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## ORIGINAL RESEARCH


# Should fertility clinics divest themselves of pornography?

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**Abstract** Some commentators object to the way in which fertility clinics make pornography available to men as an aid to masturbation when those men produce sperm for evaluation, storage or IVF. These objections typically rely on claims that pornography is generally harmful to women, unnecessary and dissociates sexual acts from conception. In light of these objections, certain commentators want fertility clinics to divest themselves of pornography, but these objections to pornography are not morally convincing. In general, pornography can have psychological value to men masturbating 'on demand' in clinical contexts. Not all erotica must, either, work to the disadvantage of women in its means of production or social effects. Moreover, the sexuality expressed in masturbation has a value of its own, and conception apart from sexual intercourse is morally defensible on its own. Divestment from pornography would do little to constrain the putative harms of pornography because clinics consume only a fractional amount of the total amount of pornography available. The provision of pornography is a defensible clinical practice, even if it is not absolutely necessary to all men in producing a sperm sample important to their fertility or their interests in donating gametes. 

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Despite its entrenched presence in many parts of the world, pornography remains contentious not only as a matter of definition but also as a matter of its value and effects. Some commentators have offered unsparing criticism of straight pornography, namely erotica featuring women but produced primarily by men for consumption by men. Feminist and legal

critics have typically maintained that pornography is both a symptom of and continuing cause of the status inequality of women, that it represents women as subordinate to men, and that it even constitutes a kind of violence against women (Dworkin, 1991; MacKinnon, 1993). Critics have also maintained that the production of pornography preys on the

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diminished social status of women by drawing them into a line of work that exposes them to harm in sexual relationships they choose only as adverse preferences (Lahey, 1991). Degrading representations of and assumptions about women found in pornography are also said to carry over to men's actual relationships with women, for example, in men expecting women to be available to them as sexual servants (Satz, 2012). Some critics press the case against pornography even if they concede that pornography might have some value for some women under some circumstances, e.g. as useful in providing an opportunity for income in the absence of other opportunities or in enhancing sexual relationships with their partners. To be sure, not all legal or moral analysts are critical of pornography, not even all self-identified feminists (Strossen, 1993), but neither have its critics backed away from their interpretations of its harm.

Political scientist Courtney Daum (2009) notes that the 1980s and 1990s saw a great deal of analysis of pornography, especially from feminist perspectives, but that since then 'theorists have dedicated less discussion to the issue.' Even so, certain critics maintain objections to pornography in its classic forms and in its new roles, one of them being its presence in the ever-growing number of fertility clinics around the world. Mindful of classic objections to pornography, some critics have explicitly criticized fertility clinics for the widespread practice of making pornography available to their clients (Purvis, 2006). For example, healthcare analyst Julia Manning (2010) has objected to pornography in tax-supported UK National Health Service clinics on a variety of grounds, saying that it fosters unhealthy attitudes toward women, leads to humiliation of the staff, and misuses taxpayer money, among other concerns. She thinks that clinics should not make pornography available even if its producers were to donate it. For her part, bioethicist Cristina Richie (2015) also objects to the presence of pornography in fertility clinics, saying 'This is highly problematic, as heterosexual pornography has been implicated with being antithetical to women's welfare, due to power imbalances.' Richie claims that 'the diseases [sic] of pornography' involve the 'malicious dynamics' of the male gaze of domination in pornography; this framing effect involves the conceptualization and control of women as subservient to men, all the more so in sexual matters. Richie claims further that 'Those using reproductive technologies – from single women selecting ejaculatory fathers, to couples using donated sperm, to the man who becomes a sperm donor for pay – are all complicit in perpetuating the heterosexual pornography industry and all it entails' (Richie, 2015).

