


Winter 1-1-1995

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Recommended Citation

Laura M. Purdy, *Children of Choice: Whose Children? At What Cost?*, 52 Wash. & Lee L. Rev. 197 (1995), <https://scholarlycommons.law.wlu.edu/wlulr/vol52/iss1/7>

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Children of Choice: Whose Children? At What Cost?

Laura M. Purdy*

I. Introduction

In *Children of Choice*,¹ John Robertson argues for the primacy of procreative liberty in decision-making about reproduction. Procreative liberty is the freedom to decide whether or not to have offspring. The primacy of procreative liberty means that debates about reproduction must be resolved in favor of enhancing reproductive choice unless there is excellent reason to believe that serious harm will result from the decision.

Robertson considers four categories of human activity that fall under the rubric of reproductive choice: (1) avoiding reproduction (contraception and abortion), (2) treating infertility, (3) controlling the quality of offspring, and (4) using reproductive capacity for nonreproductive ends.² In each of these categories, Robertson points out six possible ethical problems: (1) interference with nature, (2) respect for prenatal life, (3) welfare of offspring, (4) impact on family, (5) effect on women, and (6) costs, access, and consumer protection.³

Given the scope of Robertson's work, this Article must necessarily be selective. Although there may be feminist concerns about his approach to the right to avoid reproduction, what he says with regard to that area is relatively unproblematic, so I will concentrate on other areas. Likewise, although feminists may worry about Robertson's positions on interference

* Professor of Philosophy, Wells College. B.A., San Jose State University; M.A., San Jose State University; Ph.D., Stanford University

1. JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* (1994). A shorter version of this Article was originally presented at "A Brave New World? *Children of Choice* in the Age of Reproductive Technology," a symposium at the Frances Lewis Law Center of the Washington and Lee University School of Law, in September 1994.

2. *Id.* at 6.

3. *See id.* at 12-15. There is, of course, some overlap in these categories.

with nature, respect for prenatal life, possible impact on families, and costs, access, and consumer protection, I will, for the most part, concentrate here on welfare of offspring and effect on women.

Generally speaking, Robertson concedes that procreative liberty should be limited by the harm principle;⁴ however, in practice, his stringent criteria for harm rules out most restrictions. Robertson's worldview also seems quite individualistic in the sense that procreative liberty is chiefly negative and focuses on noninterference, even if some enabling legislation is assumed. Robertson recognizes that unequal access to costly services is a problem, but he does not press for welfare rights with respect to them.

Feminists will find a good deal to applaud in *Children of Choice*, but many will also disagree with both his fundamental assumptions and his treatment of specific issues. Although they will approve of Robertson's firm convictions about some aspects of choice, they will question his narrow conception of harm. Most will also be critical of the individualistic streak that runs through his work, as it favors those with more power and disadvantages those who, like white women and people of color, tend to have less. Other more radical writers like Gena Corea, Helen Holmes, Ruth Hubbard, Abby Lippman, and Christine Overall are highly critical of new reproductive arrangements and technologies and, unlike Robertson, believe that the burden of proof about their use should rest on the shoulders of those who recommend them, not those who would limit their use.⁵ Thus, they will deny the priority of procreative liberty.

Feminism is not a monolithic position, and I have considerable sympathy for what Robertson has to say. From my somewhat rough-hewn utilitarian perspective, the high value that he places on freedom makes sense, at least when it is coupled with a more broadly conceived harm principle. Although utilitarianism differs in many respects from the classical liberalism in which his view seems rooted, I believe that any plausible version of utilitarianism must recognize how important freedom is for human happiness.

4. The harm principle holds that the only reason for prohibiting acts is the risk of harm to others.

5. See generally GENA COREA, *THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS* (1985); *THE CUSTOM-MADE CHILD? WOMEN-CENTERED PERSPECTIVES* (Helen B. Holmes et al. eds., 1981); RUTH HUBBARD, *THE POLITICS OF WOMEN'S BIOLOGY* (1990); 1 *MISCONCEPTIONS: THE SOCIAL CONSTRUCTION OF CHOICE AND THE NEW REPRODUCTIVE AND GENETIC TECHNOLOGIES* (Gwynne Basen et al. eds., 1993); CHRISTINE OVERALL, *ETHICS AND HUMAN REPRODUCTION* (1987).

None of this means that Robertson is completely "off the feminist hook," however. My criticisms would alter both the course of his arguments and some of his conclusions; they are offered here as friendly amendments that, I believe, would strengthen his already powerful work. I will focus primarily on assisted reproduction.

II. Procreation and the Self

My most general question about Robertson's views centers on his moral theory. He presents procreative liberty as a freestanding principle, limited only by the harm principle. However, a clearer conception of how procreative liberty fits within the larger theoretical context would be helpful in evaluating the picture that he draws for us. Only such context could help us understand more fully from whence arise the many subsidiary principles, rules, and values necessary for fleshing out procreative liberty, including his conception of what is to count as serious harm. These matters are pivotal for an account of reproductive rights that is properly sensitive to gender and other markers of disadvantage.

Robertson's defense of procreative liberty also raises questions. He maintains that "control over whether one reproduces or not is central to personal identity, to dignity, and to the meaning of one's life."⁶ Women, he rightly emphasizes, are especially burdened if society fails to recognize their right not to reproduce.⁷ In addition, "being deprived of the ability to reproduce prevents one from an experience that is central to individual identity and meaning in life."⁸

I agree that preventing the conception of children that you do not want and having the children that you do want are central to human happiness and that denying people the power to carry through on their choices about these matters adds significantly to human misery. But is it really such a good idea to conceptualize the relationship between childbearing status and one's core self the way that Robertson does?

As things now stand, women are defined largely by their reproductive status. Women who fail to bear children, or who bear them but fail to rear them, are often seen as barren and inadequate. Anything that they achieve is seen as mere compensation for their reproductive failure, and their failure as women is defined as a failure to be fully human. Men are not defined by

6. ROBERTSON, *supra* note 1, at 24.

7. *See id.*

8. *Id.*

their relationship to children in this way. Men can be successful even if they do not have children, although, if they do, they may be applauded for being "good family men." Their fatherly status is not seen as crucial, and no one thinks the less of great men if they do not have children.

Robertson's emphasis on the relationship of childbearing to identity seems to assimilate (or recommend the assimilation of) men's experience to that of women. One might want to argue that that is a good thing. After all, men often feel less responsibility toward their children — to the point of abandoning them altogether far more often than do women. If men's parental status were more tightly woven into their core selves, perhaps they would be more responsible fathers.

Is such identification necessary or sufficient for responsible parenthood? On the one hand, some people who make much of their parental status are not particularly responsible parents. On the other hand, some people for whom the status is a relatively unimportant part of their lives (or is not socially recognized, like stepparents) can be excellent parents. More broadly, having a cat by no means defines who I am, yet the distinctness between me and my cat diminishes neither my responsibility for it nor my sense of responsibility for it. Thus, there seems to be no reason for believing that responsibility is tied to identity or that it ought to be.

Furthermore, there are good reasons for rejecting this model of the self. First, it encourages people to care too much about their ability to have children. Although women and men in the more privileged classes in developed countries are now generally able to ensure that they will not have children if they do not want them, there is no way to guarantee that a particular individual *will* have children. If a person's whole self-concept depends on having them, that person may be set up for devastating disappointment.

