



Creating Space for Feminist Ethics in Medical School

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Abstract

Alongside clinical practice, medical schools now confront mounting reasons to examine nontraditional approaches to ethics. Increasing awareness of systems of oppression and their effects on the experiences of trainees, patients, professionals, and generally on medical care, is pushing medical curriculum into an unfamiliar territory. While there is room throughout medical school to take up these concerns, ethics curricula are well-positioned to explore new pedagogical approaches. Feminist ethics has long addressed systems of oppression and broader structures of power. Some of its established concepts can offer distinct value as medical climates change and adapt in response to increased awareness of the experiences of marginalized individuals and populations. In this essay, we offer a set of concepts from feminist ethics that have a fundamental role to play in medical school curriculum: *relationality*, *relational autonomy*, and *epistemic justice*. Though these concepts are not exhaustive, they can be taught in tandem with the concepts that have historically grounded ethics education in medical school, such as autonomy and beneficence. Ultimately, we contend that these concepts hold particular value in ethics curriculum insofar as they diversify mainstream ethical approaches, directly address the pervasiveness of systems of oppression in medicine, and recognize the voices and concerns that may be marginalized in standard approaches.

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Introduction: Critical Concepts

Because medical school curriculum is overwhelmed by clinical science and experience, it can be difficult to find space for nuanced ethics education and practice. There is a compulsion to teach the very basics of mainstream ethics, such as respect for autonomy and informed consent, obligations towards beneficence and non-maleficence, all of which may appear on the United States Medical Licensing Examination (USMLE). And yet, medical school and clinical practice now confront mounting reasons to examine nontraditional approaches. Increasing awareness of the relationships between medicine and systems of oppression—racism, cis-sexism, homophobia, transphobia, classism, ableism, xenophobia, etc.—is pushing medical training into unfamiliar territory. Students report, and studies confirm, evidence of ongoing discrimination related to systems of oppression in medical training (Bullcock et al. 2019; Low et al. 2019; Witte et al. 2006). Unsurprisingly, medical practice continues to struggle with the influence of these same forms of oppression (Phelan and Link 2015; Miller 2019; Williams and Cooper 2019), such as the well-known association between racism and inadequate pain management (Sabin 2020). As many have recognized, these issues demand attention in medical school curricula and medicine more broadly.

Feminist ethics holds promise here. Not only does it play a fundamental role in addressing structures of power and injustice in medicine, but it also offers alternative and diverse perspectives regarding a multitude of ethical conflicts and uncertainties. As the practice of medicine continues to shift towards a deeper understanding of the social determinants of health and underlying structures of power, feminist ethics can offer a complimentary ethical groundwork. It is “a way of doing ethics” (Lindemann 2019, p. 4) that begins from how social location, social norms, and institutions influence our understanding and application of ethical value.

Feminist ethics is a vast discipline, but there are several concepts that are particularly fundamental to preclinical and clinical training. Much like the concepts of *respect for autonomy*, *beneficence*, and *non-maleficence*, we suggest including the concepts and related practices of *relationality*, *relational autonomy*, and *epistemic justice*. While not exhaustive, it is argued that these concepts hold distinct value and should be considered part of the necessary groundwork in ethics education in medical school.

Feminist Ethics as a Distinct Standpoint

Feminist ethics categorizes a broad range of ethical approaches and concepts that are grounded in feminist theory and related fields, such as social theory, critical race theory, and disability theory. Feminist ethics related to medicine in particular, began as a response to the formation of the field of bioethics in the West that largely occurred in the latter half of the twentieth century. The field has both offered important critiques of mainstream bioethics as well as proposed alternative standpoints and processes for ethical analysis in medicine. Feminist ethics centralizes relations of power, attending to how different structures of power or systems of oppression

might affect the practice of medicine and the field of healthcare. For instance, in one of the first books on feminist ethics in medicine, Susan Sherwin critiques the patriarchal practice of medicine for failing to include the voices of women. One example she provides is the neglect of women in healthcare research (Sherwin 1992, pp. 158–175). The power imbalance between *cis*-men and *cis*-women has led to a failure to include *cis*-women's bodies and voices in healthcare research, leading to medical practices and therapies that do not adequately take *cis*-women—as well as transgender and non-binary gender identities—into account.

