

Questions in the Abstract

Assisted Reproductive Technologies as
Private Choice and Social Practice

Background

What Are Assisted Reproductive Technologies?

Assisted reproduction is not a new phenomenon, but the cluster of technologies now commonly referred to as assisted reproductive technologies or, more recently, advanced reproductive technologies (ART) dates only to the late 1970s. Dr. Patrick Steptoe and Dr. Robert Edwards performed the first successful in vitro fertilization (IVF) of a human embryo that was sustained through a normal pregnancy and resulted in a live birth, that of Louise Brown in July 1978 in Great Britain. IVF was a breakthrough technology that circumvented some types of female infertility, including blocked fallopian tubes, the physiological problem that prevented Louise Brown's mother, Lesley, from conceiving. Other types of lower-tech assisted reproduction, such as artificial insemination, had long been used successfully, but IVF was something new. After another successful IVF was performed in the United States, researchers and doctors on both sides of the Atlantic rapidly developed and applied the procedure throughout the 1980s and 1990s.

ART encompasses not only the IVF procedure, where fertilization of egg and sperm takes place outside the body and the few-day-old embryo is implanted in the woman's uterus, but also a few variations. To be precise, the U.S. Centers for Disease Control and Prevention defines ART as "all treatments or procedures that involve surgically removing eggs from a woman's ovaries and combining the eggs with sperm to help a woman become pregnant. The types of ART are in vitro fertilization, gamete intrafallopian transfer, and zygote intrafallopian transfer."¹ In the case of IVF, the egg is fertilized outside the body and the resulting zygote or embryo is placed directly into the woman's uterus through her cervix, usually on day 5 of the embryo's development.

IVF provides the ability to document that fertilization occurred and the opportunity to evaluate embryo quality. The vast majority of ART cycles use IVF. In gamete intrafallopian transfer (GIFT), the eggs and sperm are combined outside the body but placed together inside the fallopian tube, the natural site of fertilization, through small incisions in a woman's abdomen. GIFT differs from IVF in that fertilization takes place inside the body. In zygote intrafallopian transfer (ZIFT), the egg is fertilized outside the body and the resulting zygote is placed in the fallopian tube, rather than the uterus, through small incisions in a woman's abdomen.²

In all types of ART, fertilization takes place without sexual intercourse. A woman's ovaries are stimulated through a regimen of drugs that cause multiple eggs to mature at the same time, a process called superovulation. After the eggs are surgically retrieved, the woman's uterus is then prepared for pregnancy (technically, the implantation of an embryo in the uterine lining) through the administration of a progesterone supplement. If an adequate number of eggs cannot be retrieved or if a woman experiences the symptoms of hyperstimulation, the drugs may be discontinued and the ART cycle canceled.³ However, in most cases, the cycle moves forward, and the retrieved eggs are combined with sperm and transferred back into the woman's body.

ART does not encompass such lower-tech methods of assisted reproduction as artificial insemination, intrauterine insemination, or the various hormonal drug therapies available to women to increase the likelihood of conception (for example, Clomid). ART also does not encompass the many medical treatments for health problems that can cause infertility (for example, surgery to treat endometriosis in a woman or to repair a varicocele in a man). ART is considered high tech because it involves sophisticated surgical and laboratory procedures, including the surgical retrieval of eggs from the woman's ovaries, which is performed under intravenous sedation; the grading and manipulation of eggs and sperm in the laboratory; and the transferring of embryos or gametes back to the woman's body, typically an outpatient procedure performed without anesthesia.

Although most ART cycles use fresh, nondonor eggs or embryos, other applications of ART also exist. For example, many couples use cryopreservation after an IVF cycle to freeze or save extra embryos for later attempts to become pregnant. Couples increasingly combine IVF with the use of an egg donor or embryo donor. In these cases, the donor undergoes the egg retrieval procedure and the intended mother undergoes the transfer procedure. A smaller number of people combine IVF with a gestational surrogate. In this case, the intended mother may undergo the egg retrieval procedure or may use a donor, and the surrogate undergoes the transfer procedure.

In addition, several micromanipulation techniques increase the chances of a successful fertilization. For example, a refinement of IVF involves intracytoplasmic sperm injection (ICSI), in which a single sperm is physically injected into an egg to cause fertilization. ICSI is beneficial when there is male-factor infertility such as low sperm count or poor sperm quality. It has also been used to increase fertilization rates in older women and in women whose eggs have thick outer walls.⁴

An even newer procedure, cytoplasmic transfer, seeks to revitalize old eggs by combining the nucleus of an older woman's egg (that is, the egg of the woman trying to become pregnant) with the cytoplasm of a younger woman's egg (that is, the donor). The resulting embryo is thought to be healthier and more likely to implant in the uterus, but it may also contain genetic material from both eggs because the mitochondria in the younger egg's cytoplasm contain genetic material. Although cytoplasmic transfer has resulted in the birth of a few live babies, the procedure remains highly experimental and is not yet widely available.⁵ Indeed, in 2001 the U.S. Food and Drug Administration (FDA) intervened and required clinicians at St. Barnabas Hospital in Livingston, New Jersey, one of the first U.S. clinics to attempt cytoplasmic transfer, to submit an Investigational New Drug application before proceeding with cytoplasmic transfer. The FDA's intervention effectively halted the procedure, as most practitioners around the country did not want to submit to the application process.⁶

Despite their complexity, all of the techniques that fall under the rubric of ART are still accurately thought of as variations, refinements, or combinations of the original IVF technology with other technologies. ART has opened up a whole new world of treatment possibilities for people experiencing infertility.

ART in the United States Today

According to the national registry, about forty-one U.S. clinics performed ART in 1986.⁷ Since then, the number of clinics has increased significantly. According to the "2002 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Report" (the ART Report, a national summary of success rates published each year by the Centers for Disease Control and Prevention), the United States had 428 ART clinics in 2002, with 391 of them submitting data.⁸ Most clinics are located in or near major cities—New York and metro Los Angeles each has more than ten clinics.⁹ The Atlanta area, where I did my research, also has several prominent fertility clinics.

Approximately 6.2 million American women, or about 10 percent of those in their childbearing years, experience infertility, which is commonly defined

as the inability to conceive after one year of unprotected intercourse.¹⁰ According to statistics gathered by the National Survey of Family Growth, the absolute number of women experiencing fertility problems increased from 5.5 million in 1988 to 6.7 million in 1995, in part because of the aging baby boom generation.¹¹ During this same period, the absolute number of women who had ever sought medical help for fertility problems grew by 30 percent, from 2.1 million to 2.7 million.¹² However, not all women who experience fertility problems seek medical help. According to the statistics gathered in 1995, 42 percent of women with fertility problems had used infertility services.¹³ The most common services reported were advice (60 percent), diagnostic tests (50 percent), medical help to prevent miscarriage (44 percent), and ovulation drugs (35 percent). Fewer than 2 percent of women seeking infertility services used ART.¹⁴

In the United States, the members of this select group tend to be older, to be married, to have college educations, to have high incomes, and to be white. Two demographers recently performed a multivariate analysis with data from the National Survey of Family Growth. By controlling for factors such as education and income, they pinpointed which characteristics were most clearly associated with using infertility services. The researchers found that race and age, by themselves, are less clearly associated with using infertility services than are having been “married, having higher levels of income and education, and having been covered by private health insurance in the last twelve months.”¹⁵ Elizabeth Hervey Stephen and Anjani Chandra further explain that they “hypothesize that race and ethnicity, to the extent that they serve as a proxy for socioeconomic status, may now distinguish those who can afford ‘higher end’ or specialized services.”¹⁶ Thus, this analysis supports the interpretation that socioeconomic status is a very important predictor of ART use and a more definitive predictor of ART use than race or age alone. Stephen and Chandra also note that marital status, “which is strongly correlated with having private insurance and higher income, is likely a proxy for an entire set of behaviors that are associated with infertility service-seeking.”¹⁷

