

IVF RESEARCH: A QUESTION OF FEMINIST ETHICS

RENATE D. KLEIN

Deakin University, School of Humanities, Geelong, Vic. 3217, Australia

Editor's Note – Research on women's experiences of IVF is proceeding worldwide, but as with any new area of research the approaches and findings vary while the bases on which comparisons can be made are not immediately apparent. To encourage research and facilitate comparisons, the *IRAGE* editors proposed a series of questions on methodology and theory to researchers who are currently engaged in, or have completed, studies on IVF.

1. What are the basic findings of your IVF research?
2. Provide details of your research methodology, for example, how many women were in your study? How was the sample obtained? How did you obtain access? How did you measure success?
3. What conclusions do you draw from the research?
4. Do you see any differences in your research and that of other feminists? If so, what are they?
5. Arising out of your research, what strategies for change do you advocate?
6. Are there unanswered questions after the completion of your research? Did new questions emerge? If so, what are they?

The first three contributions are from Canada, Denmark, and Australia. The Editors welcome further contributions, including letters, from researchers and from women who are working at a more practical and/or political level with women who are or have been undergoing IVF treatments.

Synopsis – Investigating the experiences of a vulnerable group of the population — women who undergo in vitro fertilisation (IVF) – from a feminist perspective, requires a lot of careful thought. In this paper I first provide the rationale for the exploratory survey I conducted with 40 women in Australian IVF programmes who left them without success. I then go on to summarise some of the most alarming findings. Lastly, I ask questions about research being “on” or “for” women and end by suggesting some ways of doing research ethically which will benefit the women who participate in feminist research projects.

1. RATIONALE AND METHODOLOGY OF MY STUDY

Since the early 1980s, feminist researchers have raised public awareness internationally about the problematic nature of the new reproductive technologies, and specifically in vitro fertilization (IVF) for the health and mental well-being of women. Gena Corea, for instance, in *The Mother Machine* (1985) drew attention to the pain and abuse of IVF programmes that individual women were reporting. But it was Christine Crowe who, to

my knowledge, was the first to conduct a methodologically focussed study with women on IVF programmes in Australia in 1985 (Crowe, 1986) to be followed later by Linda Williams, Canada; and Lene Koch, Denmark (see this volume) among others.

My own exploratory survey, which I began in Australia in December 1986 and finished in May 1987, had a particular focus. Since feminist research has made it public that IVF is by and large a failed technology with a five to ten percent “success” rate at best (see Scutt,

1988; Klein, 1989b), I wanted to know about the experiences of the overwhelming majority of women who undergo IVF: the 90–95% of women who are let down by this supposed “miracle” technology. Conservatively estimating there must be well over 100,000 women¹ worldwide for whom VF did not work; how do they feel, think, and experience their journey from encountering one of the many versions of “infertility”; their own or their partners’ fertility problem, and unnamed condition or a relational disposition? How do they experience often ten or more years of “conventional” fertility “treatment” before finally entering an IVF programme, supposedly their last hope for a biological child? How do the technological interventions, from taking fertility drugs for egg maturation, to having egg cells removed and embryos inserted, influence their lives and their relationships? their physical and emotional well-being? their sense of Self? Do they feel in control of the IVF process? Are they informed of health hazards, of documented deaths? Above all, have they been told that IVF remains an experimental procedure? And how do they cope with the material pressures and with the emotional “roller coaster” – hopes up ... waiting . . . hopes smashed . . . waiting . . . hopes up. . . . finally, hopes down again? What are their lives like after IVF?

