WOMENS’ RIGHT TO HEALTH IN THE FACE OF NEW REPRODUCTIVE TECHNOLOGIES

Angela Aparisi Miralles, University of Navarra
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José López Guzmán
Angela Aparisi Miralles
Universidad de Navarra
España

Abstract

New reproductive technologies are based, to a great extent, on ostensibly coherent and articulate justificatory discourse, as well as on a concrete view of the woman. Certain assumptions are presented as axioms or “indisputable truths.” However, upon careful analysis it is revealed that far from being neutral or “real” facts, we find ourselves in the face of reductionisms, imprecisions, ideological constructs – clearly patriarchal – and even outright fallacies. Among them we can mention infertility being presented as the inability to fulfil oneself, the reduction of maternity to biological maternity, the consideration of infertility as an exclusively woman’s illness, and the likening of infertility to sterility. As a consequence, the woman’s human right to health is made vulnerable and violated.

Key words:

New reproductive technologies, woman, infertility, sterility, human right to health.

The first attempts at artificial human reproduction date back to the 40’s,¹ but it was in 1978 when British scientists Steptoe and Edwards were able to achieve the birth of the first

child to be produced in a test tube.\textsuperscript{2} Since then, techniques such as these have become commonplace, so much so that nowadays, they seem to be an undeniable reality. Mass media, unable to resist the sensationalist force of certain news has unwittingly, unscrupulously, but often effectively, helped in their spread and acceptance. Neither can the significant economic interests vested in the new technologies be ignored.\textsuperscript{3}

The present-day dissemination of these new technologies is also due to a “new pragmatism”: faced with whatever medical and technical possibility, the decision of the patient and the results of the action take precedence over any ethical principle.\textsuperscript{4} These factors, among others, have determined that these new reproductive technologies be introduced into Western societies with hardly any debate, or at least, the rigour that this would require. Other issues, perhaps not as transcendent, have been dedicated much more attention. Thus, very seldom do we find those who have delved into the logic that inspires these techniques, their premises and their consequences on the statute of human life, as well as the view of the woman and maternity upon which they are established.

Actually, the practice of artificial reproduction in Western societies has meant a radical change in the way the human being is understood. \textit{In vitro} fertilisation techniques radically separate human reproduction from sexuality. The human being is no longer conceived but \textit{produced} just like objects. The modern ideal of man’s stewardship over nature has been brought to an altogether different extreme. Here we have the clear topicality of the words of Saint-Simon who, brandishing the modernity slogan, asserted that man can and should “use nature as he pleases.”\textsuperscript{5}

Particularly, and insofar as to how a woman is contemplated, these techniques have been sustained on seemingly coherent and articulate justificatory rhetoric based mostly on a concrete view of said consideration. Such discourse is based on certain assumptions, presented as axioms or “indisputable truths.” Upon rigorous analysis however, we discover

\begin{itemize}
\item \textsuperscript{2} Steptoe, P.C. & Edwards, R.G., “Birth after re-implantation of a human embryo”, \textit{Lancet}, 2, 1978, p 366. It is interesting to take into account that way back in 1974, Edwards already affirmed, “in view of the vast numbers of foetuses and offspring arising through embryo transfer in animals, without evidence of any increase in number or type of abnormality, there seems to be no point in delaying the clinical application of work on human infertility” (\textit{Quarterly Review of Biology}, 49, 1974, 3-26).
\end{itemize}
that far from being “real” or neutral information, we find before us ideological constructs, imprecisions, or even outright reductionisms. We hold that questioning science and analysing the ideological, cultural, and social parameters and assumptions from where they originate is not falling into a new brand of obscurantism, but it is rejecting the idolatry of the same and appealing to the necessary exercise of reason.

In light of this, we seek to analyse some of these assumptions in this exposition, especially those in reference to the view of the woman, the focal point of these techniques. Likewise, we will examine the consequences that derive from these technologies, with emphasis on the woman’s body, and ultimately, her right to health.