The tools and approaches of feminist ethics have sometimes been taken up by mainstream bioethics, but not as a distinct framework. Often feminist ethics is either neglected or subsumed in small ways under mainstream frameworks. For example, care ethics is a particular ethical theory within the broader field of feminist ethics. Care ethicists largely define the approach as a distinct moral theory, on par with deontology, utilitarianism, and virtue ethics, rather than a critique that should adjust the considerations of mainstream views. Virginia Held's *The Ethics of Care* begins by outlining the view that ethics of care can be understood “as a moral theory” distinct from other theoretical frameworks insofar as it is grounded in relations, dependency and emotions, as opposed to individuals, independence and rationality (Held 2006, pp. 13–22). And yet, Beauchamp and Childress, whose four principles have been widely influential in medical ethics training, address care ethics in a small subsection of their chapter on “Moral Character,” where a few of care ethics' important tenets are subsumed under the more mainstream framework of virtue ethics (Beauchamp and Childress 2019, pp. 35–38).

This is a small example that reflects a broader culture in which feminist theory is marginalized in medical education (Bleakley 2013; Sharma 2019). But there is good reason to draw feminist ethics to the center of medical ethics curricula. While the exploration of feminist ethics in medicine began with a narrower focus on issues related to *cis*-women's health, such as reproduction and assisted reproductive technologies, it has expanded to a plethora of issues related to sex, gender, race, ability, age, and other intersecting identities that are differently privileged or marginalized. Although feminist ethics has been rightly criticized for not being adequately inclusive, failing to acknowledge, for example, the voices of women of color and non-binary gender identities, most feminist theorists see their underlying motivation as overcoming all forms of oppression (Sherwin 1992, pp. 26–27, 222–240). Because the field is centrally concerned with structures of power, it provides tools to analyze oppression and respond to it in all areas of medicine, not merely reproductive health or health issues related to gender-based discrimination. This is critical in a medical climate that is becoming increasingly aware of how power and oppression impact medical culture, interprofessional interactions, clinician-patient interactions, as well as individual and public health.

Moreover, feminist theory has helped clarify ethical uncertainties in clinical settings where mainstream approaches have been unsatisfactory. For instance, feminist and disability theorists have emphasized the social construction of disability (Wendell 2006). This means understanding that disability cannot be reduced to a biological impairment, such as the loss of a limb or a brain injury, and must be understood within a social context that creates and deepens disability. For instance, a person

who depends on a wheelchair for ambulation *only becomes* disabled within social conditions that prevent ambulation via wheelchair, such as a lack of elevators, wide corridors or sidewalks. Similarly, a patient with cognitive disability may be perceived as unable to make medical decisions for themselves, when in fact they can do so with the relevant support, such as supportive decision makers (Kripke 2016) and decision aids (Stacey et al. 2017). Thus, understanding the social construction of disability—including who has the power to define disability and evaluate the quality of life for those with disabilities—is vital knowledge for clinicians who may not have personal experience with disability and may need to examine their own biases.

Today, feminist ethics is getting more attention in the setting of the #MeToo movement. The mechanisms through which systems of oppression operate in medicine, such as unfair wages (Paturel 2019; Weeks et al. 2009), sexual harassment (Witte et al. 2006), and generally hostile work environments (Miller 2019), are directly addressed by feminist ethics. But equally important is the role feminist ethics can play in offering a diversity of ethical considerations in complex medical-ethical contexts. Standard ethics curriculum in medical school could benefit from distinctly feminist theory and praxis. In what follows, we maintain that the concepts of *relationality*, *relational autonomy*, and *epistemic justice* have distinct value in medical ethics. When theoretically discussed and implemented in praxis, they (i) diversify mainstream ethical approaches, (ii) directly address social power and systems of oppression, and (iii) reinforce cognizance of marginalized voices and perspectives.