The impact of such a model of the self is also differentiated by gender, for women, because of their socialization — as well as continuing sexist and pronatalist pressure — will be more likely to adopt this understanding of the meaning of life without seriously questioning it.⁹ Women, because of their biologically more extensive role in reproduction, are also more

9. Thus, it is not true that I see any implied duty on the part of women to reproduce arising from this conception of procreation, as Robertson suggests in his response. See John A. Robertson, *Liberalism and the Limits of Procreative Liberty: Response to My Critics*, 52 WASH. & LEE L. REV 233, 235 n.6 (1995). Rather, my point is merely that women are more likely to think that they have such a duty

likely to bear the risks entailed by the assisted reproduction that might be necessary to fulfill this conception of the self.

Second, this model of the self encourages people to see the decision to have children primarily as a personal decision about themselves and *not* as a moral decision affecting others. This moral dimension of childbearing is obscured by the emphasis on self-creation, which makes it almost impossible to discuss, let alone construct, moral standards. Thus, it is hardly possible to talk about such matters as wrongful life or overpopulation without seeming to violate the individual's most intimate self.¹⁰

Feminists have been as guilty as anyone else in this area, in part because of their quite reasonable fear that emphasis on the moral dimension of reproduction will constitute yet another excuse for the imposition of control over women. Robertson himself avoids many potential difficulties by relying on something akin to Derek Parfit's widely accepted conclusion that we do not harm future people by bearing them unless their lives would be so miserable that they would prefer to be dead.¹¹ This standard seems to impose few limits because bearing a child who cannot be expected to have a satisfying life is still assumed to be in the child's best interest.

I believe that this reasoning is flawed. Robertson might have noticed that Parfit does not conclude that because we fail to harm individuals by bringing them into adverse circumstances, we are thereby freed of responsibility. Instead, Parfit explores the feasibility of adopting a different standard.¹² In addition, embracing the moral minimalism implied by Parfit's initial argument would lead to a great deal of unnecessary misery. It would be far better to adopt a more demanding moral standard that required more of us, but from which we could also expect more care and benefit. Many theorists, including feminists, have pointed out the inconsistency of the pervasive minimalist approach, based as it is on an unrealistically individualistic conception of human relationships.¹³ Because

10. A still more sinister implication of this identification of child and self is evident in Erin Conn's appeal for veto power over his wife's abortion. He pleads:

[A]fter that child is born, half of that child — part of that child is me. And I'm part of that child. And I feel like by her having the right to abort that child is her having the right to destroy a part of me without me having any say-so.

SUSAN BORDO, *UNBEARABLE WEIGHT: FEMINISM, WESTERN CULTURE, AND THE BODY* 91 (1993) (quoting *Nightline: Abortion Rights* (ABC television broadcast, July 22, 1988)).

11. See generally DEREK PARFIT, *REASONS AND PERSONS* (1984).

12. See *id.* at 443.

13. See, e.g., ALISON M. JAGGAR, *FEMINIST POLITICS AND HUMAN NATURE* 40-41

society does not — and cannot — really function according to the minimalist approach, the illusion of a libertarian public life is maintained by an officially invisible (and therefore unrewarded) base of work, mainly volunteered by or, when necessary, extracted from women.¹⁴

Given the high priority that he accords to the right to procreate, Robertson's tight linking of the self with that right creates additional problems. This constellation of values leads Robertson to view procreative liberty as a justification for a variety of subsidiary rights of questionable wisdom — rights to those things without which individuals would hesitate to reproduce.¹⁵

Robertson's conception of procreative liberty repeatedly leads him to endorse extensive and far-reaching technologies intended to produce healthy offspring. However, his professed principles seem insufficient to defend such broad-ranging powers. He argues:

For many couples the decision whether to procreate depends on the ability to have healthy children. Without some guarantee or protection against the risk of handicapped children, they might not reproduce at all.

Thus viewed, quality control devices become part of the liberty interest in procreating or in avoiding procreation, and arguably should receive the same degree of protection.¹⁶

I have argued at length elsewhere that we owe it to our potential children not to conceive them if they can be expected to have too low a quality of life; I also believe that it is beneficial for people to be reassured that their fetuses do not suffer from any known problems.¹⁷ There are reasons for seeing these rights as much more limited than the ones that Robertson endorses.¹⁸

(1983).

14. For a somewhat more detailed discussion of the Parfit problem and the morality of bringing impaired persons into the world, see generally Laura M. Purdy, *Loving Future People*, in *REPRODUCTION, ETHICS AND THE LAW* (Joan Callahan ed., forthcoming 1995).

15. I use the word "individual" here, but Robertson's analysis seems to lean toward couples. He argues at one point that single child-rearers might have less exclusive rights with respect to children because of children's need for at least two child-rearers. See ROBERTSON, *supra* note 1, at 134.

16. *Id.* at 33.

17. See generally L.M. Purdy, *Genetic Diseases: Can Having Children Be Immoral?*, in *GENETICS NOW: ETHICAL ISSUES IN GENETIC RESEARCH 25* (John J. Buckley ed., 1978); Laura M. Purdy, *Genetics and Reproductive Risk: Can Having Children Be Immoral?*, in *BIOMEDICAL ETHICS* (Thomas A. Mappes & David DeGrazia eds., 4th ed. forthcoming 1996); Purdy, *supra* note 14.

18. This same constellation of principles leads Robertson to take a still more dubious

One reason is that to avoid potential harm, a much more fine-grained analysis of the components of any right to healthy children is necessary. Another is that new reproductive technologies and arrangements may not be the best way to ensure healthy children.

Robertson's rejection of most such challenges to the right to reproduce, together with his endorsement of subsidiary enabling rights, opens the door to extensive genetic engineering. If couples have a right to healthy offspring (otherwise they would not undertake the project at all), then how can they be denied offspring of a desired sex, level of intelligence, or even hair color? Although Robertson considers this question,¹⁹ I do not think that his treatment of it is adequate.

Many people think that it is possible to distinguish between morally acceptable negative genetic engineering that eradicates defects and morally dubious positive genetic engineering that enhances desirable traits. I believe not only that it is by no means obvious how to justify that distinction, but also that the distinction has less moral weight than is often supposed.

A great deal of resistance to positive engineering is probably rooted in the assumption that any genetic tinkering is Nazi eugenics and, thus, unthinkable. The rest probably comes from a variety of concerns about interference with nature, responsibility for acts of commission (but not acts of omission), and the like. Some of these worries are speculative, as Robertson suggests,²⁰ and could not be assuaged by any proposed safeguards, no matter how carefully thought out. Some concerns, however, seem to me to be quite realistic. They are based on justifiable caution about rushing ahead in the face of obvious and significantly incomplete knowledge and on the awareness of past disasters caused by enthusiasm for technological fixes, sometimes pursued in the hopes of grandiose profits. These pedestrian but nonetheless crucial concerns should be taken seriously, and they do provide an additional check that should save us from the prospect of monkeying with delicate biological mechanisms to achieve either trivial benefits (curly hair) or characteristics of doubtful benefit to the child (extraordinary height).

position with respect to surrogacy. Robertson argues that persons who pay women to carry a baby for them would be deterred from procreating if they could not be guaranteed that the baby would be turned over to them at the end of the pregnancy. See ROBERTSON, *supra* note 1, at 131. However, it is not clear to me that this proposition is really true; but even if it were true, it is not clear that it would be sufficient reason in all circumstances for requiring a woman to give up a baby. Furthermore, this same reasoning could be used to justify a variety of morally repellent restrictions on the surrogate mother.

19. See *id.* at 165-67

20. See *id.* at 162.

Once again, although genetic and biological engineering is not intrinsically wicked and could potentially — if pursued with all due caution — provide substantial benefits, it seems doubtful that the overall welfare of society is served by emphasizing genetic approaches at the expense of preventive social programs.

