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Integrating intersectionality into autonomy: Reflections on feminist bioethics and egg freezing

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Abstract

Wilson et al. argue that the field of bioethics struggles with the complexity of diversity and power differences. Although their article ‘Intersectionality in Clinical Medicine: The Need for a Conceptual Framework’ and its accompanying commentaries are inventive and thought-provoking, key principles of biomedical ethics are overlooked. In this paper, I reflect on the debate and consider how an intersectional approach could inform normative theorizing. Traditional principlist reasoning leads to serious problems when we are trying to deal with the complexities of intersectionality, and this is especially true if we look at the principle of autonomy. I develop the idea that intersectionality is more in line with feminist inquiry in bioethics that attempts to reconfigure autonomy relationally. However, feminist critiques of autonomy often do not sufficiently engage with intersectionality. The case of social egg freezing is used to further support this claim. By foregrounding an intersectional approach to the existing claims on relational autonomy in this debate, the complicated relational and justice concerns around reproduction are better brought into focus.

Keywords

Intersectionality; feminist bioethics; principlism; autonomy; social justice; egg freezing

Introduction

Bioethics emerged in the late 1960s, triggered by the ethical issues arising from rapid advances in biomedicine and widespread protest against such gross abuses of medical authority as Nazi doctors' experiments and the Tuskegee Syphilis trial. Despite its initial concerns with the protection of vulnerable patients and research subjects, the field of bioethics struggles with the complexity of differences and marginalization. The challenges bioethics faces when it comes to integrating diversity can be attributed to its early embrace of universalistic and difference-blind analytic traditions, such as Kantian deontology or utilitarianism, and the endorsement of liberal individualism as the leading moral vision. By the early 1990s, feminist bioethics appeared as a response to these dominant ways of doing bioethics that consistently overlooked the concerns and subordination of women. This is exemplified in feminist bioethics' critique of the narrow conception of autonomy defined in terms of securing informed consent (e.g. Beauchamp & Childress, 2019) and suggestions to reconceive autonomy in ways that would give fuller consideration to the agency of women by elucidating their lived realities (Mackenzie & Stoljar, 2000).

More general, feminist approaches to bioethics have engendered a more politically engaged bioethics, whereby activist practices and academic theory could be blended, with the aim of improving the lives of the oppressed rather than just generating universal knowledge inattentive to power structures (Scully, 2018). However, feminist bioethics have been accused of presuming a commonality of moral experience among women across cultures and, in doing so, of ignoring other significant differences beyond gendered relationships. This marks an uncomfortable echo of their own critique toward malestream bioethics. To correct this situation of epistemic injustice, other lenses such as queer bioethics (Cooley, 2020; Leibetseder, 2018), disability studies (Kafer, 2013; Scully, 2008), literary bioethics (Linett, 2020), decolonization (Fayemi & Adeyure, 2016) and intersectionality (Wilson et al., 2019a) were developed, resulting in the burgeoning plurality of voices at the margins of the bioethics field.

For over three decades, the concept of intersectionality has addressed the central theoretical problem of acknowledging differences among women and the long legacy of excluding the 'other' as a normative subject (i.e. people of color, queer, disabled, and pious women). In citational literature, the term is bound to two articles of the legal and critical race scholar Kimberlé Crenshaw. In 'Demarginalizing the Intersections of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Policies' (1989), Crenshaw used metaphors of intersections and basements to describe Black women's experiences of juridical invisibility as perpetuated by social hierarchies. In 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' (1991), Crenshaw invoked intersectionality as a 'provisional concept' toward 'a methodology that will ultimately disrupt the tendencies to see "gender" and "race" as exclusive or separable' (p. 1244). Though the term is attributed to Crenshaw, the concept is couched in centuries of women-of-color activism (such as Sojourner Truth, Anna Julia Cooper, Toni Cade Bambara, Frances Beal, and the Combahee River Collective) resisting forms of institutional oppression (Carastathis, 2016).

