Procreation, Power, and Personal Autonomy: Feminist Reflections

Chapter 6

With Child: The Meeting of Nature and Culture

Birth, and copulation, and death.

That's all the facts when you come to brass tacks:

Birth, and copulation, and death.

I've been born, and once is enough.

You don't remember, but I remember,

Once is enough.

T. S. Eliot *Sweeney Agonistes*

My birth is no more an event in my life than my death which is the cessation of my world. Wittgenstein *Tractatus* 6.431-6.4311.

If anything, giving birth is more human, because we can choose to avoid it, whereas death, eventually, is inevitable. Virginia Held: "Birth and Death" 1989, 367.

Though the "bare facts" of which Eliot speaks may be universal features of human lives, these facts alone tell us virtually nothing about the human condition that would not also be trivially true of other animal species. That is, until we shift perspective from the outsider looking on to the insider enmeshed in a web of experience. For birth has a tendency to affect women's experience so intimately and complexly that few are likely to think, even of their own birth so abstractly that it is just an outer boundary beyond experience.

Virginia Held emphasizes how facilely birthgiving has been dismissed as a merely *natural* event lacking the mark of intentional aims and purposes that inform distinctively *human* events.[1] Death has been a very rich source of cultural representations--bound up with elaborate imaginative constructions, fervent philosophical speculations and extravagant claims to esoteric knowledge and authority. Birth, by contrast, has been a comparatively impoverished concept, particularly in western culture. Of course,

[1] My position here owes much to Virginia Held's insights. Note particularly her 1989 paper "Birth and Death."

none of us can remember being born, so we can only think about our own births as a time preceding conscious awareness. But when women think about birth from their perspective as mothers or potential mothers, a very different understanding of birth surfaces. Women's own representations of birth have seldom figured in literary, artistic or even religious depictions of birth. With the exception of the theatre of the absurd, the few culturally recognized portrayals of birth tended to reflect a disinterested observer's perspective. Even within metaphorical twists on the birth experience, the woman giving birth seldom appears. And within the counterculture of the '60s she remained a passive object, either of others' intervention or natural forces so powerful that her own subjective experience was obliterated.

Yet the same traditions have imbued death with considerable cultural significance. In literature people often die for causes, yet birth is rarely represented at all and never as an event through which the woman giving birth realizes a purpose of her own. Though virtually all cultures are rich in rituals surrounding death, rituals celebrating women's birthgiving are practically nonexistent.[2] In fact, those ritualistic recreations of birth that do exist, *couvade*, for instance, disregard the birthgiver altogether, transposing the subject of the birth experience from women to men. According to the last recorded practice of this ritual which took place in the Basque country during the 1950's, the father takes to bed during the birth of his child simulating the symptoms of labor. The mother returns to work a soon as possible and waits on the father. The transfer of attention to the father is seldom so extreme in modern times though the current fashion whereby physicians pressure reticent fathers to participate in labor and delivery bears some marks of the former custom.[3]

Such widespread indifference to the significance of birthgiving in human experience exemplifies cultural neglect of the experiences that give meaning to women's lives. The events of birth have obviously been considered worthy of notice only in the ways they enter men's experience. Held believes that such disdain for women's experience could only have been possible by first denying to women their full humanity. The act of giving birth could not be relegated to the status of a merely "natural" process unless the birthgiver were first denied such marks of the fully human as the capacity for choice making, conscious experience and imaginative representation.

Denial of women's humanity is evident also in metaphors distancing reproduction from other kinds of purposeful cultural activities. Pregnant women's bodies are frequently referred to in terms more appropriate to the language of machinery, factories and environment. Medical literature often reduces the pregnant woman to the "maternal environment." Emily Martin (1989) discusses in rich detail the medical metaphors that shape conceptions of women's bodies. As she is about to give birth she becomes a "laborer" under the direction and control of medical experts. Her uterus is portrayed as a kind of "machine" whose parts function in accord with a blueprint devised by the authorities who "manage" her labor and "deliver" the baby. The physician is cast in the role analogous to the "supervisor" or "foreman" of the labor process. He determines whether the pace of the work corresponds to specifications or requires the intervention of drugs or mechanical devices. Within this scenario the baby becomes the "product" produced by the laborer under the supervision of the foreman. The woman's own

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[2] Though Margaret Atwood fashions one in *The Handmaid's Tale* 1986, it is ironically turned to a pronatalist purpose that obliterates the individuality of the birthgiver.

