CREATED CO-CREATOR AND THE PRACTICE OF MEDICINE

by Ann Pederson

Abstract. There is a crisis of interpretation experienced by those making critical-care decisions and creating health-care policies and by the patients and families who make life-and-death decisions. For example, at both the beginning and end of life, new technologies are changing the way we define life and death. We can prolong life or hasten death in ways that we could not earlier have imagined. This crisis of interpretation demands new ways of thinking and doing. My task is to explicate how the created co-creator can be used as a springboard to help link theological concepts with feminist concerns about two issues: interpreting the culture and practice of medicine in a new way, and explicating the ambiguity of decision making when considering issues of life and death.

Keywords: ambiguity; bioethics; created co-creator; feminism; health; in vitro fertilization; medicine; reproductive technologies.

Recently my work in religion and science has shifted into bioethics, particularly as I consult and teach with physicians in reproductive medicine and palliative care. The questions and issues that I encounter in these areas raise ethical and theological conundrums that demand creative and careful analysis. While the disciplines of religion and science and bioethics are related, they are more like cousins than siblings. Many of the issues cover similar methodological and substantive ground, yet the field of bioethics often raises urgent dilemmas in acute health-care situations that provide opportunities for analysis that differ from those in religion and science.

Philip Hefner's theological framework of the created co-creator is a jumping-off point for advancing the discussion in bioethics. In this essay I

Ann Milliken Pederson is Professor of Religion, Augustana College, 2001 S. Summit, Sioux Falls, SD 57197.

[*Zygon*, vol. 39, no. 4 (December 2004).]
© 2004 by the Joint Publication Board of Zygon. ISSN 0591-2385

explicate how the created co-creator can be used as a springboard to help link theological concepts with feminist concerns about two issues: interpreting the culture and practice of medicine in a new way, and explicating the ambiguity of decision making when considering issues of life and death.

In my work with undergraduates, fourth-year medical students, and masters-level nursing students, I encounter a broad range of issues that need addressing. A common theme with all of the students I teach is similar to what Hefner names as a crisis of interpretation in our technological and scientific age. Hefner explains:

> Ours is a technological culture, and I believe that our culture is at a crisis point, because we are not able to direct our culture in ways that promote the most wholesome life for the human community and its encompassing natural environment. One of the features of this crisis is that we are in many ways alienated from nature and technology, and hence from ourselves. Since the created co-creator embodies our oneness with technology in a vivid manner, it is a symbol both of our truest nature and of our alienation from our nature. (Hefner 2002, 5)

This crisis of interpretation is experienced by those making critical-care decisions and creating health-care policies, and by the patients and family members who make life-and-death decisions. For example, at both beginning and end of life, new technologies are changing the way we define life and death. We can prolong life or hasten death in ways that we could not have imagined. However, many people are personally unprepared to face those decisions in informed ways. Therefore, many decisions are made in haste and with regret. The challenge before us is to be medically and scientifically informed about the issues and spiritually prepared to face them.

We are facing ways of being human that have changed in unprecedented ways, and this demands new ways of thinking and doing. Witness the human genome project as evidence. Many bioethicists regard the principles and abstract theories as insufficient for these new questions. We need frameworks that creatively confront and confound our previous ways of thinking and push us into new ways that are both fruitful and wholesome not only for human life but also for the life of this planet. Such an agenda is urgent. Hefner has found that the work of certain feminist theorists helps expand his notion of the created co-creator and interpret our relationship to technology and nature. In particular, he has drawn on Donna Haraway's use of the cyborg. I believe that Hefner's construct of the created co-creator is a matrix that provides a fruitful springboard for connecting feminist thought and theology. He notes that his construct does not challenge traditional Christian doctrine as much as it "accentuates those ancient teachings, and also puts a new face on them" (Hefner 2002, 5). His improvisation on the themes of previous traditions brings their melodies in new harmonies to different ears.

Traditional worldviews that inform the practice and science of medicine, often embedded in Enlightenment dualisms, pit technology against

nature and human against nonhuman nature. Some who practice medicine still consider the body a machine and the physician a mechanic who simply fixes parts. The focus is on cure, not care. Intervention takes precedence over prevention. We worry about the immediate decision and ignore the long-term consequences.

