# Turkey-baster Babies: A View from Europe

PATRICIA ST. CLAIR STEPHENSON and MARSDEN G. WAGNER

*Centre for Public Health Research, Sweden; World Health Organization, Denmark*

IT IS SOMETHING OF AN UNDERSTATEMENT TO SAY that the article, "Turkey-baster Babies," raises important health-policy questions. In their discussion of the practice of self-insemination by single women, the authors challenge the status of artificial insemination by donor (AID) as a medical procedure and the traditional social position of medical doctors as arbiters of reproductive mores and behavior. The authors put forth arguments that have far-reaching implications, not just for the future practice of AID, but for other reproductive health services as well.

Appropriate use of reproductive technology has become a major public-health issue in the industrialized world. Reports on the ethical, legal, regulatory, and funding aspects of the new reproductive technologies have been issued by governmental and nongovernmental bodies in Australia, Canada, France, Israel, Sweden, the United Kingdom, and the United States (U.S. Congress 1988). At least 33 other countries have had considerable public discussion concerning the new reproductive technologies (U.S. Congress 1988). Yet, in all of this activity, there has been little, if any, attention to the issues of medical hegemony, the

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medical reconstruction of problems that are essentially social in nature, or of equity and social justice in health care.

## Moral Gatekeeping and Reproductive Health Services

That physicians serve as "moral gatekeepers" is, in a sense, old news. Historically, medicolegal control over women and reproduction has not been limited to the screening of candidates for infertility services. Prior to the resurgence of the women's movement in the 1960s, physicians controlled access to contraceptives and family-planning information. Most physicians refused to supply contraceptives to single women and many required the consent of the husband before giving contraceptives or advice to married women. Prior to the legalization of abortion, whether or not a woman was required to carry an unwanted pregnancy to term depended entirely upon a physician's statement to the court as to the degree to which her health status was compromised by the pregnancy. Until recently, physicians have been willing to surgically sterilize mentally retarded women, and it was not so long ago that unmarried, poor women were subject to sterilization against their will on the grounds that they had too many children receiving public support. Today, we see the same phenomenon in cases of court-ordered caesarean section and incidents where criminal charges of "prenatal child abuse" are filed against women who take illegal drugs during pregnancy (Curran 1990; Field 1989; French 1985; Meyers 1971).

How did medicine acquire the role of moral gatekeeper? Medicine, like all powerful social institutions, is more than an area of specialized knowledge. Medicine is able to serve as moral gatekeeper because it has the capacity to define abnormal and normal physiological functioning, appropriate and inappropriate sexual behavior, and causal relationships between social factors (e.g., behavior, morality, emotions) and disease states. Although it may be said that medicine merely reflects normative social values and responds in kind, conversely, one can also argue that prevailing attitudes in a given culture are formed and dominated by the value systems and paradigms of its institutions (Foucault 1967). Thus, medicine is privileged to decide who is fit for parenthood by the simple act of determining who is eligible for infertility services. That it

is commonplace for physicians in most countries to deny access to AID and other infertility services to single women, homosexual women, handicapped people, and poor people is a reflection of medicine's underlying values.

Medicine's privilege to determine eligibility for infertility services is supported by other power structures in society: the courts, ethics committees, and political institutions. For example, the Centre d'Etude et de Conservation du Sperme of France (the national association of sperm banks) requires all member banks to ensure not only that women who receive donated sperm be married, but that anonymous donors be married as well (Lansac and Guerin 1990). In Israel, France, and the United Kingdom in vitro fertilization (IVF) is available only to women who are married or in what the clinicians deem to be a stable relationship. Denmark excludes single women from IVF programs by giving priority to married and cohabiting women. This decision was made at the national level by a political committee on the basis of advice from doctors and a national ethics committee.

