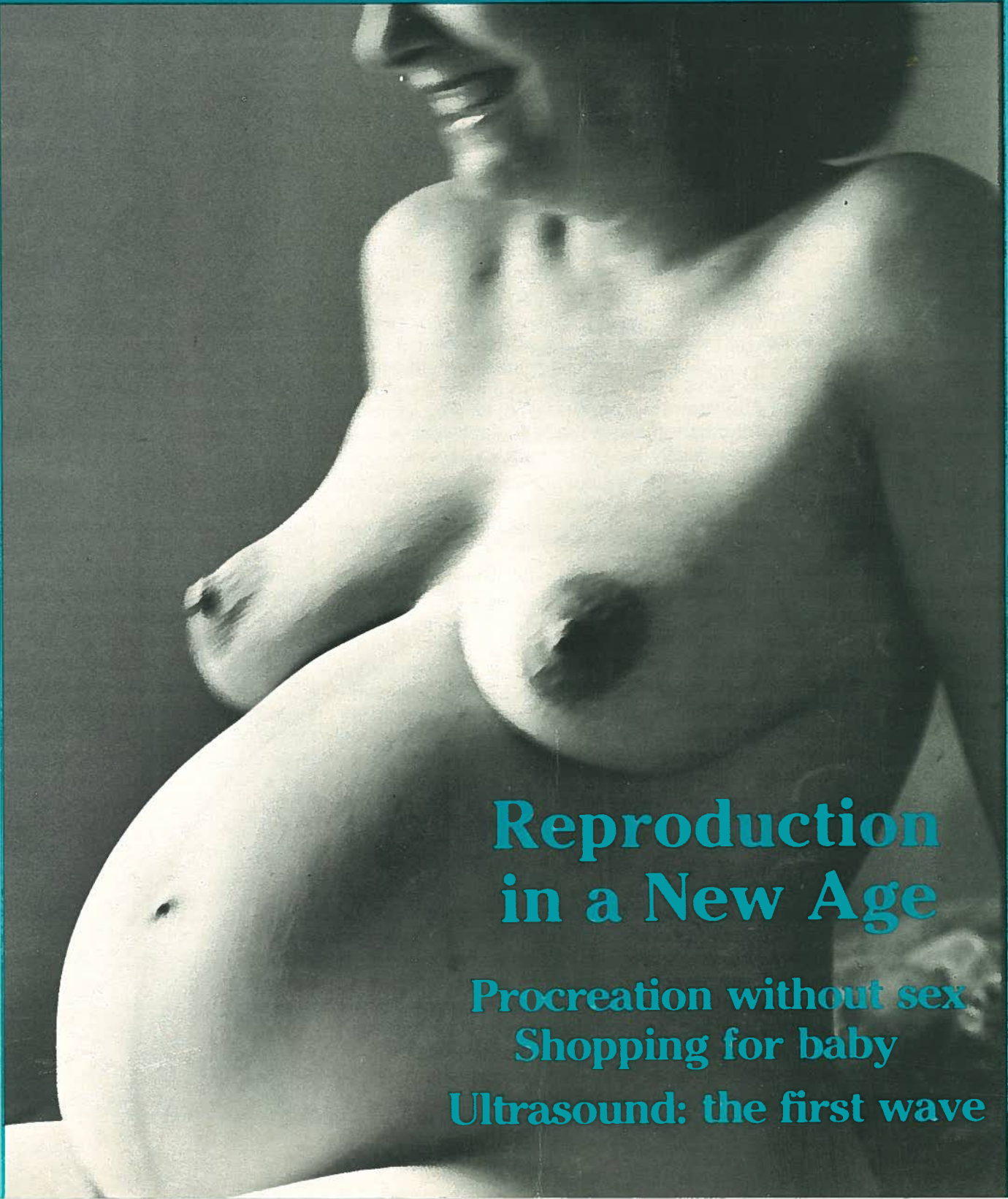


Fall, 1985

# Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY



## Reproduction in a New Age

Procreation without sex  
Shopping for baby

Ultrasound: the first wave

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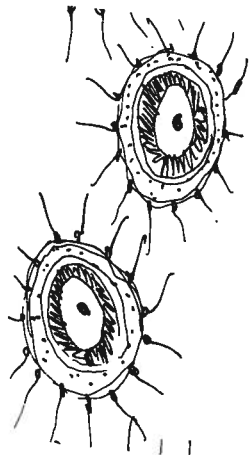
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Vol 6: 4

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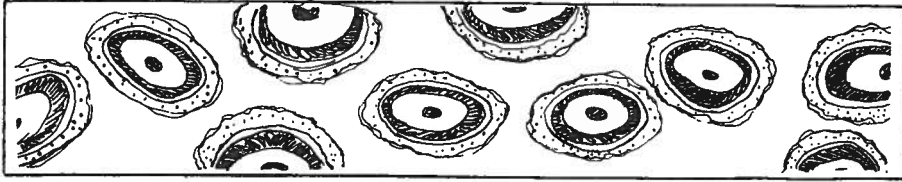
**Cover Photograph by**  
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**Typesetting**  
Lynne Fernie/Rebel Type

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Delta Web Graphics

Healthsharing (ISSN: 0226-1510)  
Volume VI, Number 4, September,  
1985. Published quarterly by  
Women Healthsharing, Inc., 101  
Niagara St., No. 200A, Toronto,  
Ontario M6S 4T3. Telephone:  
(416) 862-1791. Women Health-  
sharing endeavours to print  
material with which we agree;  
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Add \$1.50 to all foreign subscrip-  
tions, including subscriptions to the  
United States.

# COLLECTIVE NOTES



**Baby boy to girl ratios increased 100 to 1. Children made to order. Women obsolete as reproducers. White dominance ensured through reproductive control. Women reduced to servitude through genetic programming.**

Far-fetched feminist paranoia? Perhaps, but on closer examination our fears don't seem so unreasonable. Already, in the U.S., new reproductive technologies are rapidly becoming big business. You can now buy Mensa-ranked sperm, bank your frozen sperm, contract a surrogate mother, hire lab technicians to stimulate conception in a petri dish or go to a clinic to ensure conception of a baby boy. Artificial wombs are being developed and we may see the day when a man will be able to carry a fetus through pregnancy.

As the Healthsharing collective discussed the articles for this issue of the magazine, we found ourselves struggling with a wide variety of questions: basic questions about the safety and effectiveness of new technologies; ethical and moral questions about the power of scientists to develop and maintain particular pregnancies; philosophical questions about the strong desire some women have to bear children; political questions about who controls the new technology and who it is for.

In this thematic issue of *Healthsharing* guest editors Rona Achilles and Kathleen McDonnell have chosen to focus mainly on techniques that increase the ability of women and men to give birth or to have a child who is their own genetic offspring. Quantity assurance, if you will.

Our collective was disturbed by

possible health hazards of the unproven and potentially unsafe technologies addressed in this issue. Even so, our overwhelming concern, shared with the editors and authors whose work appears, is with the issue of control. Clearly, the new reproductive technology is firmly in the hands of a sophisticated and powerful group in our society – a scientific elite whose interests have rarely mirrored our own. And yet, women who want to become pregnant are lining up to make use of that technology, willing to hand over their reproductive abilities to modern medicine.

Feminists are seeking to increase the joy and social power women can experience through birth and child-nurturing by reclaiming women's control of these events. By pursuing reproductive technologies, women risk losing these positive aspects of reproduction, perhaps even risk losing the right to make the decision to reproduce. Does this loss of control outweigh the individual benefits of becoming pregnant and bearing children?

To better understand the issue of reproductive technology, we must examine the motives of doctors, scientists and researchers who are developing and using the technology. What balance is struck between their drive for status, scientific acclaim, popular support, money and a sincere desire to assist distressed women?

Technical advances have far outpaced not only feminist philosophical and ethical analysis but have raced ahead of legal and legislative interpretation. A moratorium is needed. Society must have time. Many of us in the collective wish that women would boycott new technologies until the more ethical and philosophical questions are answered. Feminists must have time to create conditions that make the reproductive technologies safer and less problematic. If feminists are to embrace reproductive technologies, class, race and heterosexist biases which currently characterize technical services must be eradicated.

Yet, in the interim, few collective members would be willing to deny women the possibility of bearing children. We speculated about the future of feminist-controlled technology and crashed headlong into our male dominated reality. We had few hard answers; we were left with a dilemma.

Above all, women need to become active and informed about reproductive technology. We urge readers to support and become involved in the newly formed Canadian Reproductive Technology Network (see page 5). Share your experiences, your understandings, your strategies with other women.

Women Healthsharing thanks our guest editors, two women who are very close to Healthsharing and whose names you have read in the magazine many times. As always, it has been a treat to work with Kathleen and Rona. We are proud to publish this issue, confident it raises important debate and contributes to the creation of solutions.

*Liz Amer, Amyra Braha,  
Connie Clement, Connie Guberman,  
Barbara Lamb, Diana Majury,  
Lisa McCaskell, Heather Ramsay*



## UPDATE ELDORADO UNDER ATTACK

WOLLASTON LAKE, SASK. — Native and anti-nuclear groups united recently in a four-day blockade and a sixteen-hour vigil in attempts to interfere with the operations of Eldorado Nuclear Ltd. The pollution from the company's uranium mine in a bay of Wollaston Lake in northern Saskatchewan affects the safety and livelihood of 800 native people in that community. The lake supplies drinking water and the main source of income, through fishing, to the town.

The Northern Survival Gathering and Rolling Uranium Mine Blockade was removed after four days (June 14 - 17) in order to hear Eldorado's response to the action. John Rico, who was part of the blockade, says the community is determined to see the mining and resulting pollution stopped; at the same time, they want to show faith in the negotiating process which began June 20 between the chiefs of Lac la

Hache Band and Eldorado executives.

One focus of meetings and workshops held during the blockade was how the issue directly affects women. Working with native activists, women in Wollaston Lake are examining the importance of their own actions to affect the future of the community.

Ninety per cent of the approximately 300 people at the blockade were from Wollaston Lake and surrounding areas. Other supporters came from Saskatoon, Vancouver, Toronto and Montreal.

A June 14 vigil outside the national headquarters of Eldorado in Toronto to support the blockade further informed the public about the issue. Karen Levin of the Canadian Alliance in Solidarity with Native Peoples (CASNP) expressed satisfaction with the turn out. The highlight for Levin was a special ceremony conducted by Mel Wabegijig at the end of the vigil which left everyone with a tremendous feeling of solidarity.

PAM RUSSELL

## CLOUD OVER FAMILY MEDICINE

HALIFAX — While other Canadian provinces continue to develop family medicine practice, Nova Scotia is whittling its programme to the bone. Although training in family medicine must be maintained in order for Dalhousie Medical School to be accredited, the quality of the programme is in jeopardy.

The province does not contribute to the salaries of the current 41 residents of Dalhousie's Department of Family Medicine; they are being carried by New Brunswick and Prince Edward Island which fully support the concept. The Halifax Infirmary recently ordered the removal of family medicine facilities from the outpatient department by August 31,

1985. The fate of the inpatient 12-bed unit is still unclear but is expected to be decided this summer.

The philosophy of family medicine training is extremely important in this day and age of high tech specialization. The programme is designed to prepare physicians to see patients as people rather than as a set of systems. Training includes family dynamics, the psychology of death and dying, doctor-patient communication and interviewing techniques — all the human elements of medical practice.

The Halifax situation is complicated by the fact that the Dalhousie programme, unlike others across Canada, is not affiliated with a teaching hospital which might help financially by providing staff and space. Halifax is also the referral centre for the Maritimes leading to an even greater emphasis on specialists.

## BIG BUCKS IN HEALTHCARE

The chairman of Humana Inc., a large and growing chain of U.S. hospitals, is a top salaried corporate executive. According to an item in the *Medical Reform Group Newsletter*, David Jones was paid just over \$18 million in 1984! On the pay ladder of American corporate employees, he ranks second. Only the head of Mesa Petroleum earned more salary. One only wishes that Humana nurses' salaries were comparatively high or that hospital patients weren't paying for his salary! □

## RIGHT TO KNOW

TORONTO — Residents in Toronto could become the first Canadians with the right to know what hazardous substances are used in local industries.

If right-to-know legislation comes into effect, industries will be required by the city's Department of Public Health to register hazardous chemicals they use, and to post notices in relevant workplaces. Notices would describe hazardous ingredients, dangers, recommended protective measures and remedies for exposure to the chemicals. Legislation is being drafted for presentation at an October board of health meeting.

Under the proposed law, the public will have access to the Department of Health's lists of which chemicals various industries use, and relevant information including how the substances are produced, processed, stored and disposed of.

Fire, health and building inspectors would have the right to inspect premises and take samples to check information submitted by the industries to the board of health.

ANNA KOHN

Tertiary-care seems to be the primary concern of the Nova Scotia Department of Health, which over the years has virtually cut off all funding that either directly or indirectly meets the family medicine programme needs.

The community served by the Infirmary family medicine facilities has been so vocal about its support that the Infirmary Board met with representatives of Dalhousie Medical School and the Halifax General Practitioners early in July. Such public awareness and pressure can only help to bring the plight of the beleaguered programme to light. And most encouraging, Premier John Buchanan has expressed concern about the Infirmary situation and promised to bring the issue to Cabinet.

## JURY AFFIRMS MIDWIFERY

TORONTO — After three weeks of testimony and 39 witnesses, a four-member jury examining an infant death in Toronto put forward recommendations urging legalization of midwifery in Ontario. The infant died last October at the Hospital for Sick Children two days after his birth at home attended by two midwives.

The inquest got off to a bad start with the coroner making several derogatory remarks — denigrating his wife's spending and talking habits — to the lawyer representing the baby's parents. Further, despite assurance

Elizabeth Alemany



Midwifery advocates responding to an inquest into a baby death in Toronto. From left to right: Holliday Tyson and Rena Porteous of the Association of Ontario Midwives; Holly Nimmons of the Midwifery Taskforce/Ontario.

that 'I do not represent hospitals; I do not represent doctors,' the crown attorney appeared to do just that. Contradictory expert testimony for and against midwifery care, for and against home birth, vied throughout the inquest. Even so, the crown's summation gave more credence to those obstetricians who argued that birth intervention has become, and *should* be, standard.

Although the jury decided that this particular death might have been prevented, they went on to recommend legalization of midwifery, improvements in back-up for home births, funding for birthing centres and medical association backing for physicians to work with midwives.

In a surprise move, the jury supported an independent College of Midwives, although they recommended that midwives fall under the College of Nurses for an interim five year period while a new college is being established. The jury further supported a direct entry educa-

tion programme of three years duration. The jury favoured a grandmother clause to allow many existing midwives to be licenced.

The inquest was held at a time when Ontario midwives had been pressuring the province to recognize midwifery as part of its re-writing of the Health Disciplines Act. Unfortunately, the inquest structure, designed to examine causes of a specific death, unfairly burdened the parents and midwives. The parents, midwives and midwifery supporters have joined to urge the province to pay costs for the parents in what was a de facto government inquiry into midwifery practices in Ontario.

With the inquest over, practicing midwives and supporters will begin utilizing the jury recommendations in continued advocacy with the new provincial government. The parents, whose support of the midwifery care they received did not waver, will continue to undertake public education about midwifery.

## CANADIAN REPRODUCTIVE TECHNOLOGY NETWORK

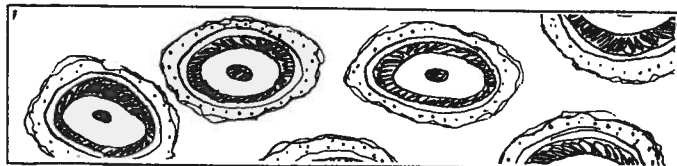
MALMO, SWEDEN — Five Canadian women attended the first international meeting about reproductive technologies. The conference, organized by the Feminist International Network on New Reproductive Technologies (FINNRET), drew together 65 women during early July, 1985.

Attendees, mostly western women, came from Canada, Australia, the U.S., Britain, Germany, Switzerland, France, Sweden, Denmark, Brazil, Bangladesh and Fiji.

The Canadian attendees, academic researchers and teachers from Nova Scotia, Quebec and Ontario, have organized an information-sharing network to continue the sharing begun overseas. The network would like to collect resources, women's individual stories, local news clippings illustrating the increasing use of technology, and theoretical developments. A newsletter will be published four times a year.

To join the network and/or contribute information, please write (in French or English): Jane Gordon, 1642 Chestnut St., Halifax, N.S. B3H 3T4.

RONA ACHILLES



## VITAL SIGNS IN NOVA SCOTIA

NOVA SCOTIA — More than 300 women came from all corners of Nova Scotia to attend 'Vital Signs,' the spring, 1985 conference of the Women's Health Education Network (WHEN). The conference confirmed that women's health is a priority for Nova Scotian women and that WHEN is a vital leader in that movement.

Focusing on women's mental health, the three day event was a fine blend of workshops and information sharing, quality entertainment and socializing, a strategy session for mapping WHEN's future, and the Annual General Meeting which produced eleven resolutions.

Resolutions established WHEN's two primary objectives as 1) strengthening its networking functions, and 2) undertaking political advocacy and lobbying. WHEN's 1985/86 focus will be issues related to women's mental health. Other resolutions dealt with consumer involvement in planning for the new Grace Maternity Hospital, support for legalization and education for midwifery and availability of abortion as an option for women. The Annual General Meeting also established an on-going fundraising committee and resolved to explore the possibility of publishing a book containing articles from *Vitality*, the WHEN periodical. □

## REGINA BUSY THIS FALL

This fall people interested in the areas of reproduction and childbirth will be able to attend several events in Regina.