Technology is changing who we are so rapidly that our self-understandings cannot keep up. For example, the traditional definition of parenthood is radically challenged by advances in reproductive medicine. Hefner joins the created co-creator with Haraway's cyborg to address the boundaries in this changing landscape of the human situation. The result is a powerful construct that shatters dualisms. With this in hand, Hefner speaks about *technonature* and *culture-nature*, constructs that expand boundaries. Technology, nature, and culture weave webs of relationships in which humans find themselves caught. Hefner's construct of the created co-creator provides a way into and through the relationships that inform, provoke, and create ways of being in relationship that promote human wholeness. Our well-being is linked to the well-being of all creation. Feminist bioethicists sharing similar concerns with Hefner also urge us to find new ways to think about the ethical issues that we face.

This reshaping begins with epistemological and methodological changes. Karen Lebacqz, a feminist ethicist, shares her concern that the "predominant western approach to bioethical issues suffers serious limitations and should be challenged in light of some emerging ethical reflection, particularly that of feminist and liberation theology" ([1980] 1998, 83). She explains that the prevailing paradigm or approach to bioethics has the following five features: (1) The focus is decision-oriented, on "doing the right thing." It assumes one right answer. (2) The primary approach is highly individualistic, specifically on the physician-patient relationship. (3) The methodology is ahistorical and does not take context or social location seriously into decision making. Generalizations abound, and universal answers apply to all contexts. (4) Scientific evidence is considered normative, and feelings and emotions are ignored as "data." (5) There is a "failure to specify the grounding of norms" ([1980] 1998, 86).

Drawing on the work of feminist and liberation theologians, Lebacqz provides some challenges and alternatives to these five features: (1) Feminist and liberationists are not as concerned about the right action or right answer as about analyzing and discerning structures of meaning and power. One must look at the dominant social structures and lives of those impacted by them. (2) The individual is interpreted in relationship to context: his or her immediate life story within the larger narrative. This is similar to the task of theology, which takes into account story and experience as data for reflection. (3) A historical approach considers the social context and location as a beginning point for ethical discernment, particularly the "oppression of people through time" ([1980] 1998, 87). (4) Scientific

"facts" are not the only sources for evidence. Experience of those who have been avoided, ignored, or oppressed must be considered. (5) The norm for ethical theory is not universal but must consider the standpoints of different groups ([1980] 1998, 84–88).

Other feminist bioethicists share many of Lebacqz's concerns. Margaret Farley notes that the themes of relationality, human embodiment, and human assessment of meaning and value of the world of nature are central to feminist bioethics ([1985] 1998, 91–95). These themes seem like a match made in heaven with the theological framework of the created co-creator. The epistemological and methodological framework for making ethical decisions is enriched through the use of narrative, social location, expanded data, and a diversity of perspectives.

Hefner's agenda, like that of many feminist and liberation theologians and ethicists, promotes concern for both the human community and the natural environment. The heart of Hefner's theological framework is:

> Human beings are God's created co-creators whose purpose is to be the agency, acting in freedom, to birth the future that is most wholesome for the nature that has birthed us—the nature that is not only our own genetic heritage, but also the entire human community and the evolutionary and ecological reality in which and to which we belong. Exercising this agency is said to be God's will for humans. (Hefner 1993, 27)

Discerning what is wholesome for human life and nonhuman life is the task of Christian theology and also the task of bioethics. Careful theological analysis is needed to make the transition from the scientific/technological discoveries to the implications for ethics. People often make gut-level decisions without careful deliberation. For Christians, that deliberation must be theological. Hefner's framework provides structure and clarity to advance the theological and ethical discussion. A place to begin this discussion is with the culture of medicine itself.

The traditional medical model and prevalent approach to bioethics often reinforces dualistic thinking. How does one change a medical model that is reinforced by power and privilege? How does one change a framework of traditional bioethics that is wed to Enlightenment presuppositions? Susan Wolf, a feminist bioethicist, explains four features of the dominant medical and ethical paradigm:

> . . . a historical preference for abstract rules and principles that disregarded individual difference and context; an embrace of liberal individualism that obscured the importance of groups; the structure of bioethics as a field frequently serving government, medical schools, hospitals, and health professionals in a way that may have discouraged attention to the views of people lacking power inside and outside those institutions; and the frequent isolation of bioethics from major trends within the academy, including feminist, Critical Race Theory, and postmodernism. (Wolf 1996, 14)

In a similar way, Susan Sherwin demonstrates a need for an approach to moral issues that involves more than theories and principles in traditional

bioethics. She claims that a feminist model of ethics has an "interconnected social fabric, rather than the familiar one of isolated, independent atoms; and it gives primacy to bonds among people rather than to rights to independence. It is a theory that focuses on concrete situations and persons and not on free-floating abstract actions" (Sherwin [1987] 2001, 540).