1. Infertility as the inability of self-fulfilment.

The first premise we shall centre on is that new artificial technologies of human reproduction are diffused in the shadow of the message that sterility implies the woman’s inability of self-realisation. Sterility, seen as a “social disgrace” or a lack of femininity or womanhood in another time, is equated with unattainable self-fulfilment. In many cases, it is even presented as an impediment to carrying out any sort of family life project. Being unable to bear a child is not understood as the acceptance of the nature of a woman and the internal logic of conception per se, but as a failure of that woman who cannot conceive.

From this perspective, the desire to bear children is, for some, indisputably presented as a legitimate exigency for self-fulfilment. As Cambrón points out, “the impossibility (due

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6 This implies even the questioning of the widespread idea of the neutrality of science. As Marcuse asserts in his critique of Max Weber, through decisions of supposed scientific character, many times ideologies or forms of control are imposed. This author maintains:

“The concept of technical reason is ideology in itself. Not only its application, but the technique itself is control over nature and man, a methodical, scientific, calculated and calculating control. It is not that certain ends or interests of control are reconciled with the technique a posteriori and from the outside, but that they go into the very construction of the technical apparatus. In each case the technique is a historico-social project, where what a society and its predominant interests intend to do with man and things are projected” (Marcuse, “Industrialisierung und Kapitalismus im Werk Max Weber”, Kultur und Gesellschaft, II, Frankfurt a. M., 1965, cit. Habermas, J., Ciencia y técnica como “ideología,” (“Science and technology as ideology”) Madrid, Técnicos, 1992 (2ª), p 55).

7 See Héritier, F., Masculin/Femenin. La pensée de la différence, edit. Odile Jacob, París, 1996.
to sterility or infertility) to realise that desire would be lived as the ultimate biological disgrace.”

Even so, it should be underscored at the same time that our society is replete with contradictions about maternity. As Monagle points out, some infertile women subject themselves to *in vitro* fertilisation without any guarantees of success, at a very high emotional and physical cost, whereas other fertile women have abortions out of pure convenience. While in the former case bearing a child is an inevitable demand of self-fulfilment, in the latter the child poses an insuperable obstacle to the realisation of a life project. It seems that in both cases, we find the intention to transform desires or personal preferences, and subjective demands, into real and legitimate legal exigencies.

These are vivid examples of the present-day trend to unduly broaden the content of certain rights, which leads to the proliferation of demands that cannot be qualified as legal. This, in turn, generates an increase in conflicts of rights, which in the long term, jeopardises the very notion itself of human rights. The solution to this situation would be to reduce every right down to its essential, and at the same time true, content. In this sense, as regards cases of the maternity of postmenopausal women, Mariapia Garavaglia has pointed out that desires are not rights and that children are not consumer goods. It must not be forgotten that a child is a subject with its own proper entity and an unconditional ontological value. Therefore, the otherness of a child should always be safeguarded.

However, this reality is repeatedly denied on many occasions. As a matter of fact, many women who undergo artificial reproduction techniques do not accept the child unconditionally, but as a requisite for their own individual and conjugal realisation. This is confirmed once it is seen that for some, the attainment of *maternity at any cost* does not result in the sacrifice of human lives, those of the frozen or discarded embryos in the process of *in vitro* fertilisation.

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vitro reproduction. The desire to bear a child, “seemingly” a right, comes to justify the death of the other children, who are indeed deserving of true rights.

Along this line, many have denounced the fact that these techniques greatly desubjectify the child, since in the end, the child is seen as an object to be produced, whose entity as a subject is degraded. A woman who underwent these techniques manifested in a roundtable discussion on the desire to have a child: “If you want to live with a child, then you can take to adoption… but if you want to produce a child, which is my case, then adoption is out of the question.” 11

It is important to insist that a child is always another, one that is not produced to satisfy a need, but a life that is to be accepted in all its richness. We highlight the ruling of the constitutional court of the Supreme Court of Justice of Costa Rica dated 15 March 2000, declaring the unconstitutionality of the decree approved by the Code of Assisted Reproduction Techniques. In item IX it declares:

“The In Vitro Fertilisation and Embryonic Transfer Technique... is an outrage against human life. The human embryo is a person from the moment of conception, therefore it cannot be treated as an object, used for research purposes, subjected to selection processes, frozen for preservation; and it is fundamental for this Court that exposing the embryo to a disproportionate risk of death is not constitutionally legitimate.”

