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Gender, Race, and Class in the Delivery of Health Care

Oppression and Illness

It is widely recognized throughout the field of biomedical ethics that people's health care needs usually vary inversely with their power and privilege within society. Most bioethical discussions explain these differences solely in economic terms, observing that health and access to health resources are largely dependent on income levels. Poverty is an important determining factor in a person's prospects for health: being poor often means living without access to adequate nutrition, housing, heat, clean water, clothing, and sanitation, and each of these factors may have a negative impact on health (Lewis 1990). Further, the poor are more likely than others to work in industries that pose serious health risks (Stellman 1988) and to do without adequate health insurance (Tallon and Block 1988). And the poor suffer higher rates of mental illness and addiction (Paltiel 1988) than do other segments of the population. Financial barriers also often force the poor to let diseases reach an advanced state before they seek professional help; by the time these individuals do receive care, recovery may be compromised.

It is not sufficient, however, just to notice the effects of poverty on health; it is also necessary to consider who is at risk of becoming the victim of poverty. In a hierarchical society such as the one we live in, members of groups that are oppressed on the basis of gender, race, sexuality, and so forth are the people who are most likely to be poor. Moreover, not only does being oppressed lead to poverty and poverty to poor health but being oppressed is itself also a significant determining factor in the areas of health and health care. Those who are most

oppressed in society at large are likely to experience the most severe and frequent health problems and have the least access to adequate medical treatment.[1] One reason for this vulnerability is that oppressed individuals are usually exposed to high levels of stress by virtue of their oppressed status, and excessive stress is responsible for many serious illnesses and is a complicating factor in most diseases. Another important factor to consider, as we shall see, is that the same prejudices that undermine the status of the oppressed members of society may affect the treatment they receive at the hands of health care workers.

North American society is characteristically sexist, racist, classist, homophobic, and frightened of physical or mental imperfections; we can anticipate, then, that those who are oppressed by virtue of their gender, race, class, sexual orientation, or disabilities—and especially, those who are oppressed in a number of different ways—will experience a disproportional share of illness and will often suffer reduced access to resources. Moreover, the connection between illness and oppression can run in both directions; because serious or chronic illness is often met with fear and hostility, it may also precipitate an individual's or family's slide into poverty and can therefore lead to oppression based on class.

The damaging connections between oppression and illness are profoundly unfair. Because this situation is ethically objectionable, bioethicists have a responsibility to consider ways in which existing medical institutions can be modified to challenge and undermine these connections, rather than contribute to them. Ethical analyses of the distribution of health and health care must take into consideration the role that oppression plays in a person's prospects for health and well-being.

Patients as Members of Oppressed Groups

Throughout this book I have argued that women constitute an oppressed group, which is at a clear disadvantage in the health care system. Women are the primary consumers of health care, but the care they receive does not always serve their overall health interests. In a report presented to the American Medical Association, Richard McMurray (1990) reviewed recent studies on gender disparities in clinical decision-making; he found that although women are likely to undergo more medical procedures than do men when they present the same symptoms and condition, they have significantly less access than men do to some of the major diagnostic and therapeutic interventions that are considered medically appropriate for their conditions. In some cases the discrepancies were quite remarkable: for example, despite comparable physical needs, women were 30 percent less likely than men to receive kidney transplants, 50 percent as likely to be referred for diagnostic testing for lung cancer, and only 10 percent as likely to be referred for cardiac catheterization. The studies were unable to identify any biological difference that would justify these discrepancies. In addition, even though biological differences are sometimes significant in the course of various diseases and therapies, McMurray found that medical researchers have largely ignored the study of diseases and medications in women; for instance, cardiovascular disease is the leading cause of death in women in the United States, but research in this area has been almost exclusively conducted on men.

Therefore, as a group, it appears that women are particularly vulnerable to poor health care. Although they receive a great deal of medical treatment, the relevant research data are frequently missing, and specific treatment decisions seem to be biased against them. When women are medically treated, they are often overtreated, that is, subjected to excessive testing, surgery, and prescription drugs (Weaver and Garrett 1983). Sometimes they are simply not offered the treatment that physicians have judged to be preferable; for example, most professionals who work in the area of fertility control encourage women seeking birth control to go on the pill, despite its known risks. Interestingly, the majority of practitioners choose barrier methods for themselves and their spouses (Todd 1989); they do not seem to trust ordinary women to be conscientious in the use of the safer, less medically intrusive methods.