Most health insurance plans do not cover treatments for infertility, so the cost of ART is borne largely out of pocket. According to the American Society of Reproductive Medicine, the average cost of a single cycle of IVF in the United States is about \$12,000.¹⁸ However, additional costs are associated with an IVF pregnancy. According to one 1994 study, “On average, the cost incurred per successful delivery with in vitro fertilization increases from \$66,667 for the first cycle of IVF to \$114,286 by the sixth cycle. The cost increases because with each cycle in which fertilization fails, the probability that a subsequent effort will be successful declines.”¹⁹ The cost is lower for

couples with a better chance of success, but for older couples with more difficult infertility problems (that is, the woman is older than forty and male-factor infertility also exists), the cost of a successful delivery ranges from \$160,000 for the first cycle to \$800,000 by the sixth. In the past few years, many clinics have instituted “shared-risk” or refund programs to patients without health insurance. In these programs, patients pay a higher fee up front to receive a fixed number of ART cycles (for example, three) but receive a substantial refund if no pregnancy or delivery occurs.²⁰

Success rates for ART depend on a number of variables, including most significantly the age of the woman undergoing treatment if she is using her own eggs. Since the passage of the 1992 Fertility Clinic Success Rate and Certification Act, U.S. fertility clinics are required to report their success rates to the Centers for Disease Control and Prevention. The annual ART Reports have consistently shown that rates of pregnancy and live births are relatively high for women in their twenties but decline for women in their early thirties and drop more sharply from the mid-thirties onward. For example, in 1999, the percentage of ART cycles (using fresh embryos from nondonor eggs) resulting in live births was 32.2 percent for women under thirty-five, 26.2 percent for women ages thirty-five to thirty-seven, 18.5 percent for women thirty-eight to forty, and 9.7 percent for women forty-one or forty-two.²¹ The 2002 ART Report, which examines trends in ART use from 1996 to 2002, notes that success rates improved for all age groups. Even so, some 65 percent of ART cycles using fresh nondonor eggs in 2002 did not result in a pregnancy. Just shy of 1 percent resulted in ectopic pregnancies, which are not viable, while 19.9 percent resulted in single-fetus pregnancies, 12.4 percent resulted in multiple-fetus pregnancies, and 2 percent ended in miscarriage.²² Fewer than 83 percent of the viable pregnancies resulted in live births.²³

In addition to age, other factors affecting success rates include whether the embryos were created from nondonor or donor eggs and whether the embryos are fresh or frozen. The success rates with fresh embryos are uniformly higher than with frozen, and the success rate using fresh embryos created from donor eggs is the highest of all types of ART cycles. (Donor eggs are typically taken from women in their twenties and thirties.) The average rate of live births per transfer using fresh embryos created from donor eggs is about 50 percent. The age of the woman receiving the donated egg does not materially affect success, so this statistic includes women of all ages (including those older than forty-two).²⁴ By contrast, when ART cycles use a woman’s own eggs, the rate of live births declines precipitously with age: for example, to 4.0 percent at age forty-four and 1.2 percent at age forty-six.²⁵

Finally, the trend of increased fertility problems appears to be associated

with the factor of delayed childbearing. Women aged between thirty-five and forty-four make up 36 percent of the general population of women but 43 percent of the women reporting fertility problems. The difference is even more pronounced among nulliparous women (those who have never had a child): nulliparous women aged thirty-five to forty-four comprise 16 percent of the general population of women but 36 percent of the women reporting fertility problems.²⁶ Women clearly are waiting longer to have their first children. According to one source, the rate of first births for women in their thirties and forties has quadrupled since 1970.²⁷

Although ART does not threaten to replace unassisted reproduction any time soon, it is growing in popularity among a certain group of Americans, some of whom attempt multiple cycles of IVF in their quests to overcome infertility. Between 1996 and 2002, for example, the total number of ART cycles performed grew from 64,681 to 115,392—an increase of 78 percent.²⁸ ART is also responsible for the lives of many children: the number of babies born through ART increased a dramatic 120 percent during those same years, from 20,840 in 1996 to 45,751 in 2002.²⁹ Finally, the increasing use of ART bears partial responsibility for the huge success of the infertility industry, which now grosses \$4 billion per year.³⁰

Ethical Questions

Since its introduction in the United States in the early 1980s, ART has generated and continues to generate diverse moral questions and answers. Within the fields of philosophical and religious ethics, feminist ethics, and biomedical ethics broadly defined, the responses have run the gamut from enthusiastic embrace to intense objection. The complex factors and distinct normative values on which these responses are based do not represent fixed or immovable points of reference so much as evolving perspectives in an ongoing scholarly conversation. I locate my particular perspective within this conversation as a means of raising what I consider to be relevant ethical questions about ART and the infertility industry.

I draw my point of view from theoretical perspectives within biomedical ethics, feminist ethics, and philosophical and religious ethics. My deeper roots, however, lie in feminist ethics and Christian ethics—in particular, in their overlapping areas of interest. To illustrate the areas of concern shared by feminist ethics and Christian ethics, I engage the work of Lisa Cahill, a feminist Christian (or Christian feminist). Cahill simultaneously attends to the social context of ART, including the cultural value of autonomy that supports its use, and ART's impact on the well-being of women, children, marriages,

families, and most broadly the common good. I share with Cahill a willingness to explore the “final ends” of ART—what these technologies are for, whom they serve, and to what good or ill effects. Like Cahill, I draw from feminism in asking what best serves women’s interests and from a religiously informed perspective in asking what best promotes human flourishing. What distinguishes my work is its methodological commitment to attend to the lived experience of infertility and to incorporate that experience into an ethical analysis.

Attending to the lived experience of infertility does not mean simply reporting data about ART and its users in the early–twenty–first–century United States. I do not think any researcher can report neutrally on a social phenomenon without letting his or her normative values frame the project.³¹ In my investigation of ART, I have asked questions that assume there are better and worse choices, not simply greater or fewer numbers of choices. This chapter seeks to describe more fully my values and commitments and thus to identify the lens through which I interpret the social world of people using ART.

What Is the Purpose of ART?

To me, the most striking problem raised by ART is that, simply put, we do not seem to know what it is for. Like most technological advances, ART seems “good” because it solves a problem: the inability to conceive a child of one’s own. However, what ART does and what this means is far more ambiguous than is typically acknowledged.

The ambiguity of assisted reproduction in many ways epitomizes a larger confusion about the general goals of medicine: Should physicians, as members of a time-honored profession with traditionally coherent moral commitments, seek to heal illness and relieve suffering, or are physicians now better understood as well-trained technicians available for hire in a morally pluralistic world, expected to promote the autonomous wishes of their consumer-patients without much comment? This question has been the subject of discussion within the medical ethics community for well over a decade because it epitomizes the challenge of moral pluralism in the context of contemporary medicine.³² Different people have different views about the legitimacy of using growth hormones on short but otherwise healthy children, for example, just as they have different ideas about the legitimacy of breast implants or the appropriateness of hastening the death of someone facing a terminal illness.

