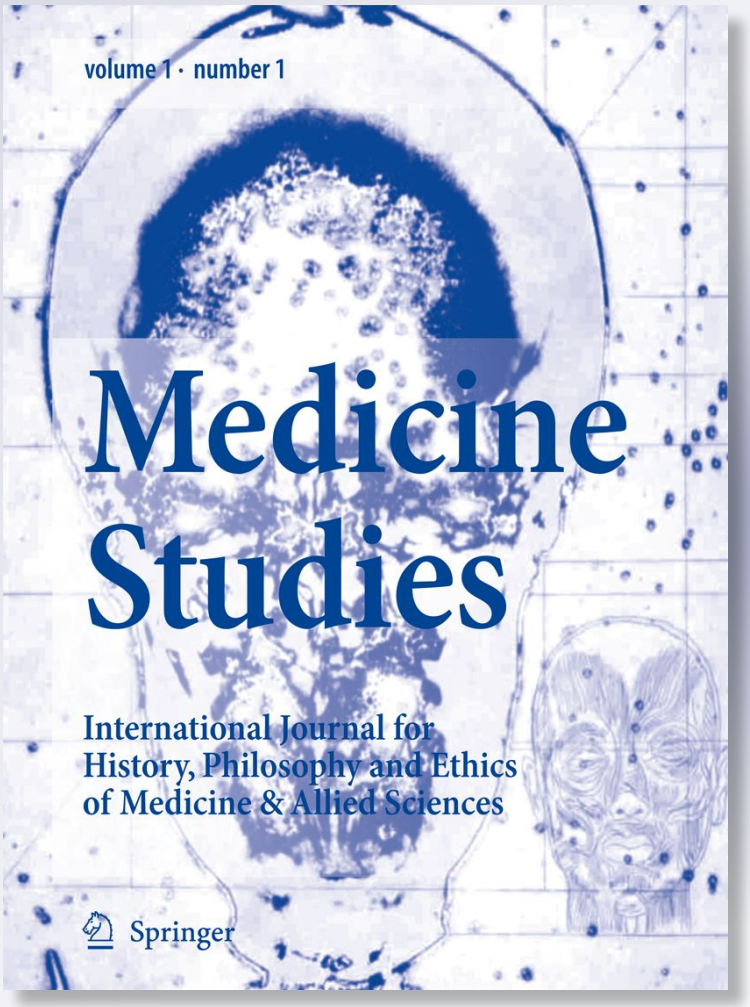
An Ethic of Care and Responsibility: Reflections on Third-Party Reproduction

Carmel Shalev

Medicine Studies
An International Journal for History, Philosophy, and Ethics of Medicine & Allied Sciences

ISSN 1876-4533

Medicine Studies
DOI 10.1007/s12376-012-0074-z



Springer

Medicine Studies
DOI 10.1007/s12376-012-0074-z

An Ethic of Care and Responsibility: Reflections on Third-Party Reproduction

Carmel Shalev

Received: 13 September 2011 / Accepted: 23 February 2012

Abstract The rapid development of assisted reproduction technologies for the treatment of infertility appears to empower women through expanding their individual choice, but it is also creating new forms of suffering for them and their collaborators, especially in the context of transnational third-party reproduction. This paper explores the possibility of framing the ethical discourse around third-party reproduction by bringing attention to concerns of altruistic empathy for women who collaborate in the reproductive process, in addition to those of individualistic choice. This would entail moving beyond an ethic of liberty that is based on self-interest and the language of rights, to an alternative ethic of care that is based on self-restraint and the language of responsibilities. An ethic of care and responsibility would cultivate the empathetic self-reflection of the autonomous actor in relation to those others who are part of the enterprise of bringing a child into the world.

This is part of a paper that was presented at the Bioethics Colloquium Series of the Bioethics Education Platform, Innsbruck Medical University and the Institute for Christian Philosophy, Innsbruck University, on October 12, 2010. My thanks to Prof. Gabriele Werner-Felmayer for her invaluable intellectual insights.

C. Shalev (✉)
Faculty of Law, Haifa University, 40 Shlomzion HaMalka Street, 62266 Tel Aviv, Israel
e-mail: cshalev@012.net.il

Keywords Assisted reproduction technologies (ART) · Third-party reproduction · Ethic of care · Responsibility

Introduction

Since the introduction of in vitro fertilization (IVF) and the emergence of fetal diagnostics in the 1980s, medical technologies have brought an unprecedented degree of control over the reproductive process, together with a dramatic expansion in the realm of possibility and choice for women who wish to be mothers. In latter years, most notably, the age of first-time motherhood has been extended by a decade so that women in their fifties are now carrying and birthing children conceived from the egg cells of another woman. Parallel changes in social norms of marriage and sexuality have made it possible for individuals and couples, both same sex and heterosexual, to exercise great creativity in making use of assisted reproduction technologies (ART) so as to shape new forms of family and biological kinship in collaboration with gamete donors and surrogate mothers.