Physicians are trained in the stereotypical views of women as people who are excessively anxious, devious, and unintelligent; they are taught not to take all women's complaints seriously (Ehrenreich and English 1979; Corea 1985a; Todd 1989). Researchers have found that physicians are often condescending toward their women patients, and many deliberately withhold medical information from them out of concern for their inability to interpret it correctly (Corea 1985a; Todd 1989). Having medicalized the very condition of being female (Chapter 9), many doctors have seized opportunities to intervene and modify those bodies in ways they are unwilling to apply to men—for example, psychosurgery, an exceedingly controversial therapy, is performed twice as often on women as on men, and ultrasound was widely practiced on women before being introduced as a therapy for men (Corea 1985a).

Nevertheless, not all women experience the health care system in the same ways. There are many important differences among women that result in different sorts of experiences within the health care system; in particular, differences that are associated with race, economic class, and ethnicity compound the difficulties most women experience in their various encounters with health care workers. Alexandra Todd observed that "the darker a woman's skin and/or the lower her place on the economic scale, the poorer the care and efforts at explanation she received" (Todd 1989, 77). Other factors that contribute to the sort of health care a woman is likely to receive include age, sexuality, body size, intelligence, disabilities, and a history of mental illness. It is a matter of serious moral concern that social factors play a significant role in determining the quality of health care a woman receives.

If we expand our scope to that of a global perspective, then it is obvious that women in other parts of the world face distinct health problems, such as those created by malnutrition, often to the point of starvation, and by the absence of a safe source of drinking water; many women must cope with the ravages of war or the hazards of living under brutally repressive political regimes. Third World women must frequently rely on unsafe drugs, which have failed to meet minimum safety standards and therefore are dumped in developing countries by manufacturers determined to make a profit from them (McDonnell 1986). Some prominent concerns of bioethicists, such as the need to obtain informed consent for treatment and research, are deemed to be the products of Western ideals and are likely to go unrecognized in nations where all personal liberties are severely curtailed; elsewhere, the ethical "niceties" are often ignored in the face of the pressing demands posed by crippling poverty and illiteracy.

The injustice represented by the differing health options and standards of care based on different levels of power and privilege is not restricted to the Third World. Inadequate prenatal care and birth services are common to poor women everywhere, and the lack of safe, effective birth control and abortion services is more a matter of politics than of economics. In North America women of color are at a higher risk than white women for many life-threatening conditions; for example, black American women are four times more likely to die in childbirth and three times more likely to have their newborns die than are white women (Gordon-Bradshaw 1988, 256). Black women in the United States are twice as likely to die of hypertensive cardiovascular disease as are white women; they have three times the rate of high blood pressure and of lupus as do white women; they are more likely than white women to die from breast cancer (despite having lower rates of incidence); they are twelve times more likely than white women to contract the AIDS virus; and they are four times more likely than white women to die of homicide (Davis 1990).

In the United States the poor usually have (at best) access only to inadequate health services. Many people who find themselves employed full time but receiving annual incomes well below established poverty lines fail to qualify for Medicaid support (Tallon and Block 1988). Those who do receive subsidized health care must confront the fact that many physicians and hospitals refuse to accept Medicaid patients. In 1985, for example, four out of ten physicians who provided obstetrical service refused to take Medicaid patients (McBarnette 1988).

Canadians have so far avoided the two-tiered system of private and public health care. In Canada poor women are not turned away from hospitals or doctors' offices,[2] but they may not be able to afford travel to these facilities. Rural women are often restricted from access to needed health care by lack of transportation. Many Canadian communities lack suitably qualified health care specialists, and some provinces simply refuse to provide needed services, especially abortion, thus making it unavailable to women who cannot travel to a private clinic in another jurisdiction. Despite its guaranteed payment for health care, then, the Canadian health care system still reflects the existence of differential patterns of health and illness, associated with both race and income level (York 1987; Paltiel 1988).