¹Given the reported “success” rate for IVF, roughly 5–6,000 children born after the initial assistance of IVF – there must be at least 95,000 women for whom this technology did not work. This number is, however, a gross under-representation because in most programmes internationally, women in IVF programmes start being counted at the stage of egg collection, or even more frequently, at the time of the embryo transfer only. This method of massaging “success” conveniently leaves out an estimated number of 30–50% of all the women who begin the IVF procedure but who never reach the stage of egg collection because the superovulation drugs don’t work or work too much so that dangerous hyper-stimulation results and the women are “cancelled” and often have to undergo emergency surgery. I, therefore, agree with Francoise Laborie who, based on her research of IVF in France, contends that already in 1987 the number of women who

For reasons I will discuss further in section 3 it was crucial to me to ensure that women who spoke out about their IVF experience(s) would do so candidly and because they wanted to, as well as unconstrained by outside forces, such as IVF personnel. It also seemed ethically advisable to restrict my investigation to women who had ceased participation in an IVF programme (see section 3 for details).

I therefore placed advertisements in two major newspapers in Melbourne, asking women who had undergone IVF to participate in a survey. I guaranteed full anonymity and explained that participation would entail filling in a questionnaire with the possibility of taking part in a follow-up interview. I soon received enquiries from 43 women, 40 of whom then returned the questionnaire – an extremely high response-rate despite the length of the questionnaire; 186 questions in seven sections². I began to realize, and it was confirmed both in the returned questionnaires and the 25 in-depth interviews I conducted, that concern about the experiences of women for whom IVF had not worked was obviously highly unusual – and much needed. Put differently, it is one of the many scandals of IVF that women who “fail” – the technodocs’ interpretation – are thrown by the wayside as “bad” statistics and totally left to their own devices to build a new life on broken dreams.

had gone through IVF may well have exceeded 200,000 (Laborie, personal communication October 1987).

²The sections were: Personal Data; Infertility; Treatment(s) before IVF; Commencing IVF; The IVF Procedure; Problems; The Time after IVF. Some of the questions were quick “yes/no” answers, others asked specific details about the IVF procedure (e.g., number of attempts, number of eggs recovered, financial cost, etc.), but the main emphasis was on open ended questions. In agreement with other feminist researchers (e.g., Du Bois, 1983; Mies, 1983), the use of quantitative research methodology appears problematic to me. For that reason I mentioned in the covering letter I sent with the questionnaire that I did not plan to evaluate the answers statistically, but that I intended to use them as the starting point for the follow-up interviews.

In both questionnaires and interviews I deeply appreciated the honesty of the women who let me share glimpses of a distressing period in their lives. Compared with prior surveys I conducted (see Duelli Klein, 1980, 1986), this exploratory survey with women who experienced IVF was doubtlessly the hardest piece of research I have ever done. Hearing about the deep pain fertility problems can produce, the pressure to seek technological salvation, the hopeful trust in medical practitioners, and then the deceit and the humiliation, the anxieties, the danger, the dashed hopes (see section 2), and *still* the desire for a child which often resulted in yet another IVF attempt, was emotionally difficult to cope with. Seeing the women often close to tears bravely reveal to this stranger – me – medical details about their “torture” – as many of them called IVF – tremendously increased my anger about the unethical nature of IVF, which continues to be trial and error experimentation on real live women who are used as test-sites. It led to my further understanding of IVF as the exploitation of a desire – a new form of patriarchal violence against women.

More positively, however, my research experience confirmed not only that women who undergo IVF are incredibly strong, courageous, and determined to make a technology succeed, which, outrageously and for the most part unknown to them, is dangerous and *in itself* a failure, but also, that many are *survivors* who after IVF bravely embark on unknown paths in search of a new life. I must point out immediately, however, that my study is biased towards women who felt they could emotionally cope with their IVF experience (despite the fact it was not successful) and wanted to write and talk about it, mainly to vent their anger and to give words to their pain both about the unfulfilled dream and the exploitative nature of their IVF experience. Almost without exception the women who took part in my study are well-

