Upon the birth of my daughter four years ago I had the occasion to experience first hand the degree of cultural significance given, in our western society at least, to 'biology': in this case, the biological connectedness of parents to their offspring. I don't think my experience was uncommon; my daughter was 'claimed' as part of my family via biological connectedness. My daughter's arrival heralded new ways for my (biologically connected) family to affirm what are essentially social relationships. New categories of relationships were established—aunt, uncle, grandmother and grandfather—with biology as the social binding. At one day old my daughter was minutely examined: she had my mother's hands, her father's feet, her great-grandfather's head shape, her uncle's nose and so on.

What was interesting was that at that stage my daughter's father and his family had severed social relations with each other. The 'biological similarity', or, as I would prefer to say, the urge to connect my daughter with her paternal family via biological symbolism was not evident, even to those with well-meaning intentions. Conflict on that side has since been resolved, and my daughter has been duly incorporated into her father's family by the same process of 'recognition' of biological similarities. This experience has brought home to me the power of the biological metaphor. The force of the metaphor rests not on biology in itself, but on its use (in many societies) to affirm and strengthen social relations.

I have been researching the development of In Vitro Fertilisation (IVF) in order to outline a feminist critique of science and technology focusing on the power relations involved. Of course, examining IVF involves discussing a wide range of areas such as the concept of fertility, pregnancy and birth, and the meaning of parenting, science, technology, and medicine. One of the most pervasive, although by no means victorious, influences on the cultural construction of reproduction (i.e. on how we think about pregnancy and childbearing) is the medical model.

Conception, pregnancy and birth are socially mediated biological events. Biological events do not have to be medical events, but with the rise of the 'male midwife', the precursor of the obstetrician during the 19th century, reproduction was brought within the confines of the bio-medical model.

Reproductive technologies refer to a range of medical interventions in the processes of pregnancy and childbirth, and with the advent of IVF the process of conception has also become a medical issue. In other words, every aspect of women's reproduction has been brought under the auspices of the bio-medical model.

The bio-medical model contains several assumptions about the body: the individual body can be separated from the social body (i.e. the social context), the body performs like a machine with organs carrying out certain functions, and that the mind is separable from the body. In other words, the body is strictly of the flesh, a 'biological given', part of 'nature'. Diseases are conceptualised as neutral entities which reside in nature—that is, in the body.

During the development of medicine as a profession the medicalisation of reproduction was one of the last areas of human activity to be brought under the auspices of the bio-medical model. It is not surprising that reproduction was one of the last areas to be incorporated, since the bio-medical model is attuned to curing infections and disease. Yet reproduction is not a disease or even an abnormal condition. In order for reproduction to be included as a medical condition, then, it has to be pathologised to some extent. Pregnancy then is perceived as a somewhat abnormal state for the body, with accompanying medically defined 'risks'. A pregnant woman's age is used as a medical factor in assessing the degree of 'risk' involved. Given this tendency, it is likely that a woman perceived at risk will then have her pregnancy and childbearing made problematic.

The medical definition of 'risk' is a constantly shifting one. The age for a woman to be considered at risk varies from country to country, but the general trend is that the age considered safe for reproduction is getting lower and lower. It is significant, however, that the degree to which a woman may be perceived to be at risk is mediated by social factors, such as her location. Women in urban Australia, for example, are much more likely to undergo some form of routine intervention such as ultrasound during pregnancy because the technology is available.

Economic circumstances, and possession of private health insurance, may also play a part in determining the degree of 'risk' involved. If we examine the extent of necessary intervention during birth, for example, we find that the chance of a woman undergoing caesarean section delivery is far greater if she is covered by private health insurance. My point here is that what is perceived as a medical condition, as a risk, may be mediated and influenced by social circumstances.

