

ETHICAL ISSUES IN REPRODUCTIVE TECHNOLOGY: A FEMINIST PERSPECTIVE

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Dans cet article, l'auteure soutient que les nouvelles technologies de la reproduction – se trouvant aujourd'hui sous le contrôle des professions scientifiques et médicales, elles-mêmes dominées par les hommes – forment le plus grand danger posé jusqu'à date aux relations entre hommes et femmes. Janice Tait décrit ces technologies et examine les questions éthiques complexes qui s'y rapportent. Dans toute analyse féministe faite des implications de la technologie de la reproduction, nous devons mettre l'accent sur le droit de la femme de prendre des décisions vis-à-vis la conception, la naissance et l'avortement.

INTRODUCTION

The domination of women by men is the most pervasive condition of alienation among people throughout history. The developing reproductive technologies, controlled by the male scientific and medical profession, represent the greatest threat to the fragile connection between the sexes that has as yet arisen. This fragile connection refers to a state of existence wherein the two sexes, while living in their same material world, live out different lives, based on divergent value systems. Neither sex understands the other; nor has the gap in understanding itself been clearly perceived.

In many societies, as Margaret Mead observed, it did not matter what was done in a particular tribe, it only mattered who did it. If weaving in a particular tribe was done by men, it was an occupation of high prestige; if done by women, it was of low prestige. Therefore a major characteristic of patriarchy can be defined as follows: what men do is valued a lot and what women do is valued less.¹

Reproductive labour has been valued less than productive labour by men because this task has been performed by women. By the same token, where reproductive labour is performed by men (gynecologists and obstetricians, as

opposed to midwives), this occupation has high prestige. When women have sought to regain control over our reproductive labour, we have been vigorously opposed by the medical profession. The exclusion of women from public life, the privatization of the family, the arguments from biological necessity have been ideological tools whereby men have ensured not only their control over a process in which they have little to do, but also their power to appropriate the surplus work of women for themselves.²

Reproduction is primarily a female activity; women everywhere, no matter what our material or psychological state, share at a deep level the knowledge of our capacity to reproduce. Even women who have never had children menstruate, and so are reminded monthly of this capacity. However, the emerging technical control over the reproductive process is profoundly altering the relationship between women and their reproductive function, and the dialectic between women and men. These new relationships began with the introduction on a wide scale of birth control technology which offered women potential liberation from the burden of mandatory motherhood (however difficult state intervention and the medical profession have made it). Just as men were always free to choose not to produce, so women now are becoming free to choose not to reproduce. The problem for feminists is that the technical control of reproduction rests primarily in the hands of patriarchal, scientific and medical professionals, whose dedication to research and "techniques" gives little reassurance that women's interests will be considered. In addition, what controls there are on the activities of these men are also mainly in the hands of male technocrats and legislators, who generally have shown little interest in representing the needs or rights of women.

As a result, new questions must be posed by women about the role of reproductive technology in our lives. The feminist position on reproductive technol-

ogy begins with the premise that decisions about conception and birth, as well as contraception and abortion, should be under the control of individual women since we are the group most profoundly affected by those decisions. The fact is that, at the present time, most of these activities are still controlled by men, although it is women who must bear the brunt of the blame for unwanted pregnancies, even where birth control has been practised and failed. Decisions about obtaining abortions still rest with hospital committees (usually male-dominated) and the birthing process remains under the control of the medical profession. The feminist assumption is that if women were more involved in decision-making, the dehumanizing aspects of reproductive technology would be tempered by consultative processes more adapted to a questioning of both means and ends. In the consideration of the techniques of the reproductive process, concern about individual responsibilities and feelings comes into conflict with rights and the "collective benefits to mankind." Women must become active participants in this debate through self-education programs in which purposes, means, risks, benefits and awareness of choices are clearly understood.