Critical Concepts from Feminist Ethics for Medical Students

Depending on the space for ethics curricula, an in-depth treatment of feminist ethical theories may not be possible, even if valuable, in medical school education. However, there are key concepts and related practices that are easily translatable to medical students and fit well with their basic science curriculum and clinical training. Our approach here is similar to what has been built from traditional ethical theories: deontology produced the concepts of autonomy, informed consent, and dignity; utilitarianism the concepts of best interests, harm, beneficence, and nonmaleficence; virtue ethics the concepts of character, professional identity, and a variety of relevant virtues. Likewise, feminist ethics provides similarly fundamental concepts in medical ethics: relationality, relational autonomy, and epistemic justice. We do not intend these concepts to be exhaustive, but rather demonstrative of the fundamental role that feminist ethics can and should have in medical school curriculum.

Relationality

The concept of *relationality* is meant to capture the relational nature of human beings. Humans are dependent, vulnerable beings, who lead lives enmeshed in relationships with other persons, communities, and social norms. They are essentially “second-persons” insofar as their survival and development depends on other persons, and their identities are formed through those relationships (Baier 1981). As Virginia Held explains, “moralities built on the image of the independent,

autonomous, rational individual largely overlook the reality of human dependence and the morality for which it calls” (Held 2006, p. 10). There are few places where this is more evident than medicine.

In some cases, a relational perspective is necessary for understanding the value systems that shape medical decisions. The values of a relationship, family, or community can sometimes displace individual interests, such as when parents make decisions that are fundamentally driven by their relationships with their children. Patients and families sometimes make medical decisions that seem to place their family or community above their own interests, possibly even risking greater individual harm. But a more relationship-based understanding of these cases reveals that many individuals see these relationships as fundamental dimensions of their own identity and well-being. While it will always be important to consider the autonomy and interests of particular individuals, it may be equally important to understand relation-based values and well-being.

The paradigm case of Baby Aaron exemplifies this perspective. Baby Aaron had significant congenital heart disease and a pediatric oncologist believed the child’s prognosis was excellent with open heart surgery to correct the defect, but the parents declined the intervention (Clayton and Kodish 1999). The parents understood that their child would die without the procedure and cited their community’s values as the primary reasoning for their decision to take their baby home. Baby Aaron and family were a part of a local Amish community. The parents referenced a recent decision made by the Church Elders to decline a medical intervention for another member of their community that was “beyond the will of God”, which they felt paralleled their son’s case (Clayton and Kodish 1999, p. 20). The complexities of this case can be difficult to grasp from an individualist moral perspective, which would typically try to weigh the obligation to protect the “best interests of the child” against respect for parental authority and choices. The problem with this approach is that Baby Aaron, his parents, and their community are not easily separable entities. As Wightman et al. articulate regarding parent–child relationships,

The value of the parent–child relationship cannot be broken down into individual gains and losses for the individual members in the relation. Nor can it be understood in universalistic terms, as there is a plurality of caring parent–child relationships. What matters in a caring parent–child relationship is both the health and well-being of the individuals-in-relation and the health and well-being of the relationship(s) as a whole. (Wightman et al. 2019, p. 20)

This means that what constitutes the best interests and well-being of the baby cannot be decided without understanding what is in the best interest and well-being of the family and community as well. Moreover, the well-being of each relationship matters in its own right, not just because it matters to the constituent individuals.

