

## THE INVISIBILITY OF GENDER: A FEMINIST COMMENTARY ON AGE-BASED HEALTHCARE RATIONING

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**ABSTRACT:** Healthcare rationing is here to stay. No one likes it and we would prefer to give everyone all the care they need and deserve. We know that there simply are not enough resources to do this, however. So resources will be rationed. In some cases, rationed resources will go to the young, not the aged. When this happens, there is a very good chance (indeed Miller claims it is fact) that there will not only be age bias, but sex bias in the rationing. Miller confronts us with the issue, and challenges us with the defense of such practices, and offers an alternative framework for dealing with the problem.

### OPENING THOUGHTS



It is fairly easy to charge intergenerational justice accounts that recommend a distribution of healthcare resources favoring the young as being ageist. Clearly, such policies strongly privilege the interests of one age group over those of another. In a time of tight resources, the elderly are to get the short end of the stick, though for reasons that some theorists believe are ethically justifiable. What is not as immediately clear, however, is the *sexist* nature of rationing healthcare resources for the elderly. In this essay, I contend that perspectives capitalizing on justice, fairness, or equity between age groups do not readily reveal, and perhaps even obstruct, a clear view of such sexist dimensions.

First, I contextualize the problem by offering a picture of the present and future situation with regard to Medicare and the seeming inevitability of rationing. Next,

I engage the work of Daniel Callahan, as representative of the intergenerational equity perspective, and criticize his views on age-based rationing and old women as a form of gender discrimination. I then offer three explanations of why gender has been so easily concealed in discussions of healthcare rationing for the elderly. Finally, exploring alternate possibilities, I turn to a feminist framework. I choose this framework, first, in order to reveal the sexist aspects of rationing recommendations. Second, acknowledging that the framework from which one begins in biomedical ethics affects (if not constitutes) the resulting policy recommendations, I demonstrate the difference that a feminist formulation in bioethics makes when encountering dilemmas of old age and limited medical resources. I do so by focusing upon three notions from feminist ethics: (A) sustaining relationships and fostering inclusion in a moral community, (B) group interests, and (C) caring toward the end of life.

### **THE PROBLEM: MEDICARE AND RATIONING IN THE PRESENT AND FUTURE**

Medicare, in its present state, will not last forever. In fact, we will be lucky if the healthcare program for the elderly in the U.S. survives unchanged into the next decade. Outside of the possibility (albeit not inconceivable) of further band aid measures such as those provided through the Balanced Budget Act of 1997, Medicare will likely reach a crisis point in less than ten years, around 2010.<sup>1</sup> Economists have been debating the question of “what to do” with the elderly for a number of years now. Policy makers, sociologists, doctors, and medical researchers have also frequently waded into the fray. With a few remarkable exceptions,<sup>2</sup> philosophers, however, have been comparatively slower to offer comment on the ethical entanglements developing around the dual difficulties of diminishing resources and a rapidly growing elderly population. Skyrocketing numbers of baby boomer retirees combined with the ever-increasing costs of healthcare will create a situation in which some degree of rationing of resources seems inevitable.

Rationing can be defined as “the denial or limitation of forms of healthcare that would be both desired by individuals and beneficial to them.”<sup>3</sup> In the case of Medicare, rationing will become a necessity when the citizenry no longer agrees to pay the higher taxes necessary to support the program. The numbers framing this ugly picture make clear how such an upper limit on tax payment can quickly be reached: “[a]t present about 1.5 percent of everyone’s payroll taxes goes to support the Medicare program (with about 6 percent going to Social Security). The projected deficits after 2010 have been estimated to gradually rise to the range of \$300 billion to \$500 billion a year, far higher than the entire federal budget deficits of recent years. To meet such costs, the estimates are that the payroll contribution would have to go from 1.5 to 20–40 percent, an unthinkable tax burden for a single federal program.”<sup>4</sup> It seems unlikely, to say the least, that U.S. citizens will dump 20 to 40 percent of their paychecks into Medicare. Hence, rationing appears to be an inevitability.