Richie also asserts an objectionable conceptual link between pornographers and fertility medicine:

Both the porn industry and sperm retrieval are predicated on metaphorical surrogacy. In both cases, a substitute takes the place of a human body and thereby severs the ancient link between orgasm in intercourse and conception. When a man provides a sperm sample at a fertility clinic, explicit materials take the place of physical foreplay. This arousal leads to ejaculation through autoeroticism rather than through partnered sex. As a man views print or video images of women, his sexual behavior is divorced from an actual association with an actual human body.

According to this interpretation, both pornography and fertility treatments presume sexual acts uncoupled from actual bodily interactions. In this way, pornography and

fertility treatment objectify women, if only because both practices involve disembodied 'sexual' relationships that function to the disadvantage of women.

In view of these interpretations, Manning and Richie both want pornography excluded from fertility clinics. Manning would turn away even donated pornography, saying that producers are aware of what she calls pornography's addictive nature. Not only would donation not resolve any of the central criticisms of pornography, she says the availability of this erotica would open men to the prospect of certain kinds of sex addiction or reinforce any addiction or dependency they already have (Duffy et al., 2016). With that kind of outcome, the donation of pornography would only be a self-serving extension of its producers' commercial interests. In any case, Manning argues that pornography is more or less unnecessary to sperm production, and she leaves matters there: at a call for divestment. By contrast, Richie recommends various alternatives to pornography as an aid to sperm collection: 'Both surgical sperm collection and electroejaculation techniques can produce semen samples without self-stimulation. So can partnered assistance and sexual intercourse with a condom.'

This paper will argue that these objections to pornography in the work of fertility clinics are unconvincing on both moral and practical grounds. In the discussion below, consideration will be limited to the provision of pornography by fertility clinics to adult males, as the role of erotica in the fertility preservation of minors requires its own focused analysis (see, for example, Crawshaw et al., 2007; Wheeler et al., 2011). I want to show that the provision of pornography is a defensible clinical practice, even if it is not absolutely necessary to all men in producing a sperm sample important to their fertility. This analysis will not evaluate specifically the claim that straight pornography is in its totality harmful to women as a class. That analysis would take us too far afield from a focus on pornography's role in fertility clinics by emphasizing issues and dynamics that would obscure smaller-grained questions. Instead, it will focus only on the defensibility in principle of pornography in clinical settings, by showing that pornography has value in those settings, that the argument that pornography involves a morally impoverished kind of sex is unconvincing as a bar to its use in the clinic, and that in any case divestment would have little practical effect on pornography markets or – indeed – access to pornography in an online age.

### Pornography in the clinic

Some commentators have defended pornography in fertility clinics on practical grounds, largely as a way of easing concerns about masturbation in a clinical setting, which can be embarrassing and involve anxiety and performance pressures (Thornhill, 2010). This is not to say that all men will welcome pornography without qualification. Some researchers have reported, for example, that access to pornography in fertility clinics may provoke a certain amount of anxiety in some Muslim men, if they believe that masturbation is wrong and that the pornography itself is also objectionable (Inhorn, 2007). Even so, other Muslim men report pleasure in having access to this kind of material where it can be culturally or legally difficult to obtain (Inhorn, 2007). For them, as for others, pornography can

'normalize' masturbation in circumstances where it might be otherwise problematic.

The value of pornography for resultant sperm quality is a matter of some debate. Some researchers have reported that sperm collected under conditions of strong sexual arousal can be more useful to clinicians than sperm collected in other ways (van Roijen, 1996). A 2000 study showed that 'sexually stimulating videotaped visual images' improved the outcome in sperm production on several criteria: sperm count, sperm motility and morphologically normal spermatozoa among them (Yamamoto et al., 2000). Other researchers have reported, by contrast, that access to print erotic materials when masturbating led to no meaningful differences in the quality of the resultant sperm (Handelsman et al., 2013). These researchers also suggest that erotic print materials are not in fact necessary at all, since subjects without access to those materials were able to produce sperm for evaluation or storage.