For instance, when the pediatric oncologist offers to go to the community and talk with the Church Elders to educate and persuade the parents and community, she acts from an individualistic perspective about what is in Baby Aaron’s best interests (Clayton and Kodish 1999, p. 20). She strives to persuade the family and community of the value of the child’s life and the protections medicine has to offer, without clear cognizance of what well-being means for the family and community. Ultimately,

privileging the individual life of the baby, without considering (i) the baby as he stands in relation to his family and community and (ii) the values and well-being of the family and community as a whole, may be disruptive and disrespectful. The family and community may feel disrespected, they may come to distrust the medical provider and institution as they continue to decline medical interventions, and their care for Aaron may be less robust without the additional support of the medical institution. A relational perspective helps to recognize the damage that can be done to caring and trusting relationships in addition to the risks of harm and disrespect to particular individuals. This perspective would compel the cardiologist to consider the well-being or flourishing of the relationships between the baby, family and community, as well as those between the medical institution and the community it serves. Thus, facilitating a more robust ethical analysis of the case.

Similar to ‘autonomy’ and ‘beneficence’, education about ‘relationality’ need not rely on specific moral theories, such as communitarianism or care ethics. Practice understanding and applying this concept can help beginning learners in medicine to understand the fundamental values of familial, communal and societal relations for Baby Aaron and his parents. These relationships are important in part because they support the well-being of individuals but also as distinctly valuable elements of a flourishing life and society. In fact, it is challenging to separate the two; individuals are never fully separable from their relations, and relations are never fully separable from the individuals that constitute them. Relationships, like individuals, are ontologically basic (Noddings 2013, p. 4) and their value should be accounted for in conjunction with the values of protecting an individual baby’s life and respecting parents’ choices.

Moreover, a relational perspective would encourage recognition of different social norms, thus acting as a check on systems of power. For instance, if the pediatric oncologist only sees meeting with the Church Elders as an opportunity to educate the community, then she is perpetuating a system in which the knowledge and values of the particular community are subjugated to the knowledge and values of the medical institution. Meeting with this Amish community may foster health and well-being as long as the healthcare professional is cognizant of the influences of relevant social norms and structures of power. This is important to consider alongside the life and well-being of Baby Aaron, as her efforts may not only fail to help Baby Aaron but also may cause harm to members of the community who may lose trust and no longer seek help from healthcare professionals outside of their community. Likewise, students can practice engaging with families and communities, seeing these interactions as opportunities to be educated about the values of the community and build ongoing relationships with the community. Without this perspective and practice, students, like the above pediatric oncologist, might both fail to secure a patient’s best interests and damage trusting and caring relationships with a community.

The concept of relationality is useful in these contexts because it helps to direct attention toward the interstices of the relationships in addition to the perspectives, well-being and values of particular individuals. As Held argues, “those who conscientiously care for others are not seeking primarily to further their own *individual* interests; their interests are intertwined with the persons they care for... they seek

to preserve or promote an actual human relation between themselves and *particular others*” (Held 2006, p. 12). Medical students can conceptualize this in the classroom at an early stage and practice its applications in their developing interactions with patients and families. By attending to *relationships*, alongside relevant *individual* autonomy, benefit and burden, students may come to a more robust understanding of ethical obligations, conflicts and uncertainties. When ethical dilemmas arise, grasping the relational elements can be essential to finding a solution that is practically suited to human dependency, recognizes the value of relationships in human health and well-being, and offers a check on the structures of power that can obstruct ethical resolution.

Relational Autonomy

The principle of respect for autonomy is widely used in medicine and often taken to be synonymous with self-sufficiency, independence, self-reliance, self-realizing, self-governance, and used alongside concepts like rights, rationality, and interests (Code 1991, p. 78). This alignment between autonomy and individual self-governance can lead to (1) an overvaluation of independence, (2) an overly simplistic view of moral agents, and (3) suggests that dependency and relationality inherently threaten autonomy (Mackenzie and Stoljar 2000, p. 6).