TECHNIQUES IN THE REPRODUCTIVE PROCESS

a) Artificial Insemination

There are three methods of artificial insemination: 1) the storage of donor sperm or female ova in sperm banks for implantation in a woman's uterus as a business; 2) the fertilization of parental sperm and egg in the laboratory *in vitro* (in an artificial environment) which is then implanted in the woman's uterus; and 3) the privately arranged artificial insemination of women by male donor sperm either through the intervention by the medical profession or independently.

Sperm banks have been set up in several countries where either male sperm or human embryos are frozen for eventual implantation in a woman's womb. Some are commercially run; others are based in universities or hospitals. Many questions arise from this activity: Should sperm banks be run as private, profit-making companies? Who decides on donors? On what grounds? Who controls and regulates such activities? What are the long-term effects of freezing sperm? How is this determined? What do women think of this form of conception?

The fertilization of a husband's sperm and the wife's egg *in vitro* has received considerable press, both in the United Kingdom and in Canada, where successful "test-tube babies" have been produced. At the moment, the fertilization of ova by male sperm is successful in approximately twenty-five percent of the tries; technicians are working to improve this success rate. It was reported on the CBC Radio program "As It Happens" (July 8, 1983) that a British medical team have taken ova donated from a healthy woman donor, fertilized it with the sperm of the husband and implanted it in the uterus of the wife. This technique allows women with genetic diseases who would otherwise produce defective offspring to bear a healthy child.

But women must be alert to the desire among medical technicians to control, explore, probe into the mysteries of human life. A *Globe and Mail* report (May 29, 1983) describes the discovery of biologists at the University of Edinburgh, Scotland. A human ovum, not fertilized by male sperm, spontaneously divided itself first into two, then four, then eight cells. At this point, the experiment was terminated "on ethical grounds." Still, nagging questions persist: Was it? Who knows? Who is controlling the controllers?

Turkey-Baster Babies. Finally, on a more human scale – but with the similar implication that our views on the reproductive process are changing – is the *Globe and Mail* story from San Francisco (August 29, 1981) of so-called "turkey-baster babies." Lesbians who wish to have a child but avoid "male-dominated medicine" seek a donor who will provide semen for insemination (AID). A booklet entitled "Artificial Insemination: An Alternative Conception" describes three methods of semen insertion: a medical syringe without the needle, an eye dropper, or a turkey-baster. Anonymity is guaranteed, legal rights to fatherhood are signed away, and monthly donations of still-warm semen are provided through an intermediary until conception takes place. Some feminists would support this manipulation of the reproductive process on the grounds that it is freely chosen on both sides, does not dehumanize the woman, and provides individual control over the process. At the same time one would want to ask whether the need for such measures flows from a belief that parenthood can only be sanctioned between husband and wife.

(b) Surrogate Motherhood

Another form of artificial insemination which has recently captured media attention, as well as that of the legal profession, is surrogate motherhood. A new element has been introduced into the dilemma of infertility and the desire of childless spouses to become parents. Two assumptions behind this extraordinary activity are: 1) "if infertile people want children strongly enough, modern science ought to offer a way" (*Time*, February 14, 1983); and 2) the special capacity of women to bear children is manipulated by women for profit. A procedure has been devised in which a human being is literally conceived as a manufactured product – by a method which one TV talk show has labelled "rent-a-womb."

Is a child a product to be bought and sold? Does this practice devalue women? Is it immoral to make babies for profit? Can deformed children be rejected as "damaged goods?" Is the reproductive process a new market to be exploited by the free enterprise system? The answer to all these questions is "yes." What is brought into question here are all conventional concepts of motherhood and traditional values surrounding female reproduction.

(c) Pre-Natal Diagnosis and Genetic Screening

These relatively new procedures have

been developed to determine whether a woman is likely to bear a child which may have a) a congenital physical malformation, such as spina bifida; b) a chromosome abnormality such as Down's Syndrome, resulting in mental retardation; or c) a genetic disorder such as haemophilia, leading to an internal chemical problem.