In both countries the services available to women through the health care system are predominately those that meet the needs of the most privileged and articulate women, namely, those who are white, middle-class, educated, and urban. The health needs of other women are likely to be invisible or to slip through the cracks of the structures and funding of the system. In most cities, for example, prenatal programs, exercise counseling, mammography facilities, and hormone replacement therapy for menopausal women are available, but other urgent services, such as programs for alcohol- or drug-dependent women, are less easily found. Although some private programs exist for affluent women with substance-abuse problems, poor women have virtually no place to which they can turn. Further, if they should manage to find a program that is not too alienating to their experience to be of value, then they may face the problem of finding child care for the duration of the program, and if they are poor, then they are liable to lose custody of their children to the state when they admit to having a problem with addiction.

Although most urban centers offer nutritional guidance to affluent women trying to lose weight (even if their main goal is to fit the cultural ideals and medically mandated norms of slimness), few programs help women on welfare learn how to stretch their inadequate welfare checks to provide nutritious meals or to locate the resources for a healthy diet. Battered women who arrive at emergency rooms are patched up by the specialists on duty and perhaps referred to local, short-term shelters—if space can be found.[3] Preventive health care, which would help the abuser find nonviolent ways of behaving, is usually not available. As a result, many women get trapped in the cycle of returning home to their violent partner, returning to hospital with increasingly severe injuries (where they encounter frustrated staff members, who frequently blame them for repeat episodes), and recuperating in a temporary shelter. In the meantime, their children become intimately acquainted with violence as a means of addressing personal tensions and become primed to continue the pattern in the next generation.

In bioethics literature the issue of justice is often raised, but most discussions focus on whether or not everyone has a right to health care and, if so, what services this right might entail. Accessibility is viewed as the principal moral concern, but even where there is universal health insurance (for example, in Canada); the system is not designed to respond to the particular health needs of many groups of women. Being subject to violence, at risk of developing addictions to alcohol or other mood-altering drugs, and lacking adequate resources to obtain a nutritious food supply are all factors that affect peoples' prospects for health and their ability to promote their own well-being. Such threats to health are a result of the social system, which promotes oppression of some groups by others. Health care alone will not correct all these social effects, but as long as the damage of oppression continues, it is necessary to help its victims recover from some of the harms to their health that occur as a result of their oppressed status.

Bioethicists share with health care professionals and the rest of the community an ethical responsibility to determine how the health needs generated by oppressive structures can best be met. Medical care per se will not always be the most effective means of restoring or preserving the health of oppressed persons. Investigation of how best to respond to these socially generated needs is a topic that must be added to the traditional agenda of health care ethics.

The Organization of Health Care

Much of the explanation for the different ways in which health care providers respond to the needs of different social groups can be found in the very structures of the health care delivery system. The dominance structures that are pervasive throughout society are reproduced in the medical context; both within and without the health care delivery system, sex, race, economic class, and able-bodied status are important predictors in determining someone's place in the hierarchy. The organization of the health care system does not, however, merely mirror the power and privilege structures of the larger society; it also perpetuates them.

Within existing health care structures, women do most of the work associated with health care, but they are, for the most part, excluded from making the policy decisions that shape the system. They are the principal providers of home health care, tending the ill members of their own families, but because this work is unpaid, it is unrecorded labor, not even appearing in statistical studies of health care delivery systems; it carries no social authority, and the knowledge women acquire in caring for the ill is often dismissed by those who have power in the system. Furthermore, support is not made available to provide some relief to women carrying out this vital but demanding work.

In the formal institutions of health care delivery, women constitute over 80 percent of paid health care workers, but men hold almost all

the positions of authority.[4] Health policy is set by physicians, directors, and legislators, and these positions are filled overwhelmingly by men. Despite recent dramatic increases in female enrollment in medical schools, most physicians are men (78.8 percent in Canada and 84.8 percent in the United States as of 1986);[5] further, female physicians tend to cluster in less influential specialties, such as family practice and pediatrics, and they are seldom in positions of authority within their fields. Most medical textbooks are written by men, most clinical instructors are men, and most hospital directors are men.[6] The professional fields that women do largely occupy in the health care system are ones associated with traditionally female skills, such as nursing, nutrition, occupational and physical therapy, and public health. Women who work in health administration tend to be situated in middle-management positions, where their mediating skills may be desirable but their influence on policy is limited.

