? Perhaps it means foregrounding the extent to which reproductive technologies reproduce social inequalities and the extent to which they reproduce whiteness itself. Perhaps it means foregrounding whose reproduction has been historically suppressed and whose has been encouraged and taking steps to amend past wrongs. Perhaps it means letting go of liberal, idealized notions of equality as equality with white men and embracing instead the goal of reproductive justice that ends oppression for all.

Reproductive justice, as comprehensively explained in a new book by activists Loretta Ross and Rickie Solinger (2017), is a broader, more inclusive frame than what has previously been known as (white) pro-choice feminism. Pro-choice feminism prioritizes reproductive freedom but starts from a position of rarely interrogated privilege. For example, in discussing the impact of the landmark US Supreme Court decision, *Griswold v. Connecticut*, Ross and Solinger explained that women on the margins did not really benefit the way affluent white women did:

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[2] Mills worries, for example, that his work, especially *The Racial Contract* (1997), has had no impact on mainstream (white) political philosophy. He has tried to bridge abstract discussions of justice and rights with a concrete political discussion of racism, which, he argues, is itself a political system.

> Achieving this privacy right—having what amounted to the “negative right” to be left alone—was not likely to help women without those resources. If you didn’t have a private doctor, if you were poor, if you were African American, Mexican American, or Puerto Rican and the target of various forms of racism including population-control measures, then reproductive rights required much more clearly defined guarantees or “positive rights,” beginning with a safe and healthy place to live with your family in a community free of the impacts of chronic racism, a living-wage job, and access to comprehensive public health services, including, if you chose, contraception. (Ross and Solinger 2017: 119)

The reproductive justice movement, now in its third decade, is a good example of the kind of questioning and broadening of the goals of feminism that must take place. Significantly, reproductive justice foregrounds the right to have children, not just the right to avoid having them. It is attentive to the history of coerced sterilization, for example, so that experience provides a vital lesson for the present. The goal becomes ending oppression for all, not enabling a few to leverage their privilege in the name of gender equality.

Transformative Empathy

Finally, empathy is both a crucial prerequisite for decentering whiteness and also a byproduct of decentering whiteness, but I mean empathy in a very particular way—not simply fellow feeling but a transformative connection that realigns and expands one’s vision.

Some call feminism the radical notion that women are people and that a woman’s experience is not peripheral, strange, other but is in and of itself a complete human experience of a real and whole person, whose perspective is wholly legitimate as it exists, however it was constructed. If that is true, then intersectional feminism intentionally expands this notion to everyone in the human community, with all of their multiple, intersecting identities: race, ethnicity, sexual identity, class, and more. If we take these radical notions seriously, then we have to let the perceptions of particular individuals like Reniqua Allen fully inhabit our field of vision. And then we must look for more people and more examples, in order to increase our knowledge and understanding of the varieties of human experience.

The goal is not to minimize the particularities of human experience or to construct from them false universals but to allow the particularities of individual human beings to facilitate true empathy. It is forging the connection across difference that should be the focus of energy in philosophy, bioethics, and feminist bioethics.

As Patricia Hill Collins has explained, the goal is not separate, dueling worldviews, but rather distinct contributions to an inclusive humanist vision (Hill Collins 1990). Decentering whiteness is an inductive project that leads to the formulation of new values. Or in the words of Camisha Russell: “We must go beyond simply adding some attention to the problems lying at the margins of bioethics; we must look from the margins to the center in favor of something more expansive, more responsible, more respons*ive*, and much more flexible in terms of its worldview” (Russell: 49).

Conclusion

Raising awareness about the limitations of feminist bioethics, important though this work may be, is only a preliminary step. The deeper question for further consideration is whether the field we call "feminist bioethics" should really be renamed "white feminist bioethics" or whether it is possible to realize Patricia Hill Collins's inclusive humanist vision, which would be built on a much more diverse range of voices and perspectives. This paper has only attempted to contribute to the first, preliminary step by calling attention to the limitations of feminist bioethics in the case of ART. Notably, it has been an exercise in self-reflection, as my own previous writing on egg freezing has placed it squarely within the framework of reproductive choice and autonomy.

White feminism/white feminist bioethics needs to examine the ways in which it has perpetuated the oppression of people of color in its single-minded pursuit of the goal of equality with men in the workplace, in parenting choices, and in society generally. Decentering whiteness changes the conversation, changes the identification of the problem, and changes what looks like a solution. The goal becomes instead ending oppression for all, not expanding or hoarding privilege. The more often voices like Reniqua Allen's can command attention and take center stage, the more likely feminist bioethics will remain vital and relevant in the twenty-first century.

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