[3] For further details about the practice of *couvade* see the *Encyclopedia Britannica*. On current practices see "Count Me Out of the Hard Labor" by Rick Marin, *New York Times*, 6/20/04, 9, 1.

birthing experience is irrelevant. Its significance and bearing on the outcome are excluded from the process. Like the laborer within industrial capitalism, the birthgiving woman is an object of interest to the physician only instrumentally. If it were possible to generate the product more efficiently by other means the laborer could be supplanted.

Even the early years of human mothering are commonly dismissed as a process that unfolds naturally requiring little conscious thought by the mother and only occasional assistance from "experts." Held observes that, like the event of birth, the experiences of infancy have also been hidden from men's conscious awareness. Birth and the early upbringing of children are portrayed as a kind of prehuman period in the lives of men (1989, 371). So natural has it seemed to relegate women's childbearing and early childrearing activities to a realm outside conscious experience that even some feminist writers have endorsed the view that childbirth is merely a biological event and the rearing of children belongs to a natural realm outside the sphere of distinctively human activities.[4]

The 1980s generation of feminists revalued childrearing practices, but very few questioned naturalizing conceptions of childbearing. Even comparatively astute observers such as Sara Ruddick (1989) claimed that taking care of the growing being within one involves no more than taking care of oneself.[5] However, women with difficult pregnancies are likely to see beyond this characterization, as are women compelled by pregnancy to renegotiate their identities and relationships and restructure their life projects and plans.

A significant factor contributing to cultural perpetuation of the presumption that one's own birth lay outside the bounds of consciousness is discontinuity between sexual intercourse and birth in men's experience. In the consciousness of many women, however, sexual intercourse, menstruation, pregnancy and birth are all bound together in a continuum that reminds them of their birth-giving capacities. Not until comparatively recently with the development of more reliable contraceptive technologies has it become possible for women to effectively separate sexual intercourse from pregnancy, either in fact or in consciousness. Though various methods of fertility control have been in use throughout history, not until hormone suppressing drugs become available in the1980s have contraceptives had the social impact to significantly reduce women's fears that with sexual intercourse they were risking pregnancy. With this extended technological capacity has come a rising social awareness of women's perennial attempts to intervene in this continuum and recognition that women have not generally resigned themselves to the inevitability of this sequence of events but have actively sought to influence their course.

This awareness has provoked more probing examination of the tendency to relegate this continuum to the realm of the natural. For if it were indeed natural, why would there be need for laws prohibiting contraception, infanticide, abortion, and infant desertion? Why would traditional literature and art have celebrated only the joys and gratifications of mothering, consigning to silence the processes of birth and the pain, danger, and risk surrounding birth-giving? What would be the point of perpetuating

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[4]Simone de Beauvoir (1953) and Shulamith Firestone (1970), for instance.

[5]More recently, she has qualified this distinction. See, for instance, in her preface to the 1995 edition of *Maternal Thinking,* she points to some of the deficiencies in her earlier conception of mothering as "caring work" and acknowledges her tendency to slight relationships of the birth-giver to her emerging child. LP: for further discussion of this issue, see Hilde Lindemann Nelson's 1994 The Architect and the Bee: Some Reflections on Postmortem Pregnancy, *Bioethics*, 8(3):247-67.

this selective construction if there were no need to bend the minds of women who might not otherwise be inclined toward motherhood.[6] Dorothy Wertz, for instance points out that: "Selective abortion stands at the center of a conflict between women's need to live as full persons in the modern world of work and their own moral construction of the world in terms of caring relationships, including relationships with unborn babies" (Wertz, 1993, 180).

So what is new since the 1980s is not so much women's own self-perceptions as agents seeking to influence the direction of their own lives, but relaxation of legal prohibitions that had prevented women from exercising agency and gaining effective control over their fertility.[7] Though there is still considerable resistance to recognizing women's authority over their own procreative powers, to use them or withhold them, the widespread dissemination of fertility control techniques in the West has contributed to increasing public awareness that pregnancy and birth are not merely biological events determined by nature but variable processes inevitably subject to human influence and open to conscious choice and deliberation. The increase in women's powers facilitated by contraception has extended further options to women, easing the way to a far greater diversity of social roles and occupational choices.