Of course, we need to recognize that certain limits or costs will discourage people from reproducing. However, it would be a mistake to dismiss those limits too quickly or to raise the burden of proof against them to such a level that they automatically become indefensible. Surely, if the discouraging factors arise from other serious moral considerations, then their effect on procreation must be analyzed with the knowledge that carefully crafted trade-offs may be necessary. Otherwise, procreative liberty and its entourage become a moral bulldozer that crushes all competing interests. It is difficult to see why procreative liberty should be granted such priority.

One should also note the selectivity of Robertson's application of the principle that there is a *prima facie* right to that without which one would be reluctant to procreate. First, he fails to take seriously the fact that the kinds of regulations on the lives of pregnant women that he discusses²¹ would be sufficient to deter many women from going ahead with a pregnancy. Second, that principle plays havoc with the strict line that he draws between the negative liberty to procreate and welfare rights that would create more equal access to that liberty. After all, lack of such welfare rights prevents many people from taking advantage of expensive methods of assisted reproduction. Still more notably, the absence of welfare rights prevents people from having the number of children that they want (by the usual methods) because they cannot afford them. Yet, the services that would alleviate this problem are routine in other developed Western nations. Why should the right to healthy children be limited to a negative right to assisted reproduction when such goods as universal access to health care and a clean environment would protect fertility and improve children's health?

In short, Robertson's justification of procreative liberty and what he takes to be its implications needs further work. As it stands, his justification will likely intensify the gender-based differential impact on women of new reproductive possibilities. It is also likely to undermine the notion that

21. See *id.* at 173-94.

childbearing is a moral activity, especially if it is paired with an almost no-fault view of when it is permissible to conceive children.

III. Choice

Robertson chooses procreative liberty as the fundamental principle governing reproductive conflicts, but there are good reasons for recognizing some form of self-determination as the more basic principle from which procreative liberty is derived. Self-determination emphasizes control over one's body and resources in a way that fits better with what I think are plausible intuitions about the asymmetry between the right not to reproduce and the right to reproduce.

Robertson sees the right not to reproduce and the right to reproduce as two sides of the same coin. From that fact, he seems to infer that the strong right not to reproduce implies an equally strong right to reproduce and also that this strong right to reproduce provides as much support for assisted reproduction as for so-called natural reproduction. Many feminists would reject Robertson's position and would argue that because the issues raised by assisted reproduction are so different from those raised by natural reproduction, the former should be viewed with suspicion. This position is reflected, for instance, in Christine Overall's recent claim that "[t]he right not to reproduce is distinct from the right to reproduce."²² She further distinguishes between weak and strong versions of each right. The weak (liberty) sense of each involves noninterference; the strong (welfare) sense involves access to services. Overall argues for both liberty and welfare versions of the right not to reproduce and for the weak version of the right to reproduce; she maintains that we should be "developing a critical analysis of the ways in which the right to reproduce in the strong sense is now being exercised."²³

On the one hand, I think that Overall's distinction between the two different rights is logically incoherent: As Robertson rightly sees, the right to reproduce implies the right not to reproduce because the right to reproduce is not a duty (that leaves one with no choice but to reproduce), but is a right (that one is free to exercise or not as one wishes). On the other hand, I agree with Overall's desire to draw a clearer line between

22. CHRISTINE OVERALL, HUMAN REPRODUCTION: PRINCIPLES, PRACTICES, POLICIES 27 (1993).

23. *Id.* at 32.

different types of reproduction than Robertson does.²⁴ Unlike Overall and other feminist critics of assisted reproduction, I do not think that it calls for a different burden of proof, but I do believe that realistic assessments of possible harm require a much broader conception of harm and greater alertness to potential harm than is evident in Robertson's work.

Overall and other feminists focus on the questionable nature of the choices that assisted reproduction provides women. Robertson acknowledges their worries that men will use reproductive technologies to control and oppress women, that assisted reproduction will reinforce the problematic traditional identification of women with childbearing and childrearing, and that women may be encouraged to undertake further reproductive burdens to benefit men.²⁵ He responds to these worries by emphasizing the desirability of the new choices available to women and underlines the safeguards for women implicit in a rights-based framework.²⁶

Robertson's comments about rights reflect feminist qualms about rights as intrinsically individualistic and limited in scope, qualms that I do not share: Rights are what we make of them, and we need not rely on them to tell the whole moral story. However, Robertson fails to do full justice to feminist concerns. His first response is simply to point to examples, like Norplant, that seem to offer new power and convenience to women.²⁷ Later, he concedes that "reproductive choices will not increase self-determination for all women, because some will be pressured to make choices that they previously would not have had to face, or will lack the resources to take advantage of the opportunities presented."²⁸ However, he concludes by saying that "[o]n balance, there is no reason to think that women do not end up with more rather than less reproductive freedom as a result of technological innovation."²⁹ Consequently, he plumps for promoting freedom, together with the safeguards necessary for limiting its

24. I have some qualms about the distinction because it is (1) relative to the accepted standards of a given group and (2) the engine of much social misery in societies like the United States that pour most of their efforts into negative rights at the expense of positive ones.

25. See ROBERTSON, *supra* note 1, at 228.

26. See *id.* at 229.

27. See *id.* It is not clear that using Norplant as an example really furthers Robertson's case here. See *infra* notes 77-79 and accompanying text.

28. ROBERTSON, *supra* note 1, at 231.

29. *Id.*

burdens, rather than for wholesale prohibitions of certain techniques and practices. He comments that "[e]ven in a world without the technological options now available, recognition of negative procreative liberty would be an important achievement."³⁰ The implication here seems to be that because procreative liberty is all of a piece, the price of recognizing the right not to reproduce is that one accept an equally strong right to assisted reproduction. That conclusion does not follow, however, because careful application of the harm principle may seriously circumscribe the right to assisted reproduction and leave the right not to reproduce untouched.

I believe that feminist concerns about assisted reproduction deserve a closer look, and the controversy about choice provides a useful context for doing so. What are the serious issues here? One problem that Robertson seems not to recognize is that what start out as new options come to be accepted as the standard of care, which women are not really free to refuse. Second, women are quite likely to end up choosing options that are not necessarily in their best interest. A third problem is that although an option may benefit a particular woman, it may harm others or women as a class. Let us consider each of these issues in turn.

What about those new options that turn into obligations? Examples are electronic fetal monitors and ultrasound, which are now routinely accepted parts of prenatal care, despite the problems and potential risks associated with them.³¹

There are other dangers here as well. One major source of danger is society's tendency to subordinate women's interests to those attributed to the fetus, as demonstrated by the disturbingly large number of prebirth seizures, court-ordered treatments, and postbirth sanctions that women have suffered.³² Enormous potential exists for compelling women to undergo allegedly therapeutic treatments on behalf of fetuses, perhaps including even *in vitro* fertilization (IVF) intended to establish that a given

30. *Id.*

31. See SUSAN SHERWIN, *NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE* 119 (1992). Fetal monitors require that women in labor be still; they also lead to far more cesarean sections than the equally safe human monitoring by nurses. See Laura M. Purdy, *Are Pregnant Women Fetal Containers?*, 4 *BIOETHICS* 273, 282-84 (1990). Ultrasound now appears to be safe, but it is being applied to developing fetuses and women without any solid evidence of its long-term safety. See Elizabeth Barholet, *In Vitro Fertilization: The Construction of Infertility and of Parenting*, in *ISSUES IN REPRODUCTIVE TECHNOLOGY* 253, 259 (Helen B. Holmes ed., 1994).

