Appendix D

Feminist Views on Reproductive Technologies

Feminist analyses largely consist of applying political, sociological, psychological, biological, and ethical analysis to the role of women in society. Just as individuals differ in their preferred political and ethical values, feminists differ in their analyses of women's roles, their approval or disapproval of those roles, and their recommendations for changing those roles (I-19). This diversity of views makes it impossible to state categorically that feminists as a group will approve or disapprove a particular application of a particular noncoital reproductive technique. Nevertheless, certain broad areas of agreement exist among most feminists (15), including the following:

- Women have been and are subordinated to men, a phenomenon rooted in women's roles as childbearers and childrearers. Subordination of certain classes and races has also taken place. Subordination of any group based on such characteristics is ethically undesirable. Feminists are particularly sensitive to the interactions of class, race, and gender in the exploitation of women.
- Feminist values emphasize the importance of human relationships, rather than ownership or traditional or legal kinship. A man does not own his wife or any other woman, nor does he have ownership rights over the children she bears. The relations people freely form with each other are to be valued and supported, whether or not they conform to a traditional family form.
- Women have full rights of bodily autonomy. Women have control over their bodies, gametes, conceptuses, and fetuses through birth. This is true whether or not there is a '(right" to have children that can be expressed by having a "right" to medical services, gamete donation, surrogacy, or financial assistance in order to be able to have children. Feminists are concerned with the medicalization of pregnancy and childbirth, and the potential subordination of pregnant women's rights to State intervention ostensibly on behalf of the fetus. Further, the choice to prevent or allow conception and childbirth cannot be considered to be freely made if political and economic institutions make certain choices impractical or impossible.

Noncoital reproductive techniques pose a challenge to feminist analyses. They offer new possibilities for personal choice at the same time as they exacerbate possibilities for exploiting some women or reinforcing societal attitudes concerning the imperative of biological parenthood. Many feminists fear that opening reproductive options for some women may jeopardize women's freedoms overall.

These techniques (gamete intrafallopian transfer, in vitro fertilization (IVF), artificial insemination by donor, surrogate mothering) increase opportunities for conceiving, circumventing male partner absence or sterility, and for bringing a baby to term. When chosen freely, with accurate information about the likelihood of success and an appreciation of the physical, legal, and emotional risks, noncoital reproductive techniques increase an individual's opportunity to realize the goal of genetic or gestational parenthood. Further, in light of the difficulty of adopting a child, they may offer the only hope of forming a family quickly. At the same time, these techniques create new opportunities for isolating and exploiting certain portions of the population, such as surrogate mothers or gamete donors.

Many feminists question how often the choice to have children, and particularly biologically related children, is genuinely free, in light of the cultural milieu in which adult women in the United States have been raised. The decision to seek out these techniques can be motivated by sincere, informed, and voluntary personal desires or by considerations many feminists would like to see deemphasized. The latter include views that genetic linkages are essential to the creation of a genuine family, particularly for men, and that women must bear or somehow provide children for their husbands in order to experience their womanhood fully and meet the societal expectations of marriage, even if at great personal risk, inconvenience, or disinclination.

The development of these techniques entails research and experimentation that may ultimately increase options for procreation, such as making delayed childbearing more feasible. It also invites, however, extensive experimentation with women. Some assert that careerism and a philosophy of "science for the sake of science" encourage research and development of infertility treatments that require women to undergo unpleasant or risky procedures. Many feminists assert that this is exacerbated by the fact that the majority of the researchers and clinicians are male. The relative lack of research into the causes of male infertility, and the resulting dearth of causes identified or treat-

ments offered, means that men are rarely subjected to the same strains of diagnosis and treatment, and so may lack the empathy necessary to appreciate fully the intrusiveness and degradation of many of the procedures. This may lead to an inappropriate degree of enthusiasm within the medical and scientific community for using these techniques. In addition, feminists note that some earlier advances in the area of contraception have actually led to infertility, such as the use of certain kinds of intrauterine devices. This history of interaction between medical advances and women's reproductive health leads many feminists to be skeptical of the success claimed by researchers for their techniques.

In addition, the use of these techniques usually involves medical personnel and procedures. Although welcoming opportunities to enhance the safety of childbearing and the health of infants, many feminists note that numerous physicians and hospitals have come to treat pregnancy as an abnormal, highly dangerous (almost diseased) state. On this basis, a number of hospitals and physicians have moved rapidly to introduce medical interventions that regard the woman as separate from her fetus, that treat the fetus as a separate patient with interests markedly different from and often opposed to the mother's, and that encourage invasive, painful, or dangerous procedures (e.g., internal fetal monitoring, in utero fetal therapy, or cesarean sections) that medicalize the process of birth. The diminution of women's authority to make decisions about the conduct of their pregnancies and childbirths concerns many feminists. This is a particularly sensitive point in the late 1980s, as the women's health movement finds itself just beginning to succeed in its efforts to persuade pregnant women to question more often the medical traditions surrounding childbirth, such as specific birthing positions or indications for fetal monitoring and cesarean section.

The developing techniques for infertility diagnosis and treatment also have potential application in areas that are quite troubling to many feminists. For example, artificial insemination allows manipulation of sperm before insemination, making preconception sex selection a possibility for the future. Given the fact that many cultures express a strong preference for boys, many feminists question whether sex selection should be permitted. While enhancing personal choice for an individual woman, it may have widespread implications for our perception of the relative values of a boy or girl, and even demographic effects should the technique become reliable and widely used. In general, feminists express great concern over the prospects for genetic diagnosis, selection, and manipulation made possible by the use of IVF and research on human embryos.

Some feminists argue that commercializing noncoital reproductive techniques makes them more available, and thus increases access and personal choice for those who can pay. For some women, they also create new ways to earn money, by selling gametes or embryos, or by gestating for a fee. A philosophy of mind-body dualism (which to some extent encourages a view of the body as an object, separate from the mind) supports the choice to use the body as an economic resource.

Other feminists, however, reject this dualism. They fear that commercialization invites a view of gametes, embryos, and even women as commodities to be banked, bought, sold, and rented as a means to procreation. As property, they maybe subject to management, such as governmental or contractual regulation of the behavior of women who are pregnant for a fee. Commercializing embryos or pregnancy, so that custody goes to someone other than the woman giving birth, may exacerbate the view of the fetus and the woman as separate individuals with opposing interests. This in turn may further the view that the interests or bodily integrity of one must be sacrificed to the other. Finally, these techniques create one employment area, surrogacy, that will be exclusively occupied by women, especially those without opportunities to earn money in other ways. Thus what is viewed as an opportunity by some feminists maybe viewed by others as an invitation to exploitation of poor or Third World women.

Overall, it is not possible to state whether feminists will oppose or support any particular noncoital reproductive technique, as there are many feminist voices and many motivations for the use of these techniques. Yet feminists generally oppose developments that explicitly restrict bodily autonomy, that subordinate the ties of pregnancy, childbirth, or childrearing to exclusively genetic or property claims, that limit use to certain classes of people or categories of family unit, or that directly exploit women.

Further, many feminists advocate an effort to provide nontechnological solutions where possible. These include making institutions more flexible in order to allow increasing integration of family life and public activities. This would allow both men and women to participate in childrearing, making it possible to choose to have children at a younger age. Nontechnological solutions also include providing education to prevent sexually transmitted diseases that lead to impaired fertility, helping people to adopt children of all races and ages, and decreasing the social pressures *that lead* many to feel unfulfilled if they do not or cannot have biologically related children.

Appendix D References

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