The field of bioethics has been slow in adopting the concept of intersectionality. To date, only a small body of research applies the concept in this field. Rogers and Kelley (2011) were among the first to introduce intersectionality as a theoretical framework to health research ethics. Various authors have also used intersectional directives to clarify the effects of transnational surrogacy, migrant care work and disability criticism of selective reproductive technology (Hankivsky, 2014; Khader, 2013; Munthe, 2020). Furthermore, Grzanka, Brian and Shim's (2016) commentary on bioethics' lack of interest in combating racism stated that the field 'must adopt an intersectional approach to the study and contestation of complex inequalities' (p. 27). These articles could be considered as precursors to the recent debate in *The American Journal of Bioethics*. Wilson, White, Jefferson and Danis's (2019a) article, 'Intersectionality in Clinical Medicine: The Need for a Conceptual

Framework' and its accompanying commentaries shine new light on this discussion through an examination of what intersectional bioethics might look like in the clinical context. These publications offer a point of departure for a more integrated and sustainable conversation in bioethics, recognizing intersectionality's relevance. But the development of intersectional bioethics is not confined to privileged spaces of academic publications and high-impact journals, of course. The individuals, organizations, and advocacy groups already fighting intersecting forms of health disparities play an equally crucial role, and will surely contribute to future directions in the field.

In this paper, I want to contribute to the emerging debate on intersectionality in bioethics by sketching out how an intersectional approach could inform normative theorizing in this field. I begin by discussing the article of Wilson et al. and its commentaries in *The American Journal of Bioethics*. Here, I note that they do not examine the relationship between intersectionality and existing normative theories (such as principle-based formulations) and their underlying central values, including autonomy. Therefore, in the second section I focus on this issue and show how intersectionality contrasts with traditional principlism. I develop the idea that intersectionality is more in line with feminist accounts of relational autonomy. However, this conception of autonomy has yet to thoroughly engage with intersectionality, as evidenced in the case of egg freezing. In the last section I examine how the in-tandem reading of relational autonomy and intersectionality offers us more and clearer directions to uncover what is morally at stake with this emerging trend in assisted reproductive technology (ART) that changes normative discourses of family-making.

The conversation starters

In their recent article, Wilson et al. (2019a) immediately narrow their engagement with intersectionality to a focus on clinical medicine.¹ Their argumentation is mostly situated at the level of clinical bioethics, and aims to apply some of the theoretical tools provided by intersectionality to this context. In the first sections of the paper, they argue that intersectionality is not just a simple analysis of multiple identities (such as race, gender, sexuality and class). Instead, they discuss it as a conceptual framework shining new light on existing social structures (of power and exclusion) that make those marginalized by such identity categories more vulnerable and often invisible. They refer to Cho, Crenshaw and McCall (2013), who conceptualized these social categories as 'fluid and changing, always in the process of creating and being created by dynamics of power' (p. 795). This raises questions of which social positions of patients we should include, drawing on an intersectional framework.

One can claim, as Wilson et al. (2019a) do, that it is important for clinicians to recognize all aspects of identity and not just focus on marginalized subjectivities. This means that attention is necessary not only for queer women of color, for instance, but also for white heterosexual men. Nonetheless, the idea of intersectionality as a tool through which all subjects can locate themselves is controversial. The majority of intersectional scholarship has centered on the particular positions of multiply-marginalized subjects and the discriminations associated with such positions. This reflects an unresolved theoretical dispute: is intersectionality a theory of marginalized subjectivity or a generalized theory of identity (Nash, 2008)? It is undeniable that we all have intersectional identities, but difficulties arise when intersecting social privileges are not taken into account. Therefore, an argument that uses this claim of 'intersectionality for all' to flatten power relations is suspicious because it creates distinctive political and representational problems for marginalized subjects in medicine.

The second part of their paper is less theoretical and contemplates how thinking

¹ Wilson et al. (2019a) do not deny the role of intersectionality in other contexts but target the very specific problems that the three clinician-authors of the article have encountered. The first author, Yolonda Yvette Wilson, has a background in social and political philosophy.

from an intersectional framework might enrich clinical experiences. The case of an ethnic-minority construction worker, with chronic lower back pain, searching for opioids and not receiving them, is discussed to highlight issues of structural disadvantage and ethnicity. This person and other patients may carry various issues into clinical encounters: for example, implicit biases of clinicians against persons of color often stereotype them as drug abusers. According to Wilson et al. (2019a), intersectionality makes physicians aware of ‘the power dynamic in the patient–physician relationship and the possible ways that the patient’s intersecting social identities could lead to social disadvantage and marginalization’ (p. 12). Thus, it is a tool to stress the importance of always situating patients in complex socio-historical and intersecting power relations. Wilson et al. (2019a) acknowledge that, by introducing the process of shared decision-making, bioethics literature has addressed worries about power differentials that encourage patients to express their personal preferences and values to inform clinical decisions. However, they argue that wider power differentials of race and ethnicity are often reduced.