educated and middle class. Almost without exception they had strong support from their husbands. This finding does counter other, more anecdotal stories about women on IVF programmes whose partners first pushed them into the programme and then reacted so badly when it did not work that their marriages broke up, with the result that they were totally destroyed by the experience. In fact we know of a number of suicides and of women who became alcoholics to forget the experience of the stigmatisation of fertility problems exacerbated by repeated IVF attempts. I thus maintain that the often harsh words of the women in my survey represent but the tip of the iceberg of what women have to go through in their IVF experience. I strongly believe that those whose lives were wrecked by the trauma of serving as “living laboratories” (Rowland, 1984, p. 364) – the invasion of their sense of Self as autonomous persons with dignity and self-respect by some particularly ruthless, success-oriented and misogynist doctors and scientists – did not reply to my advertisement in the newspaper because they may be too broken to deal with their experience: the deeply infuriating underside of a glamorous medical technology, and its promoters who like to portray themselves as benefactors.

2. IN VITRO FERTILIZATION: A CRUEL ALE OF EXPLOITATION, DANGER, AND DISAPPOINTMENT

As I have written elsewhere in detail about the experiences of the women who participated in my survey (see Klein, 1989a, 1990), in the context of this article on the principles of IVF research I will selectively focus on some of the findings that are particularly important and alarming to suggest further feminist research and action and discuss feminist research ethics.

The experience of infertility can indeed be experienced as a serious life crisis. Because of society’s rarely challenged assumption that

having children is the “normal” thing for a mature woman, thus immediately stigmatising *her* irrespective of the nature of the fertility problem, many women’s self-esteem and well-being are seriously affected when the verdict “infertility” has been pronounced. This, however, may extend to women who had children with a previous partner (seven in my study out of forty) and three with the same partner before the fertility problem arose. It takes a heavy toll to live in a family-centered society and feelings of “not belonging,” of “displacement” even extend to fertile women whose partner has the fertility problem as they feel compelled to give him “his” child. Nevertheless, a substantial number – twenty-six women – mentioned that they did contemplate adoption or “social mothering” (i.e., looking after someone else’s child(ren)) when the fertility problem was diagnosed. In sixteen cases, however – more than a third in my study – it was the husband who was against adoption or a “child-free” life; a strong force in making women seek medical “solutions” in addition to the mentioned social pressures.

The close link between the stigmatisation of infertility and women’s belief that they *must* try IVF – it might be the last hope for a(nother) biological child – is devastatingly clear. Women with a fertility problem in their relationship who suffer from it have only two bad “choices”; one is to continue being a social outcast which often translates into a sense of personal failure with the added sense of “guilt” that she has given up trying too early; the other is to follow the lure of reproductive technology and embark on a dubious medical road.

It is at this point, however, where questions about biomedical ethics must be asked: is it not cruel and exploitatively unethical to promise hope when there is but uncertainty and, in fact, lies and danger? Only seven out of the forty women in my study were told about potential adverse effects of the fertility drugs.

And what they were told ranged from “Hormone levels will be affected” (one); “Not a great deal of side effects” (one); “Multiple births possible” (two); “Lots of eggs will be produced” (one); “dizziness/nausea” (two); “weight increase” (one). One woman was told “not to worry” (in Klein, 1989a, p. 21). None of them were told about the risk of egg-pickup which has led to at least 18 documented deaths. (Corea, 1985 and work in progress) and to infections which in turn may result in infertility of *fertile* women who are on the IVF programme because of their husbands’ fertility problems. A mention of other risks such as developing an ovarian cyst, adhesions, burst ovaries, perhaps even cancer (see Carter & Joyce, 1987; Klein & Rowland, 1988); and should they be among those few who get pregnant – a spontaneous abortion, an ectopic pregnancy, a miscarriage, a stillborn child or a higher chance of a child born with some abnormality, and later perhaps early menopause, is remarkably absent from information about IVF.

The women’s verdict of the IVF doctors is almost unanimous. With very few exceptions they were described as “cold,” “up themselves,” “only interested in science not people.” Many women clearly felt they were part of an experimental procedure and “the only ones it works for are the doctors and scientists-not us” (in Klein, 1989a, p. 45). Or, as an other woman remembered:

I felt like a Friesian cow ready to be experimented upon. I did not feel like a person after talking to Professor X. The team aren’t interested in people, only in science.