Nonadherence to medical therapies provides a prime example of the different lenses through which one might interpret autonomy. Take the following case,

Beya is 42 years old and is dialysis dependent from end-stage renal disease secondary to type II diabetes and hypertension. Beya’s nephrologist has prescribed 4-hour runs three times a week. Beya seeks care at a local outpatient dialysis center five miles from her apartment. Although the center is close, it takes her 1–2 hours to get there by public transportation. She frequently misses dialysis runs. Either she does not show up for her appointment or she is more than 30 min late and the center’s policy is to cancel appointments after 15 min of the scheduled start time. Missed runs have led to medical emergencies which have resulted in five inpatient admissions this past year related to her need for urgent dialysis.

Patients like Beya may be misunderstood if autonomy is categorized as individual self-governance. Healthcare professionals may come to be frustrated with her for not adhering to her medical therapies and may consider no longer providing dialysis if she cannot reliably attend her outpatient appointments. They might worry that intermittent adherence will do more harm than good and wonder if Beya’s nonadherence is evidence of a choice to move towards comfort measures only.

In this context, the concept of relational autonomy can be vital to understanding Beya’s perspective and how to respond well to her care needs. As Mackenzie and Stoljar point out, making choices and acting as an agent depends on causal relationality and intrinsic relationality (Mackenzie and Stoljar 2000, p. 22). Social conditions may substantially affect Beya’s decision process, leading her to miss dialysis appointments or end runs early. Perhaps the commute to the center is too

far to be feasible some days, or she must balance hours at work with hours attending to her health, or she has dependents she must care for and sometimes places their needs before her own, or she experiences bias from staff at the center. Likewise, Beya's choices flow from who she is: what she identifies with and values. But her identity is enmeshed in social conditions and relationships. Perhaps her job or her family matters more to her than spending time attending to her health, or she doesn't see herself as someone who has good relationships with medical professionals because of a history of discrimination, or she sees missing dialysis as protecting herself from unnecessary harm that may result from going to the clinic and sacrificing other things in her life. These social values and relationships constitute her identity, and are the basis from which she makes decisions.

The point is that it can be counterproductive to think of Beya as merely limited by social conditions that are not constitutive of her and, therefore, she could decide to overcome. Such individualistic thinking could lead clinicians to convey strong warnings, hoping that she will "make better decisions." However, when clinicians consider social conditions and relations to be constitutive of Beya's autonomy and decision-making process, then they might instead work with Beya to change the social conditions and relationships in ways that cohere with her values and support her health. For instance, if Beya is avoiding the dialysis center due to experiencing some form of discrimination from staff, perhaps staff can be educated or Beya can go to a different center. Or, if Beya's job is threatened due to long hours at dialysis, perhaps there are options to change when and where Beya goes to receive dialysis.

Built on the above conceptualization of relationality, many feminist theorists have addressed the concept of relational autonomy, particularly in the context of medical decision making. Relational views of autonomy do not discount individual choices, experiences and identities, but rather recognize that individuality and independence are only possible in and through interpersonal and societal relationships. Choices and actions are formed with and through one's relationships with other beings and within intersecting social norms and cultures. While any individual may exhibit uniqueness and creativity, they are also fundamentally intertwined with others. In fact, truly autonomous choices and creative endeavors may depend on the perspectives of others to "liberate ourselves from our private idiosyncrasies" (Nedelsky 2011, p. 59) or may happen through intersecting and interacting relations that are transformative (Nedelsky 2011, pp. 55–56).

Consider the paradigm case of *Burton v. State of Florida*. Samantha Burton was a mother of two, 25 weeks pregnant, and a smoker, when she sought care at Tallahassee Memorial Hospital for premature rupture of membranes. Her obstetrician recommended that she stay in the hospital on bedrest and quit smoking. When Ms. Burton declined to stay in the hospital, the obstetrician obtained a court order that required her to stay on bedrest at the hospital and undergo "any and all medical treatments" her doctor, acting in the interests of the fetus, deemed necessary (Minkoff and Lyerly 2010, p. 13). Here, too, relational autonomy directs attention both to Ms. Burton's agency and the social conditions that might partly constitute her agency. One cannot fully grasp Ms. Burton's reasons without seeing her as a mother of two other children, who may reasonably make decisions to protect the health and well-being of

those two children, even at some cost to herself or a developing fetus. Additionally, relational autonomy recognizes the influence of social norms. According to traditional social conceptualizations of womanhood and motherhood, women are seen as passive, dependent, and responsible for reproduction. Understanding these norms would be critical to interrogating healthcare professionals' intuitions and reactions toward Ms. Burton's decision.