The tools used to discover the condition of the foetus include ultrasound scanning, which can give a precise picture of the baby and the position of the placenta; amniocentesis, whereby a sample of the fluid surrounding the baby is taken for analysis; fetoscopy, the insertion of an instrument into the uterus to visualize heart, face, limbs etc. Fetoscopy is also used to obtain tiny samples of blood from the umbilical cord for testing. Analysis of maternal serum is also encouraged because it presents no risk to the foetus. Radiography and x-ray can also be useful in confirming the existence of defects.

In a recent publication of the Science Council of Canada, "Social Issues in Human Genetics,"³ several major value concerns were raised. Does a woman with a known, genetically-transmitted disease have a right to prenatal diagnosis and abortion if the fetus is found to be affected? Alternatively, does the woman have the right to refuse abortion and bear the defective child? Should people with significant genetic disorders have the right to procreate? Does the public, which generally bears a large proportion of the cost of care of severely defective children, have the right to be protected from an increase in genetically-disabled children? Do people have the right to know the sex of the child – information which is denied in Manitoba? If the fetus is the wrong sex, should women have the right to abort – as is allowed in Newfoundland? If sex choice in children is sanctioned, and boys were chosen first, what might be the long term impact on girls? Many of these issues appear to be political and economic as well as moral. A major problem in rationalizing genetic screening and counselling seems to be related to the lack of involvement of lay persons in the decision-making process. Decisions on whether to report the sex of the fetus rest with the referring physician.

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Who should receive the service? At the moment, the criteria for offering prenatal diagnosis is based on Medical Research Council guidelines. But there is no national policy and the Medical Research Council has explicitly rejected the notion of a strong central authority in favor of local decision-making (MRC, Report No. 6, 1978). There is no monitoring to ensure adherence to the guidelines and no penalties for abuse.

Feminists have a responsibility to themselves, their unborn children, and their sisters to understand the technical procedures in which they are being invited to participate, including the purposes, risks and possible outcomes. While fathers, if

they are present, may be consulted, the decision on whether to abort must be made by the pregnant woman alone since she is the person likely to be most affected. Similarly, since the state leaves the responsibility for care of children almost entirely up to women, women should decide. At the same time, for some women the longing for a child may be deeply imbedded in her sense of identity and self-worth. For this reason, a feminist would wish to ensure that counselling is given by women to women, since male doctors, psychiatrists and lawyers generally display insensitive, authoritarian attitudes towards women.

(d) Gene Splicing

The human body is made up of millions of cells. Most cells share the same structure: a nucleus where the genetic information is stored and the material surrounding the nucleus called cytoplasm. Within the nucleus are the chromosomes, which come in pairs, half derived from each parent. Every species of plant or animal has a characteristic number of chromosomes; humans have 23 pairs or a total of 46. Each chromosome includes a long thread of DNA (deoxyribonucleic acid) wrapped up in proteins. DNA is made up of chemicals called nucleotides and two strings of these make up the DNA molecule.

The mechanism of splicing, or the exchange of genetic material among bacteria, is a naturally occurring phenomenon. It may account for the variations among individuals of a species. Resistance to antibiotics is another form of genetic transfer. What is new in biology is the ability of scientists to control this process. It is possible to cut into a DNA strand and insert another fragment. Once the pieces are "annealed," the "recombinant DNA" strand will be reproduced when the DNA replicates. Recently scientists have been successful in getting a recombinant gene to function in a multicell animal.

Human genetics, a developing technology, makes possible the detection of likely patterns of disease inheritance. At the present time, this capacity is still experimental and there is a degree of risk to women who undergo amniocentesis or fetoscopy. The occurrence of false positive or false negative diagnosis may lead to abortion of what turn out to be healthy infants. Alternatively, such errors could have the opposite effect of leading a woman into the erroneous belief that her fetus was healthy, only to find upon delivery that a mistake had been made. Women will need to explore the ethics of a technology that attempts to eliminate defective children in the interests of "benefits to mankind." This positive eugenics bears a likeness to "racial purity" which will require thoughtful exploration.