Yet, while the interface of reproductive technologies with medical genetics appears to empower women through expanding their individual choice, it has not eliminated the suffering[1] associated with infertility and

[1] The term "suffering" is used in its common sense, meaning the bearing of pain, sorrow or distress.

Published online: 23 March 2012

its treatment. These entail not only incidental health risks and intrusion into privacy and bodily integrity, but also emotional harms such as low self-esteem, grief, shame and blame, anger and anxiety, stress and depression, and stigma (Cwikel et al. 2004; Whiteford and Gonzalez 1995). Similar physical and emotional harms are of concern also in relation to those women who assist an infertile couple in realizing their desire for a child. In addition, women who are involved as egg donors or surrogate mothers in commercial third-party reproduction practices, are vulnerable to social harms that are rooted in the structural injustice of underlying global inequalities (Ikemoto 2009).

In an article on the ramifications of global commercial surrogacy for the children-to-be, Jennifer Parks pointed to certain relational harms that are overlooked by the liberal discourse of freedom and non-interference. She discussed the case of an infant born in India to a couple from Japan, who was not wanted by either the Japanese or the Indian mother. Her paternal grandmother wanted to take responsibility for the child, but because of certain legal formalities, she was unable to get her a certificate of identity or a passport so as to take her back to Japan. Transnational surrogacy relationships can indeed raise thorny issues around the child's right to acquire a nationality (Convention on the Rights of the Child, 1989, article 7). However, Parks points out that the case also involved "acute identity issues," "dispossession" and violation of "the right to human care". She argues that since liberal theory is an unsatisfactory framework for addressing such relational harms, there is a need to articulate and apply an ethics of care (Parks 2010).

While Parks' focus is on the children-to-be, this paper suggests a similar approach to the relationships between would-be parents and the third-party women who play an indispensable role in the enterprise of bringing a child into the world for them. It starts by describing some of the typical ways in which infertility and its medical treatment are a source of suffering for women who wish to have children and are unable to do so. It goes on to consider the vulnerabilities of third-party reproductive collaborators to physical, emotional and social harms. The paper then suggests that the liberal view of third-party reproduction as a matter of freedom of contract between rational individuals coming together for mutual benefit, fails to capture and address the relational needs and interests of the involved parties. Finally, it proposes to move beyond an ethic of liberty that is based on self-interest and the language of rights, to an alternative ethic of care that is based on self-restraint and the language of responsibilities.

Infertility and Suffering

The condition of infertility as such is a source of suffering. Despite the profound changes in the social status of women and norms of gender equality, which occurred worldwide in the later decades of the twentieth century, fertility and parenting remain important to social standing and self-identity for both women and men all over the world. Although it is widely recognized that reproductive freedom is central to women's ability to lead autonomous lives, and it is evident that higher levels of women's education are correlated with lower numbers of children, still voluntary childlessness is not common, and involuntary childlessness remains stigmatic. The experience of infertility is shaped by social context and can be devastating, especially for women (Greil 1997; Greil et al. 2010). For women, "barrenness" is a source of shame and social suffering. For men, the inability to produce offspring is a humiliation and a slight on manhood.

There are also new forms of suffering associated with the medical treatment of infertility. IVF is an invasive medical procedure, involving hormonal drugs and surgery, with relatively low success rates. The physical challenges are well known. IVF carries significant health risks to both the woman and the potential child, most significantly, those ensuing from ovarian hyperstimulation, multiple pregnancies, premature newborns and associated birthing and neonatal complications (Joint SOGC-CFAS Guideline 2006; Ombelet et al. 2006). In addition, the medical treatment of infertility is emotionally demanding for the infertile couple, and particularly for the woman. Because infertility involves an inability to achieve a desired goal (having a child), despite attempts at medical intervention, it is often associated with psychological distress (Greil et al. 2010). Infertility and its treatment are associated with higher risk of anxiety, depression and stress (Hämmerli et al. 2009; Verhaak et al. 2007). The stress of complying with the medical regimen puts strain on the couple's intimacy and sexual relations. There is an emotional toll that comes with the rise and fall of hope and despair, with each unsuccessful cycle of treatment. Especially for women, life comes to center round the

medical regimen and a compulsive preoccupation with the desire to have a child. Men employ other coping mechanisms, often taking refuge in the routine and normalcy of their work (Gilai-Ginor 2010; Birman 2010).