The Regina Childbirth Education Association will feature Dr. Michael Odent at a one-day conference on September 25. Odent, head of an internationally renowned maternity unit in France, believes birth can be reborn as a normal, safe and confident part of life. The conference will feature afternoon and evening sessions. Some of the topics covered will be: changing attitudes and philosophies in childbirth, analgesia — natural versus pharmacological methods, and an overview of birthing at Odent's clinic.

On October 19th, Regina Healthsharing Inc. and the Saskatchewan Association for Safe Alternatives in Childbirth will offer a seminar. The seminar will examine self-responsibility and self-determination in healthcare, and childbirth, patient rights and midwife-attended births as a progressive, safe alternative.

A third event will be held in Regina in the late fall when Saskatchewan Planned Parenthood sponsors a conference on 'Reproductive Ethica.' Issues examined will include embryonic research, surrogate motherhood, artificial insemination.

To find out more about these events contact the sponsoring organizations or Regina Healthsharing Inc., Box 734, Regina S4P 3A8.

SHANNON BUCHAN

## IMPETUS FOR QUEBEC MIDWIVES

MONTREAL — Quebec midwives and midwifery supporters gathered in Montreal for a conference in early May, 1985. 'Woman & midwife: a privileged bond' was the theme underlying the conference which brought together speakers from throughout Quebec, the U.S. and France. Session topics ranged from a theoretical presentation given by Gayle Harriet Peterson, author and psycho-therapist, to discussion of empirical research about clients of midwifery in Québec.

Various political forces affecting midwifery in the province were evident at the conference. Both Francine LaLonde, ex-Minister for the Status of Women, and Guy Chevette, Minister of Social Affairs, addressed the conference. Both favoured legalization of midwifery and supported many recommendations put forward in a recently released inter-ministerial report on midwifery.

Chevette told attendees the province might announce legal changes as early as this November. While this act of government support encouraged the over 250 participants, many were aware of the dangers involved in letting the initiative come from above.

The government actions are giving renewed impetus to the organizations of practicing midwives, such as Le Groupe de Travail pour la reconnaissance des sages femmes de Québec, to ensure that their own organizations are well prepared by

the time the government drafts legislation. In order to be in a good position to put forward their own agenda for change, Le Groupe de Travail, a member of the Midwives Association of Canada, is planning on several levels.

Committees are examining standards and educational programs used by midwives in other parts of the world. In establishing standards, Le Group de Travail is stressing peer review for practicing midwives to include regular group hours for case review and support, especially needed by women practicing in isolated areas. Client contracts and informed consent practices are also central to proposed standards.

A letter sent to government by Movement Sages Femmes and distributed at the conference calls for support for legalization of midwifery as an autonomous, self-regulating practice. Education should be provided through university-level programs under an independent faculty without prior university training required. Embued within the curriculum should be a philosophy integrating continuity of care, a global approach to services and respect for the choices of parents. Finally, the midwives are urging equal access to midwifery services regardless of whether the birth is planned for hospital, home or a birthing centre.

Concurrent with ongoing advocacy and promotion of midwifery and the establishment of standards, Le Groupe de Travail is organizing internal educational programs for midwives practicing in Québec.

DEBORAH VAN WYCK

# TEEN SELF-ESTEEM URGED

ST. JOHN'S — The Newfoundland pregnancy rate among teenagers is 55/1000 — twice the national average. Newfoundland also has the highest rate of teens leaving school before graduation of any province in Canada. Looking at both these trends, the statistics show that approximately half of all young women who left high school were pregnant.

A new 34-page booklet, *In Touch: For Teen Women About Sex*, has been written for teen women aged 12 - 17 to help them sort out these pressures. The booklet was produced by Planned Parenthood Newfoundland and

Labrador with funding from the Women's Program, Secretary of State. *In Touch* gives much more to readers than the traditional message: 'it's your responsibility not to get pregnant.'

Author Amy Zierler promotes positive feelings about teenage sexuality and encourages women to be in touch with and take control of their own sexuality. The booklet discusses physical and emotional changes of puberty, sexuality, decision-making, sexually transmitted diseases, birth control and unplanned pregnancy.

Publication of *In Touch*, already about to go into se-

cond printing with a few months of publication, coincides with the establishment of a multi-agency committee to spearhead efforts of government and private sector agencies.

Copies of *In Touch* are free while still in first printing. Out-of-province orders will be billed for handling and

postage. A French version of the booklet, being translated by Planned Parenthood New Brunswick, will be available in the fall. For information or copies contact Planned Parenthood, 203 Merrymeeting Rd., St. John's, Nfld. A1C 2W6, (709) 579-1009.

BONNIE WOODLAND

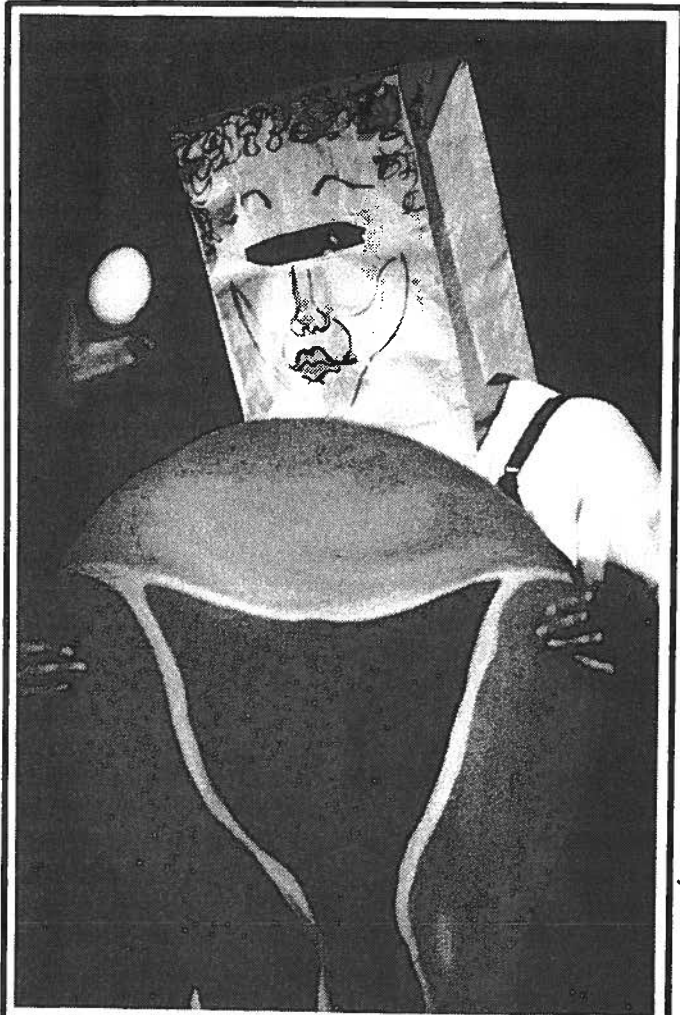
## WOMEN CONFRONTING WORK HAZARDS

EDMONTON — 'Women's work is dangerous work.' That was the message heard by about 300 delegates who attended 'Women Confronting Work Hazards,' a conference organized by the Alberta Federation of Labour which was held in Edmonton on July 4, 5 and 6. Delegates were told by keynote speaker Dr. Linda Murray that the work women traditionally do is considered safe work, yet women workers in female job ghettos face job hazards similar to those which are present in occupations traditionally dominated by men. For instance hospital workers must do heavy lifting, are exposed to chemical hazards from drugs and to infectious diseases and in some situations are at risk of physical violence from patients. Because women workers tend to be in jobs where they have little authority or power, and thus

have little control over their activities, they are likely to experience stress as a result of their jobs — and this is particularly so if they are trying to raise families at the same time as working. Dr. Murray pointed out that women who had been successful in finding employment in non-traditional fields had the most basic health and safety needs — they often were unable to obtain gloves and equipment that fit or even lacked washrooms at their job sites.

Conference delegates, who were mostly rank and file trade union members from a variety of occupations including many postal workers, health care workers and clerical workers, had the opportunity to express their views about a wide range of health and safety issues. While the conference didn't provide any easy solutions, it was a positive step in recognizing that women — like men — face risks daily on the job.

ELLEN TICOLL



Lee Lyons/Fem Fest '85

Scene from performance of *Test-tube Tots in Babylon*, Fem Fest '85, Toronto. *Test-tube Tots* and *The Egg Snatchers* are dramatic sketches, developed by the Nightwood Theatre Collective, which take a satirical, feminist look at reproductive technologies.

The plays have been performed at various events in Canada. For more information about the pieces, contact Cynthia Grant, The Theatre Centre, 296 Brunswick Avenue, Toronto, Ontario M5S 2M7. (416) 961-7207.



# HEALTHWISE

## Self-insemination

Nancy Adamson

An important part of the spectrum of reproductive rights for women is the ability to choose to have a child. For independent women, lesbians and single women, this means the right to choose to have a child without being in a long term sexual relationship with a man. Artificial insemination by donor (AID) has enabled women to make this choice. However, the medical profession, which largely controls AID through sperm banks and infertility clinics, is less than happy when single women apply for AID. Most doctors and clinics now have an unspoken policy not to inseminate single women, although they are rarely willing to say so publicly. Instead they keep the woman waiting with tests and other tactics, and finally find some other excuse to deny her their services. Even finding a doctor willing to do AID for single women doesn't solve all the problems. Most (if not all) doctors doing AID are opted out of OHIP, so in addition to the standard \$25 fee given to the donor, the woman must pay up to \$40-50 per insemination to the doctor, of which about \$30-35 will be repaid to her by OHIP. Since it frequently takes several inseminations to get pregnant, this can add up quickly. As with so many other 'medical' procedures, the medical profession has needlessly mystified the process. AID is remarkably simple to do and any woman, once she has found a donor, can do it herself, easily and cheaply.

Finding donors was the most difficult part of the process for me. I was quite certain that I did not want to know the man who was donating sperm to me. I worried about someone who would romanticize having a child and turn up

in a few years claiming 'his' child. I also worried about a 'Sunday' father – a man who was known as the child's father and appeared occasionally to take the child out for a good time, but was not involved in the everyday life of the child. Those are my own personal worries; other women have decided to use known donors and have made different arrangements about the role the biological father will play in their own and their child's life. I think the decision of what donor to use is a very personal one. With a known donor, there are the worries I have already outlined, but there is the advantage of being able to answer a child's question, 'Who is my daddy?' There's no general right or wrong on the donor question. The important thing is to arrange a situation which feels right and comfortable for now, and which you will be able to deal with in the long term.

Since I wanted an unknown donor, but couldn't afford a doctor who could provide that kind of anonymity, I asked friends to ask their friends to find donors. This sort of double-blind system protects both me and the donor: my friend doesn't know who he is and his friend doesn't know who I am. I was afraid no men would be willing to be donors, but in fact, we have had not difficulty in finding them. I ask that my donors be healthy and to indicate if there are any family diseases such as diabetes. Each woman has to decide how much the health of the donor is an issue for her, and negotiate with each donor on that issue.

Insemination is tied to the point in a woman's monthly cycle when she ovulates. By monitoring her

basal body temperature (taken in the morning upon first awakening) and her cervical mucus, a woman can determine if and when she ovulates. Each woman's rhythms and norms are different and before attempting to get pregnant with AID, a woman should learn to read her body's signs of ovulation. Books on natural birth control are handy references for explaining the ins and outs of the monthly cycle. In a 28 day cycle, the woman probably ovulates about day 14 and may want to do an insemination on day 12 and 14, or day 11 and 13 or all of those days, depending on her situation and the availability of donors. If using the same donor, it is best to inseminate every other day so that the man's sperm count has a chance to build up between ejaculations.

The insemination itself is simple. The donor ejaculates into a small clean glass container or, if he prefers, an unlubricated condom. Sperm only live outside the body for one to two hours, so the ejaculate needs to be taken quickly to the woman. The woman draws the semen up into a needleless syringe (a 5cc one is a good size) and inserts it into her vagina, near the cervix. Women I know have used a variety of different methods for actually getting the sperm into the vagina. Some have used turkey basters, others have poured the sperm into the vagina while using a speculum to open the vagina, still others put the sperm into a diaphragm or cervical cap and then insert that. After the insemination is done I remain lying down for about 30 minutes with my hips raised slightly on a pillow. Some women stand on their heads for a few minutes so that gravity can help pull the sperm into the uterus.

Once the insemination had been done you have to wait two weeks to see if your period starts. Some women are lucky and get preg-



nant on the first or second try; for others it can take longer. If your temperature and mucus chart indicates that you are ovulating regularly, just be patient. Fifty-five per cent of women trying to get pregnant do so in the first three months; 65 per cent get pregnant within the first six months; 80 per cent within the first year; and 85 per cent within two years. The statistics are no different for conceptions by AID and those by intercourse.

If you are worried, talk to a sympathetic doctor. After six months of trying and not getting pregnant, I was sure I'd never be able to have a child and headed off to talk to my doctor about fertility tests. She listened sympathetically to my worries, examined me, told me the statistics, then suggested I try for six more months. Although I hate to admit it, the voice of medical authority reassured me; I got pregnant a

few months later.

Any discussion of women's rights to make reproductive decisions must include the option of AID. That is, however, often a controversial issue among feminists. A woman deciding to have children by herself, without a man, is seen as attacking the traditional notion of the family. It questions the naturalness of the male/female unit which creates children. It questions the assumption that a woman has to be with a man to have children and be meaningful in this society. It questions the entire basis of the heterosexual family. In so doing, it is an important aspect of our struggle to control our bodies and our reproductive capacities.

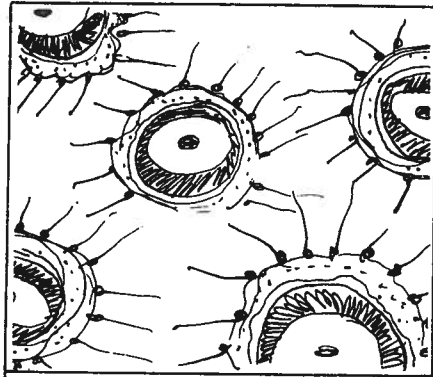
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*Nancy Adamson is currently a nursing student and teaches women's studies part-time at the University of Toronto.*



*Discussing the future of male sperm*

*Carolyn*



### **Abortion Stories Wanted**

The Childbirth by Choice Trust, a pro-choice educational organization, is compiling women's stories about their illegal abortion experiences for publication. They are particularly interested in the personal history of older women.

Have you or someone close to you had an illegal abortion? Have you had experience with illegal abortion in your professional capacity? Confidentiality will be absolutely respected. If you are willing to write or tape your story or to be interviewed, contact: Leslie Pearl, Childbirth by Choice Trust, 40 St. Clair Ave. E., Suite 310, Toronto, Ont. M4T 1M9, (416) 961-1507.

### **Caffeine & Children**

Depending upon body weight a child who drinks a 10-ounce cola can get the equivalent of an adult who drinks four cups of coffee! Knowledge about health risks of caffeine are increasing – so if you cut down on your coffee, help the children in your life cut down on their chocolate and colas.

### **Calcium**

Bone meal and dolomite, both preparations commonly taken as calcium supplements, have sometimes been found to have trace elements of lead and other toxic metals. A 1984 issue of the *Tufts University Diet and Nutrition Letter* cited 6 parts per million of lead on average. According to *Mothering* (Summer, 1985) the U.S. federal guideline is 5 ppm. Switch to calcium carbonate or herbal preparations.

Rona Achilles

# NEW AGE Procreation

illustrated by Maureen Paxton

Choice. Reproductive choice, the ability to decide how and if we become mothers is a basic tenet of the women's health movement. Medical advances in reproductive technology are having an unprecedented impact on women's reproductive choice. Even though effective and safe contraception remain an unrealized dream and abortion rights face renewed and violent opposition, we have entered a new era.

There is no question that these new techniques *do* expand women's reproductive choices. Women who for a variety of reasons would not otherwise have children can now do so – no small feat. Less evident however is the fact that the existence of new options also makes it more difficult for women to pursue some old options. For example, a woman faced with infertility today is less likely to mourn this crisis in her life and go on with other projects. The infertile woman now is far more likely to end up in an infertility clinic than she would have 10 years ago. She becomes caught in the extensive, debilitating, expensive and stressful process of 'treating' her infertility.

This is ironic given the present historical context in which there are so many more roles and careers available to women. The ostensible expansion of choices that new reproductive technologies present to us require closer examination. Choice, as generally understood appears to be a purely individual matter. But as Barbara Katz Rothman argues so per-

suasively in *Test-tube Women* (reviewed in this issue), choices, although experienced individually, are socially structured. For example, a couple using a technique to preselect the sex of their child probably assumes their choice is entirely of their own making. But research indicates that the vast majority of couples desire boys, especially as first borns. When patterns like this one emerge in what appears to be individual choice, we must look to the societal forces that impinge upon our choices.

The emphasis on the expansion of choices offered by new reproductive technologies tends to disguise the concomitant hidden pressures and loss of choices. We need to become more conscious of the ways in which these new options may threaten or enhance the quality of life for women and their families. This requires a consciousness of the social, economic and political context in which they are developed and used.

Gena Corea in her book *The Mother Machine* (also reviewed in this issue) describes the vocabulary and mentality which characterize this new era. 'Begetting and siring. Genesis. Procreation. These were the words used, respectively by Hebrews, Greeks and pre-modern Christians to describe the transmittal of life to the next generation. Today we use the metaphor of the factory: reproduction.' It has slipped into our lives silently; we already use the language. Just as we attempt to

achieve quality control in mass production of commodities, which has not been entirely successful, the goal of most reproductive technologies is to facilitate the 'production' of the 'perfect child.'