In contrast, many laws establish, such as what Article 2.5 of the Spanish law 14/2006 of 26 May pronounces on assisted human reproduction techniques for example, that the woman as receiver of these techniques can ask that they be suspended. The lives of the children produced in vitro therefore depend, solely, on the desire of the mother.

2. The reduction of maternity to biological maternity.

Secondly, the premise of the child as a requisite for a woman’s self-fulfilment rests, in turn, on a reductionist model of maternity: one is only a mother if she conceives. As Tubert\textsuperscript{12} reveals, even at this day and age we can observe the persistence of a cultural heritage that is, in fact, the premise on which \textit{in vitro} fertilisation is founded: the idea that biological maternity is the necessary realisation of femininity – that a woman is not really a woman if she cannot bear biological offspring.

It is necessary to bring to fore the reality that maternity is much more than a biological process. Furthermore, one can be a mother without having been so biologically. An infertile woman who desires to be a mother should not be left to choose only between being a biological mother and falling into despair. The solution is in knowing that her maternal sense can be developed, even if she is not a mother biologically speaking.

Some recent feminist theories have carried out a profound critique of the reduction of maternity to an exclusively biological dimension. Similarly, they have drawn attention to the incongruences of the technological mentality of “a child \textit{whatever the cost},” even risking their own very lives. Examining the modern biomedical model even further, they have emphasised that \textit{in vitro} reproduction technology ignores the necessary integral protection of the physical and psychological health of the woman,\textsuperscript{13} a point we shall return to later on in this exposition.

On the contrary, Levi-Strauss\textsuperscript{14} regards maternity and paternity to be, to an extent, cultural and not exclusively biological constructs. This author thus rejects the thesis proposed by Radcliffe-Brown, among other researchers, who maintains that the biological family is the starting point from which all society derives and elaborates its systems of relations. Conversely, a system of relations does not consist solely of biological ties, if not, it would be to a certain degree a human product. The nature of the system of relations would closely depend on the form of social structure. Undeniably, the human being is a biological reality, but at the same time is characterised by their capacity to create their own social setting. As Levi-Strauss\textsuperscript{15} affirms, among a person’s responses to internal and external situations, some correspond to that person’s nature and others to the person’s cultural context. Maternity and

\textsuperscript{14} See Lévi-Strauss, C., \textit{Las estructuras elementales del parentesco (The elemental structures of kinship)}, Paidós, Mexico, 1988, p 140 and ff.
\textsuperscript{15} Ibidem, p 35.
paternity are not, therefore, absolutely biological realities. Essentially, they involve a spirit of unconditional devotion, being responsible for the life of another. Maternity and paternity definitely come from the organic reproduction process, but are not reduced to it – other processes complement them. So, the one who defines and inserts a child into a social group as a subject loved in itself, and who is responsible for the child’s very life, is primordial.

3. The new artificial reproduction techniques, solution to the suffering caused by infertility.

Thirdly, in relation to the already aforementioned, it can be noted that the social discourse on assisted reproduction techniques quite often appeals to the sensitivity argument: it is legitimate to rectify the suffering caused by infertility.