More threatening to some people who are following the development of genetic engineering is the manipulation of genetic material to form new combinations, not normally found in nature. Concern about these scientific activities has scarcely been articulated; seldom are the issues clearly presented so that lay persons can judge. Fears are expressed about "playing God,"



Illustration: Jane Northey

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about equating human reproduction with cattle-breeding, about mad dictators determining who shall live and who shall die, and the possibilities of science creating super-intelligent humans on the one hand and armies of drones through cloning on the other. These fantasies, while feeding public anxiety, also raise important questions about ends and norms in genetic engineering; in particular, our passive faith in the capacity of scientists to make the right decisions must be challenged.

ETHICAL ISSUES AND PROBLEMS RELATED TO REPRODUCTIVE TECHNOLOGY

Behind this proliferation of techniques, there is the value system (male?) of science based on objectivity, efficiency, perfectability and control.⁴ In the medical field, practitioners search for the "one best way" to insure healthy children and eliminate defective children; the belief in the "one best way" carries with it notions of utility, predictability and, eventually, decisions on quality control. But in the case of reproductive technologies, the "machine" is a woman (at least for the time being) and the "product" is a baby. It is important to remember that when medical researchers talk about "preventive medicine," they are talking, at least to some extent, about control of the reproductive capacity – who will be born and how.

Many women suspect that male medical practitioners reduce this deeply human activity to a technological riddle to be solved. If technique can render reproduction efficient, women's bodies as objects to be manipulated will be achieved. As Carol Gilligan observes, "The blind willingness to sacrifice people to (scientific) truth . . . has always been the danger of an ethics abstracted from life."⁵ The treatment of women's reproductive functions as objects of scientific experimentation and technological manipulation carries with it the possible overtone of eugenics. This dehumanizes women and brings traditional man-woman partnerships for creating children into question.

In most of the scientific reference works consulted for this paper, the word

"woman" is almost never used. Instead we read about the "patient" or the "subject" or, in some contexts, the "parents." As well, we find an abstract language of "logic," "rights," "survival of the race," "aggregate well-being," and "balance of risk." This morality of principles serving a higher purpose seems divorced from the real consequences of choice which involve suffering, pain, and violence to women's bodies, and, often, the chance for a full life for women themselves. It is women who produce children, whether defective or not; women's wombs which are the object of genetic screening; women who abort; women who mainly care for offspring, whether healthy or disabled. The ethics of reproductive technology has totally failed, to date, to focus on these central facts.

If the techniques of reproduction are to be humanized to take account of their impact on women's lives, a fundamental shift in thinking must occur. The search for the "one best way" and, in particular, for quality control, must be replaced by the affirmation of the humanistic qualities of flexibility, freedom of choice and support for those affected.

Mary Daly and Mary O'Brien both suggest that behind the search for control of the reproductive process, another value lurks – the envy and hatred of men for the capacity of women to produce new life and the miniscule part played by men in the reproductive process.⁶ As Mary O'Brien argues, men are "alienated from their seed" and therefore seek other means whereby to repossess it. If patriarchal science and technology can usurp this function through laboratory manipulation, women's social status will be further reduced and the power to create life will pass into the hands of men.

While it is true that a few women (usually doctors) speak from time to time and that a few of the members of the current Canadian Medical Research Council are women, it is not at all clear that these women have articulated women's interests for their male peers. What may happen is that conservative or liberal women are chosen to participate in decision-making because of their willingness to go along with conventional (male) wisdom.