Assisted reproduction is just one of many areas where what the patient desires may not necessarily fit neatly into the domain of traditional medicine. When does ART treat an illness, and when does it enable the expression of an

individual patient's autonomous desires to procreate according to his or her personal values (for example, a single man who hires a surrogate mom or an older couple who hires an Ivy League egg donor)?³³ When, if ever, should a physician challenge what a patient wants, even if that goal has very little chance of being realized, as long as the patient has been informed of the risks and willingly consents to them? These questions have no easy answers in a context where the principle of autonomy has become the paramount arbiter of moral conflicts and where what serves the "patient's good" is generally assumed to be something that only the patient can authentically decide for him- or herself.

Despite the strong pull of autonomy as a dominant cultural value and a dominant concept in bioethics, reasons to challenge its preeminence still exist. Debate continues about the limits of patient autonomy and the proper ends of medicine, and debate about the limits of patient autonomy in the area of reproduction—specifically, women's reproductive freedom—is particularly intense. Many observers have criticized the trend of expecting physicians to be merely technicians for hire, with no independent moral compass. For physicians to acquiesce to patient demands can seem like abdicating responsibility for the patient's good, a deeper commitment that many people believe provides the moral core of the medical profession. At the same time, other critics plausibly assert that the ability to choose the timing and manner through which one procreates (like the ability to choose the timing and manner of one's own death) lies at the very heart of personal liberty and therefore trumps the seemingly antiquated virtues of medical paternalism.

In the midst of this ongoing debate enter the impressive technological advancements of reproductive medicine. Every year brings new developments and improved success rates. And each advancement, whatever its intended purpose or the particular medical problem it was designed to overcome, opens the door to numerous applications and consequences, some anticipated, others not. For example, the next "breakthrough" technology on the horizon of assisted reproduction, egg freezing (the physical removal and cryopreservation of human oocytes or eggs), "also might allow women to delay their reproductive choices, or enable some of them to preserve their ovarian tissue before undergoing treatments such as cancer chemotherapy, that could threaten their reproductive health. . . . In the future, as the difficulties of freezing and thawing eggs are overcome, it is probable that egg freezing will slowly join the mainstream of assisted reproductive technologies—most likely in the area of egg donation. And when this technology is perfected, women and their families and physicians will have another valuable option for treating infertility."³⁴ This discussion exemplifies the kind of ambiguity that cries out

for further clarification. The article's author writes that egg freezing could accomplish a variety of goals but does not explicitly justify any of them: it preserves fertility when a woman must undergo a fertility-jeopardizing medical treatment; it allows women to delay childbearing by saving healthy oocytes for later use; it allows fertility clinics to store donated eggs; and it "treats" infertility, although how egg freezing is a treatment for existing (not future) infertility is especially unclear.

The author uses the more established legitimacy of medical treatment to lend legitimacy to all the potential uses of egg freezing, thereby helping to bring this new technology into the mainstream. No one would deny the obvious medical benefit of allowing a woman to receive life-saving chemotherapy and preserve her fertility through egg freezing. Yet there is no attempt to argue for the legitimacy of the other uses of egg freezing, including the ability to "delay reproductive choices," other than to phrase it in terms of creating more options and greater choice.³⁵

Is ART fundamentally about the treatment of an illness, or is it fundamentally about serving other goals, such as the need or desire to delay childbearing? Is it both? Why should it matter whether society comes to any kind of consensus about the purpose of egg freezing or any other use of ART? My discussion of the hypothetical career pill (ostensibly a chemical version of egg freezing) should clearly demonstrate that I consider ART's boundaries rather amorphous. This lack of definition is problematic ethically because more is at stake in the use of ART than the expression of individual consumer preferences. I view the use of ART not simply as a private choice affecting only the individual who uses it but as a social practice with broader consequences—for women generally, for children and families, and for future generations. The use of ART is also a social practice in the sense that it grows out of a specific set of social and historical circumstances that deserve further scrutiny.

That many women desire "to delay their reproductive choices" and that this desire is perceived to grow out of a legitimate set of circumstances creates the implicit link between ART as "treatment" and ART as "elective procedure." There may be a compelling argument why the elective use of egg freezing to preserve future reproductive options in an otherwise healthy woman is every bit as legitimate as the use of ART to treat existing infertility, but the author of this article does not make the case. In fact, the literature promoting ART rarely makes the case. However, the social conditions favoring delayed childbearing should not be equated with the physical illnesses or disabilities that cause infertility. To use the language of philosopher Judith Shklar, the latter might be considered a misfortune, while the former might be better thought of as an injustice.³⁶ If we fail to recognize the constructed nature of the con-

ditions favoring delayed childbearing, we lose any inclination to question whether those conditions are just. Indeed, the perception that individuals' choices—especially in the area of reproduction—are disconnected from a larger social context and from concerns about justice encourages a certain moral complacency with regard to ART's many potential uses. Reproductive choices are thought to represent only individuals' best interests and most private desires.

How Does ART Relate to Delayed Childbearing?

Two significant and commonly discussed changes in work have dramatically affected American society: more women have paid employment than ever before, and many Americans, both men and women, feel they are overworked. Both of these statements require elaboration and qualification.

Much has been made of the enormous influx of women into the workforce over the last few decades of the twentieth century. Observers often point out that women of color have always worked outside the home in greater proportion than white women and that these working women of color have managed to combine work and family responsibilities out of necessity. Indeed, only recently have maternal employment rates for different racial ethnic groups begun to converge. Most mothers, both white and nonwhite, work outside the home: maternal employment has tripled over the past thirty years, increasing steadily for all racial ethnic groups.³⁷ But nonwhite working mothers continue to work longer hours and for less money than their white counterparts.³⁸

Second, people are working harder than ever. Juliet Schor's *The Overworked American* (1992) went a long way toward raising awareness about the amount of time Americans devote to work. Using statistics from the late 1960s to the late 1980s, she finds that the average employed person now works an extra month (163 hours) per year. She also finds a gender gap in the work increase: men are doing 98 more hours per year and women are doing a staggering 305 more hours per year.³⁹ Studies also show that even mothers who work outside the home remain the primary caretakers of children and the household.⁴⁰

Like the influx of women into paid employment, the observation that Americans are overworked needs to be qualified. Sociologists Jerry Jacobs and Kathleen Gerson argue that overwork exists primarily for the professional and middle classes but that significant underwork or unemployment exists for other groups.⁴¹ Their findings corroborate Ellen Goodman's observation that "we seem to be evolving into two classes, the underemployed and the over-employed, those who are desperate for work and those who are desperate for time."⁴²

Alongside problems with the structure of work are problems with the structure of families. The increase in maternal employment (or at least the increase in white middle-class maternal employment) and the phenomenon of overwork (or at least the overworked middle and professional classes) have together spawned a great deal of theorizing about the structuring effects of gender and the gendered division of labor. Our society apparently has been slow to adjust to the reality of working mothers. Little has changed with regard to our expectations of mothers' duties in the home or with regard to wage earners' productivity in a competitive economy.⁴³ Briefly put, "Two-earner families are trying to do something in a world that's designed for one-earner families."⁴⁴

Although expectations about families and women's duties to family may not have changed much in recent decades, noticeable changes in childbearing practices have occurred. Childbearing takes place later than in previous decades, and birthrates have declined.⁴⁵ In the professional class, many women delay childbearing until their careers are well established.⁴⁶ The significance of these trends with regard to the increased use of ART is by no means self-evident. The best data available suggest that income, education, and marital status are among the characteristics most strongly associated with the use of ART. If any relationship exists between the increased use of ART and conditions favoring delayed childbearing, what may be the most plausible interpretation is that ART is functioning not to alleviate the strain between work and family experienced by millions of American families of different social classes but rather to expand reproductive options for a select, privileged group of women. Perhaps for this group, ART enables conception later in life, after professional goals have been attained.