32. See Purdy, *supra* note 31, at 274.

fetus is free of known defects. Worse still, fertile or pregnant women might be subjected to extreme lifestyle restrictions thought to benefit fetuses.³³

There is some tension in Robertson's views about these matters. On the one hand, as we have seen, he repeatedly relies on a Parfit-like argument about harm to future persons that severely limits the grounds upon which such restrictions upon women might be based.³⁴ On the other hand, however, he seems quite open to the notion that women should be held responsible for harm to their fetuses and quite critical of feminist objections to current social trends that favor fetuses at the expense of women.³⁵ As I have argued elsewhere, it is plausible to believe that wide-ranging preventive measures would eliminate all but a few of these conflicts between woman and fetus.³⁶ Although Robertson recognizes the point that prevention should precede any recourse to stronger measures,³⁷ he seems uncomfortably willing to envision coercive and punitive measures even in the absence of prevention.³⁸ He also invests the medical establishment with more authority than it deserves on the basis of its track record.³⁹

A second problem with Robertson's treatment of choice is that a woman may choose an option that is not necessarily in her interest. Nobody, of course, ever promised humans that freedom would bring with it wisdom, but long-standing social patterns significantly raise the probability that women, especially women disadvantaged by such other characteristics as race, class, sexual orientation, or age, will find themselves making risky decisions in the absence of adequate information. Because, for example, women are often considered less intelligent, less

33. Consider the now-ubiquitous signs warning pregnant women against drinking — at the same time as treatment centers for substance abuse that accept pregnant women are glaringly absent. On this and other perils, see *id.* at 286-88.

34. See *supra* note 11 and accompanying text.

35. See ROBERTSON, *supra* note 1, at 173, 190-94.

36. See Purdy, *supra* note 31, at 285-91.

37. See ROBERTSON, *supra* note 1, at 194.

38. Robertson, however, does recognize the disparity between the standards for invading men's and women's bodies at present. He concludes that if we develop policies that invade women's bodies for the benefit of fetuses, then we must be equally ready to require men to undergo invasive procedures for the benefit of their children. See *id.* at 190-94.

39. For a very recent treatment of this subject, see generally EILEEN NECHAS & DENISE FOLEY, *UNEQUAL TREATMENT: WHAT YOU DON'T KNOW ABOUT HOW WOMEN ARE MISTREATED BY THE MEDICAL COMMUNITY* (1994).

rational, or simply less important than similarly situated men, health care providers may not take the time to ensure that their consent is informed and truly voluntary.⁴⁰ Women may also receive information biased by a provider's interest in providing profitable treatment, recruiting experimental subjects, or even, as with contract pregnancy, furthering a purely commercial enterprise. Last, but certainly not least, crucial information may simply be unavailable. This latter situation is especially problematic when its absence is barely noticed, as when a new drug or technology is firmly pronounced to be safe, despite the lack of data about long-term effects. Such situations are especially dangerous because women are often socialized to be relatively passive and because those who ask questions and think for themselves tend to be categorized as difficult or demanding.

A third, closely related problem is that an option may benefit a particular woman, but harm other women or harm women as a class.⁴¹ In these kinds of cases, one woman may benefit from the exploitation of another. Alternatively, a new option may function like a safety valve that takes the pressure off individual women, but deflects attention from serious underlying social problems; this latter situation reflects the fact that women are, on balance, in a weaker bargaining position than similarly situated men. Women may then have recourse to practices that exploit other women or perpetuate harmful stereotypes.

Why might women be in the weaker position? First, a woman's education is still less likely than that of a man to have emphasized the kind of analytic thinking required for dealing with these kinds of issues.⁴² Second, women are also more likely to have been socialized to be agreeable and not to stand up for their own perceived interests. Third, women may have more at stake in ensuring that there is an agreement at all. After all, given the social perception of women as child-bearers and

40. A glance back at the history of medicine will remind those tempted to dismiss my claims as paranoid that the issue is pressing. See generally MARY B. MAHOWALD, *WOMEN AND CHILDREN IN HEALTH CARE: AN UNEQUAL MAJORITY* (1993); NECHAS & FOLEY, *supra* note 39.

41. See SHERWIN, *supra* note 31, at 132-36.

42. This assertion would have been more obviously true in the past when women were denied higher education or were denied education altogether. However, there is ample evidence that despite the apparently equal educational experience of girls and boys at present, the sexism that was so overt earlier is still there in covert form. For a recent discussion of this question, see generally MYRA SADKER & DAVID SADKER, *FAILING AT FAIRNESS: HOW AMERICA'S SCHOOLS CHEAT GIRLS* (1994).

nurturers, a woman is likely to feel especially insecure and inadequate if it is she who is infertile. Even if it is not her fault, a couple's "barrenness" is usually more of a liability for a woman. Helping a man fulfill the desire for a genetically related child can be an important factor in keeping a marriage together, and doing so may be important to a woman for both emotional and economic reasons.⁴³ In addition, as I pointed out earlier, women are less likely to be adequately informed about the choices to be made.⁴⁴ Consequently, women may be less able to determine what they want and to hold out for it at the bargaining table. Yet, in many cases, it is they who are most at risk, especially physically, from the proposed procedures. These issues will disappear if sexism is eradicated; in the meantime, they are ignored at women's peril.⁴⁵

Many feminists believe that IVF and contract pregnancy are pressure valves for particular women.⁴⁶ Women are themselves at risk from inadequate information about what IVF entails, about possible long-term consequences, and about success rates. Furthermore, they may be driven to the procedure by the social devaluation of infertile women or by the ethic that expects women always to subordinate their own interests in the pursuit of others' goals.⁴⁷ In addition, many (but not all) feminists believe that women who contract to undertake a pregnancy for another do so only because of their already compromised position as women.⁴⁸ Perhaps the \$10,000 is almost irresistible, given women's inferior economic status, or perhaps the exploitation here is more subtle — based, for example, on

43. It is tempting to look at infertility in isolation, but this context deeply affects the lives of women at a time when men are more likely to remarry than women in case of divorce and when women are often dependent on a man to achieve a decent standard of living. See BARBARA R. BERGMANN, *THE ECONOMIC EMERGENCE OF WOMEN* 269 (1986). One must remember that the average woman still earns only 70% of what a man earns, and that this statistic hides much larger differences between particular women and men. See *THE AMERICAN WOMAN 1990-91. A STATUS REPORT* tbl. 26 (Sara E. Rix ed., 1990).

44. See *supra* note 40 and accompanying text.

45. We have already seen what unfairness results when decisions about the terms of divorce are made as if women and men are on an equal footing in society. See generally LENORE J. WEITZMAN, *THE DIVORCE REVOLUTION: THE UNEXPECTED SOCIAL AND ECONOMIC CONSEQUENCES FOR WOMEN AND CHILDREN IN AMERICA* (1985).

46. See SHERWIN, *supra* note 31, at 134.

47. See generally Judith Lorber, *Choice, Gift, or Patriarchal Bargain? Women's Consent to In Vitro Fertilization in Male Infertility*, in *FEMINIST PERSPECTIVES IN MEDICAL ETHICS* 169 (Helen B. Holmes & Laura M. Purdy eds., 1992).

