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COMMENTARY

Which lives matter in reproductive biomedicine?

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Abstract The most recent Black Lives Matter moment provides an important opportunity for consideration of the interlocking social and political systems that contribute to ongoing racism and racial inequality. What does this mean in the context of reproductive biomedicine? Which lives do reproductive biomedicine devalue and how? In this commentary, I address why reproductive biomedicine is an important site for reflection on race, and how the Reproductive Justice Movement calls on us to shift our thinking. I argue for the need to recognize the deep connections between reproductive biomedicine and eugenics, and then offer some examples of racialization in reproductive biomedicine through assisted reproductive technology. Finally, I consider what steps practitioners might take to be part of the change for which this Black Lives Matter moment calls.

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Last summer in the USA, people once again took to the streets to insist on the value of Black lives. While Black Lives Matter is most strongly associated with the struggle to end racist police violence, the name and the movement reach much further into all aspects of our lives and social practices, both in the USA and well beyond.

It is not only the structures of law enforcement that must change to reflect the fact that Black lives matter, but also those of justice, education, labour and health, to name but a few. Such changes will require community action, policy work within organizations, and new legal frameworks. It will also be crucial that practitioners within these systems become aware of the ways that their professions systematically devalue certain lives.

What does this mean for practitioners of reproductive biomedicine? In this short commentary, I will address why reproductive biomedicine is an important site for reflection on race, and how the Reproductive Justice Movement calls

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on us to shift our thinking. I argue for the need to recognize the deep connections between reproductive biomedicine and eugenics, and then offer some examples of racialization in reproductive biomedicine through assisted reproductive technology (ART). Finally, I will consider what steps practitioners might take to be part of the change for which this Black Lives Matter moment calls.

Reproductive biomedicine, like other scientific and technological innovations, reflects the values of the sociohistorical context in which it has developed. The process of human reproduction itself has never been and never will be entirely separate from social influences, including the value systems through which reproduction is both perceived and managed. Moreover, the concepts of race and reproduction are inextricably bound together in the history of western thought (Weinbaum, 2004). Race has been seen as something one inherits from one's biological parents and something that cannot be changed (even if hidden truths about one's racial lineage can be revealed).

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However, race – whether it be blackness, whiteness or anything ‘in between’ – should not be understood in this analysis as a biogenetic property (whether a scientifically meaningful property or a discredited one). Rather, it should be understood as a socially created categorization that confers or withholds social value and, as such, becomes subject to political contestation.

Therefore, when we seek to examine the part that reproductive biomedicine plays in the valuing or devaluing of lives based on race or racism, we must shift our ethical lens away from individual rights, autonomy and decision-making (although those remain important), and turn to social and political structures and inequalities, power relations, and the role that notions of race has played in creating and maintaining these. We must try to consider how reproductive biomedical practices evolve from, participate in, reinforce and even shift these structures and relations. In other words, we must shift from reproductive rights to reproductive justice.

In the world of activism, legal advocacy and community organizing, this call for a shift in thinking that connects reproduction to social structures of inequality in general and structural racism in particular has been articulated clearly and consistently for over two decades by women of colour through the Reproductive Justice Movement (Ross and Solinger, 2017). This commentary seeks to apply the call more directly to reproductive biomedical practice.

As reproductive justice scholars also point out, there is good reason to see the field of reproductive biomedicine as the direct descendent of 19th and 20th century eugenics. If not related directly, however, the two are at least scientific and intellectual cousins.

Many scientists and bioethicists believe that genetic science and technologies can be used to pursue both private and public goods without being guided by racist ideology, or allowing the coercion and abuse that the term ‘eugenics’ now connotes. While a ban on all reprogenetic technologies would itself pose serious ethical concerns, justifications of them based on the elimination of racism and coercion only scratch the surface of the issue.

Critics of the aims and practices of reproductive biomedicine see the field as a ‘backdoor to eugenics’, appealing to the sociology of knowledge to demonstrate how we have come to see the world through a ‘prism of heritability’ (Duster, 2003). Müller-Wille and Rheinberger (2007) argue, ‘As we probably are only beginning to realize today, in times when genetic screening, testing, and patenting pervade all sectors of social and economic life, and with the synthetic powers of genomics on the horizon, the epistemic space that heredity came to constitute has reconfigured life in its entirety’.