Even if this latter study is treated as wholly persuasive in regard to sperm quality, it does not follow that pornography has no value in the clinic; the latter study does not, after all, report subjects' preferences directly. Some of those preferences might be discernible indirectly by noting that men who had print erotic materials available to them took longer to produce sperm samples than those who did not. Either those erotic materials were a psychological impediment to sperm production, hence the delay, or maybe masturbation with print materials is more cumbersome relative to masturbation with video images and hence the delay. Or, to move in the other direction, maybe the men enjoyed their experience of masturbation with the materials and prolonged the time involved in producing a sperm sample for that reason. If the latter interpretation accounts for the longer time involved, it seems pornography can play a desirable – even if not absolutely necessary – role in sperm production in a clinical context. It is not clear why the perceived value of pornography as an aid to masturbation should count for nothing in an overall assessment of its morality, even if the most important effect in question is the pleasure involved. Why not, after all, try to offer men a pleasurable experience no matter that, strictly speaking, visual erotica may not be necessary for the purpose of producing sperm? Men who have religious or moral objections to the materials, or who find them distressing in any way, are of course free to decline their use. Their availability in clinics involves no involuntary affront to conscience.

As mentioned, Richie indicates that certain alternatives to pornography are available for sperm collection, but she glosses over the risks involved in the clinical alternatives. Considered from the point of view of the men producing sperm, masturbation involves little medical risk, except for men whose hearts might not be healthy enough for the exertion. Fertility clinicians would not ordinarily turn to the sperm-collecting techniques Richie holds out as alternatives, unless there were some clinically relevant reason to do so. As a matter of risk reduction, masturbation is to be preferred to techniques of electroejaculation, aspiration, or various kinds of surgical intervention. To turn to these techniques as a way of avoiding pornography in the clinic could only elevate the risks, costs and complexity of sperm collection. These techniques would introduce iatrogenic effects where none otherwise exist in reliance on masturbation aided by pornography. If pornography helps obviate the

need for more complex procedures of sperm retrieval for men, procedures involving more exposure to risk and more cost, then its use seems justified in a *prima facie* way as a matter of risk containment.

To be sure, Richie imagines any medical risks as avoidable if only people would introduce a sexual partner into the equation. Her proposal of 'partnered assistance' or 'intercourse with a condom' would in fact produce sperm for some people looking for help in having children, but the real value of this proposal – in the context of her overall analysis – seems to be in closing the gap between sexual acts and assisted conception, the very gap she says unites pornography and fertility medicine at the conceptual level. Sex with a partner would involve an actual encounter of one human body with another, as against a solitary man fantasizing to video or print images of a woman. By collecting sperm through partnered encounters, so the argument goes, fertility medicine would reintegrate conception and sexual relationships, if not perfectly then at least symbolically. From a perspective like this, one might even try and make the case that the dynamics of actual body-to-body contact would carry over to relationships outside the clinic in a positive way, contrary to the baleful dynamics allegedly carried over from masturbation aided by pornography.

While the conjunction of sexual intercourse with conception is an ideal held out in certain quarters ([Congregation for the Doctrine of the Faith, 1987 and 2008](#)), I see no reason to treat that ideal as normatively binding on all sexual acts or as a moral prerequisite for all acts of conception. Sexual acts detached from other bodies can be valuable in their own way, apart from any role in a relationship with another. For example, the pioneering Kinsey research group's book *Sexual Behaviour in the Human Male* (1948) indicated that men turn to masturbation early in their lives and apart from sexual contact with others. Masturbation can be valuable for – as the Kinsey researchers put it – 'the variety and the particular sort of pleasure involved' (Kinsey et al., 1948, p. 239). In fact, for many men acts of masturbation will be their most common sexual acts; many men will masturbate more in their lifetimes than have sex with a partner. As to possible carry-over effects of masturbation in regard to women, it is unclear that sexuality expressed this way stands in the way of conceptualizing and relating to women in morally acceptable ways. Men who masturbate more than they have sexual intercourse – even in their marriages – are not disabled by that fact alone from respecting women in morally relevant ways. Simply put, masturbation can have a value independent of physical sexual relationships with another person, and it is not clear that coupled sexuality is necessarily morally superior in itself to the sexuality expressed in masturbation.