How the Technological Imperative Transforms Pregnancy

Technological innovation has not only expanded the choice *not* to become a mother for women who opt to remain childless or deliberately limit the number of children, but has also extended options of women who wish to bear children but cannot readily realize their aims. For, as we have seen, with extended options offered by new conceptive technologies, intensified pressure has been brought on women to conform to traditional norms both in the workplace and in domestic life. On the one hand, women are pressed to comply with workplace expectations established by and for men accustomed to count on the unpaid labor of wives to sustain their domestic lives. On the other, women are still expected to distinguish themselves from men in the one respect in which women's biology marks them with a distinctive female identity, their capacity to bear children.

Apprehensions about the extent to which new reproductive technologies are likely to enhance women's agency are compounded by the increasing prevalence of other birth technologies, particularly

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[6] Realization of the powerful influence of social controls in propelling women to have children is not confined solely to recent feminists. See, for instance, Leta Hollingsworth's 1916 paper, "Social Devices for Impelling Women to Bear and Rear Children" in the *American Journal of Sociology:* 22, 19-29. Hollingworth attributes these social controls to the agency of "social guardians," among whom she includes lawmakers, obstetricians, and the press. But she also implies that the authority of agents of social control extends to cultural depictions of women which glorify the rewards of motherhood and disregard the deficits. The continuity between her themes and those of more recent feminists is unmistakable. What is new is, first, sustained effort to bring all of these threads together and reinterpret them in light of prevalent methods of social control which are (at least in Western countries) often subtle and diffused and, second, systematic attempts to understand how such devices of control fit into more inclusive structures that influence gender identity.

[7] I do not mean to suggest that the developers of these technologies deliberately intended to extend women's agency but only that they have this effect (among others). Their development has been driven by many social forces, needs to free more women for the labor force (at wages that often tend to depress the general wage scale), to reduce the birth rate, to extend markets for contraceptive manufacturers, etc.

surgical interventions during labor and childbirth (such as caesarean section) and more novel techniques that extend obstetrical intervention backward into the antenatal period. Combined together, the two most radically innovative kinds of technologies, obstetrical interventions during pregnancy and new conceptive techniques, facilitate a radically revolutionary technological future, a future in which pre-conceptive sex selection and genetic modification could become readily available. Pregnancy and childbirth would then be subject to human choice in a radically new sense that is liable to intensified political control.

As these technologies proliferate, cultural attitudes toward birth are shifting. Birth is losing the significance it once had as a sharp boundary marking life's beginning. As the fetus comes increasingly to be regarded as another patient, pregnant women are finding themselves under increased pressure to submit to an increasingly vast array of inter-uterine interventions. Though these new techniques for intervening throughout the course of pregnancy purportedly aim to increase the chance of bringing home a healthy baby, many wonder whether the harms might not outweigh the benefits—medically, psychologically and socially. For just as women have been beginning to insist that physicians recognize them as autonomous individuals, medical attention is shifting disproportionately to the moral status of the fetus. The agency of the women on whom its existence depends is again being bypassed.

Many women with grown children remember a time when pregnancy was comparatively free of technical intrusion. When we spoke of the fetus (if we used that term at all) we would pat our bellies, by way of reassurance that this growing life tucked away deep within us, in a dark and private place, was comfortable and well protected. Standard medical care for women fortunate enough to afford it consisted of a monthly visit to the obstetrician. His or her state of the art equipment seldom extended beyond a stethoscope to listen to fetal heart sounds, sensitive fingers to probe its dimensions, blood chemistry analyses to guard for toxins, vitamins, and creams to assuage anxiety about stretch marks. Bed rest was the standard therapy for difficult pregnancies.8

In marked contrast is the experience of pregnancy among women today. Within the past generations a vast armamentarium of new techniques administered by an army of technological experts has significantly transformed the experience of pregnancy for women with access to state of the art medicine. This change has had profound effects, far beyond its impact on the particular patients subjected to these bodily intrusions. New techniques include fetal visualization, laboratory manipulation of embryos, and fetal surgery performed either through the pregnant woman's womb or by temporarily removing it. Studies have shown that pregnant women are generally enthusiastic, particularly about ultrasound scans. "Seeing" the baby on the scan may be the high spot of the pregnancy, an event to be shared with the baby's father and siblings. Women seldom view scans as a threat that might reveal bad news, but tend to regard them as benign procedures that allow them to see the baby, confirm its normality and, incidentally, learn its sex. Many women report that this was the first time they felt a bond to the fetus. So what some critics see as disruptive to unity between the carrying woman and her fetus, a device for constructing the fetus as a separate individual, others see as an event through which a closer relationship is established. Unquestionably, it is a transformative experience.