Each technology is different and must be examined on its own to fully understand its implications. Artificial insemination by donor (AID) and in vitro fertilization (IVF) for example, are quite distinct. AID is a simple procedure that can and is being undertaken by women on their own without the assistance of physicians (see *Healthwise*). Within clinical settings the procedure varies from the simple insertion of donor sperm into the woman's cervical canal to the use of some fairly high tech procedures which regulate fertility. IVF, on the other hand, is consistently a high tech, costly, invasive procedure, employing several fragile steps of retrieval, or 'harvesting' of eggs, fertilization of sperm and egg in a culture dish and implantation in the uterus. This procedure is still in experimental stages and has a low success rate.

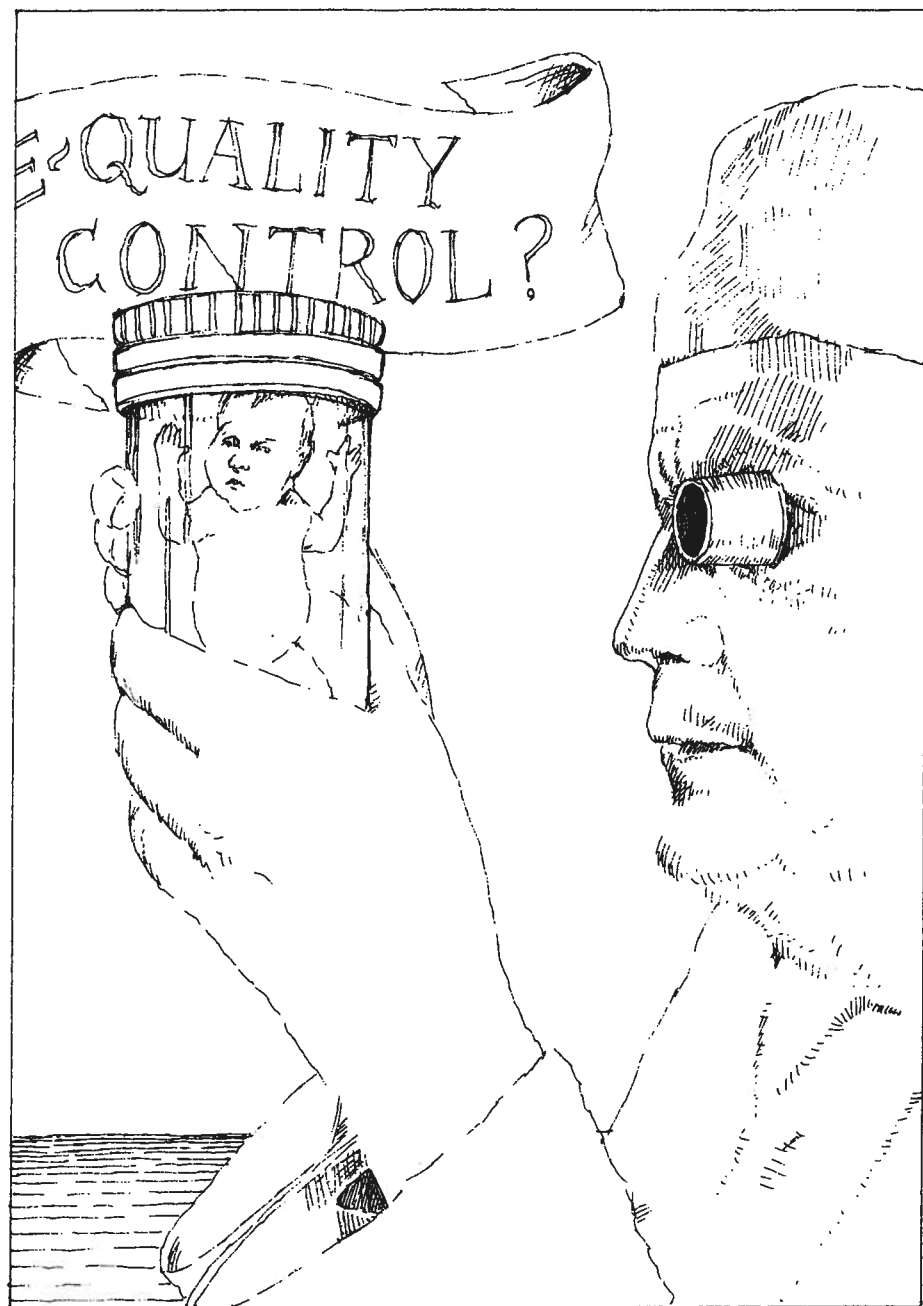
Despite the differences in the procedures there are some basic themes which emerge from the use of these technologies. The first is the increased medicalization of women's reproductive experiences and the unprecedented medical control over the reproductive process. (Women who choose self-insemination side-step this issue.) Although the woman with an infertile partner who attends an infertility clinic for AID gains the

opportunity to have a child, she loses the opportunity to choose or even know the man who will be the biological father of her child, a quite momentous shift in reproductive relations as we know them. Sperm donors are anonymous, chosen and known only to the physician (and his/her staff), and are matched to the woman's partner's physical makeup. Other than characteristics such as height, eye and hair colour, the AID mother does not know and will never know who the biological father of her child is. What he does for a living, his likes and dislikes, his talents or weaknesses, whether he has children of his own (half-siblings of her own child) all remain unknown. In some cases it may be completely unknowable depending on whether records are kept. She does have a child she would not otherwise have, but she also pays a price.

In addition to choosing who becomes the biological father to a woman's child, physicians also control who has access to these services. There is, of course, a bias in favour of heterosexual couples and, with the more expensive procedures, those who can afford to pay for them.

In medical language artificial reproduction techniques are described as 'cures' for infertility. In fact, they do not cure infertility which is not, strictly speaking, a disease) but circumvent it, through procedures that are socially created – frequently using the reproductive capacities of other human beings.

Infertility is considered to be reaching epidemic proportions. There is little feminist analysis in this area but evidence is growing that a significant proportion of infertility is socially rooted – in occupational health hazards, environmental pollution, diet and lifestyle. These are structural problems which require widespread social change rather than heroic and individualistic efforts from



physicians. Infertility also has iatrogenic causes – that is, it is sometimes caused by practices introduced by medicine itself – the IUD, which can cause fallopian tube damage leading to infertility, and DES, which is linked to fertility problems in male and female offspring of women who took it during pregnancy, are just two examples. It is typical of our society's 'technological fix' mentality that we are spending enormous amounts of money on so-called treatments and cures rather

than researching and acting on the causes of infertility problems.

I have recently interviewed participants in donor insemination programs and have been moved by the anguish of individuals who want children and are faced with infertility. A predominant theme in the interviews is the incredible drive of these women to have children, whether heterosexual and married, single or lesbian. Infertility is described by these people as a life crisis which is equivalent to the crisis of the ter-

minally ill. Frequently it requires the same stages of resolution – denial, anger, bargaining, depression and ultimately acceptance. 'People don't understand, when you want children and you can't have them, you'll do anything, you get desperate' or 'Having children is the strongest drive in the world,' are typical statements made by infertile women, and clearly they do go to some incredible lengths.

Ironically, in some instances with donor insemination, although the infertility may be her partner's problem, it is the *woman* who becomes the patient and may endure extensive infertility work-ups, including laparoscopies, hysterosalpingograms and fertility drugs – all used to increase the efficiency of the procedure. One AID mother I spoke to had experienced early menopause at age 29 as a result of the fertility drugs she had taken to regulate her ovulation during inseminations.

From the anguished perspective of the infertile, physicians are praised as miracle workers who can assist them to have children. There will be no need for marketing experts to promote artificial reproduction techniques. A large and growing market already exists.

In the early years of this wave of the women's movement, feminists challenged the traditional explanation of the biological drive among humans to reproduce. We focused instead on the social pressures for women to mother and the fact that women's roles in society were defined by mothering. The desire to reproduce, however is clearly more complicated and it is not simply the product of social pressures, although these are unquestionably important. These anguished women are not only those who have made traditional choices. They represent a broad spectrum of values and lifestyles. We need to explore more fully this expres-

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**...she loses the opportunity to choose or even know the man who will be the biological father of her child, a quite momentous shift in relations as we know them.**

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ed anguish of the infertile if we are to act responsibly towards these new reproductive technologies. For example, we need to critically examine how women handle the conflict between traditional and modern pressures in their roles in society and how this affects their feelings about mothering and infertility.

Medicalization of the reproductive process also has a tremendous impact on our assumptions about parenting. Artificial reproduction techniques provide the potential for a whole new family structure – a whole new set of parenting roles, similar in some respects to adoption and step-parenting. When we use the word parent we generally assume that the biological and social components of the process merge in one person. With adoption and step-parenting, biological and social parenting may also be severed but this separation occurs after birth and not at the point of conception. With the advent of artificial reproduction, mothering can now potentially be fragmented among three people – the genetic mother (egg donor), the uterine mother (the woman who carries the child)

and the social mother (the woman who will rear the child). Fathering, likewise can now be broken into genetic (sperm donor) and social fathers (the AID mother's partner).

The freezing of sperm, eggs and embryos, technically called cryopreservation, means that the temporal and geographic boundaries of parenting can also be altered. Does this sound like the stuff of science fiction? Conception could occur in a petri dish in Australia (eggs and sperm donated), the embryo frozen, stored and transported to Canada, where a woman (genetically unrelated) could give birth to a child ten years later. It is already possible. And if there is one thing we can count on, if we can do it, we will. A woman in California has already given birth to an 'embryo transfer baby' and an Australian has given birth to the first baby to develop from a frozen embryo.

Well, so what? As one AID offspring, now an adult put it, 'If a woman can love three children why can't a child love three mothers?' As currently practiced however, the opportunity to even know one's biological parents is being eliminated. From the child's point of view, the attempt of infertile couples to 'pass' as fertile – to not acknowledge the mode of conception to society and, most importantly, to the child – is unsettling. Although there is of yet no official policy on this issue, the general feeling among practitioners is that telling the child will only raise problems, unanswered questions and possibly pain. Whether motivated by the desire to avoid the stigma of infertility, the stigma of 'feeling different' for the child or to protect the donor or the physician, this silence about the child's origins is a deception, one that is rooted in the purported 'sanctity' of the nuclear, biologically-related family. As one AID mother put it, 'If we believe in this



[procedure] enough to do it, we should believe in it enough to say we did it.'

There is no question these are wanted children. Some parents undergo years of anguish, stress and expense to achieve a pregnancy. But this is where the choice issue gets a little sticky. There is a basic difference between a choice to *inhibit* new life with contraception and abortion, and the choice to *create* life through reproductive technologies. At its most basic level the distinction rests on the fact that artificial reproduction technologies, when successful, result in a child, a living, breathing human being.

I have recently interviewed adult offspring of AID who are not happy with their parents' decision to use it – especially the fact that they can not know, meet or learn more information about their sperm donor 'fathers.' Already in the U.S. there is a group called 'Donor's Offspring' whose members are, like adoptees, asserting their right to know the other half of their biological heritage. Despite radical transformations in family forms, we still live in a society which believes that 'blood is thicker than water.' Ironically, biological ties are taking on greater importance in medicine as genetic counselling before child-bearing becomes more commonplace.

In some instances, depending on how the 'telling' is handled and how satisfying family bonds are, it is possible some children may have no interest in their biological heritage and may even enjoy a sense of being particularly wanted. The AID offspring I have interviewed 'discovered' their origins in rather unhappy and painful ways, which is not so surprising with a secret as loaded as his one.

Transforming family structures is not in itself problematic, since social policy could provide the

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**"If we believe in this enough to do it, we should believe in it enough to say we did it."**

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ways and means to trace biological heritage. After all, have not feminist thinkers argued in favour of the liberating potential of these medical developments? Both Shulamith Firestone (*The Dialectic of Sex*) and Marge Piercy (*Woman on the Edge of Time*) suggest that technology could liberate women altogether from the burden of biological mothering. Well, *some* women anyway. And that's the crunch. We are not living in Piercy's utopia, nor are we likely to in the near future. What is central (and usually absent) to any discussion about these technologies is what a sociologist would call social context.

Commercialization is inevitable in our society in which, as we all know, you don't get much for free. It is arguable whether sperm donors (paid about \$25 per ejaculate) are really donors or sperm vendors. This is defended as payment for time and expenses, rather than as payment for the sperm itself. On the face of it, this seems fair enough and could provide significant income for, say, students or the unemployed. The major argument for payment is that, without reimbursement, donors would not come forward. But there are countries like Sweden and France where donors are *not* paid, and their AID programs continue to operate. In contrast, blood donors in Canada are *not* paid, and there is strong evidence that in countries where they do get paid the quality of donated blood declines.

However the precedent is more significant than the amount of payment. Surrogate mothering moves us into a whole different ball park with women being paid about \$10,000 for bearing a child – well below minimum wage. While we might be appalled that women are paid to bear children, it is the lawyers arranging the surrogate contracts who make the *real* money. Feminists have had a mixed response to surrogate mothering. On the one hand, it is labelled exploitation, similar to prostitution and concubinage. Conversely, there is a 'why not' attitude – it's about time we women got paid for our reproductive labour.

These trends raise the spectre of reproductive parts and processes being turned into commodities, one that is already being realized. Commercial sperm banks are already operating in the U.S., and commercialization of IVF technology is underway in Australia. Such commercialization may well provide the impetus to expand the use of these technologies beyond the infertile.

As with any commodity, the first question is the market. There is now a substantial market, and social factors indicate that the demand for these procedures will increase. Infertility is estimated to effect up to 15 per cent of couples in Canada and is increasing. (There is a bias in the data collection since we do not know about single or lesbian women who do not attend infertility clinics.) The reversal of decisions about child-bearing after vasectomies, late childbearing which sometimes incurs fertility problems, the decline in children available for adoption (especially so-called 'perfect' white babies), the desire for a genetic tie with the child, as well as the increase in single and lesbian women wanting children without contact with a male all promise a 'bullish' market for artificial reproduction technologies.

Commercialization will also introduce an inequality in terms of who has access to these services. Artificial reproduction technologies vary in cost, depending on the clinic and the procedure. Donor insemination, for example, may cost only \$25 per insemination to cover the cost of the sperm. On the other hand, I have talked to a couple who had spent \$10,000 for infertility tests and drugs and had undergone only one (unsuccessful) insemination.

Similarly, our societal context makes eugenics an inevitable issue in the development of reproductive technologies. We live in a society obsessed with perfection and overcoming nature's 'mistakes'. The 20th century has seen the rise of experts advising women how to rear the perfect child. Reproductive technologies provide the possibility of introducing 'quality control' at a new level of parenting, the biological. (Harried mothers, I'm sure will vouch for the difficulty of introducing quality control at *any* level.) Imbued with the ideology of parental responsibility for perfect children, some women, given the opportunity, will likely choose a Nobel prize winner's sperm over an insurance salesman's. And surrogates (egg and uterine donors) will potentially be valued and paid more according to the current standards of beauty and intelligence.

Eugenics, the practice of selective breeding to improve the human race, was a popular and progressive school of thought early in this century. The Nazi eugenic program, of course, dampened this initial enthusiasm. However, eugenics is the logical and inescapable consequence of the new reproductive technologies given the social context in which we live.

Just as eugenics institutionalizes racism and classism, sex selection, if widely used, could institutionalize sexism at a new level.

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### **When we use the word parent we generally assume that the biological and social components of the process merge in one person.**

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More first born males – who typically are high achievers – would be born. Prospective parents could begin even earlier with their culturally-shaped expectations and plans for male or female children.

And there will be mistakes. A midwife recently told me about a woman with three children, two boys and a girl. She strongly wanted another girl to 'balance' her family, so she and her husband used a sex-selection technique to conceive a girl. When she had an amniocentesis and discovered in her fourth month of pregnancy that she was carrying a boy, she required psychiatric treatment for the rest of her pregnancy to adjust to this knowledge. Perfect children, perfect families?

What kind of expectations and pressures will be exerted on children who are so calculatingly chosen from sperm banks, surrogate catalogues or embryo banks? Can we really predict and control biological and social processes at this level? Already Australian physicians are contending that IVF babies are more intelligent and superior in many ways to children conceived naturally.

The fascinating questions of why we reproduce, where does this impulse come from and why it is so strong underlie all these issues. Is it different for men and women? The advent of artificial reproduction technologies, like any social change that strips away at tradition, allows us to see more.

Participants in artificial reproduction programs are on the cutting edge where issues are no longer hidden by traditional values and practices. Explanations offered by participants that I spoke to include the importance of a genetic tie, even when it is with only one parent. 'Fifty percent is better than none at all' and 'I wanted someone who looked like me' are typical statements. Donors with offspring they will probably never meet or know found comfort in the fact that their 'lineage is out there somewhere' and are flattered that 'someone wanted me as part of their situation.' Social approval, genetic continuity, rites of passage into adulthood, generativity and existentialism – the possibilities are infinite and complex and ultimately form a constellation of forces which crystallize in this compelling drive.

But perhaps the question of why we reproduce is not that important after all. What is clear is that this compelling desire can be used to manipulate individuals who are vulnerable to those who promise to 'give' them a child.

My own assessment is that these technologies are here to stay, and our best efforts are to lobby for the least abusive practices and for a better understanding of what the social and health implications are. This is important for the participants, but most profoundly for the children, the so-called 'products' of these new conceptions: babies, wanted babies, who will eventually become children, then adults and have to come to terms with their origins. New choices bring new responsibilities.

