and commodification, and thus do not move us to see new levels of genuine choice, or to provide us with genuine control.

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Commentary

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Dr Rothman's paper is timely. The implications of the new reproductive technologies are profound. They are generally thought of in terms of relieving the suffering of individual couples either by enabling them to overcome infertility or by eliminating the risk of bearing a handicapped child. Dr Rothman speaks of amniocentesis and abortion when handicap is detected. Already medical practitioners have 'genetic engineering' or 'gene therapy' on their agenda to remove 'faulty' genes before birth, although many of the techniques still require much development for clinical practice and are not so near as some imagine. When designed to prevent haemophilia, for example, this must appear unobjectionable. But as Dr Rothman points out, to remove the possibility of having and accepting handicapped children may have unintended and at present unknown consequences in the reduction of choice, even though the new technologies may appear to offer more choice. Bearing and rearing a handicapped child might become normatively unacceptable.

There are also ethical problems about which children it will be deemed unacceptable to bear, just as there are already children deemed unsuitable for adoption, although far fewer than when there was a larger supply of unwanted children. There will be problems about which potential children should have gene therapy. Who shall decide? Who will in practice decide? We already know that in the care of the handicapped the dividing line between medical and social intervention is continually blurred. Our social ability to define some other human beings as less than human (on account of their body shape, brain functioning, skin colour or sexual orientation) and thus let ourselves off the hook of having to treat them as fellow human beings is already well known.

Dr Rothman is writing from US experience and, so it seems, to a US audience. She herself (p.191) draws out contrasts between the UK and the US using Titmuss's study of blood donation as an example not only of the morally correct way of doing things (in being based on altruism) but also the technically more efficient. This model is also used by the Council for Science and Society (1). Although the UK, like the US, is predominantly a capitalist society, we have hitherto consistently sought to prevent the intrusion of capitalist values into our health and welfare services. In the UK, issues associated with health and reproduction are less blatantly exploited for profit than in the US (2). However, many may be the indirect ways in which the profit motive, or corporate or self interest permeates our health service (3). In the UK well over 90 per cent of our health care is provided on a collective basis and is not for profit. In the specific area of fertility we have turned our face against womb leasing (4). We do not permit the selling of children for adoption (5).

Dr Rothman presents a powerful plea against the intrusion of capitalist values, the values of the commodity market, into affairs of human reproduction for as she rightly indicates this has consequences for the basic values upon which society rests and the respect in which we hold each other (6). Given the pressure to privatisation in the UK at present and the introduction of for-profit hospitals with international finance capital (7), it is well that those of us in the UK also heed her warnings, remembering that private

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provident institutions must be distinguished from private for-profit ones. Dr Rothman's warnings should increase our collective resolve to retain the strong sense we have in this country of the common weal, of the importance of mutual support in times of suffering, the total inappropriateness of exploiting suffering for profit, and of buying or selling human beings, a resolution which should be extended to sperm, embryos and all body parts.

However, it is not only in the area of the market that the problems arise. Many of them, as Dr Rothman indicates through her examples of the roles women as mothers are expected to play, derive from the patriarchal form of the family, which has its origins in pre-capitalist kinship structures. In these children were property (as were women and some men) and their importance, especially that of sons, in sustaining and honouring the male line has long been stressed. The only women to have parental rights were mothers of illegitimate children and both were stigmatised. In England the parental rights of an illegitimate child remain vested in the mother (8). In wedlock inheritance was largely patrilineal, from father to son. As capitalism developed the male domination based on the family was extended to the new institutions of industry and market-place and has resulted in a male-dominated gender order in the society at large and also to a strong male domination in science and medicine. The State from the outset was a male domain. The male domination has in its turn been associated with a preference for sons. Already in New York, one hears, amniocentesis is being used to sex children and abortion follows when the sex is 'wrong', more often when the fetus is female than male. In more strongly patriarchal kin systems, those of Islam for example, one can envisage this tendency being even stronger (9).

Issues of the legitimacy of babies born after *in vivo* or *in vitro* fertilisation already cause anxiety. The dominant notions of the 'family line', the 'real mother' or 'real father' already haunt adopted children. The form of these problems derives from patriarchal kinship; the notion of property in their children is felt by both women and men and high value is put on the 'fruit of my loins' valuing genetic parenthood over social parenthood. Why? After all a child is a child is a child and the gene mix unique (10). In capitalist society these notions of property in children take specific forms (11).

The power which microbiology and biomedicine has given to us to regulate and interfere with the reproduction of the species requires, if we wish to retain our humanity, that we rethink what it is we are about, what we value in each other, children, women and men, and how in the new circumstances we can achieve those values. Our present values were worked out in another technological age; but it was not, nor will it be, the technology which determines the values but the social form in which some have more power and influence that others. The more powerful decide in ways they think right, perhaps not in naked self-interest, but in what they see as the common good. The vision of the common good as seen by the less powerful may well differ.

We know that the introduction of the pill was not altogether liberating for women. In practice it made them more available for male exploitation. We also already know that, where a couple agree not to have more children, if the man will not use contraception, the woman has to; if he refuses a vasectomy she has to have the more complex sterilisation. Evidence is that the man in a couple is more likely to have his way in these matters than a woman. This is also likely to be the case in decisions about *in vivo* or *in vitro* fertilisation. Similar influences may occur at the level of policy decisions. The new technologies give opportunities for fulfillment where none existed before, for example for lesbian couples to have children, but recommendations for their use follow and reinforce the conventional family form (12). An increase of present problems is envisaged rather than an opportunity to expand our modes of child rearing.

Most discussions one hears today, for example about *in vivo* or *in vitro* fertilisation or gene therapy, are conducted in terms of reducing the suffering of individuals. This is not surprising because clinical medicine has always been individualistic, treating the pain, the suffering, the pathology which is presented by individuals. In the area of the new reproductive technology this is not enough. There are immense social consequences going far beyond the individual case as Dr Rothman has shown and as the Council for Science in Society recognises (13). We have to think, as she says, at the social level and see children as a collective joy and responsibility rather than as private property, our own or anyone else's.

In *Woman on the Edge of Time* Marge Piercy painted two visions of the future: in one high technology was used for the most horrible exploitation of women for men. In the other, associated with her peaceful and gentle vision of utopia, children were not incubated *in utero* but in a 'brooder'. The decision about birth was a collective one. Each child had three parents and men as well as women were made able to suckle. When old enough the children were sent out to fend for themselves (but not without collective overseeing) and this period marked the end of 'mothering' such that no property in children would persist (14).

When I first read this book I found the idea of the brooder quite unacceptable, because after many years of infertility I had so much enjoyed the personal experience of pregnancy and childbirth that the thought of women losing this faculty seemed intolerable. Now I'm not so sure. If that is the only way to prevent the stigmatisation, the notions of property and the anxiety about identity that I have seen in fostered and adopted children, then perhaps that is a way in which the new technology might serve humanity. But, technical difficulties apart, it is not a decision that could be made at present in our society with its immense inequalities in access to decision-

making between the sexes. At least Marge Piercy's two visions suggest to us what enormous intellectual and emotional leaps we have to take if we wish to retain and enhance the humanity of our society.

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