In addition, when IVF fails, it is the women who are blamed; they have “old eggs,” “bad eggs,” diseased tubes,” and wombs that are “hostile environments.” As one woman put it:

I felt like a baby machine; no one was interested in me as a person. I was just a

chook with growing eggs inside – and if they didn't grow properly then it was my own fault.

And yet, women stay on the programme, often repeat it despite life-endangering accidents. Once on the medical treadmill it is extremely difficult to quit. The doctors – whom the women want to believe because they represent the road to a baby – are always quick to mention yet another drug, or a new procedure: yet another chance (financial profits for them; raw material for embryo experimentation³) that the women should not let pass. Yet, as my research has so convincingly shown, IVF is not in women's best interest.

The question then is, how can we as responsible feminist researchers contribute to the exposure of IVF as a money spinner for doctors and pharmaceutical companies and as a means to embryo research; *and* to the support of women who suffer greatly, for a variety of reasons, because of a fertility problem. Do we push for adequate counselling on IVF programmes, for more dignified circumstances in the interactions between the woman and her doctor, for "informed consent" about short- and long-term effects? Do we

offer our help to women on IVF programmes? Is there anything about it that we think is beneficial? Or do we resolutely continue to resist the violent nature of IVF which fragments and dissects live human beings – women, offers the illusion of technological fixes and no baby at the end, and, in addition, is inherently eugenic as it features a range of in-built selection mechanisms from the quality control of the "right" woman in the "right" part of the world to the quality control of the "right" child "made to order"?⁴ What can we do for women with a fertility problem? How can we bring an "ethics of integrity" (Raymond, 1979) to our research and action?

3. RESEARCH "ON" OR "FOR" WOMEN?

There were many reasons for focussing my study on the experiences of women for whom IVF had not worked. One of them was, as already mentioned, that IVF works so very rarely, and that so far the great majority of women who go through IVF have been notable for their silence. But there were other reasons too that had more to do with thoughts of feminist methodology (see Duelli Klein,

³I have argued elsewhere (e.g., Klein, 1989b, 1989c), that I believe that IVF has very little to do with "help for the infertile". Rather, the myth of its potential to create children, secures a constant source of experimental subjects for research be it for investigating their hormonal cycles, or, even more in demand, as egg donors. For as Robyn Rowland put it (1987), to make embryos one needs egg cells. And where do they come from? Most conveniently from women on IVF programmes who "willingly" donate spare eggs under quite coercive circumstances.

⁴It is crucial to realise that the increasing application of reproductive technologies in the so-called third world needs to be seen in interaction with population control policies. Put differently, by means of the pregnancy vaccine – now under development, for example, in the USA and Australia – one could immunise the women of a whole country in order to later select a few "breeders" of the "right" ethnicity and class to have babies through

IVF (their egg cells will still be intact and, as they are fertile, the IVF success rate might be somewhat higher). The demand for the child "made to order" may include the demand for the "right" sex thus opening the way to routine sex-selection tests.

⁵A participant in my survey later spoke of the necessity to obey. In her words:

When I first came with my list of questions, Dr. X. patted me on my head and said, 'Now don't you worry your little head off, we know what is best for you. . . '. Later, however, he stopped being so 'nice' and once ... he commented sharply that, Doctors' wives always cause trouble,' and, 'You want a child, don't you? If you do, then give up your job, stop being a problem and cooperate.' So I felt I had to shut up or risk delay on the programme, (in Klein, 1989a, p. 38)

⁶In this, my research differs from that of Christine Crowe, Linda Williams, and Lene Koch.