48. See, e.g., OVERALL, *supra* note 5, at 120.

guilty feelings about a past abortion. Those feminists point out that the wives of men who seek contract pregnancy are in a weak position and cannot resist because it is the wives' own inadequacy as child-bearers that the contract pregnancy offsets.⁴⁹ They also maintain that contract pregnancies harm women as a class because the contract reinforces the view that women are merely child-bearers and nurturers, not equal participants in human affairs who may or may not engage in procreation.⁵⁰

A central problem for both IVF and contract pregnancy is the possibility that things will go awry and that either no one will take responsibility for genetic materials or for a baby, or too many will want control over them. The latter situation can arise when people seek to escape previously agreed-upon responsibility or when they want responsibility that they earlier renounced. The kinds of feminist concerns described earlier raise questions about Robertson's hard-line solution that participants in assisted and collaborative reproduction must make binding commitments about what they will do.⁵¹ In principle, this is an attractive solution. However, it is less appealing if the parties are not in an equal bargaining position. As I have argued, women are typically the disadvantaged parties,⁵² although a given man, of course, may be in the weaker position.

As Robertson and some feminists recognize,⁵³ the rub is that using such reasons to deny women the standing to engage in decision-making about reproduction seems equally as bad as ignoring the obvious disparities between women and men. Denying that standing undermines women's legal personhood and invites paternalistic intrusion into women's lives. In short, there are serious risks in both paths. These risks result from the relentless sexism in society — sexism that will sully any solution. The only safe course, therefore, would be to eradicate sexism before we do anything else. Although eradicating sexism is an urgent task, we cannot stop the world until this task is completed. The question becomes what to do until then.

49. See *id.* at 118.

50. See *id.* at 122.

51. See ROBERTSON, *supra* note 1, at 126, 131.

52. See *supra* notes 42-45 and accompanying text.

53. See ROBERTSON, *supra* note 1, at 132. See generally Christine T. Sistare, *Reproductive Freedom and Women's Freedom: Surrogacy and Autonomy*, 19 PHIL. F 227 (1988).

In the case of IVF, of course, there are other reasons for doubting the wisdom of the path that society is currently pursuing. On the one hand, success rates are low, probably much lower than most women engaged in IVF fully realize.⁵⁴ On the other hand, the procedures involve some known risks, as well as yet-unknown risks for both woman and child.⁵⁵ Under these circumstances, one must ask yet again whether expanding IVF programs is a good policy. The answer here surely must be that it is not.

The underlying problem here, it seems to me, is that our society is based upon a relatively unregulated free market — a market that produces expensive, high-tech treatments for some, while others suffer from similar problems that a more equal distribution of resources could easily prevent. Although Robertson seems concerned about problems of access, he does not really address this issue at the most basic level. It seems to me that the failure to do so creates serious questions about some of his solutions, as well as about his support for assisted reproduction.

If one accepts the inegalitarian status quo, it is quite reasonable to argue, as does Robertson, that it would be unjustifiable to limit how those with money can spend it. After all, no one stops them from spending it on vacation homes or yachts, so why should they not use it to attempt to produce a genetically related child? How might one respond to this argument? Some have argued that the emphasis on genetically related children erroneously promotes the notion that such children are especially valuable.⁵⁶ Of course, most people do not think that that notion is erroneous, and they seem to want their "own" children very much. Thus, even if the desire for genetically related children is morally questionable, it is important to recognize that unless education persuades people otherwise, there will continue to be much demand for them.

It would be easier to resolve this issue if the resources allocated to IVF could easily be channeled to the prevention of infertility or to some other equally good cause, but resource allocation is, of course, more complicated than that. Worse still, relatively few people seem troubled by the knowledge that a more egalitarian system of resource allocation would prevent a good deal of misery; therefore, arguing for more equal allocation of resources does not make much difference politically.

54. See SHERWIN, *supra* note 31, at 129.

55. See *id.*

56. Cf. OVERALL, *supra* note 5, at 131.

Is there, nonetheless, a moral argument to be made here that the United States ought to de-emphasize high-tech approaches to infertility like IVF and instead ought to promote basic social improvements? Given a free market economy, that change would not happen without a lot of political support, yet democratic decision-making can exert some control over how, and even *whether*, some technologies will be developed — consider the supersonic transport and the supercollider.

IVF tends to be offered in freestanding clinics on a fee-for-service basis. Does the existence of these clinics threaten more basic services? At first blush, the answer appears to be no. However, a look at the broader context suggests that the answer may not be quite so clear. Medical resources, after all, are limited, and educational programs, personnel, buildings, and other resources allocated to IVF cannot be used in other ways. Thus, unless other pressing health care needs are already being met (and we know that they are not), devoting resources to IVF does change the services available. In that case, training people to do IVF and setting up clinics are not just a matter of letting the wealthy decide how to use their disposable income.

Even among feminists, there is an active debate about IVF; some claim that reducing its use is to abandon unfairly the infertile,⁵⁷ and others claim that women's strong desire for babies is at least in part a noxious social construction.⁵⁸ This way of framing the debate, however, isolates it from the larger social context. There seems to be good reason to suspect that remediable social factors are implicated in rates of infertility. Addressing the social factors directly would likely prevent many cases of infertility. De-emphasizing IVF to concentrate instead on those social factors is therefore not to abandon infertile women, but rather to take a different approach to the problem. Already infertile women may lose out, but those who would have become infertile due to social factors would benefit. The current approach allows infertility to develop in many women, but promises the mixed blessing of IVF only to those few who can pay for it. Furthermore, judicious use of other methods, like education,

57 Cf. Michelle Stanworth, *Birth Pangs: Conceptive Technologies and the Threat to Motherhood*, in *CONFLICTS IN FEMINISM* 288, 293-96 (Marianne Hirsch & Evelyn F. Keller eds., 1990).

58. See COREA, *supra* note 5, at 220. See generally *PRONATALISM: THE MYTH OF MOM AND APPLE PIE* (Ellen Peck & Judith Senderowitz eds., 1974).

child-sharing of various kinds, adoption, or contract pregnancy, could help satisfy the already infertile.

Contract pregnancy is itself a seriously contested issue, both in the feminist community and outside it, although for different reasons. Many feminists argue that it is just the sort of debilitating choice that should not be available.⁵⁹ I have argued against this position at length elsewhere,⁶⁰ where I maintained that a carefully regulated version of the practice potentially empowers white, heterosexual women and members of other disadvantaged groups, such as lesbian and gay couples.⁶¹

I believe that these kinds of cases demonstrate that neither a sweeping principle of procreative liberty nor a fearful elimination of worrisome options should determine what liberties are justifiable. Instead, we need an issue-by-issue discussion that keeps in mind the value of individual freedom, but that is also constantly mindful of potential harms created by the sexist context in which decisions are being made.

IV Harm

Freedom is an important value, and it cannot be exercised unless those who would limit freedom in the name of harm are pressed to name clear, specific, and weighty concerns. The problem is to determine which threats meet those criteria.

59. See OVERALL, *supra* note 5, at 111-31.

60. See generally Laura M. Purdy, *Another Look at Contract Pregnancy*, in ISSUES IN REPRODUCTIVE TECHNOLOGY, *supra* note 31, at 303 [hereinafter Purdy, *Another Look*]; Laura M. Purdy, *Surrogate Mothering: Exploitation or Empowerment?*, 3 BIOETHICS 18 (1989) [hereinafter Purdy, *Surrogate Mothering*].