The outsider's perspective afforded by visualization, however, can be utilized to ground the claims of other parties too. They often have very different agendas and may see the fetus principally as a means to promote interests beyond it. The measures an obstetrician may champion to insure a healthy

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8 AD notes the need for expansion of this topic, referring to her own pregnancies.

outcome may not be compatible with the values of the pregnant woman or her partner. The practice of multi-fetal reduction, for instance, may look very different from the pregnant woman's perspective and the obstetrician's. The production of knowledge about risk operates within broader power relations. "High risk" is an elusive category that has multiple meanings for physician, nurse, social worker and patient. It may be used to reinforce unequal power relations between doctors and patient and exacerbate inequalities

Fetal imaging techniques have contributed to radical transformation in the public's thinking about pregnancy, transforming traditional symbolic meanings associated with fetal life. However, this transformation has not come about through technological change alone. In the U.S. particularly, a well-organized anti-abortion lobby has seized on visualization technology to manipulate understandings of fetal life. They borrow from the advertising industry techniques of visual representation that stir public appetites and manipulate pocketbooks. Consequently, the respective roles of the principal players in the drama of pregnancy have undergone considerable transformation. As the fetus has been shifted to center stage, physicians' role has moved correspondingly. Not only are they likely to think in terms of their own professional reputation but they are under great pressure from political forces beyond themselves to "maximize fetal outcome." These changes have contributed further to the reduction of the pregnant woman to a "fetal environment."

The transformation of pregnancy by visualization techniques and fetal monitoring is yet another instance of medicine's fascination with technology. I mentioned in a previous chapter Eric Cassell's association between this fascination and the development of medical knowledge: first, it reduces the problem of illness to the biological problem of disease and then reduces disease to observable "agents," such as the tubercle bacillus (for tuberculosis) and atherosclerosis of the coronary vessels (for coronary heart disease). Cassell notes (1985) that the results produced by the use of one technology may raise questions that only another technology appears able to answer. Through the increasing reliance on such visualizable phenomena, the information produced by technology has come to dominate medical practice, displacing knowledge acquired through direct interaction with patients and distancing physicians from the sufferings of sick people. Technological data support the reigning scientific model that demands unambiguous, quantifiable, detached information. Though technology now runs doctors, Cassell adds, they are by no means unwilling accomplices since awe of technology (by the public, the media, the law courts, etc.) confers increased power on the wielders of these weapons. According to popular rhetoric, they "ferret out and conquer the scourge of disease." Once the technological model of medical information has taken root, technology comes to be self-perpetuating and established techniques cling tenaciously, even long after they have been shown to be inappropriate. Though Cassell's examples are drawn principally from diagnostic technologies, his analysis is applicable to "therapeutic" technologies as well.

Legal Issues

In the U.S. until the 1973 Roe v. Wade decision that legalized abortion, legal recognition of the fetus was almost always contingent on subsequent live birth and the aims of law were generally supportive of parental interests in rearing children. Since Roe, advocacy on behalf of the fetus has taken a new turn. As we have seen, the fetus is increasingly regarded as an entity possessing rights independent of the pregnant woman and often hostile to her interests. This trend is in marked contrast to other areas of health care where the dominant judicial trend over the past years has been to expand the scope of patient discretion in determining treatment. Courts have generally acknowledged the limits of their capacity to

effectively regulate physician-patient relationships and have reserved to patients increasing authority over decisions affecting their own wellbeing. In no instances, for instance, has a U.S. court ever forced an individual to submit to such invasive procedures for the benefit of another party, even one's own child. No mother (or father) has ever been compelled to donate an organ or tissue for a child. Courts have drawn a line between voluntary moral duties and duties mandated by legal dictate. Since courts respect treatment refusal in instances involving organ or tissue donation, where the potential beneficiary is indisputably a person, it is particularly noteworthy that pregnant women have been singled out as the only group of which such sacrifice is demanded.[9]