A feminist approach to ethics involves more than abstract theories and principles that are addressed to abstract agents. In my work with the Masters in Community Health at Augustana College, I have discovered a program that challenges the dominant medical model and offers new ways of working with patients and their needs and fits with feminist theory. The nursing department at Augustana College embodies the heart of the created co-creator. Drawing upon different nursing theorists, they developed a program that emphasizes community health care based on patient needs. The emphasis of the curriculum is to "prepare nurses for health care provision to individuals, families, groups and communities, with particular emphasis upon populations who have limited access to health care by virtue of age, ethnicity, health status, geographic location or economic resources" (Augustana College 2002). The notion of health is constructed from the perspective of the patient, not imposed from the health-care provider. Contrary to most traditional medical models of developing notions of illness and health, this nursing department sends nurses into communities to listen and learn about the needs of people before a health protocol is ever developed. This forward-thinking program is taking risks to prepare nurses for the radically changing nature of health care. Furthermore, the nurses are prepared to serve underrepresented populations that traditional medicine has often ignored.

I teach the course "Feminist and Liberationist Approaches to Health and Wellness" for students in Augustana College's Masters Nursing programs in community health. One of the texts we use is *Refuge: An Unnatural History of Family and Place* by Terry Tempest Williams (1991). A poet and naturalist, Williams relays the stories of the slow death of her favorite bird refuge on the Great Salt Lake and of her mother's prolonged battle with and death from ovarian cancer. The stories parallel each other through movements of tragedy and spiritual grace.

In light of the nursing department's mission, I use *Refuge* as a model for how narrative and the construct of "place" help students to develop broad and inclusive notions of illness, health, and wellness. Williams's uses of story and location are powerful hermeneutical tools for developing the categories of illness and health that the nurses use in the communities with whom they are working. The students adapt Williams's understandings of place to inform how they work in the locations with the patients with whom they develop relationships. The book reinforces in stories what is learned in theory in the nursing program.

Williams writes, "Perhaps, I am telling this story in an attempt to heal myself, to confront what I do not know, to create a path for myself with the idea that 'memory is the only way home'" (1991, 4). As a theologian, I know that the way tradition is passed on is primarily through story and ritual rather than through abstract doctrine. Central stories manifest the character of the cosmic order and the human relationships within it. These stories shape the character of community life, and people find their place within the story. Identities are shaped by story, by remembering. The stories then are recalled in liturgies and rituals. Stories shape worlds, and the world also shapes the narratives.

Williams uses story as a means of expressing the metaphor of place in constructing a spiritual and ecological autobiography. The process of writing locates spiritual autobiography in the particular events and places of a person's life. We experience and interpret the world through the geographies, locations, and particulars of our lives. Feminist writers and theologians like Hefner share this use of location as a hermeneutical construct. They begin their narratives or theological exploration with the examination of lives as data for reflection. The idea of constructing spiritual geographies criticizes the disembodied, abstract writing and theological thinking so often influenced by the Enlightenment separation of mind/body, spirit/nature, God/world, male/female, subject/object.

The process of writing and reading spiritual narratives through examination of places in everyday life serves several purposes. First, constructing a narrative is a process. The very act of writing over time helps one to realize that his or her spiritual life is both a journey and a dwelling. Moments occur over a lifetime and accumulate to tell one's story. Second, narratives construct communities. In the act of sharing stories, people connect to other creative conversations and memories. These stories, much like the narratives of the gospels or the words of the liturgy, shape and bind people to one another and to a place. Third, narrative helps one to go back to know what one knew before and know it again somehow in a new and different way. Returning to the familiar, to one's origins, to one's place enables the self to be known in a new way. Fourth, writing a narrative enables a person to experience a kind of knowing that is internal and deep. This is not the location that has to do with street signs or maps; it is an embodied knowing. Williams calls it the erotics of place. Narrative helps students to look back, to return to places with new eyes. To see with new eyes is to be transformed by an alternative vision. Finally, narrative leads to transformation. We see anew what we have taken for granted. Through the process of writing our spiritual narratives, we can return to our origins.