Certainly, the existence of this suffering is a reality. We cannot ignore the pain that being infertile can mean for a man or a woman. Nevertheless, there are issues that must be raised:

a) First, these same techniques, as they pose the possibility of producing a child, engender demands that otherwise would not exist. Testard has said with respect to the advance of artificial reproduction, “couples who have practically forgotten their sterility recover their past procreative desires and sign up on rapidly saturated waiting lists.”

b) Second, despite the seeming benevolence of their desired aim (the elimination of suffering,) these techniques, in many cases, turn on those whom they were meant to help in the first place – most especially the woman, the principal recipient of these techniques. As is known, new reproductive technologies pose serious risks to physical integrity, to the point of threatening the life, of the woman. As a matter of fact, the logic behind these artificial reproduction techniques disregards the woman’s physical and psychological health. These are

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16 Testard, J., El embrión transparente (The Transparent Embryo), Granica, Barcelona, 1988, p 30.
significant questions that are clearly overlooked in the interests of the logic of results and success at any cost.

Although, it is remarkable that working from these assumptions, these new reproductive techniques cannot ensure the promised fruition of the great expectations they create. According to reports by the most prestigious centres in the USA and Australia, the average success rate of these techniques is situated at around 23%. Testard deems it indispensable to thoroughly analyse how these statistics are arrived at, since many patients who had undergone hormonal treatment but were not able to conceive are usually not included in these figures. There are also situations wherein mere conception, not necessarily resulting in live births, are considered successes, independently of whether miscarriages are produced, which incidentally is a frequent occurrence. This being the case, the success rate would be much lower. The cruel irony of it all is that while these reproductive technologies are sold as a miracle cure-all for all those women who cannot conceive naturally, only a small percentage of them will be able to conceive a child.

Accordingly, majority of women who resort to the new reproductive techniques will go just as they came: without a biological child. We can ask ourselves the following question: “In what situation are those women who have been failed by reproductive techniques left? Is the failure of these techniques the failure of their lives?

4. Infertility as pathology.

Fourthly, the appeal to the need to eliminate the affliction routinely linked to infertility as always being thought of as a pathology (whatever its cause may be.) As Cambrón points out, researchers and doctors have built a new discourse on sterility which, taking into account their categorisation of infertility as a pathology, “intends to legitimise the use of the same techniques and indirectly contribute the demand for children.” Under this assumption, the message is that we find ourselves before a treatment or medical therapy. This explanation, in

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great part, is what is used to legitimise the demand for the funding of these techniques by the public health system. In the explanatory preamble of the Spanish law 14/2006 of 26 May on assisted human reproduction techniques for instance, it states, “the appearance of assisted reproduction techniques means… the opening of new possibilities to solve the problem of sterility for a great number of couples suffering from this pathology.”

Furthermore, it is evident these new techniques are based on the premise that the inability to conceive a child is, basically, a woman’s pathology. And it is she who, de facto and in the eyes of the society, bears the burden and the disgrace of infertility. For centuries, cultural traditions have not permitted, much less even suspected, that the man could be sterile. The virility-fertility relation has been, and is, so strong that infertility has come to be equated with impotence. The influence of this assumption can be seen in poorly developed research in masculine infertility. What is more, in many cases of masculine problems, namely oligospermia and asthenospermia, it is the woman’s body that is directly treated medically, in the hopes of achieving successful results via the new reproductive techniques. This is what happens when these techniques are resorted to because the sperm cells, on their own, are unable to fertilise the egg cell.

But strictly speaking, can infertility indeed be considered a pathology? Surely this is an important issue, since its classification or not as such would depend, in great measure, on its qualification as an authentic therapy. This would then have its repercussions on its moral and legal legitimisation.

In spite of infertility always being presented as an illness as earlier mentioned, reality demonstrates that it is not quite so. The infertility attributed to the woman can be due to the deficiency or inability to ovulate, gestate, or be fertile. At the same time, this incapacity can occur unexpectedly, be congenital, or idiopathic. This last case refers to infertility without a known cause. It is important to note that this group comprises a third of the total infertility cases.  