61. Further detail is beyond the scope of this Article, but I do have some qualms about Robertson's hard-nosed approach to binding commitments in such matters, as I suggested earlier. See *supra* note 51 and accompanying text. Like many others, I cringe at the idea of a baby torn from a mother's arms, even though that is an appeal to emotion rather than to moral principle. I must say that I find it difficult to adjudicate between the forceful feminist arguments in favor of an escape clause for women undertaking contract pregnancy and the similarly forceful arguments offered by Robertson on this issue. See ROBERTSON, *supra* note 1, at 125-27. My inclination at present is to think that this is one of the areas in which it is necessary to pay special attention to women's experience in giving birth because it seems to change one's perspective so radically. As a woman who has never given birth, it may be impossible for me to make an informed and fair judgment. Naturally, that line of reasoning rules out men as well. It may be that the best that those of us in this position can do is to let those who have given birth argue the issue among themselves, as we participate only to the extent of analyzing the arguments for the usual kinds of fallacies.

There are always reasons for rejecting new social arrangements and technologies. Knee-jerk rejection leads to paralysis and a mind-set that clings to tradition and that fails, often enough, to notice the harm caused by doing things the usual way. History is rife with dire warnings of vague horrors that never came to pass or that, if they did, turned out to be benefits in disguise.⁶² Unfortunately, some miraculous innovations that promised only good things have turned into major scourges — consider how the automobile strangles cities and how television can deaden minds. If people had predicted these outcomes, Robertson might well have described their warnings as remote and speculative, yet they would have been quite accurate.

Today, researchers and physicians are barreling ahead, following grant money and promises of profit wherever they lead, and devoting relatively little thought to the full context of their decisions — all in the name of choices for women.⁶³ However, the rhetoric of choice would be more convincing if the medical establishment had a better record on women's welfare.

62. Consider, for instance, the allegedly disastrous consequences predicted for contraception by Pope Paul VI, *see* POPE PAUL VI, ON THE REGULATION OF BIRTH: HUMANAE VITAE 11-12 (1968), or the absurd theories of nineteenth-century physician Edward H. Clarke about women's education, *see generally* EDWARD H. CLARKE, SEX IN EDUCATION; OR, A FAIR CHANCE FOR GIRLS (1874).

63. Susan Bordo puts the matter nicely in the following comment on the situation:

[I]n general, the New Reproductive Technology has been a confusingly mixed bag as far as the subjectivity of women is concerned. On the one hand, women now have a booming technology seemingly focused on fulfilling *their* desires: to conceive, to prevent miscarriage, to deliver a healthy baby at term. On the other hand, proponents and practitioners continually encourage women to treat their bodies as passive instruments of those goals, ready and willing, "if they want a child badly enough," to endure however complicated and invasive a regime of diagnostic testing, daily monitoring, injections, and operative procedures may be required. Thus, one element of women's subjectivity is indeed nurtured, while all other elements (investment in career, other emotional needs, importance of other personal relationships, etc.) are minimized, marginalized, and (when they refuse to be repressed) made an occasion for guilt and self-questioning.

[In short, i]n our present cultural context, the New Reproductive Technologies *do* cater to women's desires (that is, to the desires of women who can afford them), but only when they are the *right* desires, desires that will subordinate all else (even in the face of technological success rates which continue to be very discouraging) to the project of producing a child.

BORDO, *supra* note 10, at 86-87

My own eyes began to be opened some fifteen years ago by Gena Corea's ground-breaking *Hidden Malpractice*.⁶⁴ Periodic reassessments of the situation suggest that the health care system has yet to face fully the devaluation of women's interests that was then so prevalent.⁶⁵ Only recently have the inadequacies in the health care system burst upon the wider political scene.

Not only do many people lack access to any decent care, but subtler inequities also exist. White women and members of other disadvantaged groups systematically receive worse treatment and care than white, middle-class, heterosexual men.⁶⁶ Bioethics, the academic discipline that takes the health care establishment as its subject, has been remarkably slow to notice these facts. In particular, bioethics has been wary of feminist work and has mostly relegated it to the Siberian margins of the field by ignoring its concerns or dismissing them as "political."⁶⁷

In bioethics, as in the health care system itself, women's interests are routinely discounted or ignored altogether. Sexism has been most apparent in reproductive matters; for example, a great deal of research and debate on abortion still proceeds without any reference to women's concerns. In addition, when the new reproductive technologies began to appear about fifteen years ago, their possible detrimental impact on women seemed to be of no concern to anyone.⁶⁸ Even now, the mainstream debate seldom takes seriously the issues raised by the feminist literature. Recent feminist work documents and analyzes this phenomenon.⁶⁹

64. GENA COREA, *THE HIDDEN MALPRACTICE: HOW AMERICAN MEDICINE TREATS WOMEN AS PATIENTS AND PROFESSIONALS* (1977).

65. See generally GENA COREA, *THE INVISIBLE EPIDEMIC: THE STORY OF WOMEN AND AIDS* (1992); MAHOWALD, *supra* note 40; JOHN M. SMITH, *WOMEN AND DOCTORS* (1992); Joan M. Altekruze & Sue V Rosser, *Feminism and Medicine: Co-optation or Cooperation?*, in *THE KNOWLEDGE EXPLOSION: GENERATIONS OF FEMINIST SCHOLARSHIP* 27 (Cheris Kramarae & Dale Spender eds., 1992).

66. See generally COREA, *supra* note 65; MAHOWALD, *supra* note 40; NECHAS & FOLEY, *supra* note 39; SMITH, *supra* note 65.

67. For a refutation of this charge, see generally Laura M. Purdy, *Good Bioethics Must Be Feminist Bioethics*, in *PHILOSOPHICAL PERSPECTIVES IN BIOETHICS* (Wayne Sumner & Joseph Boyle eds., forthcoming). For further evidence, see generally *FEMINIST PERSPECTIVES IN MEDICAL ETHICS*, *supra* note 47; SHERWIN, *supra* note 31.

68. See generally Laura M. Purdy, *The Morality of New Reproductive Technologies*, 18 *J. SOC. PHIL.* 38 (1987).

69. See generally *FEMINIST PERSPECTIVES IN MEDICAL ETHICS*, *supra* note 47; SHERWIN, *supra* note 31. There are also quite a few articles on specific topics written from

As both feminism and bioethics mature, feminists are looking beyond reproduction, not only at other specific issues in bioethics, but also at the field as a whole. Why does bioethics seem blind to sexism in medicine? For example, where was bioethics before it became common knowledge that medical research often fails to include women and that it concentrates on problems that plague men?⁷⁰ How could we have been so oblivious to the gender differences in physician/patient relationships, differences that lead doctors to suppose that women need tranquilizers when the same symptoms in a man suggest the need for a heart workup?⁷¹ Why are men's views about withdrawal of care so much more likely to be taken seriously?⁷² Why, too, has it taken so long for bioethics to notice the occasions when allocation decisions leave women providing the brunt of the care?⁷³ And so on.

As the magnitude and pervasiveness of such gender differentials come into focus, feminist philosophers have also started to analyze the overall structure of bioethics. Many are coming to suspect, as Susan Sherwin argues, that "the organization of bioethics reflects the power structures that are inherent in the health care field, which, in turn, reflect the power

a feminist point of view; for the most part, they are still sprinkled here and there in the literature. See generally Christine Overall, *New Reproductive Technology: Some Implications for the Abortion Issue*, 19 J. VALUE INQUIRY 279 (1985); Susan Sherwin, *Feminist Ethics and In Vitro Fertilization*, in SCIENCE, MORALITY AND FEMINIST THEORY 265 (Marsha Hanen & Kai Nielson eds., 1987); Caroline Whitbeck, *The Moral Implications of Regarding Women as People: New Perspectives on Pregnancy and Personhood*, in ABORTION AND THE STATUS OF THE FETUS 247 (William B. Bondeson et al. eds., 1983). *Hypatia* is the primary journal for feminist philosophy, and it occasionally publishes articles in bioethics. *Issues in Reproductive Technologies*, see *supra* note 31, is largely feminist, and two additional anthologies of feminist work will appear in 1995: FEMINISM AND BIOETHICS: BEYOND REPRODUCTION (Susan M. Wolf ed., forthcoming 1995); REPRODUCTION, ETHICS AND THE LAW, *supra* note 14.