Research, too, is largely concentrated in male hands. Few women have their own labs or the budgets to pursue projects of their own choosing. The standards by which research is evaluated are those that have been developed by privileged men to meet their needs. They do not incorporate considerations that some female scientists and most feminist philosophers of science find important, such as including space in the design of a project for a measure of participant control, reducing the separation between subject and object, and resisting restrictive, medicalized analysis.

When we focus directly on issues of race and economic class, the isolation of health care provider from consumer becomes even more pronounced. Although many members of minority races and plenty of poor people are involved in the delivery of health care, very few hold positions of authority. Working-class and minority employees are concentrated in the nonprofessional ranks of cleaners, nurses' aides, orderlies, kitchen staff, and so forth. Women from these groups generally have the lowest income and status in the whole health care system. They have no opportunity to shape health care policy or voice their concerns about their own health needs or those of persons for whom they are responsible. One result of this unbalanced representation is that there has been virtually no research into the distinct needs of minority women (White 1990). Both those empowered to do medical research and those expected to respond to identified health needs come almost entirely from the socially defined groups and classes most removed from the experiences of women of color and of poor and disabled women.

The gender and racial imbalances in the health care system are not accidental; they are a result of specific barriers designed to restrict access to women and minorities to the ranks of physicians. Regina Morantz-Sanchez (1985) documents how the medical profession organized itself over the last century to exclude and harass women who sought to become doctors, and Margaret Campbell (1973) shows that many of these mechanisms are still with us. Blacks, too, have been subject to systematic barriers, which keep them out of the ranks of physicians. For example, it is necessary to serve as an intern to become licensed to practice medicine, but until the 1960s, few American hospitals would grant internship positions to black physicians; those blacks who did manage to become qualified to practice medicine often encountered hospitals that refused to grant them the opportunity to admit patients (Blount 1990). Because black women must overcome both gender and race barriers, they face nearly insurmountable obstacles to pursuing careers as physicians (Weaver and Garrett 1983; Gamble 1990). Therefore, although blacks make up 12 percent of the population of the United States, they account for only 3 percent of the population of practicing doctors, and black women constitute only 1 percent of the nation's physicians; further, blacks represent only 2 percent of the faculty at medical schools (Gamble 1990).

Racism and sexism in health care have been exacerbated by the fact that different oppressed groups have long been encouraged to perceive their interests as in conflict, so that race often divides women who might otherwise be expected to unite. Darlene Clark Hine (1989) has shown that racial struggles have plagued the nursing profession since 1890. For much of that period, white nurses acted on their own racist views and fought to exclude black women from their ranks. Although their racism is not excusable, it is perhaps understandable: Hine explains that white nurses felt compelled to fight for professional status and autonomy. Acting within a predominantly racist culture, they feared that their claims for recognition would be undermined if they were to welcome black nurses into the profession on an equal footing. In other words, because the combined forces of racism and sexism made it especially difficult for black nurses to obtain respect as professionals, white nurses chose to accept the implicit judgments behind such attitudes and to distance themselves from their black colleagues, rather than joining them in the struggle to counter racial prejudice.

Moreover, the racial struggles of nurses are just one symptom of a larger problem. The hierarchical structures that operate throughout the health care system motivate each social group to pursue the pragmatic strategy of establishing its relative superiority over yet more disadvantaged groups, rather than working collectively to challenge the structures themselves. Although white nurses did seek to dissociate themselves from black nurses and claimed greater commonality with the higher-ranked (white) male physicians, black nurses were themselves driven to seek distance from other black women who were employed in the system as domestic staff or nurses' aides, by claiming an unreciprocated identity with white nurses. Within hierarchical structures, all participants have reason to foster connections with those ranked higher and to seek distance from those ranked lower. This motive breeds an attitude that encourages submission to those above and hostility and a sense of superiority toward those below; in this way, all but the most oppressed groups become complicit in maintaining the hierarchical structure of the health care system. Thus the organization of the health care system itself helps reinforce the oppressive structures and attitudes of society at large.