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20 See Informe de la Comisión Especial de Estudio de la Fertilización In Vitro (Special Study Commission Report on In Vitro Fertilisation), of the Spanish Congress, 1986, p 51.
21 Cambrón, A., “Fertilización in vitro y agresiones al cuerpo de la mujer: una aproximación desde la perspectiva de los derechos” (“In vitro fertilisation and agressions against the woman’s body: an approach from the perspective of rights”), op. cit.
Sterility is indeterminate from a statistical and medical point of view. Notwithstanding, on that same indetermination and imprecision lies the justification of these reproductive techniques. Moreover, it can be added that the meaning of infertility itself is made to depend on the sophistication of the available techniques in the market. On this, Koch has this to say: "when a new reproductive technology is introduced into the market, the definition of infertility changes."\footnote{22 "...as each new reproductive technology enters the market, the definition of infertility changes" (Koch, L., "IVF- an irrational choice?", cit. Morgan, D., Issues in medical law and ethics, op. cit., p 73).}

On the other hand, it is clear that conception does not mechanically follow a human sexual relation. In the human species, myriad factors, among them psychological factors, come into play that make conception something that cannot be preordained. Because of this, infertility generally cannot be compared to an illness. It only becomes patent to the degree that there is a project to conceive. It is the impossibility, then, to satisfy a desire, due to very complex and diverse reasons.\footnote{23 Tubert, S., Mujeres sin sombra. Maternidad y tecnología (Women without Shadow. Maternity and Technology), Siglo veintiuno editores, Madrid, 1991, p 154.} It can be maintained therefore that save for very concrete cases, infertility is not as much a question of health as it can be a characteristic of the person.\footnote{24 Mori, M., La fecondazione artificiale: questioni morali nell’esperienza giuridica, Giuffre, Milan, 1988.}

Even in the event that sterility has a known pathological origin, artificial fertilisation techniques are never therapeutic. The technique applied does not intend, in any case, to cure. Rather, it is a “substitution of an interpersonal relation of procreation for a technical relation of the production of human beings.”\footnote{25 La familia, santuario de vida y esperanza de la sociedad (The Family, Sanctuary of Life and Hope of Society), Pastoral Instruction of the Spanish Bishops’ Conference, Palabra, Madrid, 2001.} The woman who undergoes in vitro fertilisation processes will end up as sterile as before she was subjected to the treatment. Additionally, in many sterility cases, promoting artificial reproduction techniques can indirectly result in a lack of interest and resources intended for basic research of the real causes of infertility. Presently, it can be verified that efforts in the study of the causes that bring about infertility are very few. On the other hand, proposing artificial reproduction as a therapy in light of a supposed illness could lead to the ignorance and neglect of the iatrogenic causes of the same (such as the use of intrauterine devices (IUDs), contraceptives, bad eating habits, environmental factors, etc., to name a few), disregarding the fact that prevention is, in many cases, the best treatment for infertility.
It is striking, however, that in the face of a purported “illness,” the response is an intense medical treatment of the woman, to the point of seriously endangering her. Many have even denounced the haste with which different techniques go from the experimental to the clinical phase. So much as a woman’s formal consent, with an impoverished knowledge of what is really going on, is all that is needed to permit her to be used as a willing test subject for new and sophisticated techniques whose side effects are yet to be determined. Anything and everything is fitting sacrifice on the altar of success, including the very health of the woman.

These new reproductive technologies not only are not therapeutic, but also for the woman they always represent an intense and progressive aggression. To illustrate, four phases, broadly speaking, can be distinguished in the application of the In Vitro Fertilisation and Embryo Transfer (IVF-ET) technique:

1) Hormonal stimulation, which consists of administering high doses of clomifene, with the aim of inducing ovulation. French biologist Testard – one of the most prestigious figures today in this field – has cast doubt on the use of this hormone upon finding evidence of its hazards. Added to its already known adverse effects are that it is contraindicated for patients with hepatic insufficiency, ovarian cysts, oestrogen-dependent tumours, undiagnosed vaginal bleeding, mental depression, and thrombophlebitis. Also, special precaution must be taken in concurrence with Polycystic Ovary Syndrome (PCOS), Ovarian Hyperstimulation Syndrome (OHSS), uterine fibromas, endometriosis, and vision disorders, since it produces aggravation. Currently, the similarity between clomifene and diethylstilbestrol, whose use is prohibited, is being studied.