In the last part of the article, the authors consider some objections with regard to intersectionality theory and its clinical applications. For example, Eckstrand et al. (2016) have developed tools like cultural competency and humility to address health inequalities, focusing on the efforts and skills of individual clinicians to foster sympathetic understanding. Intersectionality seemingly promotes many tenets of this tool. However, it is also distinct because it takes ‘into account structural forces, cultural forces, multiple forms of oppression and/or privilege, and the unique social identities that are derived from these interlocking factors’ (Wilson et al., 2019a, p.15). Wilson et al. (2019a) additionally discuss more general objections to intersectionality, applicable beyond clinical medicine. For example, some have problematized its lack of clear methodology and inherent ambiguity (McCall, 2005; Nash, 2008). Wilson et al. (2019a) make a riposte by again referring to the paper of Cho, Crenshaw and McCall (2013). The latter conclusively showed intersectionality as not just a model of identity but an analytical sensibility or heuristic device that tries to capture the complexity of micro and macro aspects of interlocking forms of oppression.² Furthermore, Wilson et al. (2019a) conclude that this theoretical discussion of the foundations of intersectionality does not undermine ‘the application of intersectionality in the clinical environment’ because it still ‘facilitates a broadening of thought that forces clinicians to rethink the ways that axes of identity shape both interpersonal and institutional interactions’ (p. 16).

Since its appearance, the article has been commented upon by several bioethicists, philosophers, clinicians and psychologists. Their commentaries reflect a wide variety of topics and approaches. For some, the ability of intersectionality to address health inequalities has been limited due to the idealist (rather than scientific realist) ontology by which it lends to moral relativism (Muntaner & Augustinavicius, 2019). For others, the framework of intersectionality has held significant appeal (Barned et al., 2019; Grzanka & Brian, 2019). Nevertheless, these authors are critical of Wilson et al. (2019a) because of their focus on the dyadic interactions between patients and clinicians, and argue that it diminishes the importance of other requirements of intersectionality, like social justice.

Grzanka and Brian (2019, p. 23) are unconvinced whether ‘clinical interactions in and of themselves are capable of engendering social transformation.’ They point to more urgent obligations for bioethicists to research that warrant intersectional solutions. These include ‘universal health care, prison abolition, and reproductive and environmental justice’ (p. 25). Some critiques caution that the proposed conceptual framework of Wilson et al. (2019a) does not go far enough to facilitate dialogue across differences in the clinical encounter. Lanphier and Anani (2019) formulate concerns about clinicians assuming that expert knowledge is their domain, as this may stigmatize or ‘other’ patients. As an alternative,

² Matsuda (1991, p. 1189) articulated one of the most celebrated accounts of how to apply an intersectional heuristic through the method she calls ‘ask the other question’: ‘When I see something that looks racist, I ask, “Where is the patriarchy in this?”’

they introduce narrative ethics, a reciprocal practice of telling and listening, to supplement intersectionality and to guard against these biases, and to better foster mutual understanding and trust. In a similar vein, Eilenberger, Halsema and Slatman (2019) suggest a phenomenological perspective because it brings to light the existential dimension of intersecting social differences.

As a reaction to the critique of moral relativism, Wilson et al. (2019b) declare that intersectionality's focus on social identities does not preclude other modes of existence from evaluation. On the contrary, this focus on social identities works to expose mechanisms of oppression and reflect on broader values of fairness and equality. In response to comments about their supposedly narrow focus on micro-level interactions, they deny making arguments that ignore commitment to social justice. To illustrate this point, they refer to an earlier paper they co-authored (Danis et al., 2016), which calls for bioethicists to move beyond the traditional locus of clinical activity and include social factors like police violence in their analysis. According to Wilson et al. (2019b), suggestions concerning narrative ethics and phenomenology are consistent with their conceptual framework. Hence, they argue that these approaches imply analytical spaces related to intersectionality that are yet to be explored.