I have each nursing student write a spiritual autobiography and then connect it to the story of Williams. What I have learned from reading the students' autobiographies and from their discussion of *Refuge* can be summarized in three points:

1. *Health is a much broader concept than is traditionally conceived of and taught in a medical model.* Williams writes, "An individual doesn't get cancer, a family does" (1991, 214). The nursing students spend significant amounts of their time in the community they choose, listening and getting to know the people. After relationships are established and trust is developed, the community members decide what their medical and health needs are. Then the nurses help the community members develop a plan to meet their goals and needs. This is vastly different from a traditional model in which the health practitioner simply fixes the part of the person like an auto mechanic tunes up an engine. Health is fundamentally a relational concept, rooted in one's place in the world.

2. *Human health is intimately linked to ecological/cosmological health.* "There are those birds you gauge your life by. The burrowing owls five miles from the entrance to the Bear River Migratory Bird Refuge are mine. Sentries" (Williams 1991, 8). An important correlation exists between one's place in the world and illness. Several women in the nursing program experienced the loss of their family farm at the same time that they lost a parent or significant family member. One woman from Aberdeen, South Dakota, wept openly in class as she linked Williams's narrative to her own—the death of her mother from cancer and the loss of the family farm. All occurred in the same year in the 1980s during the farm crisis. We now know that infertility and many illnesses are caused by exposure to pesticides and other chemicals on the farm. Economics and agricultural practices work hand in hand sometimes to create a toxic place for the inhabitants of farms.

Like Williams, the students in the nursing program recognized that their losses were deeply interwoven, complicating their grieving. In some cases, when the family farm was sold, the students experienced an onset of serious illness. They were losing their familial, spiritual, and economic grounding. One's ancestry is rooted in the relationships of place and people. The place of one's ancestry creates a way of knowing that is profoundly spiritual and profoundly sensual, rooted in the complexities of both over time. The grieving reveals this sensual intimacy.

Stories convey history and genealogy. "I have known five of my great-grandparents intimately. They tutored me in stories with a belief that lineage mattered. Genealogy is in our blood. As a people and as a family, we have a sense of history. And our history is tied to land" (Williams 1991, 14). This history is more than human; it is a cosmic history, a natural history. And this natural history provides the clues to all the deaths in Williams's family. Her history is identified as a "Clan of One-Breasted Women" (1991, 281). Ironically, it is this family history that is most often disconnected from and ignored in the study of health, particularly in the discipline of bioethics.

3. *The traditional model of bioethics must learn from writers like Williams that the health of women, like the birds in the refuge, is the canary in the mineshaft for judging the health of the planet.*

> We spoke of rage. Of women and landscape. How our bodies and the body of the earth have been mined. (Williams 1991, 10)

> The women closed their eyes. The time had come to protest with the heart that to deny one's genealogy with the earth was to commit treason against one's soul. . . . The officials thought it was a cruel joke to leave us stranded in the desert with no way to get home. What they didn't realize was that we were home, soul-centered and strong, women who recognized the sweet smell of sage as fuel for our spirits. (Williams 1991, 290)

There is an important link between women's health and rural health care. Both women and nature are poor in body and in spirit. Williams's book connects with the insight of ecofeminism that the subjugation of nature is linked to the subjugation of women.

Instead of using a traditional medical model for developing nursing practice, Augustana nursing students are educated to recognize the relationship between the dominant social structures and the impact of those on the lives of the oppressed, to use the telling and shaping of one's life story for the ethical task, and to take seriously the oppression of people through time as valid data and evidence. Stories heal, confront us with what we do not know, and bring us home to where we started. Williams's book provides an alternative strategy for teaching approaches to both health care and bioethics. This text helps us not only to reconstruct new ways of viewing health and illness but also to call for radical change in the way that humans live in and with the natural world.

There is an abundance of material both in religion and science and in biomedical ethics about issues surrounding beginnings of life and endings of life. However, something is missing in the literature. One can hardly pick up a journal, scientific or theological, without confronting questions about stem-cell research or the human genome project. Discussions abound as well about end-of-life concerns, ranging from the definition of brain death to the movements in palliative and hospice care. However, I have not found—and this has been confirmed with colleagues—that the literature around beginnings and endings is brought together in the same discussion, although both raise questions about what it means to be a human person, about the role of technology, and about the future of humankind.