Many otherwise childless individuals and couples have been able to fulfill their desire to become parents by means of ART, but medical intervention does not cure infertility. Furthermore, the technological possibilities generate new social constructs of infertility and, hence, new forms of suffering from childlessness. For example, for postmenopausal women, it is no longer a natural fact of life that they cannot have a child, but rather a socially constructed tragedy that can be treated medically (Rothman, 2000, 179). They might be too old to conceive with their own eggs, but perfectly able to carry a pregnancy and deliver a child conceived from the egg of a donor. At the same time, eggs from donors are not a readily available resource, and there is a so-called "shortage" of eggs that makes it difficult to actually realize the potential of the technology. This can be a source of deep frustration. For example, during the parliamentary debate on egg donation in Israel, one participant testified she had traveled to Eastern Europe for an egg donation as many as ten times and still did not have a child.

Although women nowadays enjoy unprecedented autonomy, independence and control of their lives, not all their wishes and aspirations can be fulfilled. The promise of a technological fix generates new needs and desires, but if not met, they become the source of new forms of suffering for women who wish to become mothers. What is more, the satisfaction of their desire comes at substantial cost to other women who assist them in doing so. For each of the ten times that one woman seeks an egg donation, there is another woman who has placed herself at risk so as to give her what she wants.

Third-Party Reproduction

A major feature of medically assisted reproduction is the dissection of biological parenthood into five distinct functions that are not necessarily filled by only one mother and one father. In many cases, individuals who wish to have a child will need the assistance not only of medical experts and technicians but also of other persons who provide sperm or egg cells, or act as surrogate mothers. This realm of interpersonal interaction is also wrought with potential suffering.

The transnational market in egg cells for infertility treatment raises a multitude of ethical issues related to the commercialization of medicine, the commodification of human body parts and the exploitation of women (Shalev and Werner-Felmayer 2012). Similar concerns arise in relation to global commercial surrogacy. As Parks suggests, the contract between the commissioning couple and the surrogate mother creates a complex relationship that is not fully addressed by a legalistic contractual perspective (Parks 2010). The liberal approach needs to be supplemented with an ethic of care, concern and responsibility, which addresses the relational aspects of the transaction.

One major characteristic of practices of so-called "third-party" reproduction is the fragmentation of women's reproductive roles as genetic, gestational and social mothers. In many countries gamete donation (whether sperm or eggs) is based legally on a principle of anonymity, which precludes personal contact between the individuals who collaborate in the reproductive enterprise. In surrogate mother arrangements, anonymity is less feasible, but the legal principle of confidentiality, which is designed to protect the privacy of the parties to the arrangement, often precludes any ongoing relationship between the reproductive collaborators and conceals the identity of the gestational mother from the child-to-be. One of the results of these widely accepted legal norms is the objectification of women's bodily functions and parts (wombs and eggs). We do not know the names of the women, and we do not see their faces. This makes it easier to treat them as instruments for the fulfillment of our desire. In this way, the fragmentation of reproductive functions leads to the objectification and commercialization of sperm, eggs and wombs as market commodities.

In general, practices that involve anonymous reproductive actors are breeding grounds for shame and secrets. The silences go to the very self-identity of the children, and their right to know their biological origins and the circumstances of their coming into the world (Baran and Pannor 1993). Lessons might be learned from closed adoption practices, where the shroud of secrecy led to fears and fantasies of the birth-mother as a "floozy" or "whore.". For many women, egg donation or surrogate motherhood is motivated at least partially by noble altruistic motives of giving. Yet, many engage

in these activities because they are living in poverty and have few other ways to make money. Although the selling of reproductive services is not quite the same as the selling of sexual services in prostitution, one's occupation as sperm or egg donor or as a surrogate mother is far more likely to be a subject that one keeps to oneself than a proud achievement of which one might brag to others (Nahman 2008).

Third-party reproduction practices are now associated with emerging markets of cross-border reproductive medical tourism, which is largely due to legal restrictions on domestic access to medically assisted reproduction technologies that are available abroad, together with global economic disparities that create financial incentives to seek the assistance of reproductive collaborators in low income countries. For example, the standard payment for one cycle of egg donation in the USA is $5,000 (ASRM 2007), while women in Romania may earn as little as $200 per retrieval cycle (Nahman 2008). Economic and legal disparities between countries of departure and destination result in stratification of buyers and sellers, designated parents and reproductive laborers, fathers or mothers and others. Reproductive tourism raises concerns that are similar to those associated with international adoption and sex tourism (Storrow 2006). It is driven by structural inequalities that create conditions in which some women's best economic opportunity is to sell the use of their eggs or their wombs to others (Ikemoto 2009). The transnational flow of technologies, human beings and body parts is justified by an ethic of reproductive freedom but also increases the commercialization of medically assisted reproduction and the commodification of women's bodies, and is fertile ground for exploitation. When compared with transplant tourism, it becomes evident that attention should be paid to the vulnerability of egg donors and surrogate mothers to potential harm.