Wilson et al. (2019a) have demonstrated some of the challenges that intersectionality brings to clinical medicine, and highlight the importance of situating the doctor-patient dyad in historical, interlocking power relations. What remains unclear is intersectionality's relevance for bioethics more broadly and commonplace normative theories of this field. Wilson et al. (2019a) mention shared decision-making but makes no attempt to provide any further theoretical considerations for this concept. It is noteworthy, given its prominent place in the curriculum of medical students (defining norms that guide health care practices), that this article has paid little attention to the *Principles of Biomedical Ethics* (Beauchamp & Childress, 2019).

According to Grzanka, Brian and Shim (2016, p. 28), intersectionality could be perceived 'as a form of ethics itself [...] to be taught alongside key bioethical theories such as principlism, utilitarianism, and virtue ethics.' However, it would be unwise to overestimate the importance or potential of the concept of intersectionality: it does not provide a complete ethical theory and, as such, it does not *a priori* favor any particular bioethics standpoint.³ Nonetheless, its heuristic nature, focusing attention on the vexed dynamics of difference and motivated by ethical-political concerns, can help with rethinking existing frameworks such as principlism, and with re-examining their main underlying philosophical constructs. Therefore, in the following section I consider the implications of intersectionality for principlism, and focus on how one of its central tenets (i.e. respect for autonomy) can be reconceptualized.

The roadblocks and intersections of bioethical principles

Principles-based reasoning is probably the most dominant normative framework in contemporary bioethics (Shea, 2020). It is an approach of ethical reasoning based on a 'common morality' justification, featuring four abstract universal principles (i.e. respect for autonomy, beneficence, nonmaleficence and justice). These principles often conflict, but can be resolved in a given situation through pursuit of moral judgment and rational enterprise. These then rely on the processes of application, specification and balancing to assess the individual case – often taking the form of reflective equilibrium (Rawls, 1971). Nevertheless, autonomy continues to function implicitly as the hegemonic value in this approach, providing a reflexive touchstone for analysis in nearly every bioethics topic (Gillon, 2003). Herein, decisions are considered autonomous (and, by extension, morally right) if individuals satisfy the following criteria: they act intentionally, are free from direct constraint, and have

³ As Gasdaglis and Madva (2020, p. 1288) argue, intersectionality is 'a regulative ideal, that is, a guiding methodological principle, rather than a general theory or hypothesis.'

sufficient understanding of the presented information (Beauchamp & Childress, 2019). Because there are no obvious connections between the two concepts, this account of autonomy may lead to serious problems when we try to deal with the worries of intersectionality.⁴

Beauchamp and Childress' principlism is based on the assumption of metaphysical priority for an autonomous chooser. The Kantian and Millian underpinnings of this conception of autonomy have led to much criticism. Primarily because it seemingly trivializes the social dynamics and forms of oppression that constitute and situate autonomous action. As Bilge (2010, p. 12) noted, 'women, non-whites, minors and the insane were historically excluded from this liberal account of agentic subjects' because of the obfuscating power relations that constitute such subjects. Indeed, respect for autonomy often appears to be primarily of interest to (and accessible to) those with privilege and power. Furthermore, in Beauchamp and Childress' account, this concept is constructed around micro-level considerations and isolated from macro-level societal issues. This legitimizes trade-offs between local autonomy and justice. Casual constraints (attributable to institutions, traditions and communities) on a person's autonomy are regarded as secondary and may be accounted for in an ethical analysis of concerns about justice. For example, government action aimed at reducing injustices by redistribution of wealth through taxes could be perceived as an improper intrusion on individual autonomy.

Intersectionality as described above thus seems to have little in common with the concept of autonomy used in principlism. The latter, taking a rather liberal standpoint and focusing on individual patients' decision-making, contrasts expressively with the former's focus on power differentials and social justice. But, the work of feminist bioethicists that criticize traditional scholarly approaches to autonomy, offers two avenues of convergence between the two concepts.

