

AT ISSUE OF EGGS, EMBRYOS AND ALTRUISM

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Within the last ten years, we have witnessed an array of embryonic technologies move to the forefront of the new reproductive technological cafeteria: fetal surgery, embryo experimentation, embryo transfer, and most recently use of fetal tissue for transplants and fetal reduction in utero. All of this technological tinkering with the fetus or embryo has, of course, catalyzed the political and religious right to action. As Simone de Beauvoir long ago noted about the Catholic Church, it “reserves an uncompromising humanitarianism for man in the fetal condition.” In the wake of the uncompromising campaigns of the right, particularly against abortion, the medical progenitors of fetal technologies have become linguists and communications specialists, transforming “embryo” into “pre-embryo,” in an attempt to unfetter their work from the millstone of fetal moral attacks.

Meanwhile, for women who are the subjects/objects of these technologies, life goes on as usual (i.e., without much notice from the scientists, doctors, ethicists, and policy makers). Concerns about fetal technologies center on the fetus, not on the woman whose body is the locus for all of this experimentation. Here too, verbal concoctions abound. Increasingly, pregnant or would-be pregnant women are referred to as maternal vehicles, environments, and human egg banks. Women, *as women*, with integrity, autonomy, and basic civil rights remain nearly invisible in the fetal technologies debate.

A 1988 feature article in a prominent American newspaper on “egg donation” assumed a benign process of harvesting eggs from women for *in vitro* fertilization procedures. Quoting a director of an IVF program, the article explained how IVF centers have come to rely on women undergoing

tubal ligations for egg donation. “... no one is asked to put herself at any increased risk because she is already having a laparoscopy” (Brozan, 1988: B-8). In the next paragraph, we learn that “although tubal ligation patients donating eggs face no additional risk, they and other donors must typically do something that does not contribute to their own health: take hormones for about a week. This increases the production of eggs ...” (Brozan, 1988). Isn't “something that does not contribute to their own health” one form of risk? The article then states that the hormones used for superovulation are Pergonal and Clomid, and that the “risks” associated with these “are generally considered minimal.” Two sentences later, the article tells us: “With Pergonal, and to a lesser degree, clomiphene of which Clomid is one form ... it is possible that ovarian cysts related to drug use may rupture and cause an acute emergency. Cysts are a recognized side effect, though rupture is rare” (Brozan, 1988).

In the most extensive study to date on the effects of clomiphene citrate, Renate Klein and Robyn Rowland document the list of deleterious effects associated with its administration (Klein and Rowland, 1988). Increasingly, clomiphene is used in what they call “hormonal cocktails,” (i.e., in combination with other drugs such as HMG and HCG), because it *alone* does not produce enough mature eggs in women on whom it is used. These “hormonal cocktails” increase the dangers to women who are given the drug. In addition to causing hyperstimulation of the ovaries and cysts, clomiphene (whether administered alone or in combination with other synthetic or natural hormones) is cited in numbers of scientific studies in conjunction with an increased incidence of cancer in women. Rowland and Klein (1988) note

also the similarities between DES and clomiphene raising the question about long-term effects in women who take the drug, and in their children. Research reports in the 1980s have further highlighted chromosomal abnormalities in human egg cells produced by clomiphene induction.

Another “wondrous” byproduct of these new fertility drugs is *fetal reduction*. Fetal reduction is a technique used to decrease the number of fetuses in utero of a woman who has become pregnant with multiple fetuses after taking fertility drugs and/or having multiple embryos implanted in conjunction with *in vitro* fertilization. The procedure is done during the first trimester of pregnancy when fetal size is about one and a half inches long. Guided by ultrasound, the doctor inserts a needled filled with potassium chloride into the fetal chest cavity causing death by heart failure. The fetus is eventually absorbed by the woman’s body.

Yet the ethics of fetal reduction is always discussed as if the critical issue is one of the morality of abortion – not the morality of using these fertility drugs on women and the ethics of implanting multiple embryos to begin with. For example, a 1988 front page *New York Times* article on fetal reduction bore the headline: “Multiple Fetuses Raise New Issues Tied to Abortion.” The headline more accurately should have read: “Multiple Fetuses Raise New Issues Tied to Fertility Drugs and Multiple Embryo Implants.”