1983). Knowing full well the extent to which IVF doctors exert control over their “patients” – a medicalised expression for a perfectly healthy woman who asks for a doctor’s assistance to get pregnant – and how the women, in order to stay on the IVF programme, have to obey all orders without asking “difficult questions,”⁵ I intentionally avoided seeking participants by contacting IVF programmes⁶ asking to interview women still on the programme. Why would they trust a stranger who had come to do research “on them” with their worries, hopes, and fears? Even more pertinently, why would they confide in this person about lingering misgivings and anger they had about the nature of their treatment and/or their IVF doctor(s)? How could they be sure she would not “tell on them” and thus jeopardise their often long-awaited place on the IVF programme?

An even more compelling reason not to ask women who are still participating in an IVF programme to take part in a *critical* study of IVF is the very down to earth reason that women are usually *thrilled* to be on the programme (at least initially), they want to *believe* that IVF will work, and are *determined* to live with – and even play down (again, at least initially) – humiliating treatments and the often severe adverse effects from the procedure. Given the many fruitless but painful years they have spent in conventional infertility “treatments,” this sheer determination to do all that is necessary to be perhaps among the few lucky ones at last, is totally understandable. What a woman in this difficult situation needs least, or so it seems to me, is a critic of IVF who asks about problems (e.g., with the drugs or the way she is treated), which, to keep her determination to continue, she *must* deny. The parallel with battered

women comes to mind; as feminist research has convincingly shown, a woman who cannot yet face the bitter truth – which is that the batterer will continue to beat her despite his oath that he loves her and will never do it again – will not believe the researcher who tells her that this is what most batterers say, and that the average time a woman goes back and gets beaten up again, is six times. On the contrary, she will resent such a comment, and maintain that she will be the exception. This is not “false consciousness,” as critics of my position claim I am implying with my analysis of women’s persistence with IVF. Rather, I believe that almost anyone entering an IVF programme because of the dual stigma of fertility problems *and* the wish for a child (hers and/or her partner’s) will *perceive* it as a realistic last effort to succeed; even if it is at great cost to herself.

One could, of course, argue that a researcher could just ask questions, write the answers down, and probe no further, thus maintaining the distance between “us” and “them.” In the IVF context, such interviews would end quickly when all the woman who is still on IVF *can* say is that everything is “fine,” even in the face of visible stress; and all the researcher can do is to write this not very meaningful statement down. I disagree very much with this kind of research. First, it sets women up against one another; women with a fertility problem who are on IVF against the (supposed) fertile researcher who wouldn’t do “something like this.” Such an approach creates a “hierarchy of goodness” and focuses on *differences*, rather than on the many *commonalities* between us as women. Moreover, it suits patriarchy that many of us become addicts of some kind; that we deceive ourselves “for our own good”; and that we behave in ways harmful to our Selves.⁷ second,

⁷See Janice G. Raymond (1986) for further exploration of the concept of a woman’s Self in hetero-reality in *A Passion for Friends*.

⁸Both in the cover letter which I sent out with my questionnaire and at the beginning of the interview, without going into details, I said I was a critic of the technologies.

for ethical reasons, I believe that feminist researchers, wherever possible, when working with other women, should disclose their point of view.⁸ Put differently, I think it is disrespectful of women who attempt to do something that might hurt them badly, not to voice at least some of the concerns, especially if they allude to some problems. Knowing what I do about IVF and not speaking out against it and actively trying to stop it as unethical medical experimentation on women would make me an accomplice of the promoters of these procedures. But as I said earlier, with women determined to keep going, information about drugs will almost certainly fall on deaf ears, especially as the IVF doctor, when asked by the woman about the mentioned side effects, will most certainly deny them.⁹