First of all, starting from the premise that our identities and self-conceptions are constituted in relationships of interdependence and embedded in the complex contexts of social structures, feminist bioethicists offer an interesting alternative in relational interpretations of autonomy. Based on the work of Jennifer Nedelsky (1989) and Susan Sherwin (1998), a number of feminist authors have revealed how skills related to autonomy are shaped through social structures and norms. This reconceptualized autonomy has been dubbed 'relational autonomy', an umbrella term for approaches to autonomy predicated on a shared conviction that persons are socially embedded. It also holds, for example, 'that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity' (Mackenzie & Stoljar, 2000, p. 4). In this definition of autonomy, we may already observe contributions made by intersectional thought.

Consequently, the work of feminist bioethicists helps to explain why it is necessary to reconceptualize autonomy, moving away from the idea of just stipulating individual criteria—toward addressing the wider social constraints on this kind of decision-making. Choices are always embedded in a complicated network of social structures and ideologies. It is therefore much more convincing to conceptualize respect for autonomy based on the relationality of power and the impact of the self's social situation, instead of a liberal contractor model of informed consent. This is exemplified by the work of Ho (2008), which demonstrates how ableist ideology affects individuals' decisions on genetic testing. Based on a relational conception of autonomy, Ho argues that the principlist model neglects discriminatory attitudes and oppressive effects that can inform subjects' value formation. Therefore, truly promoting autonomy calls for a restructuring of the social framework.

⁴ This does not mean that I do not endorse the importance of an intersectional reading of other principles such as beneficence and nonmaleficence. However, a full discussion of all four principles lies beyond the scope of this study.

A second point of convergence is intersectionality's commitment to social justice (Collins & Bilge, 2016). The goal of much intersectional research is to identify and eliminate social inequities and thereby create more just communities. This is reflected in the praxis of the reproductive justice movement brought about three decades ago by women of color in the United States, in response to the intersectional inadequacies of the reproductive rights movement (Ross & Solinger, 2017). Advocates of reproductive justice eschew a narrow individualist focus on fertility control and self-determination in favor of building networks of solidarity that enable individuals to flourish in their communities (Bakhru, 2019). This is also in line with the concept of relational autonomy: it does not set up an opposition between autonomy and considerations of social justice. Rather, relational conceptions of autonomy lend social justice concerns greater centrality than mainstream bioethics views do (Donchin, 2001). Mackenzie (2010), for example, discussed explicitly the social justice implications of relational autonomy and highlighted how unequal distribution of resources and inequality of opportunity (created by institutions, norms, and practices) can restrict the exercise of self-determination.

Hence, both intersectionality and relational autonomy reframe agency not in a default framework of an atomistic liberal self, but are sensitive to the enabling or constraining roles of social and institutional environments regarding individual self-determination. The concept of relational autonomy shares similar core constructs (e.g. relationality, importance of the social context, and focus on social justice) with intersectionality, but its guiding premises are somewhat different. Relational autonomy is widely used in a number of specific bioethical debates and adjacent fields.⁵ However, clear intersectional premises (such as the interdependency and mutually informing interrelations of race, class, and gender in systems of power that to varying degrees affect individual members of oppressed groups) are often absent from these argumentations (Collins, 2019). Scholars mostly center their thinking on the way oppressive gender norms undermine women's autonomy; in doing so, they may tend to privilege white women as the normative subjects of their argumentation. This produces single-axis logics: thinking in terms of gender and not addressing diversity within minorities—or considering diversity only as an afterthought. Most work on relational autonomy is produced by white Anglo-American feminist scholars who still rely heavily upon the western liberal imaginary of individual subjectivity, without questioning the dominance of whiteness and other privileges. This may explain why some feminist bioethicists, despite their good intentions, hesitate to dig deeper into debates about difference as this would force those authors to consider more fully intersecting privileges and oppressions in their theories, methods and practices (Myser, 2003).

If bioethicists do not want to reinforce broader systems of stratification, it is crucial for explaining ethical dilemmas that their concepts are embedded in inclusive, relational frameworks cognizant of intersections of race, gender, class and sexual orientation. The value of intersectionality for feminist bioethicists lies in its function as a 'framework checker'. It encourages the elimination of unjust social hierarchies and provides standards that every ethical framework or concept should meet (Garry, 2011; Lutz, 2015). Exploring the interlocking social locations of persons and related conditions of opportunity should be incorporated into reflexive practices around relational autonomy. This provides a way for bioethicists to examine the implications of privilege and oppression in medical encounters, and to discover the full spectrum of autonomy. However, this is not often the case—as I will establish in the next section by referring to a recent debate in bioethics.