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Kathleen McDonnell

# A Primer of Reproductive Technology

illustrated by Dawna Gallagher

Does the brave new world of reproductive technology frighten and confuse you? Do you have trouble telling your AID from your IVF? Were you under the impression that parthenogenesis is one of the books of the Old Testament? Don't be dismayed, because you're not alone. We are all technological illiterates as far as the new developments in reproduction are concerned.

It is possible to overcome that fear and ignorance, but you need some hard information, and a bit of background. First of all, there are some basic distinctions that have to be made between the various new reproductive techniques. Fetal surgery and genetic screening techniques like amniocentesis have the aim of changing the outcome of the reproductive process – in cruder terms, they aim at 'improving the product,' i.e. the baby. Then there are techniques like artificial insemination and in vitro fertilization which assist the process of reproduction itself. Sometimes referred to collectively as 'artificial reproduction,' these techniques help make babies when nature can't or won't co-operate. To complicate the picture, these functions often overlap, and their aims can be combined in the same technique. Artificial insemination, for example, is used to bring about conception in cases of male infertility or subfertility, but can also be used for the eugenic purpose of creating 'better babies,' as the repository for Germinal Choice, the so-called Nobel Prize sperm

bank in California, is attempting to do.

Clear as mud? Good. You're now ready for the hard information contained here in our *Health-sharing Primer of Reproductive Technology*.

**Amniocentesis** This is a prenatal diagnostic technique used to detect certain chromosomal abnormalities, chiefly Down's syndrome, and is performed by inserting a needle into the abdomen of a pregnant woman and withdrawing a sample of the amniotic fluid surrounding the fetus. Amniocentesis can also detect the sex of the fetus. The test cannot be performed until the second trimester of pregnancy, and is becoming standard practice for pregnant women over 35.

**Artificial Insemination (AI):** A simple technique to promote conception in which sperm is deposited into a woman's vagina, it is known as AID when the sperm comes from a donor, AIH when the sperm comes from the woman's husband. In North America most AI is carried out with sperm obtained from paid anonymous donors.

**Chorionic villi sampling (CVS)** A newer, still experimental prenatal diagnostic procedure to detect fetal abnormalities (and to determine the sex of the fetus), CVS involves taking a sampling of cells of fetal origin through the

pregnant woman's cervix. In contrast to amniocentesis, the results of the cell analysis can be obtained quickly and the procedure can be performed during the first trimester of pregnancy.

**Cloning** This is a form of asexual reproduction from a single cell of an organism that results in a genetic 'carbon copy' of the original. Cloning occurs in some plant and animal species and has been carried out in the laboratory, but has not yet been achieved in humans.

**Ectogenesis** Literally 'produced outside,' this term refers to the still-theoretical possibility of bringing a human fetus to term completely outside the womb, through the use of sophisticated life support technology or 'artificial wombs.'

**Embryo transfer (ET)** In this procedure a fertilized egg from one woman is surgically removed and implanted in a second woman's uterus. A related procedure, embryo replacement, refers to the stage of the in vitro fertilization procedure in which the woman's own fertilized egg is re-implanted into her womb.

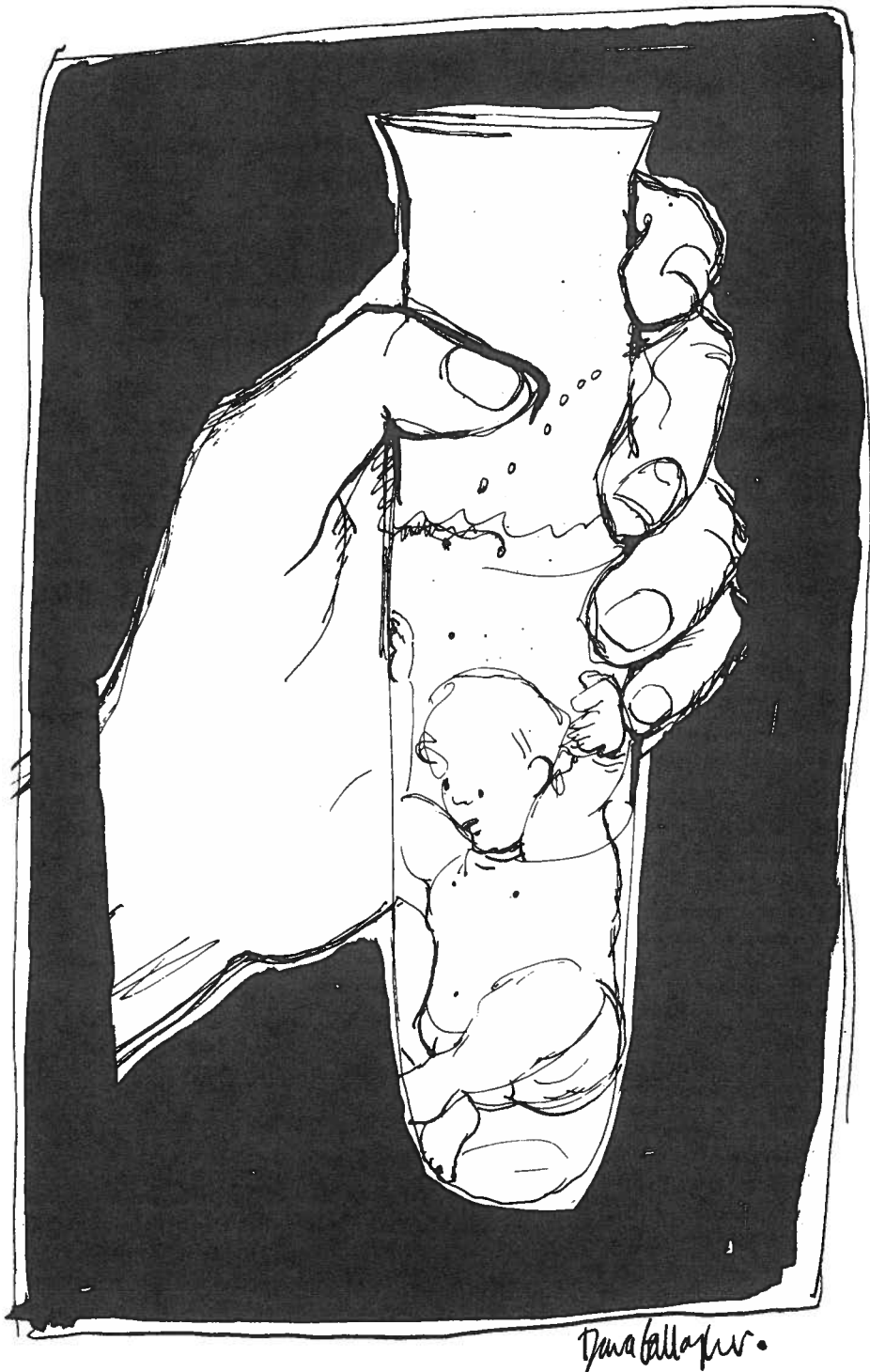
**In vitro fertilization (IVF)** A sophisticated procedure in which human ova are extracted from a woman's body and fertilized in a laboratory petri dish. In current practice the fertilized ova are

usually re-implanted back into the same woman's uterus, but they could also be transferred to another woman's uterus (see above), used for research, discarded or, once the technology is perfected, placed in an 'artificial womb.'

**Parthenogenesis** Sometimes referred to as 'virgin birth,' this is another type of asexual reproduction involving the duplication of the female egg without fertilization by sperm, a practice which results in all-female offspring. Like cloning, it occurs in some plant and animal species and has been achieved in laboratory experiments, but not in humans.

**Sex selection** An effort to control the sex of offspring, sex selection can be applied either pre- or post-conception. Currently the only highly effective pre-conception method involves 'sperm-splitting,' a process that separates out sperm bearing Y or male chromosomes from those bearing X or female chromosomes. Conception then takes place via artificial insemination with either Y- or X-rich sperm, depending on the sex desired. Post-conception sex selection involves the use of a prenatal diagnostic technique like amniocentesis with abortion if the fetus is not of the desired sex. Contemporary studies of the sex preferences of childbearing couples indicate that if widespread sex selection becomes a reality, it will be used overwhelmingly in favour of male babies.

**Surrogate Mother** This term is popularly used to describe a woman who agrees to be artificially inseminated by another woman's husband, and to bear that couple's child, usually for money. As used, the term is something of a misnomer, for in this case the 'surrogate' is in fact the true biological mother. A more accurate use of the term



would be to designate a woman who carries to term an embryo transferred from another woman's womb.

**Ultrasound** The use of high-frequency sound waves to produce an image on a video screen of internal organs or areas of the body. This technique, also known as ultrasonography, is widely

employed in obstetrics to allow examination of the fetus in the womb.

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*Kathleen McDonnell is a Toronto playwright and author of Not an Easy Choice: A Feminist Re-examines Abortion (Women's Press, 1984). She is guest co-editor of this thematic issue of Healthsharing.*



Connie Clement

# Science / Science Fiction / Fact

illustrated by Annie Lou Chester

It used to be that I didn't like reading certain types of science fiction. The emphasis on technology was too intense; machines were humanized, humans were mechanized. Boundaries faded and left me feeling chilled.

Now I don't like reading certain types of

medical literature. The emphasis on technology is too intense; cells, genes, body parts are elevated, humans are incidental. Boundaries fade and leave me feeling chilled.

The window between the worlds of science fiction and science practice are blurring.

Remember the breeding equipment in *Women on the Edge of Time*?

...seven human babies joggling slowly upside down, each in a sac of its own inside a larger fluid receptacle. ...

All in a sluggish row, babies bobbed. Mother the machine. Like fish at Coney Island. Their eyes were closed. One very dark female was kicking. Another, a pink male, she could see crying. Angrily they drifted in a blind school.<sup>1</sup>

That image left me distraught, but the robbing women of pregnancy seemed remote ... it was simply science fiction.

Contrary to popular sentiment the womb is a very dangerous place - hazardous environment. The glass womb will offer a much safer and more easily monitored container for fetuses, a place where they can be more easily manipulated for treatment and evaluation.<sup>2</sup>

I wrote ethicist Joseph Fletcher in 1974. Another commentator recently pointed out that birth defects among machine-gestated babies may be reduced, since 'artificial wombs do not smoke, drink

alcohol, contract German measles or fall down stairs.'<sup>3</sup>

*The biologist ... Hadn't he said it might someday be possible to open an embryo supermarket? A woman would choose a frozen embryo, genetically unrelated to herself, and bring it to an obstetrician who would implant it in her body.*

*Eventually that will happen, he replies ... He had spoken then of quality control in the breeding of human beings ...*

*'But if we cull down the lazy type that is not interested to contribute to society, I think we have done a great deal. We do that in race horses and in farm animals.*

*... I remind him of his comment. When will the selection begin?*

*'Eventually,' he says. 'Eventually.'*<sup>4</sup>

*'Then we will have to go to human implantation of the cloned fetus. ... we will be able to plan our future. If we need road builders, we can clone fifty or a hundred for this purpose, train them from infancy, and send them out to fulfill their destiny. We can clone boat builders, sailors, send them out to sea...'*<sup>5</sup>

Both science fiction, you say?

Wrong. The first of these quotes is an excerpt from Gena Corea's *The Mother Machine*, describing a talk with a living scientist. The second quote is from science fiction. Who could ever think seriously about cloning individuals to fulfill specific jobs? Real live Joseph Fletcher, that's who. He has written about the desirability of perhaps cloning people whose ear structure is impervious to high-decibel sounds, making these people ideal for space flights and high altitude flights. Corea tells us that Fletcher does 'not speculate on what societies would do if the clones, as adults, did not want to be pilots.'<sup>6</sup>

Dr. James Bonner has discussed a suggestion to

*remove genetic material from each individual after birth and then promptly sterilize that individual. During the individual's lifetime, records would be kept of accomplishments and characteristics. After the individual's death a committee decides if his accomplishments are worthy of procreation. If so, some genetic material would be removed from the depository and stimulated to clone a new individual. If the committee decides*

the genetic material is unworthy of procreation, it is destroyed. The question indeed is not a moral one but a temporal one. When do we start?

What happens to women in a future filled with artificial wombs and cloning?

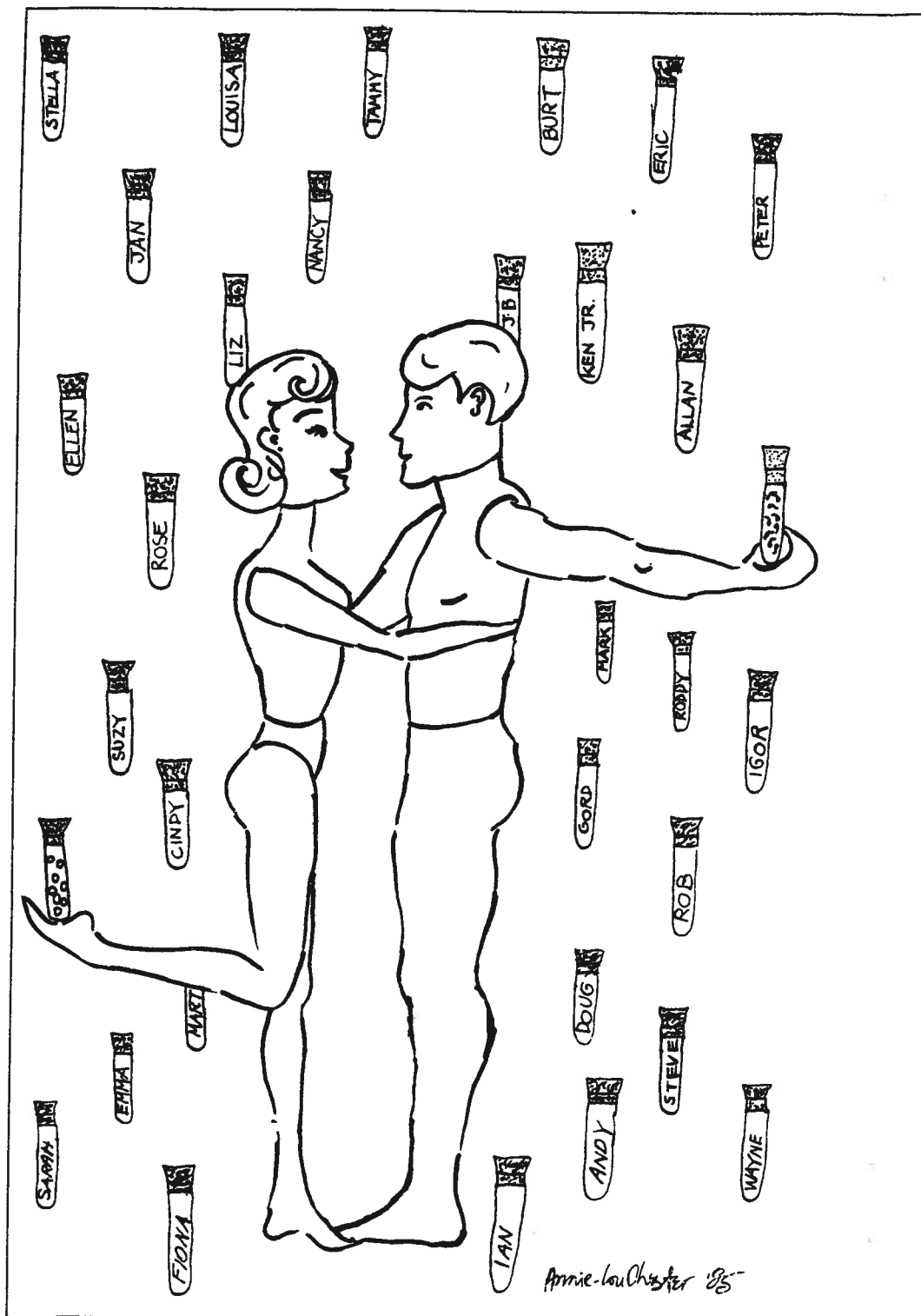
Four times they had put her in the breeders' hospital ward and installed a constant temperature gauge, and when the temperature was right, Nurse had come in with her tray and said cheerfully, 'Let's try again, shall we, Molly?' And obediently Molly had opened her legs and laid still while the sperm were inserted with the shiny, cold instrument.<sup>8</sup>

That, unfortunately, is a realistic sounding quote taken from the science fiction. Are you beginning to understand why I have increasing difficulty distinguishing fictional literature from comments without fictional intent?

In our real world, we might wonder why women would consent to be hosts for clonal implants. Dr. James Watson, Nobel Peace Prize winner and co-discoverer of the structure of DNA, illuminates this point. He has said, 'the boring meaninglessness of the lives of many women would be sufficient cause for their willingness to participate in such experimentation, be it legal or illegal.'<sup>9</sup>

And if artificial wombs might one day gestate fetuses, why shouldn't men? 'He was an unlikely looking man to be a mother: tall, with a bushy brown beard and long hair, stolidly and solidly male,' begins *The Man Who was Pregnant*, a short story by Elizabeth A. Lynne. This one is purely fiction: 'In the eighth month his breasts began to grow and ache and his cock to shrink. He understood: his body was making a pathway for the baby.'<sup>10</sup>

Yet in 1983 doctors were discussing in a Canadian courtroom the feasibility of men carrying



children. World famous geneticist Jerome Lejeune

told the court human embryos rely on their mothers only for shelter and sustenance. He said a fetus is so independent it could be implanted in a man's abdominal cavity and grow to maturity.

In fact, Regina physician Donovan Brown said a male child-bearer might have less trouble than many women experience.

'It could be done,' Brown said. ...'It's more simple than a Caesarean section. You don't have to open the womb because it's there sitting on the abdomen wall

## Nightmare

I'm shopping with my husband. My husband's name is G.I. Ken – tall and muscular, a bit rough but kind underneath. You might have met him when you were just a child. My name is Barbie.