Coupled with the power to control both the research, the funding and the policing

of research activity, the impression I have is of strong entrenched interests, complacent and self-congratulatory, justifying their work and claiming good faith while showing little inclination to subject themselves to public scrutiny. This elitism pervades the medical and scientific community; feminists who wish to initiate dialogue will have their work cut out for them. The annual reports of the Medical Research Council (MRC) are written in scientific language which conveys little to the ordinary citizen. If public money is used to support scientific research, the public has a right to know exactly what the government is supporting. Behind the MRC ethical guidelines is the assumption that scientific research adds to the store of human knowledge and is, by definition, beneficial to the collectivity. The onus rests with the public to argue the counter-case. A more humane and valid position, I would argue, is found in the ethical guidelines produced by the Canada Council (1977) on research on human subjects: they assert the value of individuals and place the onus on researchers to show how their research activities are likely to benefit the community.

The murky area of the economics of reproductive technology has scarcely been dealt with in Canada. Two major economic issues of concern to feminists are: 1) the marketing of drugs (and, by extension, techniques) which damage and/or exploit female reproductive functions for profit; 2) research as "work" for predominantly male scientists and technicians to which, in some cases, their whole lives, economic well-being and self-esteem are dedicated. Women, in particular, have good reason to fear the pharmaceutical industry (side effects of the Pill, DES, estrogen therapy). Scientific researchers, medical professionals, drug companies, hospitals and other industries form a network of people dedicated to developing new techniques and finding ways to apply them. That these people are paid to do this work is important to remember; questioning the purpose and methods of this work is experienced as threatening. The autonomy of this network is now beginning to be understood but the method for bringing it under control has not yet been seriously addressed.

Certain hidden assumptions appear to lie behind assertions made by the scientific community: church leaders, ethicists, lawyers, and medical practitioners raise them over and over in the literature.

- That technical intervention in the reproductive process is beneficial to the human species and therefore should be pursued. (This assumes the value of the collectivity above that of any particular individual).
- That the means (techniques) justify the end of controlling the reproductive process for the benefit of the human species. (This assumes that means and ends can be defined by one group for all of society).
- That technology can and should improve upon both the process and the product – eliminate defective children, repair the diseased, and eventually intervene to restructure faulty genes. (This assumes that the production of human beings is to be manipulated, to some extent, in the way that we manipulate the production of certain animals and plants).
- That individual risks are worth taking for the collective benefits that will eventually be gained. (This assumes that it is moral to sacrifice the well-being of some individuals in the interest of the growth of knowledge).
- That individuals with genetic handicaps have a moral obligation to refrain from reproduction. (This assumes that handicapped people are a blight on society).
- That men and women have equal roles in the reproductive process. (This elevates the importance of man and downgrades the central role of women).
- That the woman's body is a mechanical device for producing babies – an incubator, a hatchery for human souls. (This rationalizes the application of technology to the reproductive process).
- That many decisions on the course to be followed should not be left to individual women but must be assumed by doctors, counsellors or parents (husband and wife). (This attempt to overlook the central role of women in the process by removing our power to decide).
- That decisions about research should be left to qualified professionals – with

some modest input from lay persons, if necessary. (This highlights the underlying elitism of these "knowledge workers" and attempts to insure non-interference).

- That genetic engineering is safe enough. (This assumes that researchers know all the risks or that unintended side-effects are not significant).
- That private industry and public institutions can be trusted to act in the public interest. (This assumes goodwill, caring for people, public good above private gain without any need for monitoring).

Each of these assumptions, the product of vested interests whose power is great, must be challenged. Wherever an elite undertakes to make decisions for individuals on the grounds of benefit to society, these decisions must be exposed to public scrutiny and their reasons made plain. In my review of the literature, I have found few of these eleven assumptions clearly addressed. Nowhere was there recognition and/or support for the humanistic claims for fairness, respect for persons or the human cost of interference. Therefore the onus is on individual citizens, both men and women, to demand an accounting, and in some areas, public control. In considering the many implications of the new reproductive technologies, the moral issue for women becomes one of responsibility and care – rather than an abstract search for scientific truth or technological efficiency.

WHAT IS A FEMINIST PERSPECTIVE?