While more particulars of the case are needed for an adequate resolution of the ethical uncertainties, relational autonomy would assist this process by emphasizing different relational concerns that partly constitute a patient's medical decisions as well as systems of oppression that may inhibit a patient's agency. Thus, understanding the concept of relational autonomy can be crucial to actualizing the obligation to respect others and support their agency. As students learn to assess decisional capacity and understand patient's choices, they should practice reflecting on and integrating the social context through which decisions arise, making relational autonomy another key concept for beginning ethics learners in medical school.

Epistemic Justice and Injustice

Miranda Fricker coined the term *epistemic injustice* as a means to describe the kind of harm and disrespect that is specific to who counts as a knower and what counts as knowledge. Fricker explores two forms of epistemic injustice: testimonial injustice and hermeneutical injustice. Testimonial injustice refers to when a speaker is not given appropriate credibility. For instance, when a person of color reports severe pain in a healthcare setting, but clinicians doubt the report. Hermeneutical injustice refers to how a speaker can be unfairly disadvantaged by "a gap in collective interpretive resources" (Fricker 2007, p. 1). As a result, those in positions of power can more easily make sense of and communicate about aspects of their experiences (Fricker 2007, p.148). As Fricker demonstrates, hermeneutical injustice can be seen through the history of language like "sexual harassment" and "post-partum depression", which completely changed the way women understood their experiences of oppression and ability to affect positive change (Fricker 2007, pp. 148–152). Before the introduction of this terminology, women were not able to make sense of their experiences, sometimes blaming themselves, because they lacked the linguistic and conceptual resources to interpret their experiences differently from the dominant perspective of their male counterparts. There remains room for shifts of this kind in the hermeneutics of healthcare. For instance, a patient with a history of trauma may face difficulty articulating fear or discomfort in clinical environments because of a lack of shared social experience and resources, such as shared language, to facilitate communication. Practices of trauma informed care now try to bridge that gap by utilizing and familiarizing clinicians with open language around "safety", "resilience", "survivor of trauma", "recovery from trauma", etc. New or carefully chosen language and open discussion can help to make sure the experiences of marginalized patients contribute to defining and actualizing good care in this context.

Epistemic injustice is pervasive in medicine and can be informed or motivated by a variety of structures of power and oppression (Freeman and Stewart 2018, p. 418;

Fricker, 2007). It is found in the way that the knowledge of physicians can be privileged over nurses, such that the voices of nurses are discounted and their knowledge about a patient or medical condition fails to be taken up in the medical decision-making process. Likewise, the knowledge of clinicians can be privileged over the knowledge of patients, leading to medical decisions that do not adequately consider the patient's perspective and lead to inadequate care or inappropriate treatment decisions. The experience of Dax Cowart is a paradigm case of how the power imbalance in any clinician-patient relationship can render the patient, in virtue of being a patient, vulnerable to epistemic injustice. In 1973, Dax Cowart suffered extensive burns in a propane gas explosion and then underwent prolonged and immensely painful treatment (Cowart and Burt 1998). Cowart repeatedly pleaded, "please let me die", but his pleas and reasoning were not truly heard by his clinicians. Cowart's experience was formed by his lack of power as a patient in a culture of medicine that was far more paternalistic than it is today. He could not speak from "autonomy" and "right to control your own body", not because these words were not available but because they had not yet gained power in medicine (hermeneutic injustice). And his forceful pleas were silenced by the perspectives of his clinicians, who saw saving his life as their primary ethical obligation (testimonial injustice).