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27 Clomifene: nonsteroidal sexual hormone (stilbene derivative) with partial anti-oestrogenic activity, impedes union of physiological oestrogens on a merely hypophysaric level, blocking the process of inhibitory retroalimentaion. This way it increases the secretion of gonadorelin and gonadotropins (Luteinizing hormone (LH) and follicle-stimulating hormone (FSH)) with consequent ovarian stimulation and increase in the production of oestrogens, which induces ovulation (Catálogo de Especialidades Farmacéuticas (Catalogue of Pharmaceutical Specialties), General Board of Spanish Pharmaceutical Associations, 1997, p 884).
Alternatively, the substances used to achieve follicular maturation are, basically, anti-oestrogens and gonadotropins. These are usually applied together with clomifene. Ovulation is then induced using human chorionic gonadotropin.\textsuperscript{28}

In reality, these hormonal treatments would be indicated for those women who have hardly or null ovarian activity. However, that doctors administer them to women who ovulate spontaneously, with the purpose of improving performance is not rare. Owing to this, some have called this use “therapeutic fury,”\textsuperscript{29} especially when these applications are still, in many ways, in their experimental stages since their side effects are still being studied. Among them is ovarian hyperstimulation, which usually results in polycystic ovaries.

2) Ovum extraction, in which different techniques may be applied. One way is to puncture the follicle with a needle, performing a laparoscopy on the woman under general anaesthesia. This allows the needle to be guided to the follicle, while through another abdominal incision forceps are introduced to brace the ovary. Another way consists of introducing the needle through the abdominal wall, guided by an ultrasound scanner and without general anaesthesia. Both procedures are not free of risk. Klein\textsuperscript{30} affirms that eighteen deaths of women who undergo an \textit{in vitro} fertilisation programme seem to be related to follicle puncture with the introduction of the needle through the abdominal wall.

3) Fertilisation of the ova that is subsequently transferred into the woman’s body. After mixing the semen with the ova and obtaining embryos, these are transferred into the uterus through the vagina by means of a catheter. Once the process has been carried out, the woman must undergo continuous tests to check embryo development.

4) Pregnancy, once the embryo is transferred into the uterus and nidation is achieved. Miscarriage is among the complications that can arise during this period. This possibility is two to three times more frequent than in normal pregnancies. There also exists an increased

\textsuperscript{28} Cambrón, A., “Fertilización \textit{in vitro} y agresiones al cuerpo de la mujer: una aproximación desde la perspectiva de los derechos” (“\textit{In vitro} fertilisation and agressions against the woman’s body: an approach from the perspective of rights”), op. cit. p 180.


\textsuperscript{30} Klein, R., Personal communication (cit. Tubert, S., op. cit., p 237).
probability of extrauterine pregnancies and multiple pregnancies.\textsuperscript{31} This is due to the fact that more than one embryo is usually transferred to the mother’s uterus to raise the chances of success. The problem arises when all or most of the transferred embryos manage to be implanted, implying a very serious risk for the mother.\textsuperscript{32} The usual response in this situation is known as “embryonic reduction,” a euphemism that envelops the abortion of those embryos considered to be “in excess.” Lastly, should the pregnancy come to term, delivery is usually by caesarean section.

It must be stressed that even when the cause of sterility is masculine in origin, such as the sperm’s lack of motility, the risk of treatment is made to fall on the woman. It is her body that bears the burden of the process. This produces an imbalance between the man and woman in the gestation process. The man always loses out, whether the sperm is his own or someone else’s. In the latter case, his position is relegated to that of a mere spectator of a process in which he plays no role. The maker or “creator” of the child would be the doctor whose instrument is the woman’s body.

In short, we can assert that the woman’s body is subjected to a high degree of manipulation when she undergoes these techniques. Her body is actually transformed into a public place, into a true “living” laboratory wherein all is fair in order to reach a set goal, identified with success. In this manner, a process such as the conception of a human being, which is naturally characterised by being situated in a strictly private and intimate setting, acquires an altogether public character. It is the woman who must psychologically assume this profound transformation of reality. Incapable of doing so, she experiences grave distress and anguish.