Fetal reduction is one more example of a new “miracle” reproductive technology gone wrong. Infertility drugs, multiple embryo implants, and their recent accomplice – fetal reduction – are new iatrogenic “diseases” where the supposed cure produces sickness, and where the so-called side-effect is more accurately an *effect* of the treatment. The morbid risks of fetal reduction are many. Women can start bleeding or develop infections, causing them danger and premature labor, and the loss of all the fetuses. The risk of uterine bleeding can cause irreparable neurological damage to any fetuses that remain after others are “reduced.”

The new reproductive technologies perpetuate a self-reinforcing circle of destructive feedback. This destructive feedback is built right into the medical-technical endeavor. Touted as treatments for infertility, procedures such as IVF and superovulatory drugs are now becoming the new pathogens leading to more bodily intervention,

invasiveness, morbidity, and experimentation on women.

Why, then, do women submit to such procedures? For one thing, women receiving “pregnancy reductions” are not informed about the risks because as one doctor phrased it, “people are gun-shy about reporting the procedure [and thus] there are no reliable published data on its safety or effectiveness” (Kolata, 1988: 1). But even before women reach decisions about fetal reduction, they are not told at earlier IVF stages about all the risks associated with fertility drugs. To return to the example of women who donate eggs at the time of tubal ligations, journalists report that women are willing to do this “despite these risks and the physical and psychological screening, blood tests, sonograms and, in some case, extra surgery they must undergo” (Broznan, 1988: B-8). However, women who donate their eggs through superovulatory procedures are not told about *all* the risks involved, and the risks about which they are informed are presented as “minimal” or “rare.” Instead, women are pictured as trusting and giving donors. “‘It was no big deal,’ said a 33 year-old mother of two, from whom five eggs were taken . . . ‘You’re having your tubes tied anyway and you don’t want any more children, so even though it’s some trouble, the benefits are worth it for somebody else’” (Broznan, 1988). Or, as one director of a reproductive endocrinology unit summarized it, “Nobody would do this for the money ..” (see article by Johanna Riegler and Aurelia Weikert this issue).

One of the new/old images generated by the new reproductive technologies is that of the *altruistic woman*. The ideology of altruism makes women’s inequality noble. For example, surrogate brokers enlist the services of women who most often need the money or are economically dead-ended and portray them as women who have a “special gift” to bear another’s child. Noncommercial surrogate arrangements are depicted even more as “the greatest gift a woman can give.” Few note that the so-called altruism of noncommercial surrogacy still reinforces the fact that women are breeders or mere “maternal containers” for someone else, whether done for money or for “love.” The potential for women’s exploitation is not necessarily less, merely because no money is involved and the arrangements may take place within a family setting. The family has

hardly been a safe place for women. And now there is the issue of fetal tissue where women in aborting can “redeem” the abortion by donating their fetal tissue to give the gift of life to others who suffer from diseases such as Parkinson’s or Huntington’s chorea.

Within the context of giving fetal tissue, women move from being used as egg banks to being used as fetal tissue banks. Feminists have pointed out the increasing tendency of the medical profession – especially in the area of the new reproductive technologies – to treat the fetus as a patient while minimizing the woman and making her into a mere environment for the fetus. Surrogacy makes women into mere incubators or receptacles for male sperm. Fetal tissue transplants make women into incubators of life-saving tissue. Seen in the wider context of the new reproductive procedures in which women are being cast in the role of medical vehicles for all sorts of “miracle” technologies, fetal tissue transplants reinforce the woman as container.

More and more intrusion into the prenatal area makes women mere containers for the fetus. Increased intervention into the prenatal area has compelled women to undergo caesarians, to submit to multi-testing in utero, and to have fetal surgery. Legal infringements that compel women to submit to such tests and to have caesarians have been enforced in the U.S. by court order. Why not legal interventions that will compel women undergoing abortions to hand over their fetuses for humanitarian research and purposes?

While the altruistic woman is at the center of the new reproductive technologies’ image-making, so too is a portrait of science and technology as altruistic. This altruistic scientific “megaplan” makes all sorts of reproductive and genetic technologies noble. IVF offers “new hope for the infertile.” Surrogacy gives infertile couples the gift of a child. Egg donation, as in the cases cited above where women undergo voluntary laparoscopies and allow themselves to be superovulated, is helping others to have children. In reality, the new reproductive technologies are more of an ideological than a technical feat – more of a medical and media production. Medicine and the media propagate their “success” rates, their miracle stories, and their display of scientific prowess and progress. The underlying ideology of reproductive science and technology is framed as

altruistic and used as a cover for the development of medical research priorities and techniques.