"Google Baby," a documentary film on surrogate mothers in India (dir. Zippi Brand Frank 2009), shows women who leave their homes and families to live in a bare dormitory where they can be fed and monitored for the duration of their pregnancies. We do not see the women engaging in any activity or exercise, not even walking in a courtyard. In fact, they are kept hidden out of sight in housing that brings up images of 19th century homes for unwed mothers and prisons. After delivering the child, they might have enough money to buy a small home, but the film portrays the women's experience as emotionally complex.

Surrogate mothers might be more present in our imagination of third-party reproduction than egg donors, but it appears that the dimensions of commerce in egg cells have expanded in recent years, in response to the demand generated by postmenopausal women, and have outgrown the surrogacy market. As opposed to sperm, which is abundant and easily obtainable, mature egg cells are a scarce, delicate and hidden resource. Procurement of egg cells entails invasive medical intervention with risks of ovarian hyper-stimulation, but commercial interests will be geared probably toward maximizing yields at the expense of donor health (Shalev and Werner-Felmayer 2012). Empirical evidence on reproductive tourism is scant, and there are little epidemiological data on the actual risks for egg donors in the context of cross-border reproductive care (Hudson et al. 2011). But one UK press report brought the stories of two women who claimed to have suffered health damage after donating eggs at a clinic in Bucharest, which was collaborating with a private clinic in London. One of the women, aged 18 at the time of the donation, was left with scarred ovaries that rendered her infertile (Abrams 2006).

Liberty and the Market

The dominant approach in bioethics in general, and in reproductive bioethics in particular, is based on two key principles. First and foremost is the principle of individual liberty, that is, personal autonomy and reproductive freedom (Robertson 1996). Second is the qualification that a restriction of liberty might be justified, based on a weighing of the ratio of benefit to harm. This is also the fundamental logic and philosophy of the free market, based on the underlying value of individual freedom of transaction. Accordingly, one might argue that if there is someone who wants to buy a reproductive service and someone who wants to sell, and both are better off after the transaction, then what reason is there to interfere?

At the same time, in actuality, the market is driven for the most part by for-profit motivation, rather than any moral ideal of personal freedom. Novel reproductive technologies create new markets of consumers. For example, the technology generates the demand of middle-age women for the egg cells of other women. Once a new market is established, the greed of medical entrepreneurs is complemented by a

consumerist discourse of desire. The language of "would like" or "want" translates into "need," which then turns into a sense of entitlement (to have a child) and the assertion of a "right" (to use the technology),[2] together with a demand for immediate gratification.

The result is a technological culture of self-centered materialism that undermines longstanding values of respect for human beings by breaking down the human body into parts, reducing them to transferrable property and devaluing them as tradeable commodities. Within the market discourse, reproduction transforms from an act of sexual love into a transaction of money; donors are actually sellers (Nahman 2008), and the child ceases to be a gift and becomes a technical project (Sandel 2007). In the process, the mystery and magic of bringing a new life into the world and the human relationships that are essential to procreation lose their soul.

Thus, we see a shift from planning families or parenthood (which was the essence of the concept of women's reproductive choice when it emerged in the 1960s) to planning a child. With the mapping of the human genome and genetic research for markers of disease and traits, technology now brings promises of genetically enhanced designer babies. The main difference between this and the eugenics of the twentieth century is that the former were dictated by a state policy of race hygiene, whereas the current trends are presented as a matter of individual choice (Buchanan et al. 2000). Women's (and men's) right to choose freely *whether, when and how often* to have children, is a recognized principle in international human rights law and key to women's social equality (CEDAW 1979, Article 24). Medically assisted reproduction offers yet another level of choice, as to *with whom* to have children. Arguably, that too could be regarded as a matter of individual freedom, autonomy and privacy, and protected as such from undue state interference. But the extension of individual choice to preferences about the traits of the potential child as desired or undesired progeny is a different matter.

Even if infertile individuals have a protected right to choose with whom to have children, the question remains whether there might be justification to set certain limits on the form of the reproductive relationship. In an ideal world, where all reproductive collaborators are equally free agents, the collaboration is consensual, and no harm ensues, state interference would be "undue." In reality, the question is what restrictions on contractual freedom are needed and can be justified so as to control potential harms. Traditionally, the law has set certain constraints on private transactions in the free market. In many legal systems, agreements that are unlawful, immoral or contrary to the *ordre publique* are not legally binding. They do not constitute contracