The New Reproductive Technologies

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The new reproductive technologies represent an escalation of violence against women, a violence camouflaged behind medical terms.

Violence against women has been a part of obstetrics and gynecology ever since it was formed as a specialty in the United States. To give a hint of that violence, let me tell you about the "father of gynecology," J. Marion Sims.

In 1845, Sims hit upon a method of opening the vagina to view, thereby making it possible to repair a heretofore incurable female condition, vaginal-vesico fistula. This condition, acquired during childbirth, was a tear in the vaginal wall resulting in constant seepage of urine from the bladder through the vagina. The condition was sometimes caused by unusually hard labor but was often associated with aggressive use of instruments like forceps in delivery.

After Sims got his idea for the operation, he wrote in his autobiography, he "ransacked the country" for cases of vaginal-vesico fistula among black slave women. He made a deal with the owners of these women that allowed him to experiment on them. The owners were to clothe the women and pay taxes on them but Sims was to feed and house them. He kept the women in a building behind his home—a building he called a "hospital."

He acquired several women in this way and kept them in his "hospital" for four years, during which time he performed up to thirty operations on each, entirely without anesthesia. Anesthesia, though just beginning to be used by Dr. James Simpson in Scotland, was unknown to U.S. doctors (Seale Harris, 1950).

The operations he performed on his experimental subjects, Sims wrote, were "so tedious, and at the same time so painful, that none but a woman could have borne them."

After several years filled with unsuccessful attempts to devise an operation to repair the vaginal tears, Sims found himself in an embarrassing situation. His biographer Dr. Seale Harris explains: "Socially, the whole business was becoming a marked liability, for all kinds of whispers were beginning to circulate around town—dark rumors that it was a terrible thing for Sims to be allowed to keep on using human beings as experimental animals for his unproven surgical theories."

Dr. Harris argues that the slave women were willing experimental subjects, that they clamored for the operations, that the suffering caused them by their condition was so great they would go through any torture if it held promise of a cure.

"They love it. They beg for it. When we cut them and torture them, we're giving them what they want." This rationale sounds sickeningly familiar to feminists who fight pornography and rape.

After Sims did succeed in perfecting his operation, he was ready to perform it on paying, white, middle-class women. But at that time, anesthesia was still not available. The white women, who had to endure the already perfected operation only one time—not thirty—often cried out to Sims to stop in the middle of the operation. Even though they were women, they could not endure the pain. Yet they too suffered from the ailment just as the black slave women had. Why weren't they, like the slave women, prepared to go through any torture in order to be relieved of their condition?

The discrepancy in responses of the white and black women to the operation can be explained by this hypothesis: Someone was lying. Those black women, forcibly separated from the babies they had just delivered and imprisoned in a "hospital" for four years, never entreated the man who imprisoned them to experiment on their bodies, never begged to be tortured.

There is a bust of Sims on Fifth Avenue and 103rd Street in Manhattan near the New York Academy of Medicine. In 1978, the Medical University of South Carolina established a chair in honor of Sims. Dr. Sims, who practiced surgical violence against women—and here, I've described only his opening gambit—remains a respected figure in U.S. medicine.

Since the days of Father Sims we have had operations to remove ovaries in order to cure "ovariomania," a disease—essentially female sexuality—we don't hear too much about these days (Gena Corea, 1986a). We have unnecessary hysterectomies, a continuing scandal. We have prophylactic mastectomies that entail cutting off healthy breasts on the grounds that some day they might become unhealthy. (There are no prophylactic removals of testicles.) We have unnecessary cesarean sections—again, a scandal. We have experimentation on us with

brutal contraceptives like Depo-Provera and drugs like diethylstilbestrol (DES). A few of the many books that provide documentation are Diana Scully, 1980; Janice Raymond, 1979; Michelle Harrison, 1982; Boston Women's Health Book Collective, 1984; Gena Corea, 1977; 1980; Barbara Seaman and Gideon Seaman, 1977.

This kind of violence against women is escalating with the new reproductive technologies (Gena Corea, 1986b). Under these technologies, I include in vitro fertilization (IVF), the test-tube baby procedure. That entails pumping a woman full of hormones so she will release more than the usual number of eggs from the ovary; placing her under general anesthesia, usually, and sucking her eggs out; fertilizing the eggs in a dish and, when she's kneeling on a gynecological table, her head down by her hands and her rear end pointed upward, inserting the embryo through her vagina and into her uterus. It sounds simple. In fact, it is a complicated procedure that rarely works.

Embryo flushing is another of the new reproductive technologies. You artificially inseminate the woman, flush the embryo out of her, and then insert the embryo into another woman. That's done in cows. A couple of brothers who worked on cows for seven years figured it was time to move on to women. So they started a company to do that (Gena Corea, 1987). Their procedure is highly experimental. Only two births have resulted from it.