I'm soo thrilled Ken is shopping with me. He doesn't usually, of course. I, on the other hand, love shopping – you should see my wardrobe. And just last week I had the most gorgeous wall paper put up in the living room. It matches ... oh, never mind! Anyway, it's awfully pretty to look at as I sit with Ken on the couch examining this catalogue.

We're both blond and blue-eyed, so we're agreed we want a blue-eyed, blond baby. But beyond that we're not quite sure. Ken wants a boy, so I guess I do too. But, oh, I can't help thinking about all the adorable, little outfits I could buy for a girl.

Cookie and Joe, they live in the condo next door, their baby is four years old now. She's a doll! They bought from the same company and were really satisfied. That's why we got this company's new catalogue instead of somebody else's.

I know it's a bit old fashioned, but Ken and I have been thinking about having our own child. You know, to be the baby's natural parents as well as his loving parents. I just think it would be more meaningful that way. Maybe it was listening to my granny tell stories when I was a little girl. It makes me kind of nostalgic think-

ing about it. Holding my own little girl I'd know she was connected to my Granny – there's something special in that.

And this company offers a great deal. They'll send someone right out to our house to collect the eggs and sperm. And they guarantee a 70% first take. We even have the option, for only \$50 extra, of receiving weekly colour photographs of him while he grows in the tank. I think that would really help our bonding. The sales rep assured me parents love it. Yes, I'll tell Ken that's what I want to do.

Ah, but look at him. He's so caught up in reading the descriptions of available donors and surrogates and looking at the childhood photographs of the clones, he's practically forgotten I'm sitting here.

Ken. He's not perfect, you know. Oh, I love him, I truly do. But he is a bit slow sometimes – oh, just a bit. Maybe we could buy a clone of one of those Nobel Peace Prize winners. Or an actor with a beautiful smile. Or an Olympic athlete. All those rippling muscles growing inside *my* little babe.

Hmm, now that I'm thinking of it. Maybe I could hire the company to track down Beaver Cleaver, that little boy from next door. I really loved him first in grade four. Ken wouldn't have to know.

Ah, the possibilities are limitless.

'Ken, darling. I really think we shouldn't decide finally just yet. Shopping is a real art, my dearest, I should know.'

sperm). Cloning is most often linked with duplicating famous *men*, not women.

*That part of the population which would use the artificial womb would not have to worry about illegitimacy or doubtful paternity.*

*For the first time it will be possible to prove beyond a shadow of a doubt that a man is the father of his children.<sup>12</sup>*

Funny thing. Reading that assurance does nothing to ease *my* doubt.

### Footnotes:

1. Piercy, Marge, *Woman on the Edge of Time* (Fawcett Publications, Greenwich, Ct.) 1976, p. 102.

2. Fletcher, Joseph, *The Ethics of Genetic Control: Ending Reproductive Roulette* (Anchor Books, Garden City, N.J.), 1974, p. 51 as cited by McDonnell, Kathleen *Not an Easy Choice: A Feminist Re-examines Abortion* (The Women's Press, Toronto), 1984, p. 112.

3. Corea, Gena, *The Mother Machine* (Harper & Row, N.Y.) 1985, p. 253.

4. Corea, Gena, 'Egg Snatchers,' in Arditti, Rita et al, *Test-Tube Women: What Future for Motherhood?* (Pandora Press, Boston, Ma.) 1984, pp. 42-43.

5. Wilhelm, Kate, *Where Late the Sweet Birds Sang* (Pocket Books, N.Y.) 1976, p. 132.

6. Corea, Gena, *The Mother Machine*, p. 263.

7. Bonner, James M.D., testifying before the United States Subcommittee on Health and the Environment, 1978, as cited in Murphy, Jane, 'From Mice to Men,' in Arditti et al, pp. 85-86.

8. Wilhelm, Kate, *Where Late the Sweet Birds Sang*, p. 117.

9. Corea, Gena, *The Mother Machine*, p. 264.

10. Lynne, Elizabeth A., 'The Man Who Was Pregnant,' in *The Woman Who Loved the Moon* (Berkley Books, N.Y.) 1981, p. 123 & 125.

11. Sutton, Robert, 'Men could bear implanted babies: MD,' *Toronto Star*, May 14, 1983, p. 3.

12. Grossman, Edward, 'The Obsolescent Mother,' *The Atlantic Monthly* 227 (5).

*Connie Clement, a member of Women Healthsharing, lives in Toronto. She admits to having a Barbie doll as a girl and to reading science fiction.*

*and it just pops out.<sup>11</sup>*

Consider these various technologies in combination and my nightmares in which mothers become obsolete seem less dreamlike. Thus far the only mammal cloning experiment to use adult cells used spermatogonia (cells that become

# MY STORY, OUR STORY

## To Amnio or Not to Amnio

Betty Burcher

*My story, our story is every woman's experience – our collective experience – with health.*

I always said if I were going to have a child it would be before I turned 35. That's the age when the biological time-clock starts ringing. Also, pregnancy and birth are riskier after age 35, and there is a higher incidence of Down's Syndrome babies. When I finally became pregnant a month after my 35th birthday, my partner and I knew we would have to face the question: to amnio or not?

I knew that amniocentesis could tell me whether the child I was carrying had Down's syndrome or certain other disabilities. But I also knew that the bottom line in deciding to have one meant considering the possibility of having an abortion at 20 weeks. I am pro-choice, and I work with women facing decisions about abortion. I know it is often an agonizing situation, one not undertaken lightly.

But I had questions. At 20 weeks you look pregnant, and feel the baby moving. Would I put myself on hold until I received the go-ahead? Should I tell anyone I'm pregnant until I'm past 20 weeks? Would I bond with the baby?

Here we are planning a non-interventionist birth with midwives and a sympathetic doctor. I'm aware of all the risks of technology at birth, yet I'm opting to use 'technology' during the pregnancy, and an invasive procedure at that. Despite all my reading, I couldn't get over my fear of allowing 'them' to stick a needle in my womb. It seemed an invasion of privacy to the baby. How could they guarantee the baby wouldn't move? Sure, they make an ultrasound to get the

position of the baby and the placenta, but there is still time elapsing before that needle goes in. I knew that at age 35 my risk of miscarriage from the procedure (1 in 200) was higher than the risk of having a Down's baby (1 in 350). Would I be that one in 200? I knew, too, that the fetus had primitive neurological reflexes at 16 weeks. Would this baby need primal therapy because of the terror I subjected it to?

On the other hand, I didn't want a handicapped child. This would likely be my only child, and I wanted it to be normal and healthy. But so does everyone. The amnio results could only detect Down's, spina bifida, anencephaly, and a few other rare conditions. What about other handicaps? Having an amnio was no guarantee for a healthy baby.

Then I began to wonder if I was discriminating against handicapped people. Over the years I've worked with many developmentally handicapped adults and children. I enjoy them, I encourage their independence. But are they happy? Are they living to their full potential? Yes...but.... Then I remembered the Down's kids. They are so affectionate and happy and their potential can vary greatly.

I had to ask if this should be my decision, or society's? Was I being unduly influenced by the medical profession to have the test? And just who are we to decide who shall live and who shall die?

And what about other risks that we all face? There are severely deformed 'jellyfish' babies being born on some Pacific islands because of U.S. nuclear testing in the fifties and sixties. In the Love Canal area, abnormally high

numbers of babies have been born with birth defects. Who's to say I'm not living on radioactive soil, or that Three Mile Island won't occur at Pickering? These are risks I can't control.

But Betty, what have you been fighting for all these years? You have hope, a belief in a better world. Part of that includes the rights of handicapped people to live fully, and to be challenged to their full potential.

Then reality hit home one day when I was about 10 weeks. Maria, who is 45 and developmentally handicapped, came with her 75-year-old father to see me at work. She had been living at home, but now her parents were placing her in an institution, since they could no longer care for her. With sadness I realized that my ideal society might not be around when my child is 45. I too might be faced with a similar decision.

Basically in the end it came down to a recognition of the reality that this child is primarily my and my partner's responsibility. The work, time, energy and love is *ours* to burn, and I had to admit that I didn't want that extra work and heartache. So, with mixed emotions, we went ahead with the procedure. It wasn't as bad as I had anticipated. But waiting nearly a month for the results was very trying, because every day the belly was getting bigger and the kicks stronger.

I'm well into the third trimester now. It seems like a long time ago we got the results. We know that this child in my belly doesn't have Down's Syndrome. I still worry from time to time about all the other things that can go wrong, but probably no more than any other mother. We also know the sex, but that's a whole other My Story!

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*Betty Burcher, a former Healthsharing collective member, works as a primary care nurse in a Toronto community health centre. She is expecting her first child in mid-September, 1985.*



Debra Pilon

# Conception Without Sex

illustrated by Dawna Gallagher

Talk to an infertile woman in Canada today and chances are she will know a lot about in vitro fertilization (IVF), especially if she wants to have a baby. If she is determined to become a mother, IVF will give her a chance to bypass her blocked Fallopian tubes and become pregnant. But the chance she takes on IVF is like buying a lottery ticket that promises – *only* promises – a pot of gold. Many women are learning that even in the world of high tech baby-making, there are no quick fixes.

Since 1978, when the British medical team of Robert Edwards and Patrick Steptoe mixed John Brown's sperm with his wife's egg in a petri dish and then transferred the contents of that petri dish into Lesley Brown's uterus, the world of human reproduction has changed in profound – and some would say, frightening – ways. The birth of Louise Brown, the world's first 'test-tube' baby, caught the media's obsessive attention and gave new possibilities for childbearing to married couples who could not previously have children.

Since then, doctors and infertile couples have been frantically leap-frogging over each other to 'create' more babies. The media has egged them on (no pun intended) with sensationalistic coverage of beaming parents surrounded by proud doctors and a scoreboard mentality which keeps tallies of 'test-tube' babies born in various countries. But the reality of in vitro fertilization and of in-

fertile couples who see it is quite different.

About 10-15 per cent of the adult population in Canada are infertile. Most are married individuals who find they are unable to conceive after more than a year of sexual intercourse without contraception. When infertility is suspected, a man's sperm count is measured; if it is found to be 'normal,' then the focus of further investigation is the woman. About 600 patients visit the infertility/IVF clinic at Toronto General Hospital each month; the waiting list to get an appointment after a referral from one's doctor is at least two months.

Why is infertility increasingly prevalent? 'I think it's the changes in society,' says Dr. Jeremy Wong of Toronto General Hospital. 'When women are young, they spend time pursuing a career. And as one gets older, fertility tends to decrease.' Conditions such as endometriosis and pelvic inflammatory disease or PID (often caused by the IUD contraceptive) can cause damage to a woman's reproductive organs just at the time she decides she wants to have children. The most common reason for infertility among women is blocked Fallopian tubes – largely attributable to infections like PID and various sexually transmitted diseases.

Increasingly, the 'cure' for infertility is IVF. Canada's first IVF baby was Robby Reid born on Christmas Day in 1983 out of the Shaughnessy Hospital's IVF clinic in Vancouver. There are seven

IVF clinics in Canada: in Vancouver, Calgary, London, Hamilton, Montreal and Toronto (where there are two). All the clinics are booked to capacity. An Ottawa woman who applied early this year to the University Hospital in London, Ontario for IVF was told she would have to wait until at least April 1986 to become part of the program, although she has had all the required preliminary medical tests and is 'ready' for IVF.

According to Dr. Betty Poland, now semi-retired but formerly on staff at Vancouver's only IVF clinic, the success rate for IVF in Canada is about 15 per cent. Her colleague, Dr. Victor Gomel, the current head of the clinic, says the success rate is 20 per cent. Valerie Sasso, an infertile woman from Ottawa who has been looking into IVF for herself, was told by her doctor the success rate is 30 per cent. 'I think sometimes doctors aren't really fair in preparing patients for disappointment,' she says.

Toronto East General Hospital has Canada's most successful IVF program, if success is measured by the number of pregnancies achieved. Since 'The Life Program' – as it's called by Dr. Murray Kroach who is its guiding light – began in 1983, 43 pregnancies have been achieved through IVF. On May 17, 1985, East General celebrated its first IVF birthday – twins born a year earlier. At the time of that anniversary, the hospital's IVF program had produced a total of 10 babies, in-

### As a candidate for IVF, a woman should expect the following:

- From Day 2 to Day 7 of her cycle, she will be given Clomid (Clomiphene Citrate), a drug which 'fools' the pituitary gland into stimulating the ovaries for ovulation.
- From Day 3 until about Day 12 of her cycle, a woman is injected daily with pergonal, a drug to induce super-ovulation. Each vial of Pergonal (Menotropins) costs between \$50-\$75 and if a vial is not completely used in one day, the remainder must be discarded.
- From Day 13 onward, an IVF patient must report daily, on an outpatient basis, to the hospital where the clinic is located in order to provide blood and urine samples. Just before doctors estimate that ovulation is to occur, more drugs are administered to give the ovarian follicle a 'last minute surge' in helping it release an egg.
- Daily blood samples from the woman show when a luteinizing hormone is present in the blood. This indicates the ovary is ready to release an egg and the woman is

immediately readied for surgery called laparoscopy.

- Laparoscopy is performed under general anesthetic. Carbon dioxide is pumped into the woman's abdomen to distend it. Then, the laparoscope, a long tube with a fibre-optic telescope, is inserted into the abdomen, using ultrasound to help locate the ovary from which eggs are removed.
- Eggs extracted from a woman in this way (doctors call the process egg 'recovery' – as though the eggs had been lost) are not mature and must undergo 'capacitization' – a process of chemical reactions
- Sperm is mixed with the eggs in four or five petri dishes and each biological mass is allowed to begin the natural process of cell division. After 12-24 hours when the fertilized eggs have divided to at least an eight cell stage, they are introduced into the woman's uterus via a catheter.
- The woman must lie perfectly still for four hours after the eggs have been placed in her uterus. Then, she begins waiting to see if implantation – and the subsequent pregnancy that results from implantation – will occur.

the vagaries of women's hormones as the cause. Or consider the case of a friend of Sasso's who has tried three times to conceive with IVF. After the last unsuccessful attempt, doctors decided her entire reproductive system was being thrown out of whack by the artificial hormones she received as part of the IVF program.

What awaits women when they opt for IVF? Valerie Sasso is very well informed about all the steps along the way and she sums it up by saying women should be prepared to suffer 'tremendous physical and emotional stress during the entire program.'

Dr. Victor Gomel, however, says that 'there's no pain, really' during IVF. A microsurgeon who has kept up with the latest advances in infertility treatments by attending conferences around the world, Dr. Gomel talks about 'achieving controlled super-ovulation' and 'achieving pregnancy' in his women patients. He bristles at the suggestion that medical science is meddling with something it doesn't have much control over or much knowledge about – women's complex and delicately-balanced reproductive systems. 'Human beings have been tinkering with nature since the beginning of time,' he says. 'Aren't antibiotics tinkering with nature?'

The cost of IVF at Toronto General Hospital (and costs are similar across Canada) amount to: \$1,000-\$1,200 in laboratory fees; \$300 for laparoscopy (of which \$150 is paid by OHIP); \$100 for the embryo transfer (not covered by OHIP) and \$400-\$500 for drugs. Most people who attempt IVF have a drug plan in force which pays 80-90 per cent of their drug costs. Overall, IVF costs about \$1,500 per attempt.

'It's an awful lot of money,' says Sasso. 'But the chances of success are not any greater the more you try...and I guess you

cluding two sets of twins and a set of triplets (born in Saskatchewan but conceived at East General's IVF clinic).

Multiple births are a 'side effect' of IVF pregnancies because at least two and as many as four embryos are introjected into a woman's uterus in order to increase the probability of one embryo implanting itself. 'Mostly, there's no problem [with multiple births]' says Dr. Kroach. 'The women are happy to be pregnant and twins are not bad...,' Valerie Sasso agrees. 'If you tell an infertile woman she's going to have

twins, she'll say, "Great! I'll take as many as I can get".'

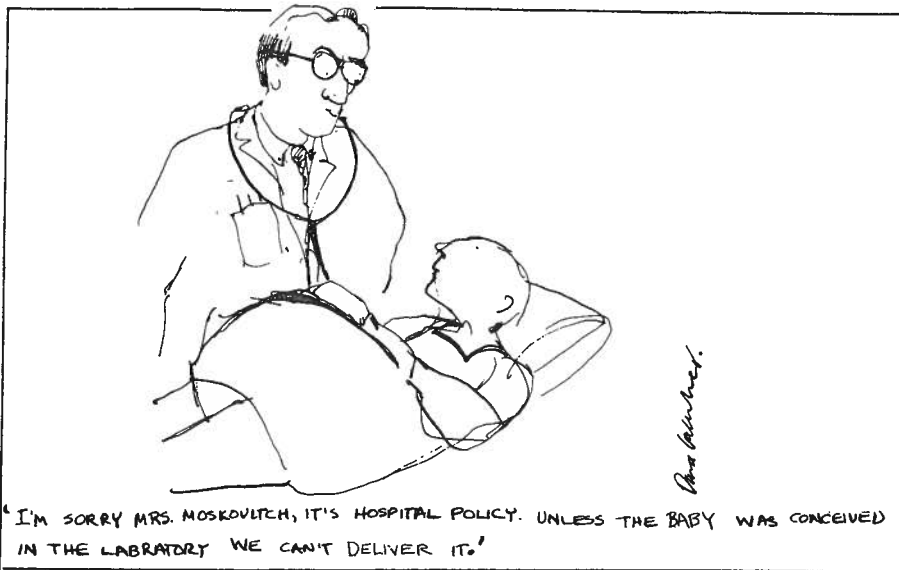
But Mother Nature is the variable that has intruded – often dramatically – into the best-laid plans for in vitro fertilization. One woman who has tried four times to become pregnant through IVF at the University Hospital in London becomes so tense when doctors try to transfer the fertilized egg into her uterus that they're unable to complete the procedure. In other cases, the fertilized egg simply won't implant itself in the lining of the uterus – doctors don't know why and invariably point to

have to ask yourself, how far are you willing to go?'