### THE SOLUTION PROPOSED BY THE INTERGENERATIONAL JUSTICE PERSPECTIVE

Rationing, theorists have noted, exists along a continuum including practices such as “priority-setting” or “resource allocation,” which can also be considered forms of rationing, though perhaps less harsh forms. The thought of rationing in the strong sense—denying people healthcare treatment that they need to continue living—is understandably a bitter pill to swallow. Though rationing is not something that we can embrace easily, its inevitability causes us to face the question of which groups we will deny resources. Here ethicists have joined with policy and economics compatriots to analyze the situation in the framework of *intergenerational justice*. And, as the intergenerational justice argument has often run, the old, rather than the young, are said to be the ones who should shoulder the burden of rationing. If resources must be denied to individuals, denying them to those who have already lived a long life can seem preferable to denying them to those who are just getting going and who require proper healthcare to start them along a healthy course of living. Forcing rationing on the elderly, however, need not be as entirely callous as it first sounds. Conscientious varieties of the intergenerational justice argument include formulations that acknowledge the elderly’s need for dignity and a livable quality of life, while still questioning the appropriateness of assigning expensive, heroic, or life-prolonging measures to such individuals.

### GENDER DISCRIMINATION AND OLD WOMEN: ANALYSIS OF THE INTERGENERATIONAL JUSTICE SOLUTION

When ethicists turn their attention to Medicare and rationing, they often fail to account for a unique dimension of the problem, one that can generate a particular form of injustice, namely, gender discrimination.<sup>5</sup> Conceptualizing the problem of “what to do with the elderly” in terms of competition between age groups for a shrinking pool of resources overlooks a very significant detail: *the majority of old people are actually old women*. This reality is reflected in a current biological fact. On average, women live 7.8 years longer than men.<sup>6</sup> (Both social and economic forces such as role in the workplace and family life, as well as physical factors such as hormones, contribute to this fact.) Thus, intergenerational justice arguments that use age as the deciding factor unwittingly discriminate against old women, who constitute the majority of the population to be denied resources. The recommendation that the elderly be denied healthcare resources through the practice of rationing therefore can be said to have a sexist dimension to it. Old women must in large part bear a burden resulting from their longevity.

Further complicating the situation for old women, their extended longevity brings with it an increase in vulnerability. This is true in at least three senses: physical vulnerability, economic vulnerability and social vulnerability. First, during the extra years of life that many of their male counterparts do not share, women

are often subject to various forms of (sometimes chronic) illness and disability. In the face of such illness and disability, old women can require both extended forms of healthcare and daily help with certain tasks (such as bathing or dressing, for example) that they are no longer able to accomplish on their own. Second, as a result of several economic and social forces (sexist in their own right), women who do live into old age are likely to live those years in poverty, which limits their ability to purchase care for themselves. Having cared for and tended to others for years—care for which they received little or no remuneration—women often do not have economic resources at their disposal in their later years. Third, networks of social support weaken as women advance in age. Heterosexual life partners for whom women cared will have most likely passed away, leaving them necessarily to look outside the home to have their own needs met as they come to require care for themselves. Friends and colleagues of many years may also have died, leaving old women in social isolation. Thus, although women enjoy longevity, the physical, economic and social vulnerabilities that can significantly diminish their quality of life turn this seeming benefit into a liability.

When focusing upon the above vulnerabilities, asking old women to bear the brunt of rationing can seem particularly uncompassionate. Such vulnerabilities accrue, creating situations in which old women who are denied Medicare assistance (be it for prescription drugs, cancer surgery, or home aid service) and instead are asked to pay out-of-pocket for such services or to find home care for themselves, which friends or family from the private realm are to provide, stand little chance of surviving. The attack on their agency is complete. Physically vulnerable, their likelihood of requiring some form of care for illness or disability is great. Economically vulnerable, their capability of paying for services themselves is significantly limited. Socially and emotionally vulnerable, their network of potential caretakers from the private realm is weakened. Granted, most theorists who suggest rationing as a solution to the coming Medicare crisis believe that not all services should be rationed. Some suggestions have centered on the notion of an age limit for expensive, high-tech medical procedures designed to prolong life indefinitely, with an accompanying commitment to providing a better general quality of life for the elderly in terms of everyday care. But adequate everyday care can also be quite expensive, as recent discussions on the successes and failures of assisted living ventures attest.