At this point in the history of fertility medicine, it almost goes without saying that taking steps to have children need not involve bodies coupled in sexual acts to be moral. Acts of conception detached from sexual intercourse or other kinds of bodily encounters can be valuable in their own way, even if acts of conception secured through sexual intercourse or other kinds of bodily encounters are important to some people as a matter of religion or morality (Murphy, 2011). The detachment between bodies and conception that occurs in IVF has enabled the birth of the millions of children conceived through IVF and embryo transfer around the globe. Unless one wants to commit to the view that children

should only be conceived in acts of sexual intercourse between men and women, and maybe only by married men and women at that, it is unclear that relying on fertility treatments that dissociate intercourse from conception constitutes any moral affront. It is also worth pointing out that a man's sexual dysfunction might be the very reason he is in the fertility clinic, meaning that 'partnered sex' might be not be very helpful to him in the context of sperm production. 'Partnered assistance' as a way of producing sperm is not, therefore, morally superior on its face to solitary masturbation, with or without pornography involved.

### What if clinics divest?

Over the last few decades, the pornography industry has only grown, showing little effect of the moral complaints lodged against pornography as a genre. The United States not only consumes huge amounts of erotica, it is the leading exporter of pornography around the world (Schlosser, 2004). It is unknowable how much demand fertility clinics create for pornography on their own, over and above other demands for pornography, since there is no way to track sales limited to those venues and private clinics have no need to report their expenditures publicly. Even so, given the global reach of commercial pornography it seems safe to assume that whatever their demand, fertility clinics represent only a minuscule fraction of the overall market for pornography. As a practical matter, therefore, it is unclear that fertility clinics by themselves play any meaningful role in creating and sustaining commercial pornography. Even if every fertility clinic declined to provide pornography to any client again, chances are that the porn juggernaut will only continue, mostly online. (In 2015, for example, online pornography even managed to shove *Playboy* magazine – one of the pioneers of print 'soft' porn – out of the game entirely; that magazine will no longer carry photographs of nude females [Somaiya, 2015].) If critics want to argue against harms that attach to pornography, fertility clinics are poor choices as a place to start that fight over a product that is otherwise widely available and whose existence depends only negligibly on consumption by those venues. In any case, it is not clear why fertility clinics should have to act against the supposed ills of pornography on their own, divesting when no other social institutions having vastly larger roles in the commerce of pornography are expected to do so.

For the sake of the argument, however, let's assume that fertility clinics divest themselves of all pornography and that no other access to pornography is available for the purposes of sperm production. Advances in reproductive treatment and the expanding range of people eligible to benefit from them mean that fertility clinics will need more and more sperm, either from spouses, unmarried partners or from donors. If we credit the idea that access to pornography reduces anxiety in a clinical setting or, at the very least, normalizes sperm production in a clinical setting, it follows that excluding pornography from clinics would only increase the total amount of any anxiety that attaches to sperm production, as more and more men come forward looking for evaluation, storage or treatments. It is not clear that this is a negligible cost of divestment.

Of course, this kind of defence – representing pornography as useful or pleasurable – would not trump all anti-pornography arguments, since some of those arguments allege serious harms to women as a class. If these kinds of arguments were accepted at face value, one could make a plausible case that pornography ought not be available to anyone, clinics and their clients and patients included. However, this kind of conclusion relies on the credibility of the claim that pornography is profoundly inimical to the well-being of women, and to such a degree that it ought to be constrained by law and policy. Some analysts have concluded that relative to the important social interests in free speech and association, this kind of claim is not persuasive as a foundation for constraints against pornography as a matter of law and policy (Strossen, 1993). Again, it is not my intention to take up this larger question about the morality of pornography as such, but for purposes of this analysis I will say that even if there is some measure of credibility to the claim that pornography is harmful to women as a class, it is unclear why fertility clinics should be required to demonstrate greater justification for their involvement with pornography or to assume greater responsibility to divest from pornography, compared with all other social institutions sustaining commerce in pornography.