The Effects on Health Care

In addition to the obvious injustice involved in distributing health care jobs on the basis of sex, race, and class, this practice also has serious repercussions for the quality of the health care that is actually provided. When health decisions are made by predominantly white, affluent, well-educated men, there is great danger that professionals will act on the basis of the familiar gender, racial, and class stereotypes of their society. They are likely to accept the culturally defined view of women as stupid, ignorant, and dishonest, especially with regard to women of color who are also poor and uneducated. Patients from cultures different from that of the practitioner may find communication difficult, particularly in the face of existing prejudices; their care is likely to suffer as a result.[7] If the people in the health care system who are most like the patient are those consigned to low-level, demoralizing, dead-end jobs—that is, those most likely to be alienated from their work and hence least likely to demonstrate commitment to the health care "team"—then both patients and providers will assume great gaps in each other's expectations and values.

It should come as no surprise, then, that the health care system is least effective at providing for the needs of people who are multiply oppressed in society. Such consequences may be quite unconscious and wholly unintended. It is part of the very nature of oppression that those with the power to set the social agenda and define the realms of knowledge view the world from their own perspective. Hence in the realm of health care, the professionals who make the decisions about policies and priorities are most attuned to needs that arise among the types of people they know best—other people with power and privilege in society. Researchers tend to pursue grants to study conditions that threaten people like themselves, such as heart disease, cancer, and infertility. They have less incentive to worry about the health effects of poverty, oppression, or racially associated conditions (e.g. sickle cell disease).

At the same time, the health consumers, who are ultimately responsible for their own health and the health of those they care for, are offered little support in their role. The very people with the greatest health needs are likely to find the whole system alien. For example, in almost all families women bear the primary responsibility for the health needs of their families, but each must negotiate a male-dominated health care system that is chiefly oriented to expensive, hospital-based care. These women must learn how the system is organized, where to seek appropriate care, and how to linguistically and culturally translate their concerns into information that will be meaningful to health professionals (Zambrana 1988). Women of color, immigrant women, and poor women, as well as disabled women and lesbians, are at a significant disadvantage in this task, as long as the delivery system is controlled by individuals whose backgrounds are so different from the consumers'.

Those who set up the major medical facilities seem to have designed them to meet the health crises of a typically middle-class life. For instance, usually neither child care facilities nor transportation are provided as health resources, although both may be essential for some patients if they are to receive care. Hospital menus reflect the dietary preferences of the mainstream in North American society and seldom take account of the tastes of minority cultures. White physicians and nurses frequently adopt paternalistic, patronizing attitudes toward minority patients. If patients do not follow "orders," then they are described as noncompliant and are treated with anger and hostility, even if the reason for failure was that there was a breakdown in communications, that the patient could not afford the drug prescribed, that the patient could not be excused from work for the follow-up tests, that the patient had to skip an appointment to care for a sick child, or that the patient's exam was scheduled on a day that the patient's religion declares sacred. Without a more diverse group of health care providers at all levels of the system, such misunderstandings may be difficult to detect and will be virtually impossible to eradicate.

Moreover, many social problems that are connected to health may not be addressed at all. The actual needs of various women are often discounted in favor of more medically defined expectations. For example, Alexandra Todd found that "*women come to doctors for help in understanding how to adjust their bodies to their social lives. Doctors' technical answers assume that women should adjust their social lives to their bodies*" (Todd 1989, 96).

Chronic health problems that arise from the circumstances of oppression seldom receive the care required. Thus low priority is usually assigned to responding to the needs of people who suffer from current or childhood experiences of sexual, emotional, or physical abuse. Therapy for such conditions requires intensive and sympathetic interaction between patient and therapist, perhaps invoking methods different from those traditionally practiced in the medical model.[8] Often only pills or lectures are offered to survivors of physical or sexual assaults; here, too, a patient's social status generally determines the treatment available to her, as was admitted in a recent textbook of psychiatry: "In the past, long-term intensive, insight-oriented therapies usually have been reserved for intelligent, achievement-oriented patients with middle- or upper-class backgrounds and values. Psychotherapeutic approaches for lower-class patients have tended to be more authoritative, behavioral, supportive, symptomatic, short-term, and infrequent in nature, and usually combined with drugs" (cited in Paltiel 1988, 196). There is no evidence that things have improved for the poor in the present.