### **CRITIQUE OF CALLAHAN'S RATIONING POSITION**

Although it is not clear that care designed to increase the quality of living for the elderly will be easily financed in the future, we must still consider whether what some theorists openly state should be denied to the elderly discriminates against women. I will focus upon the views of one main proponent of intergenerational equity, Daniel Callahan. Callahan has reasoned that when solely analyzing the services that women would be denied, namely, services associated with high-technology medicine, “women would fail to get what dead males already fail to

get as well.” He continues, “it is thus not as if women are being denied a benefit that men get. Men would fail to gain the benefit by virtue of dying before needing it, women by virtue of rationing.”<sup>77</sup> Callahan concludes that following this line of reasoning, it is difficult to see how women are discriminated against. His analysis, however, seems to miss several important points.

Callahan’s argument involves the notion of a “natural life span.”<sup>78</sup> He proposes that the elderly be denied curative healthcare that would take them beyond a “natural life span.” Critics have questioned the soundness of this notion, but have failed to acknowledge one important way in which the concept of a “natural life span” functions suspiciously in rationing recommendations concerning the elderly. That which Callahan names as the *human* “natural life span” actually turns out to be the natural life span of *men*. Women, who tend to live beyond it, bear the brunt of rationing recommendations. Thus old women, vulnerable in the three senses I have already identified, are to receive less healthcare resources while having less support (economic and social) at their disposal to counter this difficulty. With few resources of their own, old women can only turn to public resources to help them meet their increasing needs. But, as public perception goes, such women are “less deserving” of receiving public aid, as they are perceived as not having contributed to the public coffers and social good through income tax, for example. The caring labor that elderly women performed earlier in their lives—labor performed largely in the home—does not, in many people’s minds, qualify them for public assistance later in life.

By virtue of still being alive, women experience a need for certain medical procedures. Dead men do not, and presumably did not, experience the same need only to be denied similar medical procedures in their younger years. In general, Callahan’s argument seems flawed inasmuch as he attempts to compare those situated in vastly different circumstances—circumstances which differ to such a large extent as to make the point of comparison moot—namely, women who are living and men who are dead. Quite obviously, the possibility for experiencing need and harm only inheres for one of these groups. In addition, how does one adequately consider whether or not discrimination is occurring in a situation in which one half of the equation is no longer living? Most importantly, however, Callahan fails to identify what I understand to be a very significant feature of this problem: old women who are still alive and who are denied medical resources experience needs that go fully unmet. One could argue that an account that does not consider the moral claim of such need and that does not address possible obligations issuing forth from such need is notably flawed. Treating Callahan’s analysis as an exemplar of the intergenerational justice model begins to reveal the ways in which such a framework cannot adequately treat either the need-related or the gendered dimensions of the problem. Acknowledgment of such oversight calls for an explanation of how such issues could slip through without being properly addressed. Thus, I now turn to an analysis of how gender and old women’s needs have remained invisible in discussions of age-based healthcare rationing.

## THE INVISIBILITY OF GENDER AND OLD WOMEN'S NEEDS

In this section I will discuss three ways in which gender and need are made invisible in intergenerational justice arguments regarding age-based healthcare rationing. These three ways are: (A) a “thin” construal of ethical situations (often employing the concepts of fairness and justice) that can limit a full consideration of relevant differences between moral agents; (B) age serving as a “superfact;” and (C) normative assumptions of policy recommendations that conceive of women as willing to sacrifice their own needs so that others’ needs can be met.

### (A) A “Thin” Construal of Ethical Situations

Callahan employs a framework of fairness when he asks, “How can women be fairly and well treated within the rationed health care system for the elderly that surely lies ahead?”<sup>9</sup> In asking about gender specifically, he is certainly on the right track. Yet one wonders if the traditional ethical concepts of *fairness* and fairness’s frequent companion, *justice* are adequate for the task of providing what feminist philosopher Joan C. Tronto has called “a thicker version of any ethical situation.”<sup>10</sup> It is in the thicker versions of ethical situations that the complicated moral dilemmas surrounding the concept of difference (gender, race, and ethnicity, for example) can come to the fore and receive proper consideration. Frameworks of justice and fairness have not easily incorporated difference into their ethical treatments and when they have, they have done so in a way that is rather limited and insufficient. This is not to say that such perspectives are wholly incapable of accommodating questions of gender. Questions of whether policies provide for the just treatment of women as well as men are important to ask. In general, however, the problem can be said to be inherent in a deductive approach in which “universal moral rules or principles posited for the abstract, generic person erase that person’s gender (not to mention race, class and other characteristics). This makes it difficult to query the significance of gender in the moral situation. It is only when a situation is appreciated in its particulars that the full moral problem and plausible tools for its resolution appear.”<sup>11</sup> As we will see in the next section, feminist approaches to bioethics in general, and to the issue of rationing in particular, enable a robust consideration of the particulars of moral situations and offer tools with which to create innovative solutions.

### (B) Age as a “Superfact”

There is, perhaps, a more specific reason why age obstructs the view of need and gender in discussions of distributive justice. James Lindemann Nelson, in characterizing the status of age in such discussions, describes it as a “superfact.” A “superfact” is “a fact that characterizes a set of people in a manner so relevant to distribution of goods or assignment of duties that none of their other traits, nor any of the traits of potential claimants not in that group can, singly or in combination, defeat its dispositive relevance.”<sup>12</sup> Thus, age has served as the most significant characteristic of the

elderly. Some theorists have highlighted this feature of the elderly in conjunction with the argument that certain healthcare resources should not be “wasted” on those who are older. Elderly individuals, however, are not solely situated in terms of their age. As with every other individual, they are of a certain race, gender, class, religious and sexual orientation, etc. Certainly the relevance of these other factors must be adequately considered, or, if they are not to be considered, justification regarding why age is the most significant factor must be established. The “superfact” of age may make certain policy recommendations regarding resources easy. But perhaps it makes them too easy. The status of age as a “superfact” needs to be questioned. To argue this is not to deny that age is a very important factor. But, after all, it is not the only factor and arguably should not have the power to trump all other factors concerning distribution of goods between the generations.

### (C) Assumed Sacrifice

More complicatedly, normative assumptions often found within policy recommendations provide a third element that may contribute to the invisibility of need and gender in age-based rationing recommendations. Martha Holstein explains that “[p]ublic policy seeks to “balance the responsibility of individuals, families, and the state” in meeting human needs. While it rests on normative assumptions—how society should be ordered, what values ought to be enhanced, who owes what to whom—these are seldom articulated.”<sup>13</sup> Indeed, women, through their roles as caretakers (be it as mothers, daughters or sisters in the familial realm, or as nurses and other professional caregivers in the public realm) have sacrificed their own needs in order to meet the needs of others for centuries. One could argue that civil society has been built on such sacrifice. Surely, then, this sacrifice could wiggle its way into public policy, functioning as a seldom articulated normative assumption of how society should be ordered, one which makes possible, in some fundamental sense, the meeting of human needs while condoning the denial of women’s agency.

In conjunction with this line of thought, it is fruitful to inquire what the normative assumptions behind public policy recommendations advocating age-based rationing might be and how they might be gendered in nature. Hilde and James Lindemann Nelson provide one answer:

[T]he call for altruistic self-sacrifice by the old may reinforce patterns of gender socialization that have instilled in women the habit of giving way to others, and in men the habit of taking from women. Many women who are now elderly offered the best food at table [sic] to their fathers and brothers, forwent a college education so their brothers could have it, deferred to their husbands in the matter of careers, and did without certain goods so their children could have a good life. Many of them then went on to raise their grandchildren and to nurse their husbands through the last illness. These gender-influenced patterns of deference, along with simple demographics, raise concern as to whether age-based rationing is actually an instance of discrimination against women.<sup>14</sup>

A life-long practice of putting the needs of others first creates fertile ground for expectations of, and acquiescing to, similar sacrifices in old age. That women will continue to sacrifice as they always have may indeed be a normative assumption behind age-based rationing, one which helps to explain the frequent invisibility of needs and gender in such equations.