It is only after the woman has finally “quit” that she may admit to herself and possibly to an emphatic researcher, how many times she bit her lip and shut up, disregarded adverse effects from the drugs, and glossed over emotional upheaval, thus reinforcing the medical myth which maintains that women who want a baby “want IVF.” It is only then, I believe, that a feminist researcher does *not* have to stop when women who quit IVF tell us, that “it wasn’t too bad, really . . . you know, one can put up with a lot for a baby . . .,” and can, instead, ask more questions about “what exactly wasn’t too bad . . . or too good?” By assuring the woman that it wasn’t her fault, that she needed not feel guilty, that, yes, the doctor did behave outrageously and

unethically by not telling her, and that no, *she was not alone but one of many*, it might be possible for her to voice experiences that she, perhaps, hadn’t even allowed to express to herself. For example, it was only after a lot of talking about side effects, that a fertile woman with diagnosed idiopathic infertility eventually told me that after three IVF attempts she now had substantial adhesions on her ovaries, which, as the IVF doctor had told her, meant a *much reduced chance* of natural conception; in other words, she had been rendered infertile and was now advised to *stay* on the IVF programme! By the time we met, she had quit but had not yet allowed herself to voice her anger at this medical malpractice.

In sum I believe that feminist research needs an “ethics of integrity” when other women are the “objects” of one’s research. By this I mean that we respect the specific life-context of a woman – hence do not conduct research “on” women who are still trying to have a baby against all odds.¹⁰ But also, that we assess the women’s statements within the framework of feminist theory, based on the fundamental premise that patriarchy – a combination of sexism, racism, and classism (to name but three facets) – oppresses women. In other words, when women who have stopped IVF tell us that they *needed* this experience to be able to accept their infertility, I think we nevertheless have to continue to oppose it, because it is a technology that dismembers women as a means to another end (embryo research) *at great physical peril to*

⁹In the face of all evidence that fertility drugs have many proven short-term and potential long-term effects as documented in the medical literature (see Klein/Rowland, 1988), IVF doctors continue to maintain that these drugs are safe.

¹⁰An exception would be if women on IVF asked me for information in the full knowledge that I was highly critical of IVF. Then I would certainly not hold back with my critique.

¹¹Undoubtedly, there is a parallel here to the currently fashionable belief in some libertarian quarters that is OK – and even “liberating” feminist politics! – when individual sexual pleasure is derived from “danger,” that is, for instance, SM behaviour including physical violations. My view is that if a woman can experience sexual passion only if bound and beaten, this is not something that feminist theory, which is about integrity and dignity of human beings, can endorse. Rather we need to explore why women seem to need such self-hating behavior which will undoubtedly lead us to a discussion of the (sexual) abuse of women from early childhood on.

the women. It would be masochistic to lend support to a technology that achieves “acceptance” only at the price of danger.¹¹ And it is also crucial not to blame the women, but instead, to expose the “unethics” of reproductive technologies and their promoters.

Research conducted with an “ethics of integrity” also demands that it is *for* women, which means that, in one way or another, it contributes to women’s well-being and a change for the better. This is, of course, a grand aim and given financial, geographical, and also emotional constraints, not easy to achieve (for an excellent new discussion of feminist research methodology see Reinharz, forthcoming 1991). Feminist researchers cannot usually be therapists, nor should we give this impression to the women who have agreed to take part in our research projects. But there are many things we can do, such as share information with the women once they want to hear it (e.g., on adverse effects of fertility drugs); encourage them to write down their experiences and help them to get it published; or tape/transcribe their stories and have them do the editing as I did in my international anthology about women’s experiences with IVF and conventional infertility treatment (Klein, 1989b).

I also encouraged women who had participated in my Australian survey to speak out on radio about their fertility problems and their views on IVF. One is treading a fine line, however, as soon as the media enters the picture. Interested in not much else than a “good story,” women have to be very clear whether they want to be the “star” telling the “other side of IVF” one day – and to be dumped the next, when some IVF “expert” trivialises and individualises the women’s experience as an “unfortunate exception.” As feminist researchers we must make every effort to ensure that the women are not exploited by yet another arm of patriarchy. Television is even more sensationalist than radio, and many women decide not to take the

risk of being exposed to their neighbours. Nevertheless, some are angry enough and decide that speaking out about their experience will help other women to say “no” to these technologies.¹²

Another strategy is to play intermediary and bring women together who have been through IVF – upon their mutual wish of course – which sometimes leads to stimulating friendships and helps both parties to engage in new activities. Almost all the women in my study asked me if I had women friends without children – and how did one find such people – a strong indictment of western pronatalism, and a reconfirmation of the stigma of infertility.