My hope is to bring the research in biomedical ethics on beginnings and endings into conversation with each other to see how these boundary issues can inform each other. Such issues must be theologically grounded for Christian ethics, and I find that Hefner's proposal of the created co-creator is exactly the right framework for linking theology and ethics around these hotly debated issues.

The theological understanding of humans as created co-creators provides a framework for developing theological proposals concerning beginnings and endings of life. For example, at the beginning of life, prospective parents face difficult choices around pre-implantation embryo screening. The marriage between genetic and reproductive sciences changes our notions of what it means to be human, when life begins, the nature of family, and the role of technology. We raise questions like: When should genetic screening be offered and for what reasons? Should we treat the fetus in vitro? Reproductive sciences are changing the nature of what it means to be a parent, to be part of a family. Ethically heated issues such as sexual relations and the definition of life are examples raised by these new sciences and technologies. At the end of life, families face difficult choices about the continuation of care in terminally ill family members. Definitions of death have changed according to medical science and technology. In both cases, technological advances have both enhanced and complicated the ethical decisions we make about what life is and the role that humans have in creating and ending life.

How does the theological construct of the created co-creator help Christians to meet the challenge of reflecting upon the issues about life and death that confront us daily? Hefner locates theological reflection and action in the doctrine of creation, in particular the understanding of the image of God. He explains: "I have attempted to place works, morality, and praxis at the heart of the Christian faith, and I have done so by interpreting function and functionality as intrinsic both to the evolutionary processes of nature as interpreted by the sciences and also to processes of creation endowed with purposes by God, as interpreted by Christian faith" (Hefner 1993, 273). Hefner's proposal intimately connects faith and action, theology and ethics.

How then do we understand the human purpose of co-creating as we face issues about the beginnings and endings of life? We face new crises as we discover what we are capable of creating and destroying. Created in the image of God as co-creators, we must imagine new ways of thinking about our place in the world and our place with God. An area of life that demands such careful reflection is how we understand the relationship between technology, nature, and the beginning of life. The very words "artificial reproductive technologies" seem to go against our understanding of procreation. The lines drawn between natural and artificial no longer make sense. The lines between who is a parent and what a family is no longer work. How do we interpret co-creating in such a quagmire, especially when we assume that our purpose is to "birth the future that is most wholesome for the nature that has birthed us" (Hefner 1993, 27)?

Some people, for religious or philosophical reasons, object to artificial reproductive technologies such as in vitro fertilization (IVF) because they interfere with nature, raise questions about the status of the embryo, or

undermine God's predetermined plan for what a family should be. Yet, the same people may use antibiotics to treat pneumonia. What was once considered a new medical intervention is now a "natural" part of treatment. How do we decide when to use technologies or medical treatments? Simply dismissing them as "unnatural" hardly seems helpful.

Others object to IVF or other reproductive technologies because they treat embryos as objects and not subjects, because embryos do not result from a loving action but from technology that is market driven. And yet, the consumer's mentality of modern medicine is hardly confined to reproduction. Why are these particular issues so problematic? If one assumes that there is a simple or single answer, the multifaceted nature of the issues cannot be addressed. Decisions about whether or not to use artificial reproductive technologies need to be placed within frameworks like that of the created co-creator in order to interpret what the crisis is all about. Raising and clarifying the questions is part of the task.

For example, most feminists share the concern for autonomy held by most contemporary moral theorists. Women want choice and freedom with regard to reproduction. It would seem to follow that feminists would support the use of IVF. But a careful look reveals that some feminists question the nature of autonomy that is presumed for women by the dominant patriarchal culture. The procedures and technology of reproductive medicine are often controlled not by women but by a male medical establishment. Sherwin explains, "The supposed freedom of choice, then, is provided only to selected women who have been screened by the personal values of those administering the technology" ([1987] 2001, 538). The personal biases of the physicians could determine who receives treatment and how much it costs. For some physicians, a woman must be heterosexual and in a traditional marriage to qualify for IVF. While IVF might be available to women who are not married, it is not available to women who are poor. IVF is an expensive treatment.