### **FURTHER CONTRIBUTIONS FROM FEMINIST BIOETHICS**

My account has drawn upon contributions feminist bioethicists can make to the age-based rationing debate. Two such contributions include (1) a challenge to the notions of justice and fairness understood as the superior conceptual frameworks through which to approach rationing dilemmas and (2) attention to the whole of a moral situation so as to draw forth relevant differences between moral agents (beyond the age difference) and to understand the implications of such difference. There are several additional contributions that feminist bioethics can offer.<sup>15</sup> In the limited space that remains, I will briefly sketch three such contributions, centered on the notions of (A) sustaining relationships and fostering inclusion in a moral community, (B) group interests, and (C) caring toward the end of life.

#### **(A) Sustaining Relationships and Fostering Inclusion in a Moral Community**

The structure of the intergenerational justice debate on age-based rationing is such that distribution of resources must necessarily be considered in terms of a competition between individuals (or groups of individuals) for a limited number of goods. Though it is certainly the case that decisions regarding who gets which resources must be made within any society, to view the means of determining this as one of competition between individuals eliminates the possibility of other useful approaches to the problem. Feminist bioethics, with its emphasis on sustaining relationships and on fostering inclusion within a moral community, provides an alternative approach. This approach can be cultivated through a call for dialogue between community members in an attempt to reach consensus on issues together and to achieve a better understanding of varying experiences of neediness. Human interdependence functions as the foundation for such a dialogue, establishing some degree of commonality between persons with otherwise quite significant differences. Those who are now young and relatively strong will one day find themselves in the vulnerable position of the elderly. Rather than conceptualizing the situation as one of individuals going head to head to get the resources they want, feminist bioethics suggests that community members work together to devise a solution which, although not perfect for all, is at least tolerable for each.

Rosemarie Tong associates the focus of moral community with feminist standpoint theory and explains that, “[c]onstructing a moral community in which a wide variety of people can cooperate together even as they maintain their differences,



requires much more than the abstract, analytic skills of traditional moral theorizing. It requires a highly developed set of emotional skills and exceptional powers of communication.”<sup>16</sup> When a community encounters limited healthcare resources, instead of only applying principles of justice to determine that the young should be served before the old, feminist bioethicists would ask for community discussion regarding not only who should get which resources and why, but also regarding who occupies which social roles and why. Such dialogue might also address community notions of obligations to and care of vulnerable others. Through discussion, the needs, interests, opinions and personal experiences of many community members, *including elderly women*, could come forth.

### **(B) Group Interests**

The notion of asking women to speak for themselves gives credence to their own knowledge of their experience. It also calls to mind the idea that old women can express such knowledge—and interests related to such knowledge—collectively as a group. This is not to say that all of their experiences should or will be the same, but rather that by virtue of the treatment and regard that any society extends to them, they will be similarly situated. Traditionally, bioethicists have focused on two levels: that of the *individual* and that of *society*. *Groups*, however, rest at a middle level between individuals and the larger unit of society. Feminist bioethics recognizes the failure of traditional bioethics to adequately account for or respond to groups, *and particularly to the interests of groups constituted through difference*. In the case of old women, it would be fruitful to examine their moral status (if they can be said to have one as a group) and the moral standing they have within their communities (including the extent to which others acknowledge their moral agency and the forms of recognition which they receive). Although entertaining such issues will not completely answer the question of who should get which resources, it helps to reframe the question, providing a more complete account of the situation of the parties who will be most affected by rationing decisions.

### **(C) Caring toward the End of Life**

Often the proposal to set an age limit on expensive, high-technology medical procedures is accompanied by the suggestion of tending to the quality of life of the elderly, such that the goal changes from one of prolonging their lives indefinitely to one of improving the quality of the end of their lives. In principle, this change of focus is a good one, moving away from the ill-conceived notion that old age is a medical condition that must be cured, and restoring it to the final position in life before death. Providing better daily, hands-on care for the elderly is often mentioned as one of the concrete measures that would improve their lives. Such an outlook falls in line with both feminist bioethics and with care ethics inasmuch as it focuses upon the everyday experiential reality of the elderly and calls for

caring engagement in the situation of another. But care as a virtue must be appealed to cautiously, as the potential for abuse surrounding it is great. Recognizing this problem, Rosemarie Tong notes that “any approach to ethics so naive as to celebrate the value of caring without worrying about who cares for whom is not feminist. Caring can and has served as a trap for women—as a “virtue” that turns women into masochists, living only to serve other people’s interests (particularly, men’s and children’s) while steadfastly neglecting or ignoring their own.”<sup>17</sup> Thus, although we may want to extol care as a principle to prevail in age-based rationing debates, we must also understand what is at stake in asking for more care.