Behind this mounting preoccupation with the status of the fetus is another agenda. Protection of the "rights" of the unborn is seldom the principal concern even of those wishing to force medical intervention on pregnant women. Fetal health can be promoted more effectively without summoning the judge into the delivery room.[10] The qualifications of judges in no way prepare them to weigh the technical medical issues involved in these determinations without considerable background in the specifics of the case. In 88% of the cases reported in the *New England Journal*, orders were obtained within six hours, sometimes within the course of a single telephone conversation. The pregnant women who refused intervention had no opportunity to present their own case, to be represented by counsel, or to summon other physicians to speak on their behalf. In such cases circumstances are often complex and controversial, far beyond the competence of most judges to evaluate without first hearing and then weighing conflicting medical opinion. In one instance of placenta previa a court order was obtained, but before it could be implemented the woman delivered a healthy child without benefit of a C section! Noting the irony, the *Journal of the Georgia Medical Society* captioned its report of this incident: "Georgia Supreme Court Orders C Section. Mother nature reverses on appeal." There have been similar happy outcomes in breech cases. Considering the likelihood of disagreement even among physicians about indications for cesarean section and growing social controversy about the mounting C section rate in the U.S. (currently about 1 in 3) it seems unrealistic to depend on judges "to maximize fetal outcome."11

The traditional practice of relying upon the pregnant woman, herself, to safeguard the wellbeing of her fetus is still the most likely way to protect the moral interests of both mother and fetus. When a woman has an opportunity to abort early in the pregnancy (a declining option in many areas, particularly for young and indigent women), it can be assumed that the woman who does not terminate her pregnancy desires the child and seeks its well-being. Of course, no one can ever control all of the circumstances that

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[9] The case of Angela Carder illustrates one of the most flagrant abuses of a pregnant woman's bodily integrity, conveying the view that the state values potential life more highly than actual life. The judge who believed that "the state has a compelling interest in protecting potential life" ordered this critically ill cancer patient's 26 week fetus be taken by cesarean section. This intrusion predictably hastened her death (her infant also died following the surgery). Forty groups as diverse as the AMA and NOW sought rehearing and eventually won a favorable verdict. Commenting on this case the authors of a *New England Journal of Medicine* article observed that in a society that refuses to force the donation of organs or tissues even from cadavers despite their potential benefit to many afflicted persons, "we see no good reason that pregnant women should be treated with less respect than corpses" (Lawrence Nelson and Nancy Milliken, 2/19/88).

[10] From the title of Nancy Rhoden's article 1986.

11 See CDC Fastats, at http://www.cdc.gov/nchs/fastats/delivery.htm.

will affect a child's future well-being. Also, the pregnant woman needs adequate social support, medical services, and encouragement to develop a trusting relationship with a physician or midwife. It is only rarely that she alone is in a position to care optimally for herself without these supports. Since they are rarely adequate, she should not be held legally accountable for the outcome of her pregnancy. Also, there are bound to be instances where women and physician disagree about the urgency of particular obstetrical procedures. However, as has been shown in studies of malpractice, where physicians share knowledge with patients and take pains to be understand, physician-patient relationships rarely become adversarial. When pregnant women receive good prenatal care, the incidence of emergency obstetrical procedures declines sharply. Before resorting to court ordered obstetrical procedures or punitive legal action, many nonintrusive measures can be taken to forestall adverse outcomes and insure a happy experience for both mother and child

There is also another ground for caution in forcing pregnant women to submit to surgical interventions. In the *New England Journal* study cited above, 81% of the women involved in court ordered procedures were black, Asian or Hispanic, almost half were unmarried and a fourth did not speak English. Lacking any reliable aggregate statistics it is impossible to know whether or not this represents the general population subject to such coerced medical interventions. But it does suggest an additional reason for exercising restraint in authorizing such intrusive measures. For clearly these statistics indicate discrimination twice over, first by singling women out as the only class that is subject to forced surgical interventions for the benefit of another party and second, by imposing this burden disproportionally on the most vulnerable women in society.12

To this point I have cited only some of the most extreme occasions for medical intrusion, principally at birth, and all purportedly aimed to benefit the fetus. But in other circumstances, a Tay Sachs case, for instance, a judge recommended mandatory abortion. Very few such judicial decisions have been subject to the detailed scrutiny of the caesarean section cases publicized in the *New England Journal* article. Moreover, statistical data on the outcome of such interventions are sparse.