However, it is always important to remember that the causes of infertility are varied and complex and cannot be attributed solely to delayed childbearing. In fact, some of the most significant risk factors for infertility include poor health care and untreated sexually transmitted diseases. Any feminist—or any person—concerned with the well-being of women would have to ask whether ART helps women whose infertility is caused by these problems.

Does ART Promote Women's Well-Being?

To date, the largest body of literature addressing ART has come from feminist scholars who recognized early on that assisted reproduction potentially affects women's health and well-being. As their work clearly illustrates, ART also intersects with women's roles as mothers, the institution of the family, the relationship of sexual difference to sexual equality, and the roles technology and consumerism can play in liberating and/or exploiting women. Precisely

how ART intersects with these issues is open to different interpretations, and at no time were the responses within feminism more polarized than in the 1980s, when ART was first being used in the United States.⁴⁷

Although no single representative feminist position on ART exists, the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE) was very influential in setting the agenda for the initial feminist discussion. Scholars associated with FINRRAGE vocally opposed ART, believing these technologies to be highly exploitative of women as a group.⁴⁸ In her helpful historical overview, Anne Donchin describes the FINRRAGE position, sometimes referred to as “radical noninterventionist”:⁴⁹ “The FINRRAGE program calls for suppressing the development and application of fertility technologies despite claims of many women that they provide the only means available to them to fulfill their procreative desires. The dissemination of these technologies, they insist, only reinforces women’s oppression, giving scientific and therapeutic support to the patriarchal presumption that reproduction is a woman’s prime commodity.”⁵⁰ The skepticism that FINRRAGE feminists brought to reproductive technologies grew out of their deep suspicion of the medical establishment and its long history of disempowering women and women’s experience of reproduction. FINRRAGE feminists pointed out the experimental nature of ART and contended that women were serving as experimental subjects—with significant health risks—in the guise of therapy. Moreover, given the pressures on women in a sexist society to undertake motherhood, members of FINRRAGE believed that women who used ART were not “genuinely” choosing to do so. Although these feminists conceded that individual women might benefit from assisted reproduction, they strenuously maintained that ART should be disavowed for the good of the collective—that is, for “women as a social group.”⁵¹

On the other side of the early feminist debate were scholars who enthusiastically embraced ART and its many possibilities. The godmother of this “radical interventionist” position was, most famously, Shulamith Firestone, who invoked the liberating potential of disembodied human reproduction several years before the advent of ART.⁵² Real equality with men, she argued, could be achieved only by defeating biological destiny, and artificial reproduction (even extracorporeal gestation) could be a legitimate tool for accomplishing this goal. These views, even though they predated the first successful use of IVE, influenced the development of more optimistic interpretations of ART. Feminists who understand gender and reproduction to be socially constructed saw in ART the opportunity to reconstruct reproduction in entirely new ways and to encourage new forms of social organization that would benefit women. For these feminists, ART created “new possibilities in the relationship be-

tween women and their bodies, new ways of conceptualizing the family, and new ways of thinking about the social contribution of reproductive services.”⁵³ Accordingly, from this perspective, ART served rather than undermined the collective good by constituting a tool for women’s liberation.

Other feminists, also fairly classified as radical interventionists, supported the use of ART out of a more classically liberal position, advocating individuals’ rights to reproductive freedom and self-determination. Access to ART expands the range of decisions women can make about reproduction, these liberal feminists argued, increasing flexibility and choice. They also argued that ART enables women “to enter into collaborative contracts, to sell gametes or gestational services, or to bear children outside the confines of heterosexual marriage,”⁵⁴ thus increasing women’s control over the fruits of their reproductive labor and power to enact their own diverse understandings of family and parenthood.

Finally, another group of voices embracing ART from the beginning includes advocates for the involuntarily infertile. Although they would not necessarily identify themselves as liberal feminists, advocates for the infertile similarly support ART for the benefits these technologies can provide to individual women. Supporters of this position are unconvinced that women’s collective interests are served by suppressing the development and use of ART, believing it unfair to sacrifice the present interests of infertile women for future, dubious social goals.⁵⁵ Unlike adherents of the various feminist positions, advocates for the infertile are often labeled “pronatalist” rather than “feminist” because they tend to assume that the desire to procreate is natural, spontaneous, and not necessarily a sign of women’s oppression. And in striking contrast to the FINRRAGE feminists, advocates for the infertile do not perceive women who use ART as passive victims of technology or the medical establishment. By FINRRAGE standards, advocates for the infertile are unconcerned with problems of false consciousness and instead view these women as exercising considerable self-determination in deciding to use ART and in striving to achieve their goals.

Some of the initial feminist responses to ART tended to oversimplify the issues. For example, *either* motherhood is the main source of women’s oppression, and a technology that encourages “pronatalism” thus can only oppress women further, *or* motherhood is entirely natural and good, and a technology that assists in achieving legitimate procreative desires thus can only be a blessing. Many of the stronger anti- and pronatalist perspectives (as well as anti- and protechnology perspectives) still find expression in contemporary debates about ART, but some important developments and changes have also

occurred, as has a general move toward greater complexity. A generation of feminist theorizing has challenged some of the early dichotomies between nature and culture, for example, and between feminist positions that prioritize only the collective or individual benefits/harms of using ART.

In her discussion of more recent feminist responses to ART, Donchin attributes these developments to three major themes in feminist theory that emerged in the 1990s: a reclamation of women's agency, a reevaluation of mothering, and a more sophisticated appraisal of power relations.⁵⁶ She calls the FINRRAGE position "feminist fundamentalism" because it assumes that the general experience of a common oppression among women qualifies FINRRAGE to judge and even dictate the conduct of individual women. She also criticizes the FINRRAGE position because it denies the possibility of individual agency (that is, it claims that women choose ART out of irresistible pronatalist societal forces), denigrates the value of mothering (that is, it claims that mothering is closely connected to if not synonymous with the main sources of women's oppression in a patriarchal society), and assumes a simplistic picture of power relations (that is, it claims that women's reproductive experience rests largely in the hands of male doctors and/or husbands).

Donchin is equally critical of the other extreme, those who would give their unqualified support to individual decisions to use ART, especially advocates for the infertile who assume that an "individual woman's actions can be assessed in isolation from their social context," an assumption she finds politically naive.⁵⁷ In between feminist fundamentalism and pro-ART individualism, Donchin proposes a third alternative, "women who claim their desires as their own and, without disavowing the constraints of biology and social norms, still exercise self-determination."⁵⁸ According to this view, individual agency is not negated by social forces, motherhood is not the bane of women's existence, and users of ART should not be assumed to be victims operating out of false consciousness.

Most contemporary feminists occupy the middle ground described by Donchin, and it is a complex terrain.⁵⁹ Many contemporary feminists continue to criticize ART for a variety of reasons. Many support it with qualification. The nature/culture or embodiment/rationality debate seems to stand at the heart of some of these intrafeminist differences. Technology complicates the debate because, as a product of rationality, it can both threaten the "natural," such as the connections of biological-gestational-social parenthood, and mitigate natural inequalities, such as the fact that men are fertile for many more years than women. The question remains: Who wields the power of this technology, and to what end(s)?

Does ART Serve or Undermine Feminist Social Goals?