70. See generally Sue V Rosser, *Re-Visioning Clinical Research: Gender and the Ethics of Experimental Design*, in FEMINIST PERSPECTIVES IN MEDICAL ETHICS, *supra* note 47, at 127

71. For a recent eye-opening look at the medical establishment, especially gynecology and obstetrics, see generally SMITH, *supra* note 65. John M. Smith cites a 1990 American Medical Association report entitled *Gender Disparities in Clinical Decision-Making*, which notes significant gender differences in such critical matters as kidney transplants, cardiac catheterization, and diagnosis of lung cancer. See *id.* at 14.

72. See generally Steven H. Miles & Allison August, *Courts, Gender and "The Right to Die,"* 18 LAW, MED. & HEALTH CARE 85 (1990).

73. See generally Virginia L. Warren, *Feminist Directions in Medical Ethics*, in FEMINIST PERSPECTIVES IN MEDICAL ETHICS, *supra* note 47, at 32.

structures of the larger society "74 It hardly bears repeating that despite considerable progress for women in recent years, men — mostly white, middle-class, heterosexual men — are still in charge (both in society generally and in the medical profession particularly) and consciously or subconsciously choose social arrangements that reflect their perceived interests. Worse still, individual practitioners may still be gripped by common sexist, even misogynist, attitudes for which medical education currently provides no antidote.⁷⁵

The results for white women and members of other less powerful groups can be devastating. Sexist health care, for example, can rob us of physicians' respect, deprive us of safe and effective therapies, deny us the kind of birthing experiences that we value, drug us into resignation to life's injustices, legitimize violence toward us, and even undermine our last wishes about how to die. Consequently, we may be deprived of the kind of control over our lives that men take for granted. Although some writers question the value of such control,⁷⁶ it is essential for the welfare of second-class citizens in societies in which there is little support for positive rights.

The biases built into medicine and bioethics mean that it is unwise to take much at face value. For instance, Robertson points to Norplant to show how technology can make women's lives better. However, feminists are much less quick to rely on assurances of safety or efficacy from an establishment that gave us the pill, diethylstilbestrol (DES), and the Dalkon Shield. Despite assurances to the contrary, Norplant is still an experimental drug whose long-term effects are as yet unknown. Norplant also increases women's dependency on medical professionals. Obviously, such dependency cannot be helped sometimes, but it seems important both that no unnecessary dependency be created and that any necessary dependency be accompanied by vivid awareness of its possible dangers. Thus, the dependency engendered by Norplant is doubly worrisome because it can

74. SHERWIN, *supra* note 31, at 3.

75. This is a point repeatedly emphasized by John M. Smith. See generally SMITH, *supra* note 65.

76. Doubts about the value of control are to be found in the literature on ecofeminism. For discussions of control within the more general context of ethics and of control's ramifications for bioethics, see generally DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY* (1993).

lead to paternalistic refusals to remove it. Norplant's characteristics also lend themselves to potentially more sinister uses.⁷⁷

Yet another issue raised by the Norplant example is the piecemeal approach common in bioethics. Sexism and other discriminatory practices are harder to detect and to keep consistently in mind when one sees bioethics as a set of separate issues. *Children of Choice* is a salutary new effort at placing reproductive issues in the unifying context of a basic moral and legal framework, but Robertson is not always successful at forging the necessary links. In the case of Norplant, he emphasizes its convenience and effectiveness.⁷⁸ However, attention to its possible side effects and their significance for women's lives might reasonably lead one both to reevaluate Norplant's convenience⁷⁹ and to question the entire rationale for its use.

Surely, one major concern about contraceptives that emphasize convenience, like Norplant, is that such contraceptives encourage women to rely on them without thinking about whether they need to take steps to protect themselves from serious sexually transmitted diseases (STDs) like acquired immunodeficiency syndrome (AIDS). The answer is not necessarily to withhold such methods; rather, it would make sense to

77 See Anita Hardon, *Norplant: Conflicting Views on Its Safety and Acceptability*, in ISSUES IN REPRODUCTIVE TECHNOLOGY, *supra* note 31, at 11, 15. See generally Hilde L. Nelson & James L. Nelson, *Other "Isms" Aren't Enough: Feminism, Social Policy and Long-Acting Contraception*, in THE ETHICS OF LONG-TERM CONTRACEPTION: GUIDELINES FOR PUBLIC POLICY (Ellen Moskowitz ed., forthcoming).

78. See ROBERTSON, *supra* note 1, at 69-70.

79. See, e.g., Hardon, *supra* note 77, at 16-17, 22-24. Anita Hardon writes: "[T]he researchers tend to define disorders such as headaches, dizziness, and weight gain as minor side effects, of which the relationship with Norplant has not been proven." *Id.* at 23. However, anyone who suffers from such problems knows that they can be far from minor, especially in a society in which women are expected to be cheerful and thin in order to maintain their jobs and their personal relationships. Still more worrisome is the following comment:

With respect to Norplant, it is remarkable that so little has been written about the consequences of menstrual disturbances for the day-to-day life of the users. Anthropological research suggests that such consequences can be far-reaching. Menstruation is an important event in any woman's life. The meaning that is attributed to this event or its loss varies, affecting, among other things, cooking procedure, sexual interaction, and religious practices. [M]enstrual blood is often perceived to be a dangerous element for men.

Delay or absence of menstruation in many societies is considered unhealthy for wom[e]n.

Id. at 23-24 (citations omitted).

downplay the pleasures of convenience and to emphasize the importance — in all but the most solidly monogamous sexual relationship — of using condoms as well. That women are so much more at risk of contracting AIDS from heterosexual relationships than men simply reinforces this fundamental point.⁸⁰

In short, taking seriously the sexist context in which assisted reproduction occurs means that the potential harm to women is much more immediate and serious than most people are willing to acknowledge. The evidence for a feminist perspective that recognizes the potential for such harm is compelling, but it is not, on the whole, part of the accepted public knowledge. Rather, the feminist perspective must be sought out, and those who incorporate it in their work must be willing to face the charge of having "politicized" the debate.⁸¹ As I suggested earlier, none of this means that assisted reproduction should automatically be ruled out; rather, its methods should be examined on an issue-by-issue basis with scrupulous attention to feminist objections.⁸² Robertson is more sensitive to feminist concerns than most mainstream writers, but I believe that he would be even more effective if he took the literature more seriously

There is a yet more fundamental criticism of the emphasis on the provision of assisted reproduction, however. Sexism is not the only dubious ethical tendency to which our society is prone. I have been guilty, like Robertson and so many others, of focusing on the novel, the exciting, and the bizarre. Naturally, it is imperative to attempt to evaluate new technologies because they are coming at us so quickly, and it is fun to think of reasons for rejecting what so often seems like silly opposition to bright new possibilities. However, it is all too easy to get drawn into this technological wonderland and to lose our grounding in the real world of limited resources and pervasive discrimination. The situation reminds me of plans to create space colonies to escape a polluted and worn-out earth; when we examine the issues realistically, it seems far more sensible to nurture the earth instead. Similar reasoning applies here. Many of the

80. See generally A. Nicolosi, *Mechanismi di trasmissione e rischio di infezione da virus dell'immunodeficienza acquisita (HIV-1)*, 96 L'IGIENE MODERNA 556 (1991).