As women's history begins to be written, women are now learning how our capacity to care for ourselves and each other has been usurped by male "professionals." From the medieval purges of women healers to the suppression of mid-wifery, the exclusion of women from medical schools, to the sexism of Freud and his followers, this takeover of the minds and bodies of women is now perceived as a threat to our well-being.⁷ As we learn more about our medical heritage and the impressive array of medical scholars, healers and competent hospital administrators, we will be able to assert again their capacity.

As an oppressed group, women tend to experience the elitism of the medical profession in a personal way. The "doctor

knows best" syndrome has been a formidable obstacle to our informed participation in decision-making. Women will increasingly demand our right to be informed and our freedom to choose in areas which so deeply touch on our reproductive processes.

Women experience depersonalization and manipulation as "objects" in patriarchal society, particularly as this relates to our sexuality and reproductive functions. Central to the struggle for reproductive freedom is the concept of self-determination and the demand for respect as persons. Women, as well as men, have a right and a responsibility to fulfil ourselves as persons in the world. Ownership of one's body is not the central issue. As Susan Rae Peterson observed, "Neither I nor anyone else can *own* my body – I *am* my body." The fact that some women have sold their bodies, for security, for prostitution or for reproductive purposes does not negate this fact. It simply points to the confusion felt around the value of being female in society.

Another confusion, related to the value of women's bodies, is the value of the reproductive capacity itself and the length to which some women are prepared to go to become mothers. Some feminists might argue that this need for motherhood and child-rearing actually feeds and validates the scientific and medical research in reproductive technology, thereby indirectly perpetuating the value of the motherhood role for women above all other values. If women welcome and accept the technology which may potentially control our reproductive capacity, the primary issue for feminists would be: On whose terms? The fear is that, in Mary O'Brien's terms, men are beginning to "mediate" in the reproductive process, with profound and as yet unknown effects on women. Women must learn to "mediate" too.

On the broader issue of the feminist response, women can challenge the power of technology through education, coalition-building and political action to ensure public control and accountability. Only when the issues are understood can the best point of entry into the system be discovered. Once education has shown how a technology works and where its human component exists, entry can be more effective where like-minded women perceive similar interests.

Feminist perspectives on reproductive technology are urgently needed if the male power in this sphere is not to unfold

unchecked. Women's value in society is at risk, as are relations between the sexes. Women must discover our voice and speak out on these issues from the center of our reproductive consciousness so that a significant public dialogue can be generated on this profound public issue.

¹Elizabeth Dodson Gray, *Patriarchy as a Conceptual Trap* (Wellesley, Mass: Roundtable Press, 1982) p. 19.

²Lorenne M.G. Clarke and Lynda Lange, *The Sexism of Social and Political Theory: Women and Reproduction from Plato to Nietzsche* (Toronto: University of Toronto Press, 1979).

³*Social Issues in Human Genetics: Genetic*

Screening and Counselling (Ottawa: Science Council of Canada, August 1980).

Jacques Ellul, *The Technological Society* (New York: Vintage Books, 1964); see also *Perspectives on Our Age* (New York: Seabury Press, 1981).

⁵Carol Gilligan, "In a Different Voice: Women's Conception of Self and Morality," *Harvard Educational Review*, Vol. 47, No. 4 (November 1977).

⁶Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism* (Boston: Beacon Press, 1978); and Mary O'Brien, "The Dialectic of Reproduction," in *Feminism in Canada* (Montreal: Black Rose Books, 1982), p. 251. See also O'Brien, *The Politics of Reproduction* (London: Routledge and Kegan Paul, 1983).

⁷Barbara Ehrenreich and Dierdre English, *For Her Own Good: 150 Years of the Experts Advice to Women* (New York: Anchor Books, 1979).

⁸Susan Rae Peterson "The Politics of Prenatal Diagnosis: A Feminist Ethical Analysis." Paper presented at the 'Ethical Issues in Reproduction Technology: Analysis by Women' (EIRTAW) Conference, Hampshire College, Amherst, Mass., June 1979.