Feminists, as feminists, share a concern for women's well-being, but considerable diversity of opinion exists about how to define women's well-being and about what promotes it. Historically, feminists have constructed some major philosophical frameworks for approaching these questions, but feminism has become more complex and nuanced over the past decade. The categories of liberal, radical, socialist, Marxist, postmodern, and other kinds of feminism, while still relevant, may be less decisive than was once the case. Martha Nussbaum, for example, is a liberal feminist philosopher who rejects elevating the collective good of any group (including the good of women as a group, families, communities, or nations) above the individual well-being and agency of group members. Yet she also retrieves from the liberal tradition the argument that individual freedom can be served only by tending to the social structures that make its expression possible. She simultaneously embraces "liberal individualism," which she defines as maximizing individual freedom and respect for individual worth, and a more typically "communitarian" concern for the common good.⁶⁰

What divides contemporary feminists is not that some care about social goods and others do not but rather which social goods to support and how best to support them. Two distinct areas of disagreement arise in arguments about whether ART serves or undermines feminist social agendas: what these agendas or goals should be, and how this particular technology affects them. According to Maura Ryan, the social good of ART is ambiguous, especially with regard to whether it transforms human reproduction for the benefit of women: "The question of whether artificial reproduction can serve the social transformation of reproduction and reproductive choice is extremely complex. The fact that the advent of reproductive technology has proved to be a crisis for feminism—of social vision, of loyalty and ideological solidarity, of meaning and definition—is a testament to the importance of what is at stake."⁶¹ One possible feminist response is that ART promotes the goal of redefining women's relationship to their bodies, which in turn can also promote the goal of sexual equality between men and women. ART makes human reproduction more of a volitional undertaking, giving women greater options, more control, and more time to combine career and motherhood.

As Ryan notes,

The more control women have over the manner and timing of reproduction, the more it is a personal accomplishment, an event which is undertaken and not simply suffered, and an intentional celebration of the immense creative and transformative power that is physical generativity. . . .

The radical version of this argument, that technology ought to be embraced as a means of freeing women from reproducing biologically altogether, has not found many supporters. But the availability of techniques in non-coital reproduction is a positive development if they allow women to overcome the biological clock, for example, to have both a career and a fulfilling parental experience.⁶²

This relatively positive appraisal assumes that women, rather than the medical establishment or a patriarchal, pronatalist society, generally wield the power of ART. This view also assumes that ART can indeed overcome the biological clock and that doing so is desirable. Ryan's conclusions do not ultimately embrace this view, however. She argues instead that the only legitimate warrant for ART is as a health care claim, "as a medical treatment which addresses the personal anguish accompanying infertility," not an elective procedure to extend individual "procreative liberty" or to serve any particular feminist social goal.⁶³

An alternative feminist response that Ryan does not develop in her argument holds that ART may indeed overcome the biological clock but that doing so in this manner is not necessarily a good thing. Such a view does not endorse a regressive "biology is destiny" naturalism but rather questions whether women wield the power of ART. This position takes a more negative view of how ART functions, arguing that it counters the feminist goals of sexual equality, justice, and adequate support of childbearing. For example, Laura Woliver argues that ART has become a technological means of allowing women to conform "equally" with men to modern capitalist timetables in education and employment.⁶⁴ According to this view, both women and men are now free to conform to structures that do not necessarily serve their own interests, benefit the interests of families, or contribute to the flourishing of the human community generally.⁶⁵

Another major problem with ART is how it affects U.S. racial inequalities. In *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (1997), Dorothy Roberts suggests that technological solutions can sometimes obscure social problems by leaving them unaddressed or passing them on to others: "Although the 'biological clock' metaphor is grossly exaggerated, one reason for infertility among white, educated, high-income women is their postponement of childbearing in order to pursue a career. The cause of these women's infertility is not biological; rather, it is a workplace that makes it virtually impossible for women to combine employment and child-rearing. These women can avoid this social problem by seeking expensive fertility treatment after achieving some status in the office."⁶⁶ As Roberts summarizes

her argument, women “can afford to bypass the structural unfairness to mothers through technological intervention. Similarly, many affluent white women gained entry to the male-dominated workplace by assigning female domestic tasks to low-paid dark-skinned nannies.”⁶⁷ Roberts expresses concern that expensive technological interventions may take the place of wider social reforms that could help resolve the conflicts between family and work for all women. Rather than serving feminist social goals, she believes, ART undermines efforts to restructure the workplace and the family so that participation of women and men of all races in both spheres could become more equitable.

The thesis that ART might provide a technological fix for structural injustices and that only some women have the opportunity to exploit the benefits of this fix is compelling because it offers a multidimensional interpretation of some of the ethical problems raised by ART.⁶⁸ This idea recognizes not only that ART expands individual freedom of choice, which may represent a real benefit for many women, but also that this expanded freedom of choice exacerbates many existing inequalities, including inequalities of class and race. In addition, this perspective suggests that technology constitutes a less than optimal solution for underlying social problems by diminishing the likelihood that lasting, transformative change will occur. It also places the burden of fixing a social problem on women’s bodies.

The feminist critique of ART as a technological fix for social or structural problems may overemphasize a causal connection between the various factors contributing to the cultural trend of delayed childbearing and the increasing use of ART. The connection between delayed childbearing and increased fertility problems, while demonstrably accurate, does not logically require any one explanation for why women delay childbearing or choose to use ART rather than pursue some other alternative. Other causes of infertility must not be neglected, and the reasons why women might be drawn to ART in increasing numbers must not be oversimplified. Ignoring the complexity of these phenomena risks endorsing an overly narrow or reductive interpretation of ART, the women who use it, and the forces that make it attractive.

Does ART Expand Human Freedom?

In general, assisted reproduction is gaining wider acceptance in American society. Infertility is a booming industry in the United States, and the practices of IVF and the less high-tech artificial insemination are well established in many parts of the country. In addition to an increased demand for services, increased openness about infertility and infertility treatments has also developed. Prospective parents can acquire donor sperm through Internet catalogs,

advertisements for donor eggs run in college newspapers and national magazines, and women willing to serve as surrogate mothers can meet infertile couples through surrogacy Web sites. Even the adoption process has moved toward greater openness, with biological and adoptive parents often meeting each other and maintaining contact throughout the child's life. These cultural changes, including society's increased comfort level and acceptance of a variety of procreative "choices," likely result (at least in part) from hard-won reproductive freedoms in other areas, including contraception and abortion rights. These protected freedoms are the fruit of major legal decisions as well as powerful philosophical arguments for procreative liberty.

A major, though underexplored, question in the literature on reproductive technologies is whether this increased freedom of choice equates with human flourishing. Are these concepts really synonymous? Moreover, what assumptions about the meaning of freedom and the meaning of human flourishing underlie our increased acceptance of reproductive technologies?

One definition of human freedom, which relies heavily on the assumptions of liberal individualism, comes from the work of John Robertson, a philosopher and legal scholar who has written widely on the subject of reproductive technologies. In his *Children of Choice: Freedom and the New Reproductive Technologies* (1994), Robertson examines different types of assisted reproduction (including artificial insemination, IVF, and surrogacy) as well as the issues of contraception, abortion, and nonreproductive uses of reproductive capacities (for example, research on embryos). He clearly advocates a standard presumption in favor of procreative liberty: unless there is a clear indication of tangible harm, people should be free to procreate when and how they please.