Sex predetermination—that is, predetermining the sex of a child—is also one of the new reproductive technologies.

Surrogate motherhood could be used with the embryo flushing technique or with in vitro fertilization or with sex predetermination. Many combinations of the different technologies are possible.

Before discussing the violence of the new reproductive technologies, let me point out briefly that these technologies were not developed out of compassion for infertile women nor are they just for the infertile. They will eventually affect the vast majority of women.

A pattern has emerged in the spread of a new reproductive technology. When it is introduced, it is presented as something for a small proportion of women in certain groups. But then, quickly, physicians expand the indications for the technology so that it is used on a large proportion—or even the majority—of women. For example, in obstetrics, electronic fetal monitoring was introduced for use on women judged to be at high risk of obstetrical complications. But now in many industrialized countries, it is used on most birthing women. The same pattern is evident with ultrasound, amniocentesis, cesarean section, and genetic testing and counseling.

It is likely that this pattern will emerge with newer technologies such as IVF, egg donation, sex predetermination, and embryo evaluation.

IVF, for example, was originally proposed for use on a small group of women—those whose infertility was caused by blocked or absent fallopian tubes. But physicians quickly extended the indications for IVF so that now even fertile women are among IVF candidates. These are women married to men with low sperm counts. Instead of physicians saying, "Maybe there's a terrific hormone we could inject into men to see if we could raise the sperm count," they operate on women's bodies.

Very early on, technodocs began saying that once they found a way to use donor eggs with in vitro fertilization, many more women—for example, women with bad eggs—would become candidates for this procedure. I asked one reproductive technologist, "How do women get 'bad eggs'?" He said that women who work in places where there are toxic chemicals may have their eggs damaged by those chemicals. These women could simply use another person's egg, he said, and they won't mind because the process of birth is much more important to women than the genetic content of the child. (I guess he'd say that the average woman is very unlike Bill Stern, the man who hired Mary Beth Whitehead as a so-called surrogate and for whom the genetic content of the child—*his* genetic content—was so overwhelmingly important it justified impairing the lives of scores of people around him, most notably Mary Beth Whitehead's.) The technodoc said this was a large group of women and would grow larger as we learn more and more about the effects of toxic chemicals on eggs.

In Melbourne, Australia, a couple of years ago, we learned from Carl Wood, a physician heading an IVF program, that some women in his program were asking him to use donor eggs rather than their own in the in vitro fertilization attempt. The allegedly said they didn't want to reproduce themselves because they were dissatisifed with some of their own qualities, like their appearance and intelligence. They wanted to use donor eggs, the eggs of women who, unlike themselves, were adequate human beings (Karen Milliner, 1984; John Schauble, 1984; and Fiona Whitlock, 1984.)

Now, I don't know how women suddenly, without prompting, come to the conclusion that they don't want to use their own eggs. I suspect that Wood's announcement was a trial balloon floated to see if there would be much objection to this selective breeding practice. He was just announcing a fact and was quite helpless before it. He was being subjected to these consumer demands and really, what could the poor man do?

His plight opens up the vision of a whole new clientele for IVF with donor eggs: women who feel inadequate. It is a large clientele.

There's another way in which I think the use of the new reproduc-

tive technologies will expand. I talked with one of the developers of the embryo flushing procedure, one of the men who worked with cows for seven years. He said that embryo flushing may become a routine part of prenatal care. In other words, every single pregnant woman would go to the doctor and have the embryo flushed out of her. It would be checked to see if it comes up to snuff. If it does, it would be transferred back to her at some little risk (this, he didn't mention) of a potential ectopic pregnancy. If the embryo did not pass the tests, the woman would try for another, more acceptable, pregnancy. So that's another way in which use of the technologies could expand widely.

In the literature on reproductive technology, the suggestion appears again and again that female sterilization could be combined with the various technologies. This practice would always be carried out in order to benefit women. Women would just be sterilized and then they wouldn't have to worry about all these dangerous hormonal contraceptives. (This is one of those rare times there is an admission that these contraceptives are dangerous.) The women would have their eggs frozen. Then, when they want to have a child, they simply get out a frozen egg or, if they're married, frozen embryo, and have in vitro fertilization. This is tremendously convenient. Various technodocs have indeed pointed out that embryo freezing would offer a terrific new form of family planning.

In 1976, which was two years before the birth of Louise Brown, the first test-tube baby, two physicians wrote in the *Western Journal of Medicine* that in the future, in vitro fertilization may become the standard way to reproduce (Laurence Karp and Roger Donahue, 1976). The rationale for this was that it may be possible to develop embryo evaluation methods and people would want to have their embryos evaluated before implantation so they could be sure the child is free of defects.