On closer scrutiny it seems apparent that the locus of the conflict in these cases is not primarily between the pregnant woman's desires and fetal interests, but between the perspectives of the pregnant woman and her physician. Few women intend harm to their fetus or even foresee it if they deny consent for treatment. But from a physician's point of view if a fetal condition goes untreated, handicap to the child would be a far greater burden than would treatment on the pregnant woman. So many physicians believe they are justified in seeking legal authority to override a woman's refusal to consent to intervention.

Those positioned at the other end of the spectrum see this focus on medical interventions during pregnancy as an extension of anti-abortion campaigns. They point out that the relation between pregnant women and their fetuses is unique. They constitute a single unit. So the conflict of interest analysis is inappropriate. Concern for health of the fetus is misplaced. Those who hold this position suspect that the real interest of people who seek to impose mandatory treatment on pregnant women is to limit their life options—to keep them under male control and confine them to the "private" sphere, to their traditional role in the home.

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12 LP: adding insult to injury, they have the worst access to high quality health care for themselves and their families.

From the perspective of libertarian legal thinkers, women should be held to reasonable behavior toward their fetus taking into account: the likelihood of harm, its severity, the degree of intrusion into the woman's body, the offense and risk to the woman affected, disruption in her life plans and the availability of less restrictive alternatives. To minimize bias toward intervention, those holding this view tend to recommend intervening only on a case by case basis. They propose limiting legal action to tort law and object to imposing criminal sanctions. Thus cases could only be brought by the affected parties: child, father or physician.

Medical ethicists who weigh a greater range of physician duties to patients might wonder whether this approach would be likely to achieve its intended effect. From this perspective concerns to be considered include:[13]

- The unequal power of physicians and patient
- The need to weigh the seriousness of the intrusion and select the least intrusive remedy
- The fallibility of physicians and limitations on their qualifications to judge conflicting pressures on patients, e.g. economic, domestic
- Difficulty in following physician advice about weight, smoking, rest, sexual abstinence etc.
- Likelihood that the proliferation of legal action would lead some women to avoid medical care altogether rather than risk punitive intervention
- Possible increase in the tendency to play defensive medicine[14]

Feminist scholars often question the social context that structures pregnant women's options. They point to the paradox in a public policy that punishes pregnant women for conduct during pregnancy and narrows their abortion options. They call for redirecting pressures to the medical research establishment's quest after an unending array of fetal diagnostic innovations, the commercial enterprises that create a market for them, the legal system which drives up malpractice insurance rates, and providers who indiscriminatingly push the use of technical innovations.

The central fallacy of those who seek to incarcerate pregnant women and foreclose their reproductive choices is the assumption that prevention of all harm that might befall a fetus and maximization of fetal benefit lies within the pregnant woman's control. Pregnancy, even among the most diligent women with the best of medical care, is still risky. First, much criticism of pregnant women's conduct betrays a false confidence in the reliability of medical information. Medical opinion fluctuates

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[13] I am indebted, to Daniel Wikler whose paper provided the model for the "medical ethicist" whose position I summarize here.

[14] When the finger is pointed at physicians for the great disparity in caesarean section rates in different localities, they often counter with the need to practice defensive medicine in order to avoid malpractice claims. But when a patient asks her physician why he recommends a cesarean section for her, he never cites the fear of malpractice as a reason.

widely. Hot baths which were once considered soothing and relaxing for pregnant women have become taboo. "Excessive" heat during the first trimester is now believed to contribute to neural tube defects.[15] Criticism is dominated by an individualistic bias.16 Intervention in individual cases is unlikely to have much impact on infant mortality and morbidity. A public health policy that emphasizes the provision of more adequate information and preventive strategies is likely to be far more effective without unfairly burdening individual women with unwanted bodily intrusions or prison sentences to protect their fetuses. Like a mine disaster or a child is caught in a well, focus tends to become riveted on identified lives. The number of statistical lives that would be affected by a preventive policy is ignored. Ignored, too, is the importance of supporting pregnant women's confidence in their ability to adequately care for their self/fetus. State intrusion is bound to be piecemeal and punitive. In the long run it will lessen likelihood that women on the fringes of society will seek prenatal care at all.