The medical engine driving the need for embryos and fetal tissue is not only therapeutic use in diseases such as Parkinson’s and Huntington’s, but the whole area of embryo experimentation as well. Research on embryos is not only done to improve techniques associated with *in vitro* fertilization. IVF clinics in Australia, for example, practice freeze-thawing of embryos for future use by couples, for donation to other couples, or for experimental research. IVF research is primarily concerned with experimentation, not infertility. Robert Edwards, the British technological progenitor of Louise Brown, has stated that embryo research can shed light on better methods of contraception, birth defects, and the creation of cancer cells. While doctors and scientists draw distinctions between the use of excess embryos and the development of embryos specifically for research, the distinction blurs immediately. The major debates now center around what can be *developed* through embryo experimentation. This *development* is a prelude to research connected with genetic engineering. More and more embryos will be needed for more and more genetic experimentation.

Fetal tissue is becoming increasingly important to all sorts of high-tech medical research – to what I call “Rambo” medicine. Rambo medicine is based on male heroic technical prowess that requires more high tech, more high drama, more high publicity, more high funding, and more high risk for more women, with little immediate success – but of course, the *promise* of it. Rambo medicine, like messianic religion, is always promising a future that is yet unrealized. Rambo medicine is a medical eschatology of things to come.

The commercial engine driving the need for embryos and fetal tissue is shockingly crass. In 1985, a West German Social Democrat documented an international trade in embryos for “commercial purposes.” He stated that in March 1981, French customs officials seized a consignment of embryos from Romania, on their way to a California manufacturer of beauty products. In 1982, the California police seized some 500 embryos intended for cosmetics production. The politician, Horst Haase, asked the Parliamentary Assembly of the Council of Europe for legislation banning commercial and industrial

uses of embryos in keeping with its declarations and directives on human rights. Nevertheless, Haase contends that the legislation stalled in committee because lobbyists for scientists and the pharmaceutical industry inhibited any passage of such legislation (*New Scientist*, 1985: 21). More and more embryos will be needed for commercial purposes.

Where will all these embryos and fetal tissue come from? Not just from spontaneous abortions. Not just from elective abortions where the fetal tissue will be donated to medical research. Most likely from *planned conceptions for abortions* with the specific purpose of growing fetuses for medical research. And probably from later abortions, since many doctors say older fetuses may be better for providing the best tissue. And most likely, from the third world when there are not enough fetuses to meet the demand for them in the west. This raises the whole question of a traffic in fetal tissue which is very closely related to the international traffic in women for sexual and reproductive purposes. Concerns have already been raised about prostitutes in the Philippines, Thailand, and Korea – countries with the highest numbers of prostitutes in the world – who become pregnant and are aborted. For what purpose? Fetal tissue is already being distributed to researchers in various countries. One company plans to market cells that are grown from fetal tissue.

The religious right is worried about the fact that abortions will increase and that women will conceive for the express purpose of aborting fetuses to aid family members, or for money. Recently, a California woman offered to be artificially inseminated with sperm from her father who suffers from Alzheimer's disease. Her fetus would then have been aborted for brain tissue which in turn would have been transplanted into her father's brain. This focus puts the moral onus back on the individual woman and in effect blames her. Feminists are concerned that increased persuasion and pressure will be put on women to conceive for others health and lives; that women choosing abortions will be persuaded into having later abortions; and that the commercial and medical world won't be held responsible for this proliferation of the supposed need for fetal tissue and the generation of an altruistic megaplan.

The debates over fetal tissue and embryo experimentation raise serious ethical doubts about

the whole concept and reality of altruism and the ways in which it is used by science to work against women. The altruistic population in this whole area of the new reproductive technologies is limited to women. What is wrong here is that women constantly are expected to be the donors of services and to caretake the world. Women give their bodies over to painful and invasive IVF treatments when it is often their husbands who are infertile. Women are encouraged to have babies for others and to offer their bodies in a myriad of ways so that others may have babies, health and life. These noble calling and gift-giving arguments devolve mainly on women. They reinforce women as self-sacrificing and as ontological donors of wombs and what issues from them. Gift relationships often disguise social pressures, persuasions, and expectations that make women think that giving is one of their chief roles in life.