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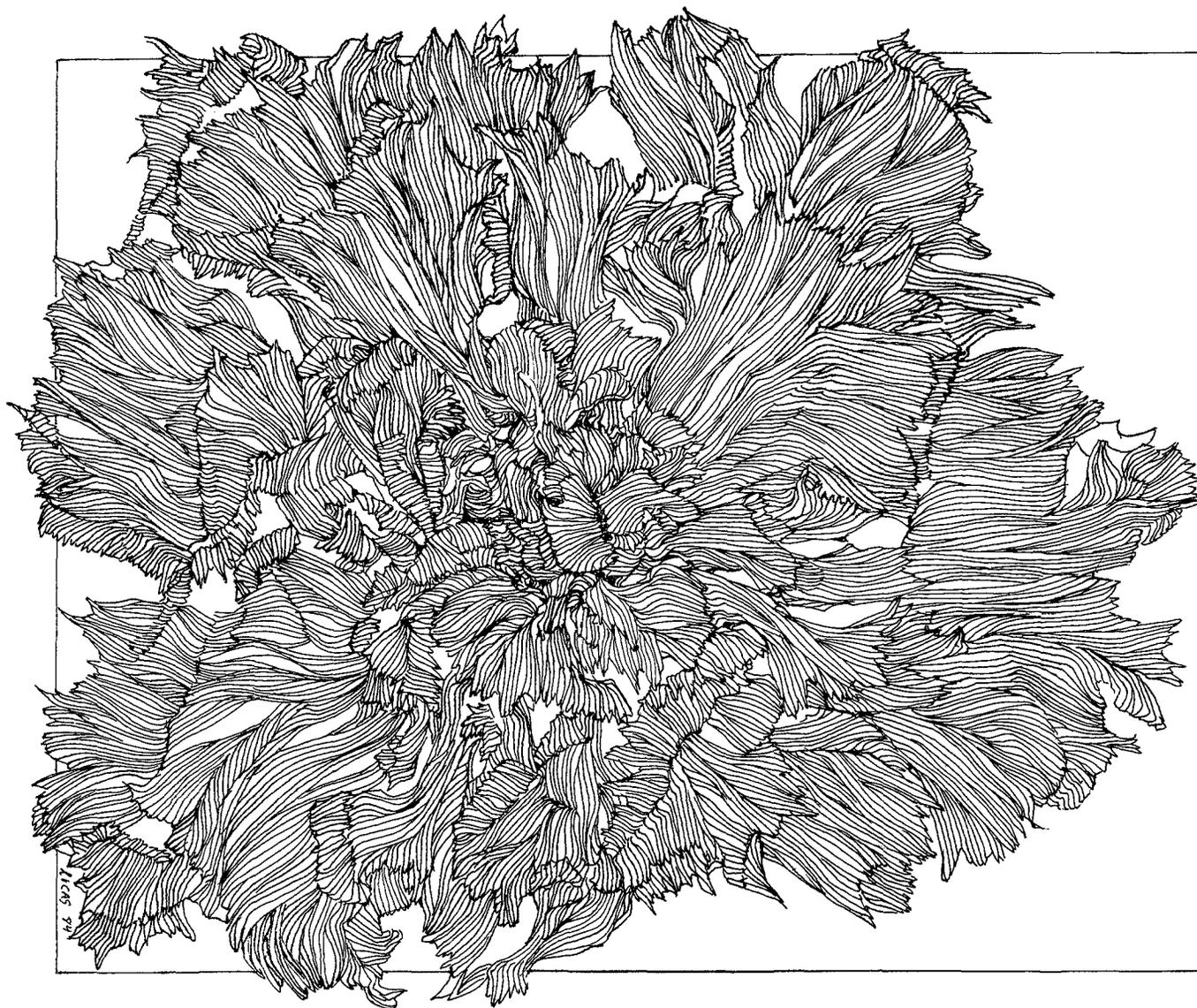


Illustration: Helen Lucas