Robertson's strategy is to extend the more well-established right to avoid unwanted procreation to an analogous right to procreate when procreation is desired. This right to procreate, he then argues, should include the freedom to use technological assistance when it is needed to achieve the desired goal. Robertson reviews the legal protections of the right to avoid procreation, including the U.S. Supreme Court's 1972 *Eisenstadt v. Baird* decision, which claimed a constitutionally protected freedom to use contraception,⁶⁹ as well as the relevant Supreme Court decisions on abortion. Drawing on language from the Supreme Court's decision in *Planned Parenthood v. Casey* (1992), Robertson articulates a broader philosophical justification of procreative liberty: Because procreation is so important, so fundamental to the human experience, "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy,"⁷⁰ individuals should neither be forced to undertake it nor deprived of the opportunity to accomplish it. If procreation cannot be achieved through sexual intercourse,

the right to procreate should include the freedom to use technological assistance or the assistance of a third party (although no positive obligation exists on the part of the state to provide such assistance). According to Robertson, “If bearing, begetting, or parenting children is protected as part of personal privacy or liberty, those experiences should be protected whether they are achieved coitally or noncoitally.”⁷¹

After so defining procreative liberty, Robertson weighs the benefits of this liberty against possible competing interests. Although he claims procreative liberty is not absolute, he believes it deserves “presumptive priority” because in most cases the competing interests do not rise to the level of “tangible harm” to others.⁷² Robertson recognizes that the use of some reproductive technologies can occasion ambivalence and doubt, both for individuals and for society as a whole, but he believes that protecting liberty itself is the most important value in a free society such as ours.

Not unlike legal scholar Ronald Dworkin, who uses a similar strategy with abortion and euthanasia in *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (1993), Robertson “privatizes” the issue of reproductive technologies as a means of defending their use.⁷³ Robertson claims that human reproduction is a matter of great personal significance and importance for an individual’s sense of dignity and meaning. But human reproduction, according to Robertson, is foremost a private experience, one that individuals invest with private and diverse meanings. The state should not interfere with this experience unless tangible harm to others will result. “Merely symbolic” concerns, including religious and moral objections to separating sex and reproduction, “should not override the use of these techniques for forming a family.”⁷⁴ That some people’s sensibilities might be offended is not enough to constitute actual harm.

Robertson identifies himself as using consequentialist reasoning to weigh benefits and harms in the exercise of procreative liberty. He rejects out of hand deontological arguments about a “right way” of reproducing, claiming them to be fundamentally illegitimate as public arguments. Because reasonable people will differ in a pluralistic society about the “right way” to reproduce, moral concerns about reproduction are more appropriately resolved by private consciences. Robertson thus presents a typical, if almost caricatured, liberal defense of the so-called value-neutral public sphere and the priority of freedom of conscience.

Robertson’s vision of the person—or what it means to be human—is grounded in a very strong view of autonomy. What matters when we decide to procreate is what we voluntarily will. Robertson states that we should honor the “prime movers” in all reproductive arrangements—those persons who decided

to create a child using whatever collaborative means they desire.⁷⁵ Robertson also believes that assisted reproductive arrangements should be contractual and binding, implying that preferences and needs can be known ahead of time and are not subject to change. He is confident that parties to the contract will be able to make “free choices” provided that informed consent exists. Even concerns about social justice, whatever those might be (for example, it is unfair that access to ART is severely limited by its cost), do not constitute compelling enough reasons to limit procreative liberty.

What emerges from *Children of Choice* is a view of autonomy as the primary ethical value governing the use of reproductive technologies and as the primary characteristic of human beings. Other values, such as social justice or shared symbolic meanings, receive little weight. “Tangible harm” is taken to be literal harm to already existing persons, not to children that would have no other way of being born or to the wider community whose views about parenthood and the dignity of children might alter profoundly over time.

A striking contrast to Robertson’s view of human freedom appears in the works of Cahill and Oliver O’Donovan, both of whom are better described as religious ethicists. Religious ethics has an enormous range, and O’Donovan and Cahill are only two voices within one religious tradition, Christianity. Still, they offer views of human freedom and human flourishing that provide an alternative to Robertson’s singular emphasis on autonomy. They also suggest the diverse and complex ways that any religious tradition can be interpreted. For better or worse, the Christian perspective on assisted reproduction is often monolithically reduced to the Catholic Church’s prohibition against separating procreation from the sex act in marriage.⁷⁶ This unequivocal prohibition is not, however, the final word on assisted reproduction from a Christian perspective—in either the Protestant or Catholic traditions.

For example, in his influential text, *Begotten or Made?* (1984), O’Donovan articulates what he believes to be at stake ethically in the use of assisted reproduction by focusing not on the autonomy of the adults who wish to procreate but on the relationship of parent and child.⁷⁷ All of O’Donovan’s arguments are based on his interpretation of the Christian tradition as a person of faith (he is Protestant) and seem to be addressed to an audience that shares his point of view. Not necessarily compelled to make his arguments more generally or publicly persuasive, he concludes his chapters with explicit directives about how a Christian should proceed in these matters.⁷⁸

Despite O’Donovan’s somewhat insular approach (that is, his perspective of speaking to a community of like-minded believers), his insights have a wider applicability and have had lasting influence. In brief, his interpretation of assisted reproduction hinges on drawing a distinction between *praxis* (beget-

ting) and *poesis* (making). Simply put, he states that human beings beget other human beings, but only God “makes” or creates human beings. The significance of this distinction is that only by begetting do we respect the dignity of the begotten as a being of equal moral worth, as another “I” with a distinct personality and destiny.⁷⁹ Only by begetting do we treat the child as an end in itself rather than a means to our own ends. O’Donovan explicitly grounds this view in a faith in God: Because of the equality of humanity before God, all human beings are understood to be on an equal moral plane with each other.

The problem with *poesis*, he argues, is that it alienates the product from its maker. We can never be on equal moral ground with that which is the object of our art or craft because it is subject to our will. This alienation can alter the meaning of parenthood and attitudes toward children, promoting the idea that children serve as means to adult fulfillment and self-definition. Lost is the idea that children are gifts—more explicitly, gifts from God—for which we have special responsibility or stewardship. What is feared is that children might come to be seen as objects or commodities that unfortunately cannot be returned or exchanged if they disappoint parental expectations.

O’Donovan’s analysis begs the question of what exactly constitutes “making” in the realm of assisted reproduction. We do not want to treat children as means to adult ends, but how does any kind of assisted reproduction promote that attitude? O’Donovan sees as problematic the use of a third-party donor (sperm or egg) and/or gestational surrogate, not necessarily the use of a medical technology that enables conception to occur, such as IVF by itself. He contends that when we separate biological (including genetic and/or gestational) parenthood from social parenthood, we move closer to “making” rather than begetting our children. When we break that connection with biology, we undermine our knowledge of what it means to be a parent. Being a parent, according to O’Donovan, is something more than whoever freely chooses to assume that role.

O’Donovan’s preference for *praxis* over *poesis* as a way of understanding human reproduction is based on his belief that our knowledge possesses a “natural substrate.” Like the papal encyclicals on assisted reproduction, O’Donovan’s writings seek to articulate the value or the dignity of procreation as an embodied good. One lives in one’s body and experiences bodily existence. The givenness of the body and the biological processes of reproduction are part of the created order. However, as human beings, we are always more than mere biology. O’Donovan ultimately draws the line in a different place than does the Vatican—he is open to certain forms of assisted reproduction where the Vatican is not—but he similarly tries to retain the idea that the bodily has moral significance. Unlike Robertson, who exclusively prioritizes

the volitional, O'Donovan attempts to make room for that which is not chosen in life and for the good of embodied existence, believing these to be part of full human flourishing.