If we wish the situation to be fairer in the future, then we need to investigate means of responding more effectively to differing needs and situations. One important step in that task would be to broaden the base of the network of "experts" who shape the definition of health needs in our society. We can assume that, by virtue of their very success in their roles, those currently recognized as authorities on health matters are removed from the perspective of many of the members of society who face the most serious health risks.

Gender, Race, and Class as Ideological Influences in Health Care

Beyond the basic injustice apparent in the differential opportunities and care that result from an unequal health care system, indirect moral costs are also created. The hierarchical organization of our health care system not only reflects the sexist, racist, and classist values of society but also lends support to them.

That the demographic patterns of the health care system are reflections of those found in the larger society compounds their effect. When the patterns of gender, race, and class distribution that are found in health care are repeated in most other major social institutions—including universities, the justice system, the business community, and the civil service—they appear inevitable. In health care, as throughout society, the most prestigious, rewarding, and powerful positions are occupied by privileged white males, who are supported by a vast pyramid of relatively undervalued, white, professional women; unskilled laborers of color have been relegated to the realm of "merely physical" work.[9]

This arrangement is of moral concern not just because of its obvious unfairness but because it provides an ideological foundation for maintaining a hierarchically structured, stratified society.[10] Within the realm of health care, authoritarian structures are rationalized as necessary to the goals of achieving good health. The metaphors that structure participants' experiences within the system appeal explicitly to models of dominance: doctors "command" health care teams, "battle" illnesses, and "lead campaigns" against dangerous life-styles. Their expertise entitles them to give "orders" to workers in the affiliated health professions (nurses, physical therapists, pharmacists, and so forth) and to patients. These arrangements are justified in terms of their end, health. Because the end is of unquestionable value, the means are usually considered acceptable to the degree that they achieve this goal. Thus medicine's worthy goals and remarkable accomplishments are said to demonstrate the benefits of retaining power and privilege for a socially vital elite. That numerous critics have questioned the success of this model in the actual achievement of health has done little to dissuade the medical establishment from encouraging the public to accept its structures as necessary (York 1987). When feminists and other critics challenge the legitimacy of social hierarchies, the medical model can be held up as evidence of the value of hierarchical structures in achieving important social goals.

Moreover, when the physicians are overwhelmingly male, white, able-bodied, and upper- or middle-class, social messages about the appropriate holders of authority are delivered with the technical medical information they control. When predominately white, female nurses accept the authority of mostly male doctors and follow their directions, they convey gender messages to patients and health care workers alike. When these nurses assume professional superiority and authority over nonprofessional hospital workers of other races, the patterns of racial oppression are also sustained. In these ways, the role patterns of the health care system rationalize society's sex and race inequalities and confirm the existing stereotypes that maintain these inequalities.

There are further reasons for concern over the close correspondence between system and social power in an oppressive society. Decisions about illness in members of oppressed groups may be tainted by the social expectations that accompany discriminatory practices. Such decisions often reflect cultural stereotypes, which themselves derive from unjust social arrangements. At the same time, those decisions may serve to legitimize particular damaging stereotypes and the social divisions that depend on them.

For example, white health care experts (and others) have identified alcoholism as a pervasive problem in the native American community; they have preached abstinence as a response. Generally, these judgments are made without examining the devastation that white culture has wrought on native community values and without extending any support for traditional, native healing options as alternative paths to recovery. Often health care workers have uncritically accepted the stereotypical view of "drunken Indians" and suggested that natives are either weak-willed or have some genetic propensity to alcohol dependency; either way, their misfortune is a reflection of some deficiency within them, not society. Most health professionals are committed to the individualistic medical model, which views diseases as belonging to individuals; although they may acknowledge a role for genetic or sociological factors, they believe that the individual is the proper site for health care treatment.