In most instances of conflict the principal parties are the physician and the pregnant woman. Characterizing these as instances as maternal-fetal conflict displaces the locus of authority and control. Seldom does the pregnant woman have access either to the information or the institutional resources to override her physician's authority. Where a case is brought before judicial review (usually initiated by a physician or a hospital) the judge's authority supersedes hers. The widespread use of the technique of electronic fetal monitoring during labor demonstrates the actual dynamics underlying maternal-fetal conflict rhetoric. The technique first came into widespread use in the early 1970s in response to studies pointing to a correlation between patterns of fetal heart rate and signs of fetal hypoxia (a condition where there is less than normal oxygen in the organs and tissues of the body). Unfortunately, no randomized controlled trials were carried out to determine the benefits of fetal monitoring before this form of technology became the general standard of care. Subsequent trials have shown that the technique does not reduce intrapartum death or any of the other anomalies which its proponents anticipated. Yet it remains a standard measure of fetal risk and is relied on to determine when cesarean delivery is warranted. There is consensus now that routine electronic fetal monitoring is the most substantial factor causing the high caesarean section rate in the U.S., currently about 30%.17 According to a recent WHO Report, the optimal rate for these operations ranges between 10 and 15%.18

Selecting the Sex of Offspring

Sex selection technologies raise further issues and contribute to the illusion that the outcome of pregnancy can be brought wholly under human control. Though feminists frequently raise moral objections to the

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[15] *Wall Street Journal*, August 19, 1992.

16 LP: These proponents of incarceration also apparently fail to consider the noxious health conditions in prisons.

17 A recent study supports the view that fetal monitoring does not improve outcomes, even though it does lead to higher rates of C-Section. See Health Behavior News Service, "Popular Fetal Monitoring Method Leads to More C-Sections, at http://www.cdc.gov/nchs/fastats/delivery.htm

18 Luz Gibbons, José M. Belizán, Jeremy A. Lauer, Ana P. Betrán, Mario Merialdi and Fernando Althabe, "The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage," *World Health Report (2010) Background Paper, No 30,* p. 3.

use of these techniques, many are hesitant to condone legal means to limit the use of sex selection since they would seriously affect the options of childbearing women. This issue has become the focus of much debate, particularly among feminists. During the 1980s it was conjoined with abortion controversy. In recent years with increasing use of prenatal sex selection techniques the emphasis has shifted. Here I consider some key aspects of historic feminist debate and then seek to show why this issue continues to be so vexing for feminists.

Mary Anne Warren set the stage for formulation of feminist dialogue. She argued that the decision to preselect the sex of one's child may often be "motivated by an unselfish desire to ensure that the child will have the best possible life" (1985). Julie Zilberberg revisits Warren's argument and partially supports her stance but distinguishes between the situations of women in dissimilar geographical and cultural contexts (2004). She points out that sex selection has different meanings in different cultural contexts, for poor women in developing countries and affluent women in developed ones.

Christine Overall (1987) challenged the individualistic assumptions underlying Warren's position, but on another ground. She questioned the view that sex preselection is a victimless act and argued for a broader basis of analysis that is not limited to the production of direct harm or individual injustice. Like others including Hilary Rose (1994) she is persuaded that differences between the experiences of men and women involve material conditions as well as social constructions. Consequently, she believes that preference for a child of a specific sex need not always be sexist.

Yet the move from preference to action is still troubling. For, in a patriarchal and misogynist societies, such a choice is likely to reinforce biases against females. Overall raised another objection to sex preselection that seems for her to tip the scales decisively against the practice. She joins sex preselection to other conceptive technologies--like IVF, embryo transfer and embryo freezing—all of which she sees as threats to both the present existence of the fetus and its future well-being. She also classifies as harms obstetrical procedures for monitoring and intervening in fetal development--such as amniocentesis, ultrasound and fetal surgery. Joining many other feminist authors, she shares the concern that this growing array of treatments are evidence of the gradual commodification of reproduction.