Reproductive technologies such as Chorion Villus Sampling (CVS) and amniocentesis have been introduced as pre-natal tests which claim to detect certain foetal conditions deemed by some as undesirable. These tests may be offered to pregnant women over 40, 37, 35 or 32 depending on the particular definition of risk in relation to age. The tendency to utilise these tests as a routine procedure is a manifestation of the general pathologisation of pregnancy. A technique initially introduced for a very small group of women considered at risk during
pregnancy becomes a routine procedure for many. With the proliferation of reproductive technologies involved with surveillance of a pregnant woman’s body, the chances are that more ‘risks’ will arise.

At the moment, age is a dominant factor in determining ‘risk’. I would argue that that this is part of an attempt to contain reproduction within the bio-medical model. The tensions involved in attempting to incorporate reproduction into the bio-medical model, in line with the ‘disease model’, are great. By introducing age as a medical factor, the tensions are somewhat alleviated. In other words, the expanding medical definitions of ‘risk’ currently based on age, allow more pregnancies to be pathologised, or at least problematised.

It is from this perspective that I approach some of the issues raised in Romaine’s article above. I agree that one’s fertility should not be seen as a never-ending resource and should be seen as a potential. Fertility is actually a relationship or interaction rather than a static entity, since fertility can never be “assessed” on one’s own. Reproduction, a fulfilment of fertility potential, is a biological event which is quintessentially social. I agree that parenting should be given more importance, and social infrastructure should be put into place which meets the needs of parents and potential parents so that more acceptable options are created, thus enriching the lives of children and all adults.

In addressing some of the main themes raised by Romaine, I wish to add to the debate around reproduction, parenting and non-parenting. Of course, these issues have always been present; the expansion of reproductive technologies have highlighted these debates and brought what was previously considered by many to be ‘private’ into the ‘public’.

My first sense of unease came when reading that, of a sample of eighteen pregnant women, the only ones who had ‘uncomplicated’ pregnancies and births were those who were under thirty. Without knowing further details, one might hypothesise following my previously made point about ‘risk’ in the bio-medical model, that perhaps pregnant women of a certain age are more likely to have their pregnancies and/or births complicated rather than having complicated pregnancies and/or births.

On a more general theme, the advocacy of a social policy which encourages childbearing between the ages of 25 and 30, because this is deemed to be the ‘healthiest’ time, comes close to accepting the bio-medical model of reproduction—a model which separates the biological body from the social context, and which asserts (in this case) that reproductive organs and fertility in general are at optimum performance levels and should be utilised at that time. The implication here is that reproduction is seen primarily as a biological function, and this function should be performed at peak times which are defined and redefined by the biomedical model.

Reproduction is a life event which may or may not take place according to one’s life situation. In brief, even if one has children before the age of thirty, the desire to have another or more children may arise at a later stage because of changed social and/or financial circumstances, or even simply the desire to do so. Biological fitness may be one factor to take into account at such a stage, but in privileging biology over other factors there may be a tendency to view reproduction as a strictly biological rather than a more broadly social event.

There is also the question of the ecological sustainability of the choices we make about reproduction. Romaine seems to imply that ecological sustainability may involve making choices either to have fewer children or no children at all. This seems to rest on the ‘overpopulation’ thesis that high population contributes to impoverished circumstances both individually and nationally. This is a contentious argument which does not hold up under scrutiny. My response would be that the concept of ecological sustainability needs to be clarified to avoid adopting unwanted and ‘hazardous’ conceptual frameworks in our debates.

In general I don’t see any necessary opposition between feminist demands for increasing choices, and the recognition by feminists that there need to be different attitudes which respect both diversity and a balance in the ecosystem. There need not be any opposition if the choices created come from women themselves. At present, ‘choice’ is confined to a series of yes/no decisions in relation to a number of options presented to women. Some of us may be able to ‘choose’ from a virtual supermarket of reproductive options, but do not participate in the creation of the choices themselves.

Our bodies tell a story about who we are and who we have been, and what has happened to us in our lives. One’s life history is essentially a social history. In this light I would regard ‘biology’ not as a static entity passed on to us via genetic inheritance, but as a physical symbol of our social life—our biology is at the same time our biography.

CHRISTINE CROWE teaches in health care sociology and is completing a doctoral thesis on reproductive technologies at the University of NSW.