On an individual level, there are times when a person may feel obliged, morally, to make certain gifts. Many, for example, feel an obligation to donate bone marrow in response to a family member's need. This kind of limited individual situation gets expanded to a social level, however, when a giving population has been socialized to give as part of their role. Within such populations, givers who apparently give freely are also powerfully bound by social expectations and the regulation of gift behavior. Women are the archetypal givers to whom all these expectations and regulations apply par excellence.

Reproductive scientists and others are also expanding the "Good Samaritan" principle to an exponential level. Speaking in favor of embryo research and experimentation, doctors constantly reiterate that it's unethical not to help people in need. We must question, however, what passes for need. Do people who have certain diseases, such as Huntington's and Parkinson's, need fetal tissue? Do infertile couples need babies? Does science need embryo experimentation to move ahead? The ways in which desires get transformed into needs is a study in itself. Desire becomes a need supported by an ethics of altruism.

Noel Keane, a well-known American surrogate broker, has made an educational video called "A Special Lady." This film, designed to promote surrogacy and women becoming surrogates, is shown in high schools where young girls especially are ripe for this kind of "specialness."

The video promotes the idea that it takes a special kind of woman who will bear babies for others, and that women who engage in surrogacy do so not mainly for the money but for the special joy it brings to the lives of those who can't have children.

A 1986 article in *The Australian* used exactly the same "special" language to promote "Why rent-a-uterus is a noble calling." Sonia Humphrey, the author, states: "It does take a special kind of woman to conceive, carry under her heart and bear a child which she knows she won't see grow and develop. It also takes a special kind of woman to take a baby which is not hers by blood and rear it with all the commitment of a biological mother without the hormonal hit which nature so kindly provides . . . But those special women do exist, both kinds. Why shouldn't both be honoured?" (Humphrey, 1986)

While it may seem exaggerated to forecast future ads that state "Women wanted with a special gift to be able to conceive and abort for humanity," more realistically, the admen won't have to be so blatant. The sacred canopy of female altruism, combined with scientific altruism, covers over a multitude of technologies. I doubt that justifications for the use of fetal tissue will need to be as slick as the previously quoted altruistic hypes of surrogacy. The spectre of diseases such as Huntington's and Parkinson's strike an immediate sympathetic note.

Altruism joins with the "great benefits" of fetal tissue use in degenerative diseases such as Huntington's to make a powerful argument for the new reproductive technologies. Everything is nice! People don't push further and ask just how many great benefits, how many successes, have occurred using fetal tissue in the treatment of degenerative diseases. For example, Dr. Robert Gale used fetal liver cells to generate bone marrow for six victims of the Chernobyl disaster. All six died. There have been no huge success rates in other Rambo medical research areas such as heart transplants. And the biggest pseudo-success story of all is the *in vitro* fertilization statistics which have been inflated based on the fluff of chemical pregnancies.

The focus on altruism sentimentalizes and thus obscures the ways women are exploited by the new reproductive technologies. This whole stagecraft of reproductive gifts and gift-givers – of egg donations, of "special ladies" who serve as so-called surrogate mothers for others who go to such lengths to have their own genetic children, of women aborting to donate fetal tissue, and of reproductive technology itself as a great gift to humanity – fails to examine the institutions of reproductive science and technology that increasingly structure reproductive exchanges.

Most importantly, however, this new reproductive altruism depends almost entirely upon women as the givers of these reproductive gifts – women who have been tutored culturally and historically to put others' interests before their own. The reproductive desires of others increasingly come to depend upon the bodies of women. This is not to say that women cannot give freely. It is to say that things are not all that simple. It is also to say that this emphasis on giving has become an integral part of the technological propaganda performance. And finally, it is to say that the altruistic pedestal on which women are placed by the new reproductive technologies is one more way of glorifying women's inequality.

REFERENCES

- Brozan, Nadine. 1988. Egg Donations: Miraculous or Immoral? *Providence Journal*, January 24: B-1 and B-8.
- Humphrey, Sonia. 1986. Why Rent-a-Uterus is a Noble Calling. *The Australian*. December 19.
- Klein, Renate and Rowland, Robyn. 1988. Women as Test-Sites for Fertility Drugs: *Reproductive and Genetic Engineering* 1 (3): (251-273).
- Kolata, Gina. 1988. Multiple Fetuses Raise New Issues Tied to Abortion. *New York Times*, January 25: 1 and A17.
- New Scientist*. 1985. Embryos to Lipstick? October 10: 21