Traditionally, caretaking has been a form of labor (both paid and unpaid) that has contributed to women’s oppression. Unpaid in the home, women have been expected to care for their children, their husbands, their failing parents, and in-laws. Such caring work has served as a barrier to their full participation in civil society, blocking them from numerous life pursuits. As paid laborers, caretakers have not been paid well, such that the ranks are often occupied by women who are not comfortably situated socially and economically. More recently, feminist theorists have focused on the fact that women of color and/or women from countries other than the U.S. are often the ones to perform caring labor, hence relieving other women—often white and economically advantaged—from having to perform dependency work. These realities of the current care labor situation make calling for more care a complicated remedy.

Yet the notion of care itself is not a negative thing. In recommending more care for the elderly, though, we must work to expand the boundaries of who cares for whom. Men and women must come to care for one another such that old women—the ones who often fall through the growing holes in a disintegrating blanket of care—also receive care from their friends and relatives of both genders. Paid dependency work should be better paid, a move that would mitigate the economic vulnerability of care workers, would elevate the respectability of caring labor, would encourage involvement of both genders in caring labor, and could improve the kind of care that paid dependency workers give to the elderly. Thus the burden on women to care should not increase, but rather the call for more care should be equally shouldered by both genders.

## CONCLUSION

What I have provided in this essay is not meant to serve as a full programmatic approach to the question of age-based rationing. Instead, I present a critique of the intergenerational justice perspective’s endorsement of healthcare rationing for the elderly. My point has been neither to suggest that all rationing be eliminated (as if this were a reasonable or possible option economically), nor to counter the sensible notion that life should not be extended indefinitely simply because we develop the medical technology to do so. Certainly, there is something to the idea that an acceptable death can occur as the completion of a full life. Further reflection is required, however, to offer a complete analysis of what we understand a natural

life span and a full life to be. Are women living beyond the span of a natural life? Can we feel confident that women's roles as caregivers allow them to live a full life? If we answer in the negative to either of these questions, we might need to rethink age-based rationing, paying closer attention to the gender discrimination it promotes.

In revealing what I understand to be the gender bias found within age-based rationing, one must then move on to suggest alternative approaches. In the last section, I have offered a sketch of a few useful elements for an alternative approach. As the discipline of bioethics itself experiences a period of growth and change (one could argue from an approach of principlism through anti-principlism to an as yet undetermined result), additional approaches are sure to rise to the surface. Feminist bioethics provides one innovative set of ideas that move toward better solutions to the problems of intergenerational justice.

### ENDNOTES

1. Callahan (1999), p. 189.
2. See, for example, Daniels (1988), Goodin (1985) and Callahan (1987).
3. Callahan (1999), p. 190.
4. *Ibid.*
5. Bell (1992) presents one notable exception to this claim.
6. Nelson and Nelson (1996), p. 360.
7. Callahan (1999), p. 193.
8. This argument can be found in Callahan (1987).
9. *Ibid.*, p. 192.
10. Tronto (1999), p. 262.
11. Wolf (1996), p. 15.
12. Nelson (1999).
13. Holstein (1999), p. 231.
14. Nelson and Nelson (1996), p. 361.
15. By no stretch of the imagination is feminist bioethics a singular enterprise. Just as there are numerous approaches within feminist ethics, so, too, are there numerous approaches to feminist bioethics. Varieties of feminist bioethicists include cultural, liberal, and radical feminist bioethicists. For a clear account of the various kinds of feminist bioethics, see Tong (1996).
16. Tong (1996), p. 86.
17. *Ibid.*, p. 72.

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