The longstanding human practice of breeding livestock (and crops) for vigour, resilience and other desirable traits – a practice that saw significant success long before scientific theory could identify its biological mechanisms – lies at the root of our widespread modern belief in the ability of humans to control, manipulate and improve upon processes of reproduction (be they human, plant or animal). It is from within this essential belief and conceptual framework that the eugenics movement, the concept of race, and reproductive biomedicine emerged and developed.

In the 19th century, analogies to animal breeding fostered the impression among both scientists and the public that humans could and should ‘help’ or ‘correct’ nature. Insofar as solving any particular ‘problem’ in human heredity was framed as desirable or necessary, animal breeding practices proposed a promising model.

But is race still considered a ‘problem’ for reproductive biomedicine to solve? Not explicitly – aside from government policies and practices that leverage domestic and foreign aid to incentivize long-acting reversible contraception for poor women (who are disproportionately women of colour) (Gomez et al., 2014). That does not mean, however, that reproductive biomedicine no longer participates in determining what is considered valuable in human heredity, and which genetic profiles are considered to be consistent with a good life (or the future thriving of the human race). Within the field, disability remains something to be fixed, avoided or eradicated.

The underlying ableism of reproductive biomedicine and the underlying racism of policies and practices which see certain women as better candidates for contraception than assisted conception are connected. The many real problems plaguing poor and minority communities have long been blamed on ‘irresponsible’ reproductive decisions within those communities, rather than on an extensive and continuing history of marginalization, exploitation and discriminatory social policy. The contemporary focus on genetic correction and enhancement exacerbates this trend, suggesting that all parents hold personal responsibility to avoid bearing children with genetic ‘flaws’ that might burden their society. Like the old idea that ‘responsible’ decisions not to procreate could end poverty, this new focus on individually accessed technological solutions to reproductive ‘problems’ shifts attention from social and political solutions aimed at the structural inequalities themselves (Roberts, 2005).

Reproductive justice draws our attention back to structural inequalities, demanding real access for women of colour not simply to abortion or contraception, but to the means to raise the children they do or will have in healthy and safe environments. Black Lives Matter draws our attention back to structural inequality in law enforcement and the criminal justice system, demanding that myths of Black criminality stop being used to justify oppressive and violent policing of Black neighbourhoods and Black bodies. These two sets of demands are intimately connected; both insist that Black life (and the lives of indigenous people and people of colour) be understood as something to be preserved, rather than a social threat to be eliminated.

Likewise, in this commentary, I wish to draw attention back to the structural and racialized inequalities reflected in and amplified by reproductive biomedicine, demanding that practitioners consider how to address and not deprioritize the reproductive needs and inherent reproductive value of non-white people (Davis, 2019).

Some clear examples of how reproductive biomedicine becomes implicated in racialized systems of inequality involve assisted reproduction. Globally, poor women are both more likely to be infertile and less likely to be treated for it. This is not simply because fertility treatments are rarely publicly funded, and thus require significant private resources in the USA and in many other countries around

the globe. A major cause of infertility among poor women (and also disproportionately among minorities) is inadequate reproductive health care, including during a previous birth. Infertility among industrial and agricultural hourly-wage workers is often the result of workplace and environmental toxins (Shanley and Asch, 2009). In both cases, prevention would do more to ensure health (and protect the environment) than substantial state spending on fertility treatment for either group of women.

The fact that much of the development and innovation taking place within the field of reproductive biomedicine occurs within the private and commercial sector, where it addresses the infertility or 'improved' reproduction of middle-class, white-collar and typically white-skinned people, is not an accident. To value equally the reproduction and reproductive capacities of poor people, often also people of colour, would require the dedication of public or private funding to securing universal access to reproductive health care and ensuring workplace safety in agriculture and industry.

The advent of in-vitro fertilization (IVF) also became entangled rapidly with global, racialized systems of inequality. Eerily enough, even before its successful execution, the new possibilities for IVF surrogacy were laid out by John Stehura of the Bionetics Foundation, Inc., an organization that arranged 'traditional' surrogacies. He predicted that 'once it is possible to have what Stehura calls an "authentic" surrogate – a woman into whom an embryo is transferred and who herself contributes none of the child's genes – clients will find the breeder's IQ and skin color immaterial' and that 'the surrogate industry could look for breeders – not only in poverty-stricken parts of the United States, but in the Third World as well'. Stehura also speculated (with disturbing accuracy) that in these cases 'perhaps one tenth the current fee could be paid women' (Corea, 1985). Today, these possibilities are realities.