Those who opt for IVF must be prepared for hefty bills which include not just the cost of medical procedures but also transportation and accomodation costs incurred as a result of travelling to cities where the program is available. This puts the procedure out of the financial reach of many people. As well, most IVF clinics refuse their services to anyone but married, heterosexual couples by instituting psychological tests which label single women or lesbians unfit to participate on the grounds of increased stress or lack of support, either emotional or financial. Vancouver's Dr. Gomel is firm about this: 'We don't want to start with a controversy,' he says. In Toronto, Dr. Kroach says that, legally, the hospital cannot refuse people on the basis of marital status or sexual orientation but The Life Program prefers married couples or common law spouses.

IVF is undoubtedly a medical phenomenon which includes men as well as women. But for a man, taking a 'chance' on IVF involves much less trauma than a woman. In strictly medical terms, his role is limited to ejaculation.

This stark difference between the intervention required on women's bodies and the participation of men in IVF is a reflection of general obstetric/gynecological practice which almost always focuses on women's 'problems.' Yet the 'male factor' is responsible for infertility in 40 to 50 per cent of infertility cases, says Dr. Wong at Toronto General Hospital. Furthermore, doctors working with IVF are increasingly discovering that the fertilizing capacity of sperm is often too low to penetrate an egg in a petri dish, even in men with 'normal' sperm counts. Twice in recent months Dr. Wong says he has worked with male sperm that was 'so bad' that when it was placed 'right next to the egg,' it could not



penetrate the membrane for fertilization.

Why has medical research not concentrated on finding ways to make sperm a little zippier? Why are men who are part of infertile couples not being bombarded with drugs to make them 'achieve super-spermatozoa'? According to Dr. Peter Garner of Ottawa, 'we [the medical profession] haven't been able to investigate [the causes of infertility in] men.' An endocrinologist with a special interest in infertility, Dr. Garner says medicine has concentrated on women's infertility because 'we can't get sperm counts to increase.' Why not? Has any male scientist or medical researcher really tried to 'investigate' male infertility? Or is there an ingrained sexist bias at work which sends male researchers in search of 'solutions' in women's bodies, women's organs? As for easing the pain and reducing the need for surgery on women participating in IVF procedures, Dr. Garner believes the need for serial laparoscopy could be circumvented by removing a woman's ovary from her abdomen and implanting it in her thigh for easier access!

Ten years ago, before IVF was possible, infertile couples had to accept their infertility as a sad

reality, especially when they had still not conceived a child after three or four years of medical testing and intervention. 'People just had to somehow cope with that fact,' says Marie Morrissey who, along with Valerie Sasso, conducts a self-help program for infertile couples in Ottawa. 'But now, there's always something new and I think, yes, the new technologies open the doors for people to become obsessed [with having a biological child].'

Linda Williams, a doctoral candidate in the sociology department at the Ontario Institute for Studies in Education in Toronto, is writing her thesis on this apparent obsession. She is interviewing and studying people who have undergone IVF in order to understand their motivations. At a conference on reproductive technologies sponsored by the National Association of Women and the Law in Ottawa in February, 1985, Williams suggested a correlation between obsessive desires to procreate and traditional notions of masculinity and femininity. 'It seems that womanhood and motherhood are equated,' she said. 'And instead of providing technologies, maybe we need to redefine what manhood and womanhood are.'

The use of IVF has opened the door to charges that women are

being used as human laboratories in which new techniques can be perfected – techniques whose final purpose may not be to our liking.

Not many people know that the pioneering doctors behind Louise Brown's birth in 1978 were refused funding by the British Medical Research Council on three grounds: that their research into IVF presented possible hazards, that it had not been preceded by preliminary studies on primates and that it used laparoscopy for purely experimental purposes. An article entitled *Egg Snatchers* by Genoveffa Corea in *Test-tube Women*, outlines how Edwards and Steptoe were able to pressure friendly male gynecologists into 'bequeathing' to them eggs from unsuspecting women undergoing hysterectomies in order to continue their research. On at least one occasion, Edwards added his own sperm to these stolen eggs in an attempt at fertilization in a petri dish. Furthermore, neither doctor will reveal who funded their early research except to say it was 'private' funding which came primarily from the United States.

Since only 10 to 15 per cent of Canadians are infertile and since IVF is available only to a select group within that percentage, it's important to ask the question: why are hospitals allocating huge sums of money and considerable medical expertise to the development and implementation of new birth technologies? 'Probably the patient demand is pushing us,' says Dr. Kroach at East General in Toronto. 'Most doctors aren't usually adapting to new techniques so quickly.' The prominence of 'test-tube baby' stories in the media has had a substantial effect on patients, he says. Some of them are 'knowledgeable' people who pressure their doctors for the latest procedures. One might ask: since when have most doctors been influenced by 'knowledge-

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### Why hasn't the medical research concentrated on finding ways to make sperm a little zippiier?

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able' patients? At the lowest rung on the medical ladder, 'baby catchers' see in IVF a chance to hit the medical big-time. With conferences to attend, new procedures to try and public exposure for a job well done, it's no surprise that the obstetrician/gynecologist who wants to make a name for himself gravitates to IVF.

What might be described as a Tweedle Dum, Tweedle Dee relationship between infertile people and their doctors is, nevertheless, a complex one. The doctor offers hope which may never be realized; the patient offers her body and pins her hopes on the doctor. Along the way, she may or may not get pregnant. If she does get pregnant, she may have one child or she may have three. Whose interests are paramount in this kind of biological engineering: the woman's or her doctors?

IVF raises important social questions beyond the 'right' of an individual woman to bear an individual child. Without chastizing women for whom infertility is an unfortunate reality and for whom IVF may seem a liberating procedure, there is a need to examine the implications of IVF in terms of the present power relations between the sexes. As well, IVF should make us think about the future, which would surely be bleak if women were more deprived than they are today of any substantive say in reproductive matters. Should an artificial 'womb' ever be created which could sustain the fetus, there is the

ultimate possibility that women may become irrelevant to reproduction altogether except as egg donors.

Already technology is being proposed as the 'solution' to the abortion debate. Dr. Bernard Nathanson, a high-profile anti-abortion crusader from New York, has seriously proposed embryo transfer (first used as part of the IVF procedure) as a replacement for abortion. In his scheme women with unplanned pregnancies would have the unwanted embryo removed and placed either in the body of a woman who wishes to bear children, or in an artificial womb.

Some feminists have begun to raise the alarm. They have declared reproductive technologies to be the newest frontier on which women must fight for control of their bodies. In a chapter called *The Coming Gynocide* in her book *Right Wing Women*, Andrea Dworkin bluntly outlines her fears about the male power inherent in reproductive technologies such as IVF. 'All these reproductive intrusions make the womb the province of the doctor, not the woman; all make the womb extractable from the woman as a whole person in the same way the vagina (or sex) is now; some make the womb extraneous altogether or eventually extraneous; all make reproduction controllable by men on a scale heretofore unimaginable.'

Whether feminist or not, whether looking at IVF as a manifestation of patriarchal power or not, women must be aware of the spiral of possibilities that could lead to less and less control over when, how and whether we give birth. Only our vigilance and our voices raised as one will protect our birthright – the power to give birth.

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*Debra Pilon is an Ottawa feminist and writer.*

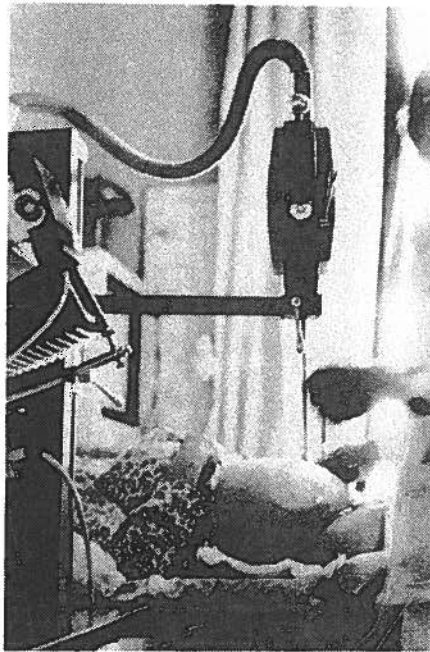


Dianne Patychuck

# Ultrasound: The First Wave

'Is it necessary?' More and more women in Canada are asking this question about ultrasound examinations, which are increasingly becoming a routine aspect of obstetrical practice. While there clearly are some valid medical reasons for obstetrical ultrasound, its *routine* use as a screening tool in pregnancy is not justified. Evidence is accumulating which raises questions about the safety of ultrasound for the developing fetus. Broader political analysis show that its use may be part of a multifaceted attack on women's rights.

The story of ultrasound is much like the history of other medical interventions in childbearing. Each new discovery promised safer pregnancies, less painful deliveries and healthier babies, but at the same time provided new ways for medicine to take greater control over the management of pregnancies. Of course we want to do everything we can to have healthy children. But like forceps, stirrups, and induced labour, the new prenatal technologies (ultrasound, fetoscopy, fetal surgery, and, on the horizon, artificial wombs) similarly exploit our concerns about having healthy children, and in the process take away our power. Our control over our bodies, over the protection of the fetus and over our experience of pregnancy itself is challenged by the way these technologies are being developed and used. Very much like the role played by fetal monitoring in labour and delivery, ultrasound



provides opportunities for medical monitoring and information collection which form the data base for the definition of new categories of high risk pregnancies, and thus for greater medical management and control of the pregnancy itself. There is not doubt that prenatal technologies can do many of the things they have been designed to do – but can they do them without driving a wedge between women and their future children?

## A New Tool and a Captive Market

Visualization of the fetus by ultrasound was first noted in the early 1960s. Within a decade, it had become an integral part of obstetrical practice. Heralded as a 'safe' alternative to harmful X-rays, ultrasound was welcomed by

parents and medical practitioners alike. In the 1970s and early 1980s, medical and nursing journals and patient pamphlets all carried the message that ultrasound was safe, and doctors reassured women that the examination would not harm their baby. This impression of safety opened the door to its widespread use. Hospitals and physicians began to increasingly rely on the data it produced for reassurance about expected delivery dates and fetal growth patterns. Women began to accept and expect the objective reassurance their doctors could now provide. In 1974, 15 per cent of pregnant women in the U.S. received ultrasound examinations. In 1984, the Canadian Medical Association estimated that 80 per cent of pregnant women in Canada had at least one ultrasound during their pregnancy.

Huge amounts of research funds and energies were directed into collecting and organizing the data generated by ultrasound to establish growth rate curves and other standards by which to categorize 'normal' fetal development. The subjects of this research were, of course, the women and fetuses who were exposed to the examinations as part of their obstetrical care, as specialists on both sides of the ocean collaborated on their findings.

In the race for profits, many new companies joined the medical supply, pharmaceutical and electronic companies already producing ultrasonic equipment for medical use. The market for this

## What Is Ultrasound Used For in Pregnancy?

Ultrasound examinations are currently used primarily for the following:

- to establish gestational age (between the fifth and 25th week)
- to detect abnormalities during early pregnancy such as ectopic pregnancy, congenital malformations, and threatened abortions
- to investigate vaginal bleeding
- to locate the placenta and ascertain fetal position when amniocentesis is to be performed
- to confirm abnormal fetal presentation
- to confirm multiple pregnancy
- to demonstrate fetal life
- to detect pelvic tumors
- to conduct fetal growth studies in the second trimester

While several benefits are claimed, the disadvantages and

possible dangers of ultrasound make its use as a routine screening tool highly questionable:

- its long term safety is unknown
- the early detection of conditions that resolve themselves spontaneously without intervention, creates needless anxiety
- diagnostic inaccuracy – false positives and false negatives have been reported
- because of the lack of equipment standards and the lack of information provided by the manufacturers about the dose intensity of the sonic beams, it cannot be assumed that any specific piece of equipment is emitting doses which are in the current presumed 'safe' range for the fetus.

Pregnancy itself does not constitute reason enough for diagnostic ultrasound. The following public health and professional organizations have all examined the evidence concerning biological

effects and have all recommended that ultrasound not be used routinely but reserved for cases when it is clinically indicated: the U.S. National Institute of Health, American College of Radiologists' Commission on Ultrasound, U.S. Food and Drug Directorate (FDA), United States Bureau of Radiological Health, American College of Obstetricians and Gynecologists, Society of Obstetricians and Gynaecologists of Canada, International Childbirth Education Association, and the Environmental Health Directorate of the Health Protection Branch in Ottawa. The consensus of these and other groups is that further clinical, laboratory and epidemiological studies are needed to accurately evaluate the long-term safety of ultrasound. Researchers at the University of Manitoba are currently conducting a long-term study of children who received prenatal diagnostic ultrasound.

equipment continues to be one of the fastest growing instrument markets of all time, expanding at a rate of 16 per cent annually.

Little research funding found its way into exploring the possible adverse effects of high frequency sound waves on the embryo or its developing organs. The technology was accepted and embraced by medicine without adequate prior assessment of its risks.

Throughout the 1970s, laboratory experiments demonstrated fetal abnormalities, fetal and maternal deaths in animal studies, and chromosomal and other abnormalities in human cell studies. This research remained largely hidden in the basic science and clinical research journals.

So it is not surprising that when a 1982 conference sponsored by the March of Dimes and Columbia University made public the evidence about biological effects, it fell on deaf medical ears. Hospitals, medical practitioners and

corporations had too much to lose. But the evidence could not be ignored. One radiologist at Albert Einstein College of Medicine in New York demonstrated that the cellular changes caused by ultrasound were comparable to the observations recorded by cell exposure to 250 chest X-rays. Public health and professional associations advised against routine use and recommended that it be reserved for situations in which it was clearly medically indicated. Despite these research findings and cautionary statement, routine use of obstetrical ultrasound is still increasing in North America. We have to ask why.

## Who Benefits?

One explanation for the increasing routine use of ultrasound is that it serves medical interests. For example, medicine's focus on the obscure, the new and fas-

cinating, the challenges and wonders of what medicine can do contrasts sharply with the relatively mundane reality of medical practice, and the involving, toylike nature of the new technologies helps compensate for this fact. Technology producers are sensitive to this attraction and incorporate practitioners' need to 'fiddle with dials' into the design and packaging of equipment.

With increasing specialization, many physicians have little actual contact with the equipment itself. But the information it provides fills another need. It is much more satisfying for a research, action-oriented practitioner to make a diagnosis or predict an outcome on the basis of 'objective' measurements than to sit back and wait for nature to take its course. This medical need to know what is going on inside the uterus is satisfied by the data which ultrasound provides. For one of modern medicine's greatest

ears is to be accused of 'missing something,' of not considering every conceivable possibility.

The bonding between mother and child, which ultrasound is believed to promote by its often impressive pictures of the breathing, swallowing, active fetus, must also have a similar impact on the attending physician. No longer dependent on the pregnant woman's reporting of her experience, obstetricians can now observe the mysteries of fetal life firsthand. In fact, a large part of the medical interest in controlling women's sexuality, fertility and reproduction can be explained by the fact that it allows men to participate in a realm from which their biology largely excludes them. The proud comments of practitioners after completing a complicated delivery and newspaper photographs of proud specialists presenting 'their baby' after a successful attempt at fertilization or implantation of an embryo, attest to this desire. These successful births are more than an affirmation of the skill, benefits and social need for obstetrical intervention in pregnancy. They also demonstrate the profession's ability to 'create' human life.

Ultrasound also opens the door into the pregnant uterus for economic benefit, increasing medicine's competitive edge in a contracting market. For while feminists argue that pregnancy and childbirth should be considered a natural life process controlled by women, medical science is fostering technologies which provide a seemingly objective basis for demonstrating the need for obstetrical intervention in *most* if not *all* pregnancies. The technology therefore legitimates medical power, providing obstetrical specialists with some leverage in a situation of increasing competition for patients due to a generally low birth rate, surplus of doctors in urban areas and increasing

consumer interest in woman-controlled alternatives such as midwifery, home birth, and out-of-hospital birth centres. These technologies also serve the research and status needs of medicine: there are reputations to be established, diseases to be named after, articles to be published, research contracts to be secured and promotions to be won, as well as money to be made.

Yet another benefit to medicine of the new prenatal technology is that it provides opportunities to save lives – those not yet born – at a time when medicine's ability to cure diseases which affect the living is shrinking. Chronic diseases such as heart disease and cancer offer some opportunities for heroic medical efforts but, by and large, these are not things conventional medicine can do much about.

The kinds of reproductive technologies being developed are consistent with what can be expected under a capitalist system. They are individualistic, invasive, heroic and require specialist intervention and supportive technology. They are not accessible to all, they blame the victim and the biggest risk is paid by the patient. They do not threaten business; in fact they create opportunities for investment, expansion, and profits.

### **Social, Ethical and Legal Issues: A Cause for Concern**

Part of the power of new prenatal technologies is that they meet perceived human needs. If fetal surgery can prevent serious brain or kidney damage, then why not perform it? If chorionic villi sampling (see *A Primer of Reproductive Technology*) can provide the earliest possible assessment of serious congenital anomalies then why not do it? If ultrasound can provide evidence of fetal abnormalities, multiple pregnancy and placement of the placenta, why

not perform it routinely 'just to be sure?' If an artificial womb could keep the premature fetus alive until its systems are mature enough to survive independent life, why not develop one? These are difficult dilemmas in a society which places a high moral value on new or potential human life. But some doctors, nurses, lawyers and ethicists are voicing concern that the technology is advancing faster than our ability to evaluate it.