Thus, epistemic injustice can help to make sense of Dax Cowart's experience, which was not merely one of failed respect for autonomy, but additionally one of being unfairly disadvantaged in the politics of knowing. His experience of injustice resounds today through complexly interwoven structures of power. Patients are vulnerable to epistemic injustice not just as patients, but also because of their race, gender, ethnicity, sexual orientation, country of origin, religious beliefs, ability, access to secure housing, etc.

Although the term is not always used explicitly, its presence in patient narratives is profound. Consider some of the stories of patients who experience homelessness. Patients report avoiding discussion of their experience of homelessness with clinicians, even sometimes falsely stating that they have housing, in order to secure credibility and access to care (Greysen et al. 2013, pp. 448–451). In response, some healthcare professionals have tried to shift clinical language to be more sensitive to the experiences of those who experience homelessness. For instance, some suggest shifting away from language like "are you homeless?", which defines patients as homeless individuals rather than as individuals who are experiencing homelessness (Greysen et al. 2013, p. 451). The standard phrasing of the question disrupts the patient's ability to articulate their experience as it feels to them and to focus on the knowledge they have about their healthcare needs. Patients who experience homelessness suggest instead using questions like "do you have a place to stay where you feel safe?", which seeks the patient's knowledge about their experience and centralizes concern for the patient's well-being and safety (Greysen et al. 2013, p. 451).

Epistemic injustice is also prevalent in stories of patients of color who are perpetually misdiagnosed when clinicians do not give appropriate credence to their assessment of pain or concern for the severity of the problem. For instance, Bettina Judd articulates her experience of misdiagnosis of ovarian torsion, drawing connections to a long history of oppression of the experiences of women of color in medicine (Judd 2014; Vendantam et al. 2017). Similarly, many clinicians and

bioethicists weighed in on the ethical conflicts associated with the story of Jahi McMath, a 13-year-old who was declared dead by neurologic criteria after complications following a tonsillectomy in 2013. Jahi's parents pressed for ongoing treatment to sustain Jahi's life, and the public debated what constituted life and death as they watched the narrative of this family unfold. Less time and attention has been paid to the role of bias and how Jahi and her family claimed to have had knowledge that was dismissed by her clinicians, possibly leading to a death that may have been preventable. As Jahi's mother Nailah told journalist Rachel Aviv, "No one was listening to us, and I can't prove it, but I feel in my heart: if Jahi was a little white girl, I feel we would have gotten a little more help and attention" (Aviv 2018).

Nailah's concern demands attention to both testimonial and hermeneutical injustice in Jahi McMath's narrative. Jahi and her family may not have been treated as credible because of their intersecting identities as patient/family and people of color, perhaps causing clinicians to fail to adequately attend to their concerns and the evidence they pointed to (testimonial injustice). Additionally, the discourse both in the clinical environment and in resulting bioethical discourse focused primarily on the discussion of the meaning of death, largely avoiding the language of systems of oppression and bias (Goodwin 2018). The language is there, but the politics of medicine and ethics sometimes disallows open or direct expression and accurate reflection of one's experience (hermeneutic injustice). Could Nailah have said to Jahi's clinicians, "I'm worried about racism affecting my daughter's care"? It seems unlikely given how structures of power do not make room for this language or empower its use. If the hermeneutics of medicine permitted direct communication regarding systems of oppression, might that have changed Jahi's outcome?