81. Susan Sherwin provides an excellent introduction and compilation of the studies. See generally SHERWIN, *supra* note 31. For a discussion of "politicization," see Laura M. Purdy, *Politics and the College Curriculum*, in NEUTRALITY AND THE ACADEMIC ETHIC 236, 248-56 (Robert L. Simon ed., 1994). See generally Purdy, *supra* note 67

82. See generally Purdy, *Another Look*, *supra* note 60; Purdy, *supra* note 14; Purdy, *Surrogate Mothering*, *supra* note 60.

alleged benefits of assisted reproduction could be achieved more efficiently and more equitably by revamping familiar social arrangements.

.So what is the attraction of high-tech proposals? I believe that such proposals feed a kind of escapism that both arises from and helps perpetuate a number of intellectual, moral, and political tendencies pervasive in our society, tendencies connected with our disinterest in what Virginia Warren calls "*housekeeping issues*."⁸³ Housekeeping issues involve ongoing situations, unlike crisis issues that can provide the satisfaction of being resolved once and for all.⁸⁴ Housekeeping issues, unlike dramatic crisis issues, seem trivial, yet housekeeping issues require us to rethink big chunks of our lives: "our character traits, how we think about ourselves, and how we relate to others."⁸⁵ In addition, housekeeping issues call upon a variety of intellectual and moral resources beyond those that we consider usual. Because of the appeal of tackling crisis issues, much of the applied ethics establishment has fallen into a sort of "crisis of the month" mentality by leaping from one problem to another without stopping to think about how those problems might be related or what might prevent them. As a result, we are drawn to stopgap solutions that are often shortsighted, authoritarian, or punitive; technological fixes tend to look better than fundamental social change. However, unless we face the ongoing, systematic problems in our social arrangements, new versions of old problems will arise to replace those that we think that we have solved.

How might these realizations change our perception of assisted reproduction? Well, if infertility is such a problem, would it not make more sense to investigate and eradicate its causes and to concentrate on environmental toxins, STDs, iatrogenicity, and social patterns that require women to conceive later in life if they want both family and career? Addressing these moral and political issues not only would be likely to be far more successful and less risky to women and babies than new high-tech interventions, but also would have positive "side effects" on all of our lives. For example, everyone would benefit from a cleaner environment, better public health, and the kind of social equality that values equal consideration of the interests of all persons.

This approach would look less daunting if the true costs of high-tech solutions were factored into decisions about how to deal with the problems.

83. Warren, *supra* note 73, at 36.

84. *See id.* at 37

85. *Id.*

For example, because of unwarranted technological optimism and the sexism or racism that fails to take seriously potential or real harms to members of disadvantaged groups, evaluations of high-tech solutions often underplay or fail to mention altogether the tenuous benefits and high, socially skewed costs that they involve. Thus, the facts that IVF has extremely low success rates, is expensive, and puts women through a strenuous cycle of drugs and surgical interventions do not really count against IVF when policy decisions are being made.⁸⁶ Little attention is paid either to the risks for women or to their distasteful experiences during the therapy.⁸⁷ As Sherwin points out, "[t]o date, only feminists have raised these issues."⁸⁸

The same kinds of issues could be raised with respect to the health of fetuses and babies. I too have been guilty of focusing on the problem of genetic disease in isolation. However, looking at genetic disease and other risk factors in the larger context has convinced me that it is unreasonable to concentrate on possible genetic approaches to health *before* addressing the social factors that so seriously affect perinatal morbidity and mortality. According to a government task force, "if we just delivered routine clinical care and social services to pregnant women, we could prevent one-quarter

86. For a list of IVF's possible dangers, see COREA, *supra* note 5, at 148-50.

87. See SHERWIN, *supra* note 31, at 125. Susan Sherwin argues:

The bioethics literature has not considered the chemical similarities between clomid, an artificial hormone that is commonly used to increase women's rate of ovulation, and DES, a drug that has belatedly been implicated as carcinogenic for the offspring of women who were prescribed it decades before. The uncertainties surrounding superovulation and use of ultrasound and the dangers associated with administering a general anesthetic for egg collection and embryo transfer have not been deemed worthy of attention in the nonfeminist bioethics literature. Women who do succeed in achieving and sustaining pregnancies through this method experience a very high rate of surgical births, but those risks also are generally ignored. Furthermore, most ethical discussions do not explore the significant emotional costs for women that are associated with this therapy

Id. (footnotes omitted). Paul Lauritzen provides a description of the process of infertility workups and attempts at a technological fix, as well as an example of a woman undertaking the risk of IVF because of a man's infertility. See Paul Lauritzen, *What Price Parenthood?*, HASTINGS CENTER REP., Mar.-Apr. 1990, at 38, 38-39; see also Lorber, *supra* note 47, at 169. For an analysis of the differing views of the enterprise, see generally Lene Koch, *The Fairy Tale as Model for Women's Experience of In Vitro Fertilization*, in ISSUES IN REPRODUCTIVE TECHNOLOGY, *supra* note 31, at 275.

88. SHERWIN, *supra* note 31, at 125.

to one-third of infant mortality "⁸⁹ Children's health could be still further ameliorated by a variety of policies such as guaranteed health care, clean environments, more liberal parental leaves, and better nutrition programs for the poor. The social choices now being made about improving perinatal health are especially troubling given their racist and sexist implications, for if poor black women did not have to live in such miserable conditions there would be far fewer dead, disabled, or sick babies. It is difficult to feel much enthusiasm for the Human Genome Project or spectacular new experimental therapies when the remedies for many problems now facing women and children are so close at hand.

It seems clear that we cannot "have it all." We seem to be faced with a choice. Either we push ahead with high-tech solutions and thereby ignore the ongoing social problems that play a substantial part in creating them, or we concentrate on ameliorating the social problems and thereby de-emphasize possible high-tech solutions, including the enticing nonprocreative uses of reproduction. Following either path means that some needs will not be met. Of course, there is no reason for approaching this issue in a completely all-or-nothing fashion. Indeed, I suspect that a primary emphasis on basic social problems, together with a limited and carefully thought-out program of technological innovation, would be the optimum approach.

The questions that face us in this context are similar to the allocation questions common in the rest of the health care system and, indeed, in society at large. The special twist here is the potential for harm to white women and members of other groups. The more cautious path that I advocate bypasses those harms and begins to address age-old problems of inequality

V Conclusion

Thus, procreative liberty's emphasis on assisted reproduction is all very well: The shivers that it elicits in those who worship tradition, predicate the personhood of embryos, or fear the unknown may be groundless. When we look at the overall social context, however, funding some of the more exotic proposals cannot compete morally with the need for providing basic necessities like health care, nutritious food, decent shelter, education, jobs, and a clean environment for all. This is not an

89. BORDO, *supra* note 10, at 84.

argument for banning the more exotic approaches, but rather for more careful and selective encouragement or discouragement of particular options.

If we let these high-tech approaches flourish, it will come at the expense of these more basic approaches to human well-being. We could thus create a society in which some people enjoy a wide range of choices, even if those possibilities do not necessarily enhance their own welfare. Alternatively, we could work toward a society that attempts to achieve a far more fundamental and widespread kind of well-being. I believe that justice requires us to choose the latter course.