Further developing the relationship between intersectionality and bioethics

The technology of vitrification is developing rapidly in the field of ART, and witnesses application in a variety of contexts. The attendant debate in bioethics often focuses on social

⁵ For example, there have been debates concerning reproductive/genetic technologies (McLeod, 2002) or end-of-life decision-making (Gómez-Virseda et al., 2019).

egg freezing: women freezing their eggs for so-called social reasons (e.g. the lack of a partner or to invest in their education and career). Specifically, bioethics inquires whether this option empowers women's reproductive autonomy. Little research has examined issues of reproductive justice and intersectionality that determine access to (and quality of) this treatment (De Proost & Coene, 2019). But, this debate may illustrate the foregoing theoretical reflections on relational autonomy and the resulting call for an intersectional framework check. The aim of this section is therefore not to offer an all-things-considered judgment about how clinicians can best respect the autonomy of women freezing their eggs. Rather, the intention is to help us approximate a list of considerations by which to adequately judge how society should deal with this practice, and to develop a more nuanced understanding of possible barriers to autonomy.

A number of scholars deploy a relational conception of autonomy in their assessment of social egg freezing. Goold and Savulescu (2009, p. 50) recognize that women's choice for the use of this technology is socially constrained, but claim it 'can be viewed as [a] kind of reproductive affirmative action' for improving women's employment situation. Petropanagos (2010, p. 9) acknowledges their argument for the permissibility of social egg freezing, but remarks that 'the context of patriarchy is integral in shaping women's reproductive choices.' In a similar vein, Shkedi-Rafid and Hashiloni-Dolev (2012) argue that women lack freedom of choice because of the interrelationship between the technology and the constraints in patriarchal society that push women to simultaneously fulfill career and motherhood goals. These scholars, injecting a relational autonomy framework to this debate, ask: will egg freezing provide greater autonomy or reinforce patriarchal norms? Can it be a symptom of deeper problems related to the gendered division of labor? These ethical accounts make gender a hyper-visible category but still place the middle-class white woman as the normative subject. The common theme among these papers is the need to make greater efforts to address social concerns related primarily to highly educated professional women. Existing bioethical discourses are thus limited in reach and scope, and fail to represent (in the descriptive and normative sense) the experiences and interests of bodies that have been othered through mechanisms of oppression.

The questions above therefore benefit from the framework checker of intersectionality, allowing a relational analysis that interrogates the social categories that emerge at first sight. This demonstrates how the debate insufficiently assess other oppressive conditions that undermine autonomy. Intuitively, the exorbitant costs of egg freezing⁶, combined with sparse insurance coverage for the procedure, already presents an insurmountable barrier for most women. An intersectional approach, however, transcends reflection on one social category, and requires a specification of the relations of inequality.

Indeed, scholars have seemingly ignored the critical importance of race and its interaction with class in social egg freezing. Most European and American egg freezers are highly educated, affluent white women. Women of color, more often poor and working-class, have less access to this technology (Inhorn, 2017). The stereotypical image of professional women as key players in social freezing therefore centers on whiteness and class-based conditions.

As Russell (2015) showed, the notion of race functions in the social imagery making expensive ART procedures more accessible and appealing to some groups than to others.⁷ When racialized women face reproductive dilemmas, their disposition tends to be shaped by structural violence and microaggressions (Dierickx et al., 2018; Rapp, 2019). As Roberts (2012) notes:

⁶ In Europe egg freezing costs between 2000 € and 3000 € for one cycle.

⁷ Data on the use of ART according to race occur mainly in the United States (Voigt et al., 2019) but several scholars have also demonstrated the ethnocentricity of fertility services in Europe. This is illustrated by institutional discrimination and lack of optimized care for minoritized and racialized groups with regard to ART (Culley et al., 2009).