Numerous are the testimonies of women in this sense. Duelli Klein, in a field study on the situation of women who have stopped artificial fertilisation programmes without conceiving a child, confirms the existence of recurrent sentiments of abuse on the part of doctors, the lack of real information, including the “trauma of having been treated as living


laboratories.”\textsuperscript{33} This attests to the conviction that their bodies were converted, in some way or another, into tools, subordinate to the logic of success and production.

Artificial reproduction methods are not only an assault on the woman’s organic dimension, but they can also affect her psyche, because these techniques provoke and aggravate the schism between a person’s biological and psychological dimensions. Whereas in natural reproduction both dimensions are called to harmonious union, in artificial reproduction this integration is virtually impossible. A complete rupture from the natural way of conceiving arises. Conception is transformed into a process of production, and the biological is torn away from psychological. Women must dedicate themselves entirely to the process; they must radically subordinate themselves to a very concrete and reductive way of understanding medicine. This, along with other factors, like the aforementioned displacement of the male figure in the process, ushers in frequent internal conflicts of women, as well as conflicts in traditional family relations.\textsuperscript{34} The woman’s emotional, familiar, economic, and social investment (among others) is so vital that it can very easily become an authentic obsession, committing one’s entire life project to this cause.

5. The reduction of human pain to a technical problem.

In actuality, when, immersed in a consumer society, a child is understood as just another good and directly dependent on a lifestyle option, the premises that allow for the comprehension of the logic of the nature of human procreation are eliminated. The scientific journal \textit{Nature} dedicated an article in August 2008: in commemoration of the birth of Louise Brown 30 years ago, significantly entitled \textit{Making Babies: the Next 30 Years}.\textsuperscript{35}

In line with this, Illich calls the decline of the level of health \textit{structural iatrogenesis}: the growing artificiality and medicalisation of life, and the consequent inability to confront essential experiences such as pain, illness, or death, generating a demand for manipulation.\textsuperscript{36}


\textsuperscript{34} Cambrón, A., “Fertilización \textit{in vitro} y agresiones al cuerpo de la mujer: una aproximación desde la perspectiva de los derechos” ("\textit{In vitro} fertilisation and aggressions against the woman’s body: an approach from the perspective of rights"), op. cit. p 177.


Pain loses its human dimension and is transformed into a technical problem. Lacking any sense whatsoever, its maintenance leads to the very extreme of depriving human life itself of meaning, that same life that experiences it.

Categorically, it is not about giving pain an absolute meaning, nor is it about not taking measures to eradicate it. Nonetheless, it is important to let it have its place in human life, as pain will always be an inevitable part, even a reality, of life.

As for the woman, the apparent pain of not bearing a biological child, upon being considered as something totally devoid of sense, is identified as a disease to be eliminated at all cost. This is why no preliminary and necessary space is given to study and situate this pain, perhaps detecting an origin different from that of simply not bearing a biological child. There is simply no room or margin for such in the social imagination. As Illich emphasises, in cases of those who resort to in vitro fertilisation, it is highly exceptional that doctors ask about the meaning of the suffering of the woman seeking to bear a child. It is customary that this pain is systematically written off as an organic dysfunction without giving it a second thought.

We cannot afford to lose sight of the possibility that the patient’s request may not coincide with a real or unconscious desire. For Lacan, there is always something underlying, something other than or even more than just the demand or the satisfaction sought (in this case, bearing a child.) It is always a demand for affection and love. This is why it is important to raise and deliberate the need to substitute the strictly medico-technical view for listening to and understanding the situation of the patient. Lesley Doyal maintains that, reproductive technologies are ordinarily not confined to being simply a response to infertility. In many cases they are taken to as a (bio)technological response of people who find themselves in a situation of a full-blown integrity crisis.