Other conceptions are available, however, and it is useful to reflect on alternatives in these circumstances. Some native healers suggest that alcoholism in their communities is really a social disease of the community, which should be understood as connected to the brutal separation of their people from their culture. Their account leads to an alternative strategy for recovery and a distinct form of health care; where the medical model treats the individual, native healers believe it is necessary to heal the community.[11] Nevertheless, only the medically authorized response receives approval and support from those with the power to allocate health care resources.

The social harms extend further. Because the authority of health care decision-making is concentrated in nonnative hands, native people who identify themselves as alcoholics are required to adapt to treatment programs that have been designed for a white, urban population. They are deemed to be failures if the programs do not succeed in curing them. Because the problems usually continue, native people are seen to fulfill their culturally generated stereotypes; their severely disadvantaged economic and social position is then explained away by experts who speak authoritatively of native peoples' "natural" propensity to alcohol abuse. As long as health care decision-making resides in the hands of an elite, nonnative few, we can anticipate its continued failure to recognize and address the real needs of the native community.[12] These failures, in turn, support the cultural prejudices that view natives as inferior members of modern society who cannot hope to rise above their designated status on the socioeconomic scale.

Similar self-fulfilling prophecies can be found in other consequences of a socially unbalanced health care structure. For instance, one of the truisms of modern health care is the recognition that stress is an important contributing factor in illness, but the standard social understanding of stress is that it is connected with positions of power and authority. When, for example, experts compile lists of events that contribute to stress, they focus on events that occur in men's lives, such as being drafted, promoted at work, or having one's wife begin work. Experiencing an abortion, a rape, or a change in childcare arrangements usually does not appear on these lists, and hence these events may well be ignored as stress factors in a woman's life when she seeks medical care (Paltiel 1988). The paradigmatic picture of a stressful occupation is that of a high-powered, business executive. An American study on stress and the workplace found, however, that lower-status workers, especially clerks, are more likely to experience stress-related health effects than are senior managers; the most stressful, damaging jobs are the ones that combine high work demands with low control over the job (Paltiel 1988). Poor women, with no control over their jobs and with unsatisfiable responsibilities for their children's well-being, suffer more from stress than either professionals or managers, but they receive little support or relief for their problems. Instead of genuine strategies to help relieve their stress, they are often offered platitudes and judgmental lectures about their coping behaviors (which frequently include smoking, drinking, or use of drugs). Because those who control the provision of health services have such different life experiences from those of their female patients on social assistance, they are not likely to recognize the stress factors that afflict such women, and they have little advice for responding to poverty-induced stress, when it is acknowledged.

Furthermore, physicians use their authority to entrench their social attitudes toward women on a broad scale. For example, nineteenth-century physicians espoused theories about the competition between women's brains and their uteruses to support policies for keeping women out of universities and "protecting" them from political activity. Today many doctors promote estrogen replacement therapy for menopausal women, despite the risks of cancer associated with the treatment program, because of their belief that women should want to avoid the embarrassment of aging. Over the years, some physicians have gone to great lengths to make women fit their stereotypically defined social roles; they have responded to individual women's disaffection from feminine roles of procreator, housewife, mother, or companion with genital surgery, psychosurgery, psychotherapy, hormone therapy, or tranquilizers, depending on the fashion over the years (Ehrenreich and English 1979; Mitchinson 1991). Few doctors, however, have responded to women's complaints by challenging the roles to which women were (are) required to adapt.

The power and authority that society has entrusted to doctors give them the opportunity to destroy many of the patriarchal assumptions about women collectively and the racist, classist, homophobic, and other beliefs about various groups of women that are key to their oppression. Few physicians, however, have chosen to exercise their social power in this way. Many doctors have accepted uncritically the biases of an oppressive society, and some have offered evidence in confirmation of such values. As a group, physicians have held onto their own power and privilege by defending the primacy of the authoritarian medical model as a necessary feature of health care. Most have failed to listen honestly to the alternative perspectives of oppressed people who are very differently situated in society.