She articulates another concern as well: a link between fetal technologies and apprehensions about women's bodies. She suspects that much of the increasing concern about fetal well-being springs from a fear that the female body is dangerous and threatening—even to the embryo/fetus, which is perceived by the fearful as needing protection, even from its own future mother. Overall (1) opposes measures that commodify reproduction, (2) stresses the need to restore the sense of the pregnant woman and the fetus as interdependent and interactive, and (3) proposes that the weight of moral obligation to the fetus be shifted, from beneficence to nonmaleficence. That is, in considering medical intervention that would affect the fetus, the primary obligation is to avoid harm. The possibility of causing harm should be assessed first before undertaking any intervention intended to promote fetal good. So physicians who perform abortions are "morally obligated" to cause the least possible harm to the fetus and take all reasonable measures to preserve its life that are consistent with carrying out the abortion.

Something seems seriously lacking in the moral context taken into account here. It presupposes that the fetus has independent interests which may conflict with those of the pregnant woman. It also appears to rest upon a very narrow conception of what is to count as harm. So Overall takes another step that has aroused considerable controversy. She argues that since no one owns the fetus, no one (neither the pregnant woman nor the person performing an abortion) has the right to destroy it. But neither does the fetus have a right to the use of the woman's body. She readily acknowledges the apparent conflict

between these two moral claims but believes it will be resolved once technologies are available for gestating the fetus outside the woman's body or transferring it to the uterus of another woman. So she recommends laboratory gestation as a viable alternative when a woman opts to terminate her pregnancy [19]

But to count this as an option perpetuates a view of personal autonomy tied to a kind of territorial imagery popular among contract theorists. The appeal to personal autonomy operating here is equivalent to a right to control what falls within one's bodily boundaries. The use of property rights language to characterize the pregnant woman's relation to the fetus fails to capture the meanings of pregnant embodiment and the felt experience common to many pregnant women: that pregnancy reconfigures their way of being in the world. Perhaps that is why emphasis on rights language has been far more prevalent in the legal struggle for free access to abortion than in feminist abortion discourse which has tended to emphasize the significance of abortion within a broader moral framework.

Abortion through a Feminist Lens

Feminists often view abortion within a more inclusive set of conditions for realizing women's capacities for self-determination and controlling the conditions that shape their lives. Though abortion is surely a necessary option for realizing these aims, it is far from sufficient. Many women who seek abortions now do so only for lack of other alternatives—adequate income and support services, pregnancy leave and competent infant and child care. Many middle class women see abortion as a trade-off; either one's fetus or one's career survives but not both. And some are led into abortion by the ideology of the nuclear family—that every child "deserves" both a father and a mother. Feminists who understand abortion in these ways are likely to see in the development of technologies for maintaining fetal life outside women's bodies distrust of women as bearers of children. For, on what ground can we assume that laboratory technicians are likely to do a more competent job of gestation than pregnant women? And if extrauterine gestation were to become an established practice, would not many women be pressured to adopt it—for the good of their baby"? To look to such a technological “fix” as a solution to the moral ambiguities involved in abortion only misconceptualizes the real problems and diverts attention from the urgent need for social programs: for a workplace structured to meet the demands of women's lives and for new patterns of family life that do not depend on advancing patriarchal and capitalistic interests.

The practice of risking the health or life of pregnant women to save fetal life not only overrides the self-determination of adults, but also intensifies that injustice by transforming pregnancy into a condition of forced servitude that few women would be willing to risk.20 Surely not only pregnant women but *all* members of society have moral responsibility toward future life--including fetuses. If we were serious about meeting this obligation we would clean up the environment and provide more adequate nutrition, prenatal care and education to pregnant women. And, we would not stop caring at

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[19] Peter Singer also endorses such a future, 1984. LP: One wonders whether they would alter their positions after reading Coleman’s sensitive and thorough consideration of the issue.

20 LP: For further exploration of this view, see my “Abortion, forced labor, and war,” in *Reproducing Persons.*

birth: for the sake of both mother and fetus we would establish parental leave provisions and provide quality day care as most of the world's other countries do.21

Pregnancy beyond "The Bare Facts"

In fact, the U.S. is one of just four countries in the entire world that does not mandate some amount of paid maternity leave for their citizens.[22]

LP: AD clearly intended to add more to this chapter; some of the chapter subheadings suggest that material was added instead to later chapters.

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21 LP: Not to mention rights to health care, education, and so forth.

[22] The other countries Lesotho, Papua New Guinea and Swaziland. See Public Citizen at robert@citizen.org