Most telling is a case in the United Kingdom wherein a married woman applied for and was accepted by an IVF program and placed on the waiting list. After some time had passed and she had not heard from the clinic, she investigated, only to discover that she had been removed from the waiting list. Further inquiry revealed that the hospital ethics committee had judged her unsuitable for IVF because some years earlier (before her marriage) she had worked as a prostitute. When her appeal to the ethics committee was unsuccessful, she turned to the court. The court ruled that the ethics committee had not broken the law and their decision was allowed to stand (*Guardian* 1987).

It is patently obvious, that moral gatekeeping is just another form of discrimination on the basis of social prejudice. As McLean (1990) points out, "Health care resources for the treatment of infertility are allocated solely on a grace and favour basis and those with the power to dispense them can and will do so according to their own assessment as to the appropriate recipients." This phenomenon is most peculiar because, in many countries, the law claims to hold dear the principles of justice, fairness, and nondiscrimination (McLean 1990). Yet physicians are allowed to discriminate in the provision of health care in ways that the law would never tolerate if the commodity in question were housing, employment, or educational opportunity.

## Beyond Gatekeeping: The Issue of Reproductive Control

The authors present a cogent discussion of the process that led to the medicalization of AID. We hasten to add that conception is not the only reproductive function wherein medicine has found a role. Pregnancy has been turned into an illness and birth into a surgical procedure. Present-day medical practitioners are inclined to view normal female reproductive functioning as inherently pathological and in need of medical intervention, just as their Victorian predecessors did a century ago (French 1985, 380–82).

This proclivity is founded on the needs of society to control the reproductive behavior of women. If one accepts the argument that social institutions (in this example, medicine and the courts) not only conform to the values of society, but also have a hand in shaping them, then it is possible to reframe the issue of medicalization in terms of reproductive control. French points out:

> Patriarchal cultures control women, exclude women, and attempt to control all those things women produce—from children to manufactures. They attempt to take over as their own the very physical functioning of procreation by assigning children to men and diminishing the role of women in procreation. [This is accomplished through social institutions]—independent hierarchical structures devoted to control in a particular field or area. (1985,55)

Of course, the literature is replete with theories as to why society seeks to control women and reproductive behavior. Most commonly mentioned are variations on Engels' ideas concerning patriarchy, ownership of property, and inheritance through the male line (Engels 1972). However, it may be equally plausible that contemporary social changes give new life to old mores. For example, the birth rate has been falling in Europe and North America since 1965 and is even below replacement in many countries (World Health Organization 1988). In some countries, birth rates among the poor and ethnic minorities have not fallen to such an extent. This has given rise to unabashedly open discussions about a pending demographic disaster wherein the white middle class will soon be outnumbered by ethnic minorities and the poor. Added to this, or maybe because of it, is the resurgence of nationalism and the profamily and antiabortion movements. These trends have led

to the end of an era of progress in attaining reproductive choice and control.

## Back to Basics

As there is little reason to believe that medicine, on its own accord, will relinquish its gatekeeper role, one can only hope that the law and other social institutions will reassert themselves as forces for equity and justice in health care. We are reminded that international law discourages discrimination against individuals on the basis of personal, racial, or social characteristics (United Nations 1948). Health policy makers, legislators, and the courts should commit themselves, as an integral part of the provision of infertility services, to a policy of nondiscrimination by ensuring that access to infertility services not be based on inappropriate use of irrelevant personal characteristics, such as race, sexual preference, socioeconomic status, or marital status (World Health Organization 1990).

This, of course, does not imply that health systems are under any obligation to ensure the availability of infertility services to any person who might desire to have a child. Even if one acknowledges an individual's right to reproduce, this right cannot be extended to those who do not have the capacity to reproduce (World Health Organization 1990). It does mean that when services are available, in whatever form, eligibility is determined on the basis of biomedical criteria.

We agree with the authors' position that policy making by default is unwise. Policies concerning eligibility for infertility services must reflect the opinion of the entire community, not just an elite group of service providers. The issues surrounding control over reproductive behavior cry out for reexamination and public debate.

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*Address correspondence to:* Patricia St. Clair Stephenson, Senior Researcher, Centre for Public Health Research, Landstinget i Värmland, S-651 82 Karlstad, Sweden.