For O'Donovan, assisted reproduction's threat ultimately lies in the threat of a technological culture in which it becomes harder and harder to think in categories that are not artificial, that are not driven by means/ends instrumental calculation.⁸⁰ If everything is taken to be "made" or constructed, the category of "natural" becomes evacuated of meaning. Thus, O'Donovan maintains that we need to accord respect to nature—whether that be respect for the natural environment or respect for human reproduction—to avoid undermining the conditions that make life possible.

One final concern raised by O'Donovan pertains to the impact of assisted reproduction on future generations. Decisions to use assisted reproduction—with or without third-party donors, cryopreservation, or micromanipulation techniques—are never only about the current decision makers but always implicate the well-being of future persons. O'Donovan points to the injustice of taking risks on behalf of the health of future persons who have no way to hold accountable those responsible. Others make the case that the logic of these technologies leads to eugenics.⁸¹ Just as parents have special responsibilities toward individual children, so too does society have special obligations to the human society of tomorrow, including the health of the human gene pool. These arguments rest on potentially more generalizable views of justice and reciprocity but also find roots in Judeo-Christian values about how human beings ought to treat each other and interact with the natural world.

Does ART Promote Human Flourishing?

Like O'Donovan, Cahill's interest in ART extends considerably beyond the subject of whether it promotes the individual autonomy of its adult users. Cahill's singularly incisive critique of ART (and of our times) is not that technology is "bad" and only "natural" procreation is good but that the way we consume infertility services, the way we choose ART without a broader societal conversation about the significance of what we are doing, and the way the infertility industry generally resists regulation are signs of our society's elevation of "choice" itself as a nearly absolute value. It is the elevation of individual autonomy without regard for the embodied and social dimensions of human experience. Cahill is particularly worried that a lack of critical discussion about the "final values or ends for which reproductive clients act" will leave room for the "still strong forces of patriarchy and market economics . . . to govern 'autonomous' reproductive choice."⁸²

A feminist scholar working out of the tradition of Catholic social ethics, Cahill combines an interest in both the social context of ART and the moral significance of “private” decisions to use it. She specifies what she believes are the goods of marriage and parenthood and discusses how assisted reproduction, including the use of third-party donors, may affect them. Her book, *Sex, Gender, and Christian Ethics* (1996) seeks to construct an overarching Christian feminist sexual ethic that has sexual equality as one of its core values yet also retains the Catholic commitment to embodiment and sociality. She uses the case of ART to illustrate some of the key features of this ethic.

Cahill, like O’Donovan, places ART in the larger context of a vision for human flourishing, asking specifically whether certain uses of this technology promote such flourishing. For example, Cahill does not endorse egg donation simply because it gives infertile women and older women more options, nor does she approve of sex selection simply because it gives parents greater control over and thus greater satisfaction in the composition of their families. While there is nothing inherently wrong with expanding one’s options, we must also ask whether creating a child through the use of a third-party donor or creating a child according to our preferred sex at the time of conception truly contributes to the flourishing of the child, the parents, and human society generally. These questions are legitimate and important but are obscured by the rhetoric of choice.

Of course, Cahill is well aware that not everyone is interested in her vision of human flourishing and the place of ART within it. She recognizes that the rhetoric of choice has to some extent evolved as a reaction against oppressive “visions of human flourishing.” Indeed, she knows that many people are skeptical that any vision at all of human flourishing can be shared, so thoroughly have our normative foundations been shaken by postmodernism. But Cahill is unwilling to retire the concept of human flourishing. Mindful of the formidable challenges posed by postmodern thinking, Cahill nevertheless aims to develop a normative Christian feminist ethic of sex and reproduction. She believes she can describe this ethic in a way that is publicly accessible, that she can be forthright about the faith commitments that underpin this ethic without undermining its integrity or persuasiveness, and that her voice and all religious voices ought to have a role in shaping the common good. She believes that the facts of pluralism and diversity do not make it impossible to derive some universalizable norms that are based on shared human needs and that seek to achieve human flourishing.⁸³ She is not persuaded by the argument that power determines values and that values are no more than whatever the prevailing views of the day may be.

How does she arrive at this position? Cahill uses critical realism to develop

her normative ethic of sex and reproduction. Specifically, she works out of the Aristotelian-Thomistic natural law tradition, using its inductive approach to build norms from empirical reality.⁸⁴ This is not to say that she takes the category of “natural” as a simple, self-evident given. Cahill looks at both bodily realities and the social constructions that people in different cultures give to those bodily realities, asking whether these constructions necessarily depend on the body. For example, the fact that females give birth does not justify sexual discrimination. She also asks whether existing human institutions (for example, marriage) contribute to human flourishing.

Cahill has a great deal at stake in reclaiming a view of bodily experience as a real phenomenon that cannot be wholly collapsed into or explained by social construction. She is committed to affirming the good of creation and the good of bodily experience. She is committed to upholding the basic relational nature and sociality of human beings. And she is committed to avoiding the common slippage into mind/body dualism, which she believes is the particular vice of the “ideology of choice.” She defines the ideology of choice as a tendency, especially prevalent in American culture, to absolutize the value of autonomy while neglecting other legitimate values. Cahill’s commitments, which she identifies explicitly as Catholic commitments, lead her to question attempts to subordinate the bodily aspects of parenthood to its intentional or volitional aspects.

Despite her clear ties with natural law ethics, Cahill criticizes the Catholic Church for basing its disapproval of reproductive technologies on an insistence on procreative unity in each and every sex act.⁸⁵ Parting company with the Vatican, Cahill does not condemn all forms of ART. She carefully delineates those forms that she thinks contribute to human flourishing and those that do not. She draws an important distinction, as the Vatican does not, between types of assisted reproduction that use the couple’s own gametes (that is, sperm and eggs) and types of ART that use third-party egg and/or sperm donors. Cahill finds acceptable the use of a technology to assist a couple in having a child as long as a third-party donor is not introduced into the relationship.⁸⁶ “Laboratory conception” by itself does not violate the sexually expressed love relationship of a couple, according to Cahill.

In taking this position, Cahill tries to strike a reasonable balance between the bodily and other important aspects of human existence. The physical experiences of sex and parenthood do have normative meaning, but that meaning is not absolute. Cahill writes, “The physical or embodied aspects of marriage and parenthood are not as important morally as those which are psycho-spiritual and social, which is why sexual intercourse is not a morally necessary means of conception.”⁸⁷ Cahill believes an absolute ban on assisted reproduc-

tion does not adequately honor the larger context of a relationship, which can encompass both the procreative and unitive aspects of marriage over time and in different ways.

Cahill draws the line at third-party donors because she believes that the connections among genetic, gestational, and social parenthood constitute an ideal worth retaining for those who are reasonably able to meet it. This ideal is not meant to exclude or punish, she claims. The ideal is compelling because holding these aspects of parenthood together is good for both the parents and for the child. It is good for the parents because it preserves symmetry in their relationship, among other reasons. It is good for the child because biological kinship is an important (if not all-important) aspect of personal identity. Cahill treats adoption separately from the issue of assisted reproduction with third-party donors, primarily because adoption does not involve intentionally severing the connection with the genetic or biological parent as part of the process of achieving conception.⁸⁸ Cahill summarizes her normative position by declaring the biological component of parenthood and of personhood “subsidiary” to social components, but it remains important. When the connections among genetic, gestational, and social parenthood are deliberately severed, the biological component receives too little weight. Producing children becomes a matter of willful intentions and is “disembodied.”⁸⁹ Cahill sees that something important is lost when freedom of the will triumphs completely over the body, and the loss is more than sentimental, fundamentally altering how human life is valued.