It is also worth noting that, parsed closely, standard objections to pornography do not necessarily require the exclusion of all erotica from fertility clinics. To be sure, not all critics of pornography argue against straight erotica *per se*; some typically build a case only against certain kinds of pornography, for example, pornography that objectifies women and represents them as subservient. If so, maybe what's needed in fertility clinics is only a different kind of straight pornography, one that has no objectionable components in its assumptions about women, no objectionable practices in its production, or objectionable social effects. Some pornography is perhaps more sensual in style than explicit, and some theorists defend this kind of pornography, even if they do not also defend the more explicit kind (Royalle, 2000; Willis, 1993). Perhaps more 'woman friendly' pornography would pass moral muster. Some critics of pornography might reply that no unobjectionable erotica is possible, but that's a hard argument to make: that all erotica must necessarily represent women as degraded in social status, contribute to that degraded status, or otherwise work against women's interests. This is not the place for a full-scale consideration of whether and what kind of erotica could avoid these baleful effects, about how lines might be drawn between acceptable and unacceptable erotica, about who should sit in judgment on where individual examples of erotica fall in relation to those lines. Those are meaningful questions in their own right, once one cedes the moral legitimacy of some kinds of erotica. For the purposes of this analysis it is enough to note, however, that as a matter of principle it is not clear that all erotica must necessarily degrade women in either its assumptions, its methods of production or social effects.

To make this point with another example, let me note that gay pornography would normally be immune to most of the standard objections to straight pornography. For example, men turning to gay porn belong to the same class of people being depicted in that pornography. Men presented in a sexual way for an audience of other men need not be presented as or presumed as social and sexual inferiors as a class. It makes little

sense to argue, for example, that gay pornography encourages men to assume the social inferiority of men as a class, comparable to the effect said to attach to straight pornography in regard to women as a class. Pornography involving men for consumption by men seems therefore exempt from standard objections to pornography, especially in regard to putative harms and threats to the social status of the people depicted. Unless gay pornography somehow otherwise propped up and sustained the much larger straight pornography industry, it would not seem to be complicit in the ills of straight pornography. If so, even in the face of criticism of straight pornography fertility clinics might in good conscience make gay pornography available to men looking to produce sperm, regardless of their sexual orientation, for any help it would provide.

## Conclusions

In arguing that fertility clinics are complicit in the social ills of pornography, some recent commentators note standard objections raised against pornography in general, namely objections that pornography involves harm to individual women and/or harm to women as a class. Over and above these concerns, these commentators also maintain that pornography is not necessary in fertility practices and that in various ways it presupposes and reinforces objectionable gender roles and meanings of sexuality. They therefore want clinics to divest themselves of pornography.

Is pornography necessary for sperm production for clinical and research purposes? For many – and maybe even most – men, probably not. Even so, for those men who find that ‘masturbation on demand’ can induce degrees of anxiety, access to pornography can help normalize the experience of sperm production. Even if pornography were not valuable that way, it is unclear why it should not be available as part of the overall accommodation of patients and clients as a matter of their comfort and preferences. Private clinics frequently offer amenities having no direct bearing on sperm production, but which make people feel more comfortable. For example, Manning (2010) reports that the British government spent £700 for pornography in one year, far less than it paid for tea, also available in clinics, which is entirely non-essential to sperm production (Thornhill, 2010). It is not clear why clinic accommodations must be framed entirely in terms of what is minimally necessary to clinical success. Even if pornography were necessary in some way, one could of course try and argue that its broader social harms are so significant (Whisnant and Stark, 2005) that clinics should nevertheless divest themselves of it. As a matter of moral consistency, that’s a hard argument to make when other institutions more fundamentally involved in producing and sustaining the commercial enterprise of pornography are not themselves under any moral or legal obligation to divest.