The medical model organizes our current attempts at defining and responding to health needs. It has been conceived as a structure that requires a hierarchically organized health care system, in which medical expertise is privileged over other sorts of knowledge. It grants license to an elite class of experts to formulate all matters of health and to determine the means for responding to them. As we have seen, however, there are several serious moral problems with this model. First, it responds differently to the health needs of different groups, offering less and lower-quality care to members of oppressed groups. Second, its structures and presuppositions support the patterns of oppression that shape our society. Finally, it rationalizes the principle of hierarchy in human interactions, rather than one of equality, by insisting that its authoritarian structures are essential to the accomplishment of its specific ends, and it tolerates an uneven distribution of positions within its hierarchy.

Some Conclusions

We need, then, different models to guide our thinking about how ways to organize the delivery of health care. In addition to the many limits to the medical model that have been named in the bioethics literature, the traditional model reflects and perpetuates oppression in society. I conclude by summarizing some feminist suggestions that I believe should be incorporated into alternative models, if they are to be ethically acceptable.

A model that reflects the insights of feminist ethics would expand its conceptions of health and health expertise. It would recognize social as well as physiological dimensions of health. In particular, it would reflect an understanding of both the moral and the health costs of oppression. Thus it would make clear that those who are committed to improving the health status of all members of the population should assume responsibility for avoiding and dismantling the dominance structures that contribute to oppression.

Such a model would require a change in traditional understandings of who has the relevant knowledge to make decisions about health and health policy. Once we recognize the need to include oppression as a factor in health, we can no longer maintain the authoritarian medical model, in which physicians are the experts on all matters of health and are authorized to respond to all such threats. We need also to recognize that experiential knowledge is essential to understanding how oppression affects health and how the damage of oppression can be reduced. Both political and moral understandings may be necessary to address these dimensions of health and health care. Physiological knowledge is still important, but it is not always decisive.

Therefore, a feminist model would resist hierarchical structures and proclaim a commitment to egalitarian alternatives. Not only would these alternatives be more democratic in themselves and hence more morally legitimate, they would also help to produce greater social equality by empowering those who have been traditionally disempowered. They would limit the scope for domination that is available to those now accustomed to power and control. More egalitarian structures would foster better health care and higher standards of health for those who are now oppressed in society; such structures would recognize voices that are now largely unheard and would be in a position to respond to the needs they express.

The current health care system is organized around the central ideal of pursuing a "cure" in the face of illness, wherein "cure" is interpreted with most of the requisite agency belonging to the health care providers. A feminist alternative would recommend that the health care system be principally concerned with empowering consumers in their own health by providing them with the relevant information and the means necessary to bring about the changes that would contribute to their health. The existing health care system, modeled as it is on the dominance structures of an oppressive society, is closed to many innovative health strategies that would increase the power of patients; a feminist model would be user-controlled and responsive to patient concerns.

Such a change in health care organization would require us to direct our attention to providing the necessities of healthy living, rather than trying only to correct the serious consequences that occur when the opportunities for personal care have been denied. Moreover, as an added benefit, a shift to a more democratized notion of health needs may help to evolve a less expensive, more effective health care delivery system; most patients seem to be less committed than are their professional health care providers to a costly high-tech, crisis-intervention focus in health care (York 1987).

A health care system that reflects feminist ideals would avoid or at least lessen the contribution that the system of health care makes in the maintenance of oppression. It would be significantly more egalitarian in both organization and effect than anything that we are now accustomed to. This system not only would be fairer in its provision of health services but would also help to undermine the ideological assumptions on which many of our oppressive practices rest. Such an alternative is required as a matter of both ethics and health.

To spell out that model in greater detail and with an appropriate understanding, it is necessary to democratize the discipline of bioethics itself—hence, bioethics, as an area of intellectual pursuit, must also recognize the value of incorporating diverse voices in its discussions and analyses. Like medicine or any other discipline, bioethics is largely defined by the perspective of its participants. If we hope to ensure a morally adequate analysis of the ethics of health care, then we should ensure the participation of many different voices in defining the central questions and exploring the promising paths to answers in the field. I hope this book facilitates that wider conversation and the transformations it may bring both to the provision of health care and to the study of health care ethics.

Notes, References, and Index