Recent legal discussions and court decisions are setting some alarming precedents concerning who will decide what is best for the fetus. For example, Edward Keyserlingk, head of the Law Reform Commission's Protection of Life Project, argues that the courts should order amniocentesis and fetal surgery against parents' wishes, and that women should be held responsible for fetal effects related to their behaviour during pregnancy, such as smoking, alcohol consumption, medication use, and failure to seek medical treatment for infections. Critics of this position point to the hypocrisy of blaming women for the fetal effects of smoking and alcohol when the government collects millions of dollars in taxes from their sale.

We should ask whether we want to place our health at the whim of an ever-changing and expanding technology. Given that each new discovery or invention carries a risk to mother, fetus or both, how will decisions about interventions be made? Chorionic villi sampling can detect fetal abnormalities in the first trimester, and thus allows for earlier decisions to abort than does amniocentesis. But many of these would have been spontaneous abortions a few weeks later, if left to nature. Should women be expected to go through the personal trauma of *choosing* to abort, accepting that active personal responsibility and unnecessary stress? Another example is artificial wombs. The

development of this technology will allow the fetus to sustain life outside the womb at earlier and earlier stages, which will create serious dilemmas about what to do with aborted fetuses and whether they should be 'destroyed.' Clearly, science and technology alone cannot solve these dilemmas.

In contrast to all the hype surrounding prenatal technologies, there is a notable lack of government, corporate and medical interest in reproductive hazards in the environment and the workplace. Little if any support is given to women and men who refuse unsafe work and working conditions, and there is a lack of adequate legislation, regulation, inspection and enforcement in this realm. Industry is seldom held responsible for the health hazards it creates. Instead workers have to pay the price. For example, seven pregnant CP Air workers in Mississauga, Ontario had no recourse but to stay home, losing salary and benefits, while their poorly-ventilated office was recently painted with a substance known to cause embryonic damage. There is similar government neglect in ensuring the safety of ultrasound equipment, which can vary widely in the doses emitted.

## The Threat to Women

As women we receive contradictory information all our lives about our bodies. We are viewed both as the objects of male sexual gratification and as reproductive vessels. These conflicting social attitudes towards our reproductive functions are also seen in the high rates of battering of pregnant women, the design of maternity clothing which aims to hide the fact of pregnancy and the difficulty new mothers face in finding acceptable public places to breast-feed in. Yet while social attitudes towards pregnancy dictate that

women experience it as a *private individual problem*, the state and its institutions stand ready to intervene to protect the fetus *in the public interest* should a woman choose not to continue with the pregnancy. Current medical and legal discussions raise serious questions about women's right to control our bodies whenever a fetus or potential fetus is involved. Should we be forced by the capabilities of medical technology to undergo tests to evaluate whether or not the fetus is 'normal' by medicine's standards? Even if the occurrence of false positives and negatives can be greatly reduced in the future, does this kind of information increase our rights and freedoms, or will it be used to further control or prescribe our choices? Unaware of the implications, will we adjust our notions of what constitutes legitimate medical practice and submit to even greater social control during pregnancy? If we refuse to follow medical prescriptions for what is best for the fetus, will we be forced by the courts to submit to intervention into our uterus? What social and political priorities are behind this not so subtle attack on women's basic human rights?

In Canada today, women's struggle for control over our bodies, our health, our right to protect our physical and emotional integrity, has become a struggle of optimum importance. Women all over the country are questioning the need for routine ultrasound examinations and refusing them. The onus is on medicine to prove that it is necessary, and we must fight to exercise our choice as to whether or not we agree. We must restrain the temptation to do everything science and medicine say is necessary in order to ensure healthy babies, and oppose efforts to use the rights of the fetus as a way of discrediting our own knowledge and experience of pregnancy.

Prenatal technology is not

## How Does Ultrasound Work?

In the ultrasound scan, high frequency sound waves are sent into the woman's abdomen where they rebound from structures and surfaces at different rates depending on the density of these structures. On their return to the source the sound waves produce echoes which are transformed into electronic signals which can be converted to a graph or picture on a video screen. One type of scan produces a static picture or cross sectional view of the fetus. Another type of scan which emits rapid, pulsed sound waves produces a moving picture. A third type which uses continuous sound waves produces audio signals and is often used to monitor fetal heart tones.

neutral. History shows us that the development of new technologies and reproductive interventions have largely served the needs of the already powerful. Medical technology is a subtle but powerful weapon, because it promotes voluntary changes in attitude. Prenatal technology provides opportunities for considering the fetus as an individual with its own rights. This focus on fetal rights, by appealing to our concern for our children, may be a way of getting women to give up our hard-won rights. The health-promoting potential of prenatal technologies must be weighed against this potential for challenging women's right to control our bodies and our destiny.

*Dianne Patychuk is a researcher and writer whose main interest is the international politics of health and medicine. She has an extensive collection of resources on the adverse effects of ultrasound and can be reached at 100 Bain Ave., 46 The Oaks, Toronto, Ontario M4K 1E8.*



# REVIEWS

## Women's Rights and Women's Rites

**THE MOTHER MACHINE:**  
**Reproductive Technologies from**  
**Artificial Insemination to Artificial**  
**Wombs, Gena Corea, Harper & Row,**  
**New York [Fitzhenry & Whiteside,**  
**Canadian distributor], 1985, \$27.95**  
**Hardbound, 374 pp.**

Reviewed by Linda S. Williams

In 1978 the world's first test tube baby was born in England. Since that time, innumerable books, articles, and television shows have been produced about the new reproductive technologies (RT's for short). In spite of this glut of 'information,' what is almost always missing from these accounts is an analysis of what these new technologies will mean *for women*. Gena Corea has done all women an invaluable service by providing such an analysis in *The Mother Machine*.

Corea examines artificial insemination, embryo transfer, in vitro fertilization and related technologies such as sex determination, surrogate motherhood, artificial wombs, and cloning – truly a staggering array. She begins with a simple but crucial observation: the overwhelming majority of doctors and scientists who develop RT's are male, and the overwhelming majority of persons on whose bodies these men experiment are female. Given what we know about the existing power relationships between men and women in general, and between women and the medical profession in particular, what does this fact mean for women?

To answer this vital question, Corea uses two concepts borrowed from earlier feminist writers – the 'Foreground' and the

'Background.' The Foreground of any phenomenon is the surface reality that is presented to us by those who control it. The Background is the truths that lie behind the surface, and these may be entirely different from the Foreground.

The meaning of these abstract concepts becomes chillingly clear when we apply them to modern medicine and its latest invention, reproductive technologies. These technologies are presented to us as treatments for infertility or the prevention of genetic diseases, administered by doctors who claim to have our best interests at heart. These men speak glowingly of how RT's will increase women's reproductive 'choices' and produce 'better' babies. According to these men, since research is constantly producing new and better techniques, things can only get better! This is the Foreground of the new RT's, their surface reality.

However, if one views medicine as a possible means of social control, as Corea and most feminists do, the Background of these technologies is something very different. Corea points out that medicine, especially when allied with the state, can become a powerful means of social control, not just a source of healing. She believes that this is exactly what is happening with the new reproductive technologies – male-controlled, scientific procedures are being developed which will eventually allow men to almost completely control women's reproduction.

Corea is not the first feminist to make this frightening observation, but she is one of the first writers to present extensive empirical evidence to support it. Her research is thorough and compelling. She has spent years reading medical journals, monitoring the

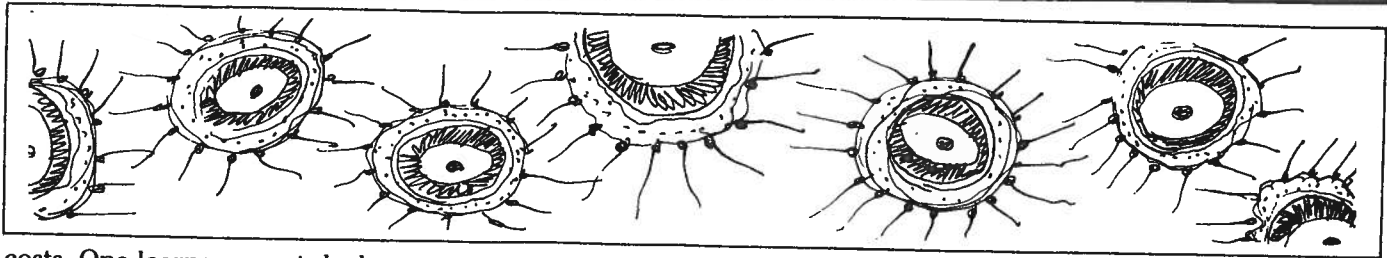
popular media, and actually interviewing many of the men (and the few women) who have played vital roles in developing RT's. These painstaking efforts have produced a volume which is outstanding in several respects.

First of all, Corea places RT's in their historical context. Contrary to popular belief, the research which led to these 'new' technologies actually had its beginning more than a century ago. The outcomes we are now seeing are just the end results of a long sustained effort. As part of this historical approach, she outlines in some detail how research on artificial insemination and in vitro fertilization in animals led directly to research on women. At first glance this might seem an unusual way to proceed, but it provides important insights into the attitudes of researchers, many of whom see little difference between experimenting on animals and experimenting on women. This is an important part of the Background which never emerges in public accounts of RT research.

Secondly, the sheer amount of factual information on the new RT's which has been brought together in one place is overwhelming. Not only is the development of each technology described, but also its physical risks and financial and emotional







costs. One learns a great deal about how these technologies work biologically. This book does not assume that the reader has a PhD in physiology nor does it descend on technical matters. Corea's writing style is clear and straightforward. The bibliography alone is a valuable contribution to feminist research, and a chronology of the development of RT's at the end of the book is useful and fascinating.

Corea also makes an important theoretical connection by examining the new RT's in the light of Mary O'Brien's theory of reproduction. (Mary O'Brien, *The Politics of Reproduction*). Unfortunately, space limitations do not allow even a brief outline of O'Brien's major premise, however, the linkage of Corea's research and O'Brien's theory is powerful and does much to increase our understanding of why men might wish to co-opt women's reproductive power.

*The Mother Machine* is an incredibly frightening and important book. Gena Corea has brought together empirical research and feminist theory in a way that exposes reproductive technologies for what they really are – powerful tools which may eventually allow men to completely control the reproduction of women. What can we do about this as women? Corea says that we must speak out, often and loudly – 'When many women break silence, when many women finally speak their truth, and speak it again and again and again, the world will have to change.' These are hopeful words, and Corea is guardedly optimistic. After one reads this book, it becomes absolutely clear that what little con-

trol we now have over our own reproductive lives is severely threatened. These are the stakes, nothing more, nothing less.

Read this book and start fighting.

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*Linda S. Williams is writing a doctoral thesis on in-vitro fertilization at the Ontario Institute for Studies in Education in Toronto.*

### **TEST TUBE WOMEN, WHAT FUTURE FOR MOTHERHOOD?**

Rita Arditti, Renate Duelli Klein and Shelly Minden (ed), *Pandora Press, London, 1984.*

#### **Reviewed by Somer Brodrigg**

This thoughtful and urgent collection explores the power relations structuring human reproduction. The recent development and use of biomedical techniques is placed in the context of the worldwide devaluation of women. Previous feminist writing has exposed the medicalization of childbirth, what Adrienne Rich called 'the theft of childbirth' from women. *Test-tube Women* illustrates how the use of new genetic technologies and experimentation extends and continues that process. As contributors to this volume point out, women do not control pharmaceutical companies, medical training or reproductive engineering units. However, the editors hope to take action by initiating 'international exposure of the policies of reproductive technologies.'

A plurality of voices and experiences enriches the collection. There is a willingness here to confront and struggle with difficult

issues, although diversity is never reduced to divisiveness. Various issues are highlighted: infant mortality, midwifery, cloning, surrogacy, egg farming, prenatal feticide, family planning policy in India, and sterilization abuse. The need to recognize all women's experiences is central. Differences among women in terms of accessibility are confronted and the various implications of these biomedical techniques according to race, class, and age are suggested. At least one voice cautions against the outright rejection of technology and the new romanticization of childbearing and rearing.

However, that technology is a social institution currently reflecting a violent masculinist science, and dominated by white men living in industrialized countries is a concern echoed throughout the book. The collection stresses the importance of understanding how women's reproductive rights and choices are determined and created in a liberal democratic patriarchy which urges us to exert individual rights to consumer choice, but which resists women's collective control. The tension between regulatory protection of women, and individual preferences and choices is particularly relevant in the question of surrogacy. Author Susan Ince indicates in her article, *Inside the Surrogate Industry*, that before penetrating the surrogate industry, she had 'no substantive answers to the questions of proponents: what's wrong with it, if that's what the women want to do? Are you against them making money? Are you saying the industry should be regulated by the state? The questions were naggingly familiar, the same ones

sked by apologists of the sex-buying industries, prostitution and pornography.' She exposes how the surrogate mother is portrayed as 'a happy hooker with a heart of gold,' and argues that we must reject a 'quiet liberal complicity with the new reproductive prostitution.' The dangers of an uncritical and unreflective acceptance of the use of these technologies are demonstrated when a chapter of the National Organization of Women endorsed surrogacy after meeting with an industry representative. In an analysis of the control of abortion K. Kaufmann also warns us, 'When the choices are not our own, what choice can women have?' Julie Murphy looks at egg farming and argues:

The benefits that reproductive technology extend to women in terms of ways to reproduce become suspicious when we realize that egg farming does not enable women to refuse to be reproductive bodies. What looks like personal fulfillment and occasional convenience for women, has, when placed in a patriarchal context, devastating implications for women.

None of the contributors remove a discussion of state regulation, and individual rights and choices from the context of masculine dominance in economic, social and political terms. It is this context which is shaping legislation and technology along the contraception/reproduction continuum, from infertility to fertility. The refusal to respect women's corporal autonomy in the question of abortion has implications for the control of the embryo transfer as Rebecca Albury points out in *Who Owns the Embryo?*:

The ownership of the embryo has profound implications beyond the often raised questions of frozen embryos in laboratories. If the ownership of an embryo in vitro is legally established, what will be the status of an embryo in vivo?



Meanwhile, in the lab....

Will a man be able to prevent an abortion because he is the joint owner of the implanted embryo regardless of whether a woman consents to continuing the pregnancy? Could a man take out an injunction to enforce a particular diet, non-smoking, or regular exercise on a pregnant woman as an expression of his concern for the care of his property – his share of the fetus? Such speculations reduce women to little more than ambulatory incubators, but are not as far-fetched as they might seem for men have already gone to court in attempts to deny women abortions in several countries.

Ince's experience as a 'surrogate mother' revealed to her that 'The careful screening process was a myth. I encountered no evidence of real medical or psychological safeguards, just enough hurdles to test whether I would be obedient.' These are the realities of women's lack of control under which we

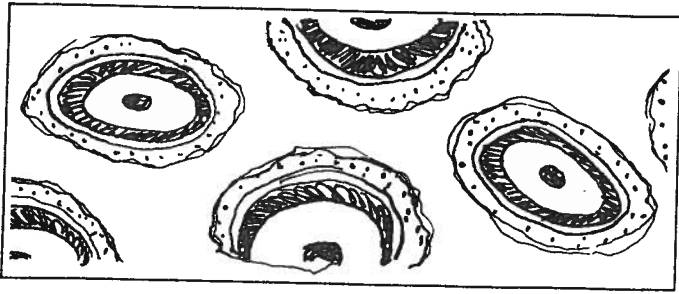
must contextualize medical promises of consumer choice. Robyn Rowland suggests that the right of women to bear children is the right that will ultimately be threatened by the masculinist use and development of these techniques. Nevertheless, the anthology's inclusion of women's rites in verse, myth and feminist dystopia turns this chilling expose into a confident call to attention. The opening piece, *A Yenga Tale* by Barbara Neely, promises that the resources we need, 'and the cave of the ones still exists and will be found by the women in the time when all else fails.'

Somer Brodribb is a doctoral student at the Ontario Institute for Studies in Education in Toronto.

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# LETTERS



In our spring, 1985 issue, for the first time in six years of publication, we asked readers to write us about a specific article. The response was wonderful. Many of the letters received about *Not the Oldest Profession: Two Women Talk About their Experience as Professional Patients* are shared here.

Next issue we will once again print letters about varied topics. Please don't wait for a specific call for letters...write us now.

## No Changes at U of T

I was a professional patient in the University of Toronto's 1983 fall program. My experience was similar to Michele's and Wendy's; I guess nothing has changed, except that we were advised to phone and reschedule if we began to menstruate unexpectedly; we were discouraged from teaching during our periods, probably because of the added discomfort and the small increased risk of infection. The pay is still \$30 an hour and each teacher works alone.

Every year at the end of the program there is a meeting so that the professional patients can make comments and recommendations. Last year I was the only one who showed up, and I had nothing to say because I felt insecure. After reading the article, I wish I had spoken up. Like Michele, I feel that teams would be more effective, and that there should be fewer students at a time, with more time spent on the emotional aspects of the pelvic exam. I also wish

there were nurses involved in the teaching. At this time I do not intend to sign up for another season; I'm disillusioned.

I had joined the program after a horrendous hospital birth experience at the hands of obstetrical residents; I was angry and depressed, and suffered nightmares of rape and torture for months. I vowed that I would do something, anything, to try and change the system so that another woman would be treated differently, humanely, by the next generation of doctors. I was naive. I'm sure I made no difference; how could I, an embarrassed and shaky-voiced novice with no paper degree, undo in 20 minutes what western authoritarian medicine engraves on medical students over the course of seven years?