This is the argument most women who are willing to take all sorts of risks in order to bear a child use to explain themselves. Some authors have sustained the impossibility of

attributing any real freedom to these women who avail of these new technologies. Cambrón\(^{38}\) affirms that material violence against the woman exists

"With real consequences for everyone involved in said relation. It is a silent, invisible violence unknown to its own victims... It is a kind of violence principally exerted through the symbolic network of communication and knowledge." Clearer still, through “ignorance, cognizance, or ultimately, feeling.”\(^{39}\)

Similarly, to cite lines taken from Silvia Tubert’s book *Women without Shadows. Maternity & Technology*,\(^{40}\) obtained from field studies of concrete cases of women who go to the maternity ward of the Ciudad Sanitaria de la Paz in Madrid, seeking *in vitro* fertilisation:

“Everyone tells me: ‘Go for it, if not, one day you’ll regret that you could have done it and didn’t…”

“So many tests and things have a way of traumatising you a bit, you get fed up with it all. When nature withholds it from you, you can’t force her. I’d decided to give it up, but the doctor was nice enough to call me so here I am…”

“In my village, my family, the people... they all told me to go see the doctor – I didn’t come here on my own initiative. I just did what I was told so that in the future, people won’t think I didn’t have children out of fear or a lack of interest…”

Other authors describe what they understand as the problem of “access to infertility,” in other words, the right to assume infertility, or the right to “surrender” or “give up” without having risked their own health and without having to assume any guilt or responsibility in the least.


6. Legal protection of the woman’s right to life and health.

Lastly, we draw attention to the legal vulnerability of the right to life and health of a woman subjected to these techniques.

Naturally, one of the functions of a democracy is to protect and ensure the health of its citizens, deriving from the right to life. This means a commitment in the promotion and the real enjoyment of the necessary means to maintain this health. In turn, this involves controlling the products and techniques available in the market with regard to their harmlessness to human health. In the same way, this implies the establishment of legal sanctions for those who injure or threaten the citizens’ physical and psychological integrity.

However, the study of legal reality faced by women whose health has suffered because they underwent these techniques shows that in these cases Law has relinquished its functions. Specifically, Spanish legislation leaves the woman legally vulnerable as it likens the new reproductive technologies to therapy. With nothing more than her formal consent, she can be exposed to techniques that pose important risks and whose side effects have not even been assessed.

7. Conclusion

In conclusion, we find ourselves before an issue of great complexity not to be dealt with superficially. It is of utmost importance to seriously go deeper into the underlying interests of the new reproductive technologies, the logic that inspires them, as well as the view

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of the woman upon which they are based and above all, their consequences to human life itself.\(^{43}\)

Then again, after what has been earlier explained herein it is surprising that different agencies and authorities favour and promote the use of these techniques, and even seek public funding for them, in the name of an alleged woman’s right to freedom and to health, ignoring or unmindful of the very real aggressions involved against a woman’s life and health. Public authorities must question the unconditional support (mainly economic) for artificial reproduction techniques. In its place, more resources should be allocated to research the origins of sterility and its real therapy.

Last but not least, if what is really intended is to give a child to a family and that this child is to be loved for what it is, it would be much more coherent for public authorities to support, more effectively and convincingly, processes of adoption. In effect, intervention must be carried out in three main directions: a) facilitating adoption in those countries where there exist serious administrative obstacles for adoption, such as Spain for example; b) expediting adoption in third world countries where legal impediments and the seeming lack of impetus of public authorities complicate adoption and make it very tedious; and c) economically supporting parents who have to resort to international adoption as their only recourse and cannot shoulder the elevated costs adoption entails.

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\(^{43}\) There is evidence that IVF, in affecting such personal and intimate aspects of people, does not only affect a woman’s life and health, but it also affects the psychology of the children. It is not irrelevant that they come to discover they were produced availing of these technologies (See Siegel, G., Dittrich, R., Vollmann, J., “Ethical opinions and personal attitudes of young adults conceived by \textit{in vitro} fertilisation”, \textit{Journal of Medical Ethics}, 34 (4), 2008, pp 236-40).