Those are the reasons I think these technologies will not be confined to the infertile.

The use of these technologies on women's bodies is an experiment, not a treatment. You may think the technologies are treatments because language is routinely used here to obscure what is really going on. For example, in its section on surrogate motherhood, the American Fertility Society's ethics report uses medical terms to describe the sale of women (Ethics Committee, 1986). A man's desire to have a genetically related child becomes a "medical indication" for buying a woman's body. Such terms sanitize the sale of women and remove the reader emotionally from what is actually going on.

In vitro fertilization and other new procedures are called "treatments" and "therapy." In fact, the success rate for these technologies is extremely low. We don't have accurate figures on success now be-

cause over the years that technodocs have been developing the technologies, they have displayed no interest (for very good reason) in gathering the information necessary to determine the actual success.

Medical writer, Susan Ince and I did a survey of all the in vitro fertilization clinics in the United States for the *Medical Tribune* in the spring of 1985 and for the first time exposed routine deception in the reporting of IVF success (Gena Corea and Susan Ince, 1985; 1987). Briefly, we found that half the clinics in the country had never produced even one test-tube baby. Despite that, they were claiming high success rates, some as high as 25 percent. They could do that because they were in total control of the definition of success. No uniform definition exists. Any clinic can define success in any way it wants. Clinics don't define it in terms of live births, which is the way many women entering the clinic would think. "Twenty percent success rate? That means I have a 20 percent chance of coming away with a baby." It doesn't mean that at all.

One of the definitions of success was "percentage of pregnancies per laparoscopy," the operation performed in order to suck eggs out of the ovary. But the fact that there's a pregnancy doesn't mean that there will be a birth. When it is a chemical pregnancy, as many are, that simply means that there is a slight elevation in the level of hormones present during pregnancy. There will be no baby. Some technodocs count that as "success" knowing that there will be no baby.

There are many, many tricks with the statistics to make it look as though a clinic is successful. IVF clinic directors explained the tricks to us when we interviewed them. They were telling on each other. That's how we learned what they were doing.

I want to describe briefly some of what the women go through because women's experience of in vitro fertilization has been rendered invisible. It lies in the shadows, quiet and dark.

Women who go through IVF have already been through an incredible amount of medical probing and prodding, much of which is painful and humiliating. Many have had biopsies of the endometrium, the uterine lining; tubal insufflation—the filling up of the oviducts with pressurized carbon dioxide to see if the tubes are open; injection of dye into the uterus and oviducts; drug treatments; and blowing out of the tubes to maintain an opening.

But once in an in vitro fertilization program, the manipulations of a woman's body and emotions begin in earnest. Drugs are administered; blood samples are taken, and the hormones within measured; ultrasound exams are done to estimate when the women will ovulate; sterile normal saline is put into a woman's bladder through a catheter for the ultrasound right before the laparoscopy; the laparoscopy for egg

capture (they actually call it that) is performed, often repeatedly. In an Australian in vitro program, when the woman is sick, drowsy, and sore from the operation she's just had, she is sometimes asked to arouse her husband sexually so that he can masturbate for the sperm sample. (For information on women's experiences in IVF programs, see Renate Klein, 1989; Christine Crowe, 1987; Barbara Burton, 1985.)

Remember that the vast majority of women who go through all this do not come away with a baby. In a study of women's experience of in vitro fertilization in Australia, one woman told a researcher: "It [the in vitro procedure] is embarrassing. You leave your pride at the hospital door when you walk in and you pick it up when you leave. You feel like a piece of meat in a meatworks but if you want a baby badly enough, you'll do it" (Barbara Burton, 1985).

Isabel Bainbridge had seven failed in vitro attempts in Australia before giving up. She now says of in vitro fertilization: "It's a very brutal way of coming to terms with your infertility. I think there could have been kinder ways."

Let me tell you about an unkind incident.

Several years ago technodoc Milton Nakamura arranged for scientists from Monash University in Melbourne, Australia, to give a practical course on in vitro fertilization in his country, Brazil. The Globo television network paid for the travel and other expenses of the visiting Australian doctors, in return for which it received the first—but not the exclusive—shot at the news coverage.

The fourth and tenth floors of the maternity hospital where the course was given and where the operating rooms were located were partly taken over by security guards who were principally employed by the television network. The presence of the press with photographers and television cameras led the president of the Brazilian Society for the Advancement of Science to criticize the project and describe it as "an obstetrics carnival."