Race plays a crucial part in the deep structural inequalities that characterize not only global markets in general, but global reproductive markets in particular, with the contributions of non-white reproductive labourers being both necessary and necessarily erased (Deomampo, 2016; Winddance Twine, 2015). Thus, by creating a market for gestational surrogates, and leaving the selection and recruitment of those surrogates to be shaped by entrepreneurs and market forces, reproductive biomedicine takes part in a long historical pattern of structural inequality and creates new possibilities for the economic exploitation and ideological devaluation of women of colour.

In many ways, the role of race in assisted reproduction hides in plain sight. Even where both users and practitioners are aware that racial identities are social rather than biological, and that a child's value should not be determined by their skin colour, there is little expectation that users would or should make decisions about gamete donors without taking race into account (Moll, 2019). The existence of drop-down menus for race and ethnicity on gamete bank web pages are, on the one hand, a stark reminder of the deep social practices that have divided and continue to organize people in terms of race. On the other hand, the fact that the existence of such drop-down menus is not seen as strange or regressive reveals how race is still fundamentally viewed as the natural outcome of reproduction. Both cross-racial

donor selection (in which a consumer purchases or attempts to purchase gametes from donors whose self-reported race does not 'match' the consumer's or their partner's) and 'racial mix-ups' (in which consumers mistakenly receive gametes from a donor with a different self-reported race than the intended donor) continue to garner media attention (Cuevas, 2014).

In these gamete sale practices, categories which most scientists and anthropologists (and even many lay people) have acknowledged are 'real' only in the sociohistorical sense are given genetic or at least pseudo-genetic status. This is true not only for 'traditional' ART users, but 'non-traditional' ones as well (Newman, 2019). In the adverse reactions to cross-racial donor selection and 'racial mix-ups', their social meaning and importance is also reaffirmed, sometimes by medical practitioners themselves (Ikemoto, 1995; Quiroga, 2007).

Even if you agree with all of the above, you might argue that it simply reflects: (i) the sociohistorical context in which reproductive biomedicine emerged and developed; and/or (ii) the desires and choices of the patient-consumers whose autonomy practitioners are bound to respect. In other words, you might wonder how I can expect practitioners to alter these structural realities.

Even when guided by the needs and desires of patients, practitioners of reproductive biomedicine still exercise a great deal of power, both structural and individual. Structurally speaking, the authority accorded to practitioners is shaped through various forms of licensure, professionalization and bureaucratization (Rose, 1996). Individually speaking, prospective parents/patients/consumers who seek to employ reprogenetic technologies (or, increasingly, any parents at all) find themselves very much dependent on the expertise of practitioners to carry out that project. Indeed, most parents rely on medical experts even to understand what it is possible to desire and pursue in the field of reproductive biomedicine.

Practices around prenatal genetic testing demonstrate the major role of authority through expertise. Many doctors simply expect women to undergo prenatal genetic testing and do not take time to discuss what it is, why it is done, or the potential consequences of an 'abnormal' result. Furthermore, studies indicate that, after an 'abnormal' result, the options presented to intended parents by experts favour therapeutic abortion of fetuses likely to be born with disabilities, and that experts do not provide prospective parents with important forms of information that might make continuing the pregnancy feel more viable (e.g. information about the wide range of severity in certain conditions, the experiences of people living with the conditions, or the perspectives of parents raising children with those conditions) (Parens and Asch, 2000).

In other words, both practitioners and patients experience structural constraints based on structural racism. For patients, these include both economic constraints and social ones, some of which I have described above. For practitioners, these include the norms, policies and expectations of their medical training, professional communities and home institutions. When patients struggle against these constraints, a lack of structural power often limits what they can accomplish, even collectively. If practitioners were to join in those struggles, working collectively with

other practitioners (and patients) to name and oppose the racial bias and racialized practices within their own institutions, the possibilities for change would be multiplied and magnified (Zheng, 2018).

Whether considered consciously or operating in the background of one's perception and decision-making, practitioners, patients and politicians alike hold values concerning human reproduction. Those things we value about our own lives or see others valuing in our own lives inform our imagination of what our children (or our patients' children) will value and what we owe them. Too often, however, what we value in life slips into assumptions about what constitutes a valuable life or which lives are valuable. Too often, these assumptions are written into policies.

As Black people around the world argue explicitly for the value of their own lives against a broad range of social attitudes and practices that effectively deny that value, I ask that practitioners of reproductive biomedicine take the time to consciously consider the values embedded in their expertise and institutions. I ask them to examine which lives they might implicitly and unconsciously be devaluing in their practice, and to meet this moment with resistance.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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