In some ways, of course, technology runs ahead of calls for fertility clinics to divest themselves of pornography. Even if fertility clinics withdrew from providing it altogether, pornography would not disappear as an aid to sperm collection since many of the men looking for help in conceiving children or intending to donate sperm to others will not need to rely on the good graces of clinics for erotica. For example, anyone

with Internet access via a wireless phone or mobile device will have access to pornography that way at all times, maybe even to texts and images from their own sexual partner(s). In regard to print, video or online erotica, some clinics counsel clients to bring in pornography of their own choosing, and one study shows that a good number of clients prefer that option (Crawshaw et al., 2007). Respondents in one study of males involved in fertility preservation indicated that bringing in material from home ‘was more likely to make sperm banking successful for them’ (Wylie and Pacey, 2011, p. 1263). Some clinics now also rely on home collection of sperm samples (Thornhill, 2010; Agarwal et al., 2015). Men producing sperm samples at home are, of course, free to do so with or without pornography, beyond the reach of anyone’s gatekeeping powers. This is all to say that even if clinics declined to make pornography available, it could be – and probably would be – very much involved in the production of sperm samples in large swaths of the world.

Turning over the responsibility for the use of pornography to clients and patients would, of course, shield clinics from anti-pornography criticism; clinics would be absolved of even the perception of complicity with the harm said to be involved in pornography. Shifting the burden this way, from clinics to male patients and clients would not, however, necessarily reduce the total overall consumption of pornography, but instead simply shift the sites of its consumption, in which case divestiture would be an empty victory for critics wanting less of it all the time. In any case and moreover, it is unclear why shifting patterns in access to pornography (from print and video tied to a specific location to online images available anywhere) should be understood as a moral argument against the right or privilege of clinics to provide pornography if they wish to do so, so long as the pornography provided is otherwise a legal product and morally acceptable for use by adults in general. That a previous means of delivery for pornography is supplanted by a novel means does not invalidate the prior means of access on moral grounds. Even in the age of online access, some clinics might still wish to offer pornography to men who, for example, lack access to pornography altogether for one reason or another, or they might wish to offer it simply as part of the amenities they offer, online or otherwise.

Beyond questions of necessity and access, a more philosophically sophisticated objection to pornography in clinical settings is that it presupposes and reinforces objectionable views of sexuality, specifically by dissociating sexual acts from bodily interactions. While this argument is more philosophically sophisticated, it is not for that reason more convincing relative to law and policy. Some people might find it desirable that body contact be involved in conception somehow, but it does not follow that all conception must approximate that ideal so far as possible in order to be morally defensible. Masturbation is pleasurable in itself and need not suffer in that value by moral comparison to sexual intercourse. Moreover, too many children have already been conceived by IVF and embryo transfer to cast doubt on the value of dissociating – for some people – their sexual acts and acts of conception.

Ultimately, the morality of pornography cannot be evaluated only in regard to its alleged harms, whatever those might be; neither will its morality depend only on its alleged benefits, whatever those might be. Its morality will

ultimately depend on the comparative weight of those harms and benefits measured against background rights and duties, rights and duties that are both moral and political in nature. The broader debate about the morality of pornography will not therefore be resolvable by reference to its role in the fertility clinic alone, but so long as pornography is defensible as a matter of expression, relationships and commerce generally, it is hard to see that any particular moral significance should be attached to its use in fertility clinics. If access to pornography in clinics requires a moral justification over and above its immediate pleasure, helping people conceive children seems about as persuasive a justification as is necessary, barring any argument that the overall effects of pornography are so harmful that no one should ordinarily produce it or have access to it.

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