Gender, class, and race inequities help determine the reproductive options available to women, such as a woman's access to assisted reproductive technology (ART), and the consequences that a woman's childbearing decisions have for her, her family, and her community. (p. 778)

We can further complicate this picture beyond the race–class–gender triangle by including queer bodies as a relevant social position for moral theorizing about social egg freezing. According to several scholars, assisted reproductive technologies perpetuate (hetero)normativity, and LGBTQI peoples' use of these technologies is shaped by gender, class, and race stratifications (Leibetseder, 2018). For example, egg freezing may enable childbearing possibilities for queer and trans people, but the low-income and precarious positions where LGBTQI persons of color are often confronted with exclude them from this reproductive service. All these complex social determinants should be unpacked if a judgment is to be made about the extent of risks to autonomy.

Furthermore, intersectionality asks us to be more attentive to the complex differences produced by social stratification, and to reorient our considerations of social justice. As Campo-Engelstein (2020, p. 85) argues, 'these technologies on their own will not benefit all, or even most, women.' It is important to consider and recognize how an expansion of reproductive choices is interconnected with the commoditization of (other) women's bodies. The short-term reproductive interests of all women are not always aligned. Privileged groups lead the lives they do precisely because of other multiple oppressed groups, and the privileged may actually entrench the oppression of some subset(s) of women (Khader, 2013).

At the moment, social egg freezing is not used by a majority of women: from statistics alone, we can identify a niche market, and access to which affects women outside the niche. Indeed, the development of egg freezing plays a pivotal role in the thriving global bio-economy of eggs and may have a significant effect on the practices of egg donation (Baldwin et al., 2019; Waldby, 2019). Evidence suggests that egg donors for third-party reproduction are often marginalized and less economically stable groups of women, subject to exploitative arrangements (Nahman, 2011). Improvements in the technological processes of egg freezing may lead to increased exploitation of those involved in the selling and donation of eggs.

Nonetheless, the fertility industry maintains a 'calibrated socio-political distance' between social egg freezers and third-party reproducers, such as egg donors and surrogates (Ikemoto, 2015, p. 1). This is remarkable because two groups of women undergo a near-identical treatment but are stratified according to race, class, and place. An intersectional approach facilitates a recognition of their radical interrelatedness and shows the strategies women use to exercise their reproductive autonomy. These strategies may function remedially, but they may also reproduce existing social hierarchies. Moreover, the technology of vitrification might privilege the family-making projects of already-privileged women and exclude marginalized women. The introduction of this application has therefore generated new ways of thinking about childbearing and parenting for some women. However, we should be careful that systematic social structures of oppression are not exacerbated in the name of respect for women's autonomy. Relational autonomy and intersectionality are apt conceptual tools to analyze this situation of moral trouble and to set better-contextualized normative boundaries.

Concluding thoughts

Intersectionality has gained an influential status in many disciplines. However, its popularity is less widespread in bioethics as the field struggles with issues of diversity and power differentials. Recent publications in *The American Journal of Bioethics* offer a point of departure for a more integrated and sustainable conversation on intersectionality's relevance in bioethics. I have analyzed these recent publications but, as yet there is no detailed

investigation of the relationship between intersectionality and existing normative theories such as principle-based formulations. I have sought to offer a deeper exploration of the theoretical relationship between intersectionality and one of the central values of bioethical theory—namely, respect for autonomy.

A traditionally principlist account of autonomy is problematic when trying to deal with the complexities of intersectionality. It fails to account adequately for social backgrounds and conditions, nor does it sufficiently address institutional power relationships. Feminist inquiry in bioethics, attempting to reconfigure autonomy by integrating these shortcomings, creates a better theoretical convergence with intersectionality. Yet, clear intersectional premises often lack in applications of relational autonomy. Therefore, intersectionality must be included as a framework checker for any bioethical argumentation based on relational autonomy. I have used the recent debate on social egg freezing to demonstrate this claim.

By foregrounding an intersectional approach to this debate, the complicated relational and social justice concerns of reproduction are better brought into focus. This debate needs further normative and empirical analysis of the specific intersections of race, place, class, gender and sexuality among women who are influenced by different reproductive concerns. Furthermore, it is clear that new research needs to test out the relationship between intersectionality and principlism in different moral contexts. This paper focuses mostly on feminist approaches to bioethics but building alliances with other perspectives on the margins, such as queer and crip perspectives, is crucial. Introducing other dimensions and possibilities for future bioethics research, the conversation of intersectionality goes on and will stir debates and actions to tackle issues of diversity and unequal power relations.

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Conflict of interest

The author declares no conflicts of interests.

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