Twelve infertile women were used in this course on in vitro fertilization. Following the laparoscopy, one of the women, Zenaide Maria Bernardo, died. Dr. Nakamura's only consolation, the press reported, was that Zenaide may have lost consciousness under the sweet illusion that she was going to have a baby. He wanted to name his test-tube baby center after Zenaide "in honor of the woman who symbolized the iron determination to be a mother."

The Brazilian publication *Veja* reported that Dr. Nakamura considered the accident a "lamentable and rare misfortune," and "water under the bridge." From a scientific point of view, the publication *Manchete* reported, the IVF program had been a success (Ana Regina Gomez Dos Reis, 1987).

When it is asserted in Germany that in vitro fertilization and similar technologies are all about helping infertile women, German feminists impatiently brush that claim aside. They are irritated at any suggestion that they ought to take such a claim seriously. It is, they say, a "Deckmantel," which means "cloak," "disguise." In conversations with them, one hears occasional references to the political naivete of Americans who accept such a "Deckmantel" at face value.

German feminists have known all along that the stakes in this issue are high. They are particularly sensitive to the ways in which these technologies can and are beginning to be used to manufacture human beings to specifications and, in the process, to reduce women to breeders or, less elegantly, to raw material for a new manufacturing process.

Unlike U.S. feminists, they organized as a movement on the issue and began spreading their critique beyond the feminist movement.

That the stakes are indeed high became dramatically evident in December 1987.

The German equivalent of the FBI (the "Bundeskriminalamt") staged thirty-three simultaneous raids, many of them against feminists, throughout the Federal Republic of Germany, December 18 at 4:30 p.m. A total of 430 heavily armed police burst into the workplaces of activists. Fifteen to thirty in a group, the police swept into homes in Cologne, Dortmund, and Düsseldorf. In Essen, Duisburg, Bochum, and Hamburg, the raids were directed overwhelmingly against feminist critics of genetic and reproductive technology, according to Prozessgruppe Hamburg, a watchdog group.

The targeted critics have written and spoken on such issues as in vitro fertilization, amniocentesis, sex predetermination, and genetic engineering. They have actively opposed surrogate motherhood. Many worked together in a massive coalition to stop Noel Keane's attempt to open a branch of his U.S. surrogate business, United Family International, in Frankfurt. (Keane's New York firm arranged the Mary Beth Whitehead surrogate contract.) Their campaign to stop the sale of U.S. women to European men for breeding purposes ended successfully January 6, 1988 when a West German court ordered Keane's business closed, three months after it had opened.

Grounds for the police raids? In many cases, the women were not given any. But the next day, newspapers reported that the police conducted the searches to ascertain whether any of the individuals were members of a terrorist organization. They were specifically looking for a group called Revolutionaren Zellen and its feminist wing, Rota Zora.

The police were operating under Paragraph 129a of the terrorist act, "Support or Membership in a Terrorist Organization."

The women raided were forced to undress. All "non-changeable

marks" on their bodies—scars, moles, etc.—were noted down in police records. The women were fingerprinted.

Two well-known and widely respected women were arrested: Ulla Penselin, active in two groups in Hamburg, Women Against Genetic Engineering and another group critiquing population control policies; and Ingrid Strobl, a journalist for eight years with the national feminist magazine, *Emma*. Strobl is accused of buying a clock used in a bombing attack against Lufthansa offices in Cologne to protest the exploitation of Third World women in the sex-tourism industry. Both women were charged under the terrorist act, Paragraph 129a. Strobl remains in prison while Penselin has since been released.

In the nationwide raids, police confiscated materials from an archive on genetic and reproductive technology established by women in Essen and from private homes and apartments. They seized drafts of the women's speeches, material prepared for seminars, names and addresses of those attending seminars, published work, videos, tapes of radio programs, scientific articles, postcards, brochures and private address books.

The police raids appear to be an attempt to stop the widespread antigenetic technology movement in Germany by linking legal organizations with more militant ones, Maria Mies, author of *Patriarchy and Accumulation on a World Scale* and professor of sociology at the Fachhochschule in Cologne, told me in a telephone interview from her home.

"No concrete accusation or crime was being investigated," she pointed out. "This means that women doing 'Aufklarungsarbeit,' that is, researching reproductive or genetic engineering or talking about it or giving seminars, are already doing enough to provide a pretext for the attorney general to launch such a police action."

Mies, an organizer of the world's first massive feminist conference against reproductive and genetic technology in Bonn in 1985, said of the police action: "We think it is an effort to criminalize and intimidate the whole protest movement of women against reproductive and genetic engineering and frighten others away from participating in order to prevent the movement from spreading even more widely."

Mies added: "We are planning another conference against reproductive and genetic engineering just to demonstrate that we are continuing our work."

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