A woman's autonomy also might be compromised by the society's pressure on her to reproduce. Sherwin explains that "women are persuaded that their most important purpose in life is to bear and raise children; they are told repeatedly that their life is incomplete, that they are lacking in fulfillment if they do not have children" ([1987] 2001, 539). Many women do not feel part of the mainstream of society unless they have children. A woman's worth is still judged biologically. However, children are not "property" of just their parents; ideally, everyone would help bear responsibility for the well-being of children. According to Sherwin, "in such a world, it would not be necessary to spend the huge sums on designer children which IVF requires while millions of other children starve to death each year. Adults who enjoyed children could be involved in caring for them whether or not they produced them biologically" ([1987] 2001, 539).

Artificial reproductive technologies raise the crisis of interpretation (nature/culture) about which Hefner is concerned. Do reproductive technologies best serve the interests of the human community or the rest of the natural world? This question needs further examination. The interrelationship of nature and technology can range from questions about the causes of infertility and the alienation of women from the very process of birthing to issues about access and cost of the treatments. A feminist ethic considers the social, economic, racial, political, and religious structures and relationships that influence the role, status, and health of women. To develop policies and protocols about artificial reproductive technologies is to consider the obligation we have to those who bear the burden of reproduction. Ethical decisions must begin with considering the impact that these technologies have on women's lives. Women must not only be a part of but should take leadership in decision making.

Co-creating in this context involves not only the physical procreation of giving birth but also active participation in the decision making about policies and procedures that arise from the technologies. Most reproductive technologies and matters are concentrated in the hands of those who do not do the actual bearing and rearing of children. For years, women were reduced to their reproductive functions. This compromises not only women but also men. Women must become much more involved in the political and medical arenas where decisions about their health are made.

To be a created co-creator is to be caught in an ambiguous web of freedom and responsibility. The freedom that identifies the created co-creator is not synonymous with the "autonomy" of Enlightenment individualism. "The appearance of a *Homo sapiens* as created co-creator signifies that nature's course is to participate in transcendence and freedom, and thereby nature enters into the condition in which it interprets its own essential nature and takes responsibility for acting in accord with that nature" (Hefner 2002, 5). No area of life bears greater witness to this relationship of ambiguity and freedom than the responsibility that comes with the use of reproductive medicine. We are asking: What is the nature of the family? Who is a parent? Are children a right, a responsibility, a privilege? Who should reproduce and why? What does it mean to be a human person in light of reproductive technologies? These questions are examples of what we face as we seek to give birth to our future.

Technology complicates, frustrates, and enhances our lives. We live in communities and cultures that create and construct the meaning of what it means to be human. To be human is to live in the freedom of ambiguity. The richness of the context in which we make decisions reflects the ambiguity of our creatureliness and of our freedom. Our freedom must always be interpreted in light of that context which is the cosmos writ large.

NOTE

A version of this essay was delivered at the Chicago Advanced Seminar in Religion and Science, "The Created Co-Creator: Interpreting Science, Technology, and Theology," organized by the Zygon Center for Religion and Science, Spring 2002.

REFERENCES

Augustana College. 2002. Master of Arts in Nursing: Advanced Nursing Practice in Emerging Systems. *Http://www.augie.edu/dept/graduate/nursing.html.*

Farley, Margaret A. [1985] 1998. "Feminist Theology and Bioethics." In *On Moral Medicine*, ed. Stephen E. Lammers and Allen Verhey, 90–103. Grand Rapids, Mich.: William B. Eerdmans.

Hefner, Philip. 1993. *The Human Factor: Evolution, Culture, and Religion*. Minneapolis: Fortress.

———. 2002. "The Created Co-Creator." *ZCRS: Reports* 2 (March): 1–5.

Lebacqz, Karen. [1980] 1998. "Bio-ethics: Some Challenges from a Liberation Perspective." In *On Moral Medicine*, ed. Stephen E. Lammers and Allen Verhey, 83–89. Grand Rapids, Mich.: William B. Eerdmans.

Sherwin, Susan. [1987] 2001. "Feminist Ethics and In Vitro Fertilization." In *Bioethics, Justice, and Health Care*, ed. Wanda Teays and Laura Purdy, 537–42. Belmont, Calif.: Wadsworth/Thomson Learning.

Williams, Terry Tempest. 1991. *Refuge: An Unnatural History of Family and Place*. New York: Vintage Books/Random House.

Wolf, Susan. 1996. "Introduction: Gender and Feminism in Bioethics." In *Feminism and Bioethics*, ed. Susan M. Wolf, 4–44. New York and Oxford: Oxford Univ. Press.