*Aliss Terpstra  
Toronto, Ont.*

**Down There, Down Under**  
We read with great interest (and some disquiet) the in-

terview in *Healthsharing* (Spring, 1985) with Wendy Barrett and Michele Dore titled *Not the Oldest Profession*. The interview shows clearly that the pelvic examination teaching programs have the *potential* to be used against the women working with them, and thus against all women, through the reinforcement of patriarchal power relationships of which the doctor/patient relationship is archetypical.

We have been involved in a program for teaching pelvic examination for several years. The program (at the Flinders University of South Australia) has been a very positive experience for the team of women (Teaching Assistants or TAs) teaching within it, as well as for the medical students for whom it is the first exposure to the pelvic examination.

There are several features of the program which we consider to be responsible for its success – success both in terms of improving students skill as well as in its subversive aims of challenging medical assumptions about female passivity, about professional rights and about male/doctor supremacy.

Finally the program is largely controlled by the women who teach within it. We recruit TAs, organize their training, and decide upon the structure of the program and the emphasis that it will take. We are responsible for monitoring and evaluation of the program. This autonomy occurs with the full and active support of two senior medico's within the Department of Obstetrics and Gynecology who remain formally and financially responsible for the program.

The second important feature of the program is

that the issues of sexuality and of power that are embedded within the pelvic examination are acknowledged. A discussion of feelings and behaviours which result from these issues are discussed between the students and the TAs in as direct and non-threatening a way as possible.

Thirdly the central message of the program regarding respect for a woman's right to control over the examination situation is practiced by the TAs. We can, and will, require a student to stop an examination if either their attitude or technique causes us discomfort or distress.

Finally the ratio of TA to student is 1:1 so that no woman is ever required to have more than one examination in a single (two hour) teaching session. Payment is made at the instructor rate rather than as a patient body. This reflects a valuing of the skills and experience that the TAs bring to the program, rather than simply being the availability of a crotch.

*Margie Ripper and  
Carole Wiles  
Bedford Park, Australia*

## Comfort and Dignity

I am writing to you on behalf of the Clinical Teaching Associates (CTA) of the University of Manitoba. At a staff meeting we reviewed the article in your Spring, 1985 issue entitled *Not the Oldest Profession*, and we all felt that our program and experiences are so vastly different from the women interviewed that we would like to respond in the hope of effecting change.

We strongly believe that promoting a more positive attitude towards and about women on the part of healthcare professionals is

ital. Our program therefore stresses not only the teaching of clinical skills, but also the woman-as-patient perspective; respect for her comfort and dignity are paramount.

Our job includes both advocate/teacher and patient/teacher roles. Our sessions are unsupervised by physicians and include two medical students and two CTAs. We are planning on producing a video for use in medical schools.

The women in our program all feel good about our experiences. It is erroneous to say that the University of Toronto program which seems so terribly demeaning is patterned after the University of Manitoba program, as Michele seems to think.

We would like to network with other CTA programs across the country.

*Ruth Corobow  
Winnipeg, Man.*

### Well Women Teach

I have been involved in a Professional Patient program at the University of Calgary Medical School for four years. Our program incorporates several of the suggestions put forward by Wendy Barrett and Michele Dore to improve the program at The University of Toronto. Our founding mothers and the physicians they worked with to implement the Well Women Teaching Assistants Program, as it is now called, were all committed to ironing out all the perceived issues before the program started.

We work like this: a team of two Well Women (WW) receives a list of couples of medical students and arranges a mutually convenient meeting time of two hours duration; we meet at the Family Practice Suite in

the hospital and break up into pairs, one WW and one medical student practice interviewing; we then come back together and one WW demonstrates a gentle pelvic exam on the other WW; the students then have a chance to do the pelvic exam on each of the WW. At all times the WW are the teachers. The situation mimics a real clinical setting in that the student must develop a rapport with the woman she/he is examining. The feedback we get from the students is very positive and we have yet to run into anyone who treats us with disrespect.

Besides wishing to improve the skill of physicians in caring for women as far as pelvic examinations go, my personal agenda with the students includes a discussion of care in childbirth because I am a midwife.

*Jan Teevan  
Calgary, Alta.*

### Organizing for Change

While agreeing with each criticism of the professional patients program discussed in *Not the Oldest Profession* (Spring, 1985) we found it interesting to see how different our perspective on working within the program is. Ironically, as midwives we have been proudly claiming to be in actual fact the oldest profession, and our daily work involves dealing with the sexism of that younger profession, medicine.

As labour coaches and patient advocates, we are used to entering a system we have not designed nor have formal input into. We are struggling both to help individual women give birth with greater control and dignity, and to make wider political changes in obstetrical care. Perhaps we

have become desensitized through constant exposure or perhaps we have been encouraged by the progress we have seen while working in this way. But for us, teaching in the professional patients program has been an extension of this approach.

We have probably continued to find participation in the program useful because we have a specific hidden agenda – when the students ask why we work in the program, we explain that we are midwives. This frequently leads to an extensive discussion of everything from the politics of obstetrics to the management of labour, to how to deliver a baby without an episiotomy. We often meet the students we have taught later on the labour floor and have found they treat us with increased respect.

The program obviously has serious problems, typical of the whole medical system. Given the difficulty in funding an independent feminist-controlled teaching program at this point in time, it seems obvious that our criticisms might be most effectively answered by organizing the women working as professional patients to press for changes as a group.

*The Midwives Collective of  
Toronto*

### Work Respected

I am writing in response to your article on *Not the Oldest Profession* (Spring, 1985). I spent one year as a Gynecological Teaching Assistant (GTA) at Queen's University in Kingston, and fortunately my experiences were quite different to those described in your article.

The physician/professor overseeing the program, Dr. Paul MacKenzie, clearly viewed our work respect-

fully, valued and incorporated our input and was responsive to any problems that arose.

The structure of the program at Queen's was such that during one afternoon a week, two GTAs would work with three students explaining the reasons for the program, demonstrating the pelvic examination and discussing different aspects of the doctor/patient relationship. At no time would any woman have more than three pelvic exams a week.

It was made clear to the students in their class by their professors that we, the GTAs, had final say on how to do the examination and our expertise should be respected and accepted.

The informal but informative interaction we had with the students allowed us to discuss many ethical aspects of the doctor/patient relationship, particularly pertaining to women's healthcare. While most students were obviously nervous at the beginning of the class, the approach offered certainly helped to create a strong learning environment. Over the year, I can only think of two or three students who did not leave expressing strong gratification not only for being given the opportunity to learn to do the pelvic exam in this way, but also for having the chance to discuss many issues pertaining to healthcare not raised in their other classes.

I have had several teaching jobs at universities, and can say that this was one of the most rewarding both in terms of what I feel I offered the medical students and in the reward I felt for having taught something important in a worthwhile way.

*Paula Rochman  
Toronto, Ont.*

# Resources & Events

## CRIAW Conference

The Canadian Research Institute for the Advancement of Women (CRIAW) will hold their annual conference Nov. 8-10, in Saskatoon. The theme is 'Women: Social and Physical Isolation.' Sessions will focus on both the phenomenon and the experience of isolation, and on ways to end women's isolation.

For further information, contact Betty Pepper, Conference Organizer, 842 University Ave., Saskatoon, Sask. S7N 0J7, (306) 242-0081.

## Disabled and Elderly Travellers

*Handi-Travel* is a comprehensive travel guide for people with disabilities affecting their mobility, hearing and sight. Written by Cinnie Noble, an expert in travel for the disabled, it provides detailed information on transportation by air, rail, bus and ship - both in North America and overseas.

The book costs \$9.95 and is available from the Canadian Rehabilitation Council for the Disabled (CRCDD), 1 Yonge St., Suite 2110, Toronto, Ont. M5S 1E5, (416) 862-0340.

## Tour India and Nepal

A women's study tour of India and Nepal led by Fran Hosken, editor of Women's International Network (WIN) News will be taking place March 3-22, 1986. Travelling to Delhi, Ahmedabad, Jaipur, Agra, Varanasi, Calcutta, Kathmandu and Dhulikhel, travellers will visit schools, health clinics, orphanages and women's groups as well as seeing many classic Indian sights

and attractions.

The trip, leaving from New York City will cost US \$3365 and includes all land and air travel, deluxe or first class hotel accommodation, entrance fees and daily breakfast and dinner.

For reservations contact Odyssey Tours, 1821 Wilshire Blvd., Suite 524, Santa Monica, Ca., 90403, (800) 654-7975.

## Violence on View

The Federation of Junior Leagues of Canada is holding a conference on violence against women, children and the elderly to explore causes, effects and possible solutions. The program will discuss government and community reactions to violence, how stereotyping, media, pornography and chemical abuse contribute to the problem, and strategies for action.

The conference is scheduled for Oct. 18-19, 1985 at the Chateau Laurier Hotel in Ottawa and will cost \$150 plus an additional \$70 for hotel accommodation. Contact Judith Dowler, Junior Service League of Ottawa, 1414 Eastcliffe Way, Gloucester, Ont. K1B 5H6, (613) 990-8568 or (613) 746-2428.

## WCREC Anniversary

The Toronto Women's Counselling Referral and Education Centre (WCREC) will be celebrating its tenth anniversary on Nov. 8-9 by holding two days of workshops and an evening celebration dance. Daytime workshops will be offered under four themes: identity, empowerment, creativity and relationships. Hogie Wyckoff, well-known feminist therapist and

author of *Solving Problems Together* will be the keynote speaker.

For further details call Gwen Roe at (416) 534-7501.

## Psychiatric Inmates and the Charter

*Phoenix Rising* - a rights advocacy magazine for the psychiatricized - has published the first major analysis of the potential effects of the Canadian Charter of Rights and Freedoms on psychiatric inmates. Published in August 1985, the authors explore issues such as the equality clause, psychiatric inmates' right to vote, involuntary committal, forced treatment, the right to refuse treatment and review boards.

For copies, contact Phoenix Rising, P.O. Box 7251, Station A, Toronto, Ont. M5W 1X9, (416) 699-3194.

## DES: An Uncertain Legacy

This new film from Studio D is an in-depth study of Diethylstilbestrol, better known as DES, a synthetic form of the female hormone estrogen. The film examines the development, marketing and medical consequences of DES, which was widely prescribed between 1941 and 1971 to prevent miscarriage. Focusing on Harriet Simand, co-founder of DES Action: Canada, the film also looks at health consequences among daughters and sons of women who took DES.

The film, directed by Bonnie Andrukaitis, will premiere across Canada in October and November. Check with your local National Film Board office for further information and to encourage showings. The film, approximately one hour in length, can be borrowed free of charge in 16mm, rented in video, or purchased in either 16mm or video format.



## Unity Through Diversity

The Alberta Status of Women Action Committee (ASWAC) will be holding their annual conference Nov. 22-24. The location has not yet been finalized.

Workshops will be held to discuss ideas, issues and organizing, focusing on themes such as reproductive technology, native women's rights and sexual harassment. Organizers hope also to highlight women's culture with artwork, music and theatre.

For further information contact ASWAC, P.O. Box 1573, Edmonton, Alta. T5J 2N7, (403) 424-3073.

## Women's Image in Media

A 223 page study, *Sex Role Stereotyping: A content Analysis of Radio and Television Programs and Advertisements* has been released by National Watch on Images of Women in the Media (MediaWatch) Inc. The broadest comparative study to date on the problem of sexism in Canadian radio and television programming, it provides a detailed analysis of sexism in public affairs shows, situation comedies, open-line shows and advertising.

The report contains information gathered from every province and territory during two separate time periods of media monitoring in 1980 and was designed in part for the Canadian Radio and Telecommunications self-regulation hearings on sex-role stereotyping held in September 1985.

The report is available from MediaWatch, 202-636 West Broadway, Vancouver, B.C. V5Z 1G2, (604) 873-8511.

It costs \$25 for the full report and \$12 for the synopsis which is available in French and English. A discount rate is available for women and students. Include an additional \$3 for postage.

## Family Guide to Sexuality

Planned Parenthood Nova Scotia and Health and Welfare Canada have co-produced *The Parent Kit: A Family Guide to Sexuality Education*. The kit, which fits in a briefcase, provides step-by-step instructions and materials for seven workshops. Topics explore sexuality, communication, values, teen pregnancies, sexual abuse. The kit includes books, audio tapes, overhead transparencies, community resource guides and an annotated bibliography.

Thirty kits are available for loan with the user paying only transportation costs. Nova Scotia residents have first preference. Two kits are located at each of the five Planned Parenthood-N.S. affiliates. Contact Mary Hamblin, Planned Parenthood-N.S., P.O. Box 1206, Halifax North, N.S. B3K 5H4, (902) 455-9474.

## Directory for Women in Conflict with the Law

The Ministry of the Solicitor General has released a comprehensive listing of existing programs and services for women in conflict with the law in Canada. Approximately 800 organizations are listed including information on the scope of their programs and the range of clients served. Programs which provide direct services are listed as well as those intended to educate the public. Information is also given about groups that lobby on behalf of women in conflict with the law.

The document is available in French or English from Sheila Arthurs, National Program Consultant, Women in Conflict with the Law, Solicitor General of Canada, 340 Laurier Ave. W., Ottawa, Ont. K1A 0P8.



## THE HEALTHSHARING BOOK

*Resources for Canadian Women*

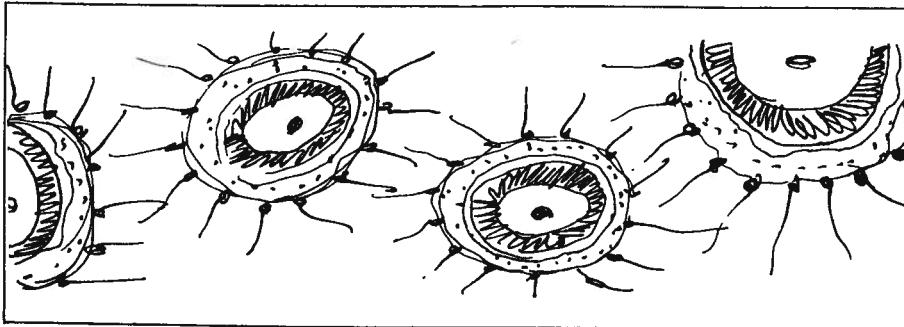
Edited by Kathleen McDonnell  
& Mariana Valverde in conjunction  
with *Healthsharing Magazine*

A must for every woman, library and resource centre, this guide includes articles, annotated listings of organizations across Canada, bibliographies of reading matter, and audio-visual materials. Subjects covered are childbearing, aging, eating disorders, drug and alcohol abuse, fertility, sexuality, therapy, violence, menstruation, menopause, occupational and environmental health, cancer, DES and disabled women.

\$9.95      200 pages



# THEMATIC RESOURCES



## **Humana Press Books**

Two companion volumes, *Birth Control and Controlling Birth* and *The Custom-Made Child?*, cover a wide range of new reproductive technologies from various feminist perspectives. The presentations arose out of a U.S. conference held in 1979 and include some of the more spirited debates on the ethics of sex pre-selection, in vitro fertilization, ectogenesis and gene manipulation.

The books, both edited by Helen Holmes, Betty Hoskins and Michael Gross, are published by The Humana Press, Clifton, N.J., 1981.

## **Women & Reproductive Technology**

The organization Women and Reproductive Technology (WRT) is a sub-committee of The Committee for Responsible Genetics, a U.S. organization set up to monitor developments in genetic technologies. Established by feminists active in health and technology, WRT focuses on the impact of new reproductive and genetic technologies on women's lives. They are especially interested in acquiring

information about women's personal experiences with new reproductive technologies and collecting resource information.

Contact WRT, 5 Doane St., 4th Floor, Boston, MA. 02109.

## **New Conceptions**

This is a consumers' guide to the maze of new reproductive technologies. It includes information on emotional and physical hazards of infertility and a very readable discussion of social, medical, ethical and legal problems. Written for a U.S. audience, much of the book pertains well to Canadian readers.

The book, authored by Lori B. Andrews, is published by St. Martin's Press, New York, N.Y., 1984.

## **Infertility: Facts and Feelings**

This national information and self-help organization deals with infertility and related issues. The organization publishes a newsletter and is organizing local chapters across Canada.

Infertility: Facts and Feelings can be reached at 639 Petrolia Rd., Downsview, Ont. M3J 2X8.

## **Artificial Insemination Booklet**

This packet is a collection of articles which cover the medical and legal aspects of donor insemination.

The packet is available from the Lesbian Mothers National Defense Fund, P.O. Box 21567, Seattle, WA. 98111. Cost is \$3.00 (U.S. funds).

## **Self-Insemination**

This is a how-to pamphlet on self-insemination written by a group of British feminists.

The pamphlet is available from the Feminist Self-Insemination Group, P.O. Box 3, 190 Upper Street, London, N1, U.K. Cost is £2.00.

## **Machine ex Dea**

This anthology contains several articles which touch upon issues of reproductive technology.

The book, edited by Joan Rothschild, is published by Pergamon Press, Toronto, 1983. List prices are \$27.50 hardbound, \$10.95 paper.

## **Human Artificial Reproduction**

The Ontario Law Reform Commission's findings in this area have just been published in the two volume *Report on Human Artificial Reproduction and Related Matters*. This report is likely to supercede all other provincial reports on artificial conception. It is essential, but dense, reading to understand what's coming in terms of law reform in this area.

Available from the Government of Ontario Bookstore, 880 Bay St., Toronto, Ont. M5S 1Z8. Cost is \$12.00.