Feminist research with a conscience – an ethics of integrity – in my view must attempt to support women *away* from the medicalisation of infertility into a new phase of their lives.¹³ German women have pioneered feminist self-help groups, counselling and, if so desired, individual therapy in feminist health centres (Winkler & Schöenberg, 1989). The idea is to enable women to think, feel, grieve, rage, be sad, and learn to live with the, for the most part, unexpected fertility problem in their lives which, to emphasise this once more, is a shattering experience for many of them and

¹²When women who have undergone and survived these procedures speak out against them it is very powerful. In Australia two women from my survey spoke out against IVF on prime time television (SBS, 7.30 report, May 2nd 1989). As expected the next day an IVF “expert” (Alan Trounson) was given time and denied any side effects from the procedure! Another group of women who speak out very effectively against these technologies are so-called surrogate mothers, amongst them, for instance Elizabeth Kane.

¹³Feminist therapists have an important role in helping women to overcome problems associated with infertility (e.g., low self-esteem). And as long as IVF exists, many of the women who survive it, will only do so with the help of a woman-centered therapist who is able to help them to radically reorient their lives (see also Klein, 1989d).

must be taken seriously. Importantly, this possibility of coming to terms with the fertility problem must be available *before* the women begin their often long and traumatic journey of conventional infertility treatment and, lastly, IVR.

More generally, alternatives like adoption (especially of orphaned and handicapped children as well as those of the “wrong” colour¹⁴), “social mothering,” and professions in which working with children is rewarded, must be encouraged. In Muslim countries where adoption is illegal, legislative changes, as fought for by feminists, are obviously imperative.¹⁵ Likewise, the decision not to have children must become socially acceptable, not as “second best” but as an equal alternative to biological procreation.

Research *with* women on IVF programmes can become research *for* women when the similarities between researchers and researched are established. Many of us know what it means to be stigmatised and marginalised – be it because of our skin colour, sexuality, age, nationality, or social class. Many of us also know that women, mostly, survive, sometimes against tremendous odds. When the main aim of a research project is to improve women’s lives as autonomous human beings entitled to integrity and dignity, and to do so ethically

while exposing patriarchy’s machinations, then feminist research is squarely grounded in the diverse material and spiritual realities of women’s lives where women are always both victims and (subversive) survivors.¹⁶

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¹⁴I have been told that as many as 40,000 black and disabled children are waiting for a home in the USA (Heinz, personal communication, New York, June 1990). The fact that these children cannot find a home while the IVF and surrogate industry blossom in order to create *white* babies says a lot about the motives of people who cry out that they can’t live without a child. It is really a *biological* child of their own that they want, and, in the case of surrogacy, very openly *his* biological child.

¹⁵I am most grateful to M.A. Hélie-Lucas, Algeria, who, as organiser of “Women under Muslim Law” and fighter for adoption rights, urged me to keep in mind this ongoing injustice. Self-help groups and counselling, she pointed out, are a less significant priority and in fact are eurocentric. What is needed first are legislative changes.

¹⁶Such a feminist ethics will also guide us in future research projects, for example in researching the lives of the few women who have had children from IVF. Anecdotally, we know already of continued trauma and un-happiness of women who are now expected to be “super-mothers” to their “superchild.” Anti- and nonfeminist researchers have already targeted women who seek IVF, as “neurotic” and “narcissistic” (see Petersen, 1985; Bachmann, 1987); undoubtedly, any problems arising in the relationships with their children will be blamed on them too. Feminist research, if it is undertaken at all, must aim from the beginning to offer support to women who will be even less likely than before IVF to ask for help, after all, they now have their “dreamchild” so why are they not happy?

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