I do not wholeheartedly accept the balance Cahill strikes between honoring the volitional and embodied aspects of parenthood, even while I appreciate her effort to hold these two together and reclaim the importance of “embodied autonomy.” A troubling vulnerability in her argument is the inherently subjective appraisal involved in discerning when enough weight has been given to the bodily or the biological. This judgment seems impossible in the abstract, and it inevitably involves excluding some people who are unable—for whatever reason—to hold the genetic, gestational, and social aspects of parenthood together.

Nevertheless, if any merit whatsoever exists in Cahill’s argument for universalizable norms based on shared human needs and aimed at achieving human flourishing, it would be important to check our society’s evolving comfort level with manipulating human reproduction against the actual well-being of children who result from ART, their parents, and human society generally. Cahill attempts to articulate a substantive vision of human flourishing that is not thoroughly relative. We would do well to continue to debate the precise weight that ought to be given to biological ties.

Moreover, and perhaps more importantly, since we are free to disagree with the reasons she gives for her position on third-party donors, Cahill's most relevant point may be the more general one that when we do not make an effort to articulate a substantive vision of human flourishing and instead rest the morality of our actions on the ideology of choice, we create a dangerous vacuum of moral language. Our preoccupation with choice can lead our choices to become very shallow, unexamined, and driven by larger social forces, such as the pressures of consumerism (including the pressure to buy one's way out of a problem or even the pressure to create a "better" child) or the pressures of pronatalism, which is the idea, historically more relevant to women, that to be a complete and fulfilled adult you must be a parent.

Cahill suggests that "free" choices, like the choice to be an egg donor or egg recipient, need to be examined with an awareness of the larger social context, including social structures that have historically worked to the disadvantage of women. So, whether we accept her vision of human flourishing as a test for ART or reject her disapproval of third-party donors, she raises a legitimate point about our inattention to the larger social context of "private" decisions to use ART. We need a broader, more critical discussion about the "final values or ends for which reproductive clients act."⁹⁰ Otherwise, we may discover that our free choices were not so free after all.

Summary of Key Questions

The question of moral agency: Delayed childbearing increases women's likelihood of encountering fertility problems, yet many working women today choose to delay childbearing as an adaptive strategy. Delaying childbearing is adaptive in the sense that it conforms to rather than transforms existing structures and expectations with regard to work and family, but it is purposeful in that it actively seeks the fulfillment of many legitimate life goals. Life-course decisions, such as when to have a baby, may be one of the most highly scripted in our society, but individuals subjectively understand those decisions as well. How does ART express individual agency?

The question of social justice: ART may serve economic and political interests in contradiction to the well-being of individual users, however self-aware and conscious their choices may be. We must then ask who wields the power of this technology and to what ends. Insofar as women wield the power of ART and use it to actualize their reproductive goals, who is left out of this benefit? How does ART affect existing racial and socioeconomic inequalities? Insofar as women do not wield the power of ART and its use contradicts their best interests, including potentially bodily health, what compels them to try it? Is it

the promise of having it all, of combining the goals of work and family, of attaining sexual equality? Is it even appropriate to speak of “women’s best interests” as a collective? What other issues of social justice are implicated in the use of ART?

The question of family goods: Families have assumed many shapes and sizes in different cultures and time periods, and the United States today witnesses a great variety of family forms. This diversity does not preclude the identification of certain goods that occur in families, including what individual family members provide for each other and how they understand the nature of their relationships and the bases of their obligations to each other. Other possible goods include what families contribute to the larger society and to future generations. Do family goods necessarily depend on having biological ties to one’s children or even on having children at all? How does the use of ART impact these goods? Does ART alter parental attitudes toward children, increasing their commodification?

The Social Phenomenon of ART: Engaging the Particular

I have described selected theoretical perspectives from within feminism and Christian ethics as a way of locating some of my normative commitments and assumptions. I have also provided this account to show the inadequacy of existing theory. Cahill writes that what is “shared” in normative ethics “is not achieved beyond or over against particularity, but rather in and through it. . . . Participants in communication, judgment, and action will always be irreducibly concrete and historical characters who recognize humanity in one another, without leaving their own individuality behind.”⁹¹ Yet despite this claim’s appeal, none of the ethicists I have engaged here attend seriously and consistently to the particular experience of using ART.

Donchin wisely argues that responsible ethics requires holding the general and the particular in some kind of healthy tension. I agree that it is politically naive to assume an individual woman’s actions can be assessed in isolation from her social context. Likewise, it does not advance the insights of theory to assume that the general experience of a common oppression qualifies someone to judge the actions and choices of other individuals.

I have concerns about the use of ART, yet I still deeply value the resolution these technologies can offer individuals suffering from infertility. These commitments often seem to pull in opposite directions. On the one hand, an argument for social reform that might lessen the demand for ART tends to be insensitive to individual needs and individual suffering. On the other hand, attending only to individual needs and the expression of procreative liberty

tends to ignore the larger impact of these technologies and the social inequalities that might be exacerbated by the growing use of ART. This book's unique methodological challenge involves holding these competing commitments together by investigating how decision making is socially shaped and how individual women experience the social practice of ART.

One primary weakness of the ethical theory discussed in previous sections is that it does not speak from experience. Feminists and religious ethicists share a tendency to focus on the general rather than the particular. They address the use of ART only in the aggregate, without verifying or testing assumptions against the diversity of people's experience with infertility. They also tend to speak on behalf of the infertile, speculating about their needs and interests.

As Barbara Berg writes in "Listening to the Voices of the Infertile," feminists have overwhelmingly approached the issue of ART from a generalized perspective:

Feminists have entered this discussion voicing concern over the pervasive influence of pronatalism in our society, the increasing medicalization of reproduction, the commodification of women and children, the overvaluation of genetic versus social linkages, and the potential exploitation of women. There is much to be concerned about. But much of the feminist discourse on this subject has come from the perspective that these technologies should not be pursued because of their potentially negative effects on women and children. Although many legitimate concerns have been raised, complex issues have sometimes been oversimplified and, most disturbing of all, some feminists do not appear to be taking the role of advocating for infertile women so much as speaking for them. But the infertile have their own voices.⁹²

It is important not to accept uncritically what these voices have to say but rather to consult and learn from them and discover where theoretical orientations were inadequate to the task of interpreting the use of ART.

The same criticism could be made of scholars in philosophical and religious ethics, including Cahill, who do not often test their normative arguments against reality. How do parents feel toward their child born of a third-party donor? Does it disrupt the parent-child relationship in the way that ethicists assumed it would? How does it affect the child's sense of identity and connection to his/her heritage? These questions cannot be answered without consulting reality, primarily because they exist at the level of interpersonal experience and individual attitudes. Similarly, do husbands or a patriarchal medical establishment pressure women to use ART? Is husband or wife more motivated to use ART, and why? If women do experience pressure to use ART, where does

this pressure originate? Ethics itself cannot answer these questions but requires the input of the social sciences to devise answers and to build responsible ethical arguments that attend to the complexity of lived experience.

For all these reasons, I decided to conduct a year of empirical research, engaging in participant observation and conducting interviews with individuals experiencing infertility. In the next chapter, I introduce and describe the group I studied, RESOLVE, a national organization with a thriving Atlanta chapter.