In order to combat oppression and safeguard *epistemic justice*, Fricker asks that hearers take on a special sort of responsibility. She argues for a virtue of "reflexive critical openness to the word of others" (Fricker 2003, p. 154), such that hearers are cognizant of stereotypes and the possibility of prejudice. The goal is to remain open to the possibility 2003 a hearer can "fail to adjust for the way in which their own social identity affects the testimonial exchange" (Fricker 2003, p. 169). And being critically aware means to successfully "[correct] for the way testimonial performance can be prejudiced by the inter-relation of the hearer's social identity and the speaker's social identity" (Fricker 2003, p. 169). Studying and practicing this virtue is important at early stages of medical training (if not before). Medical environments rely on adequate and sensitive exchanges of knowledge so as to insure good care. At the same time, these environments can be drastically affected by structures of power and steeped in prejudice as the intersectional identities of clinicians and patients come to interact with one another.

Education around testimonial and hermeneutical injustice could substantially shape the way medical students understand some of their primary obligations to patients and colleagues in medicine. After all, clinicians too can face epistemic injustice from colleagues, families, and patients, so this terminology can help them to articulate their own experiences and seek institutional change accordingly. Thus, the terminology of epistemic justice becomes a tool that can help

to articulate harms, disrespect, and unfairness that are different than disrespect for autonomy and failures of beneficence. At the same time, a failure to appreciate epistemic injustice may lead to a lack of respect for autonomous choices (e.g., when a patient's reasons are not acknowledged as reasonable), or lead to harm (e.g., when important medical evidence is not taken into account). Thus, addressing epistemic justice and injustice alongside other core ethical principles should be fundamental to the education of medical students, who may face epistemic injustice in healthcare themselves and will soon enter a profession in which their role as physician confers a degree of authority and power to shape epistemic space and its role in the care of patients.

Conclusion: Finding a Feasible Pedagogical Approach

We hope to have offered a beginning structure for incorporating feminist ethics in medical school education. Nuanced conceptualizations of relationality, relational autonomy, and epistemic justice are found in feminist ethics and offer distinct value to both theoretical and practical training in medicine. Even students early in their medical program can grasp the basics of what these concepts have to offer, practice them with colleagues, and then continue to work through their nuances and complications as they gain clinical experience. As they begin to practice applying other ethics concepts, such as autonomy and beneficence, they should be able to simultaneously apply relationality, relational autonomy, and epistemic justice as key components of good care and flourishing clinician-patient relationships.

Knowing the paucity of time afforded to all curriculum in medical school, it can be difficult to have nuanced discussions. Ethics often finds itself instantiated in short bursts of case-based discussions. Though we cannot afford this topic adequate exploration here, we suggest that feminist ethics may additionally offer diversity in pedagogical approach (Bleakley 2013; Sharma 2019). Because feminist ethics focuses on social relationships, understanding deeper narratives and the influence of social conditions, ethics pedagogy may require longer sessions where students can practice developing things like empathy and critical reflection. Though this might mean fewer ethics sessions overall, depending on the time allotted in the curriculum, there is value in practicing deep reflection and curiosity with other students, clinicians, patients, and communities so as to build knowledge of the complex interwoven relationships that enter into the clinical setting. Some examples include ethics sessions in which students hear the narratives of patients, or practice family meetings where there is a complex ethical issue, or creating early authentic clinical experiences in which students can observe the interaction of social identity and structures of power, or finding small and large ways to build relationships with the community they live within and/or serve while in medical school (Warsaw 2018).

Ultimately, feminist ethics has a multitude of tools, concepts and approaches that can serve ethics curriculum in medical school. The concepts and related practices that we have offered here are not standardly taught in this setting, but

they are fundamental to all clinician-patient encounters. They are also accessible to early medical students, who may not yet have clinical experience, but likely have personal experience with relationality, relational autonomy and epistemic justice. With guidance, they will quickly come to see the concepts play out in patient care, which often highlights dependency, intersectional identity, connectiveness, trustworthiness, credibility, authority, and power. In the end, cognizance of the theoretical and practical import of these concepts will help to reshape ethics curricula by directly addressing the pervasiveness of systems of oppression in medicine, hearing the voices and concerns of those who are marginalized, and generally diversifying the toolkit of future physicians at a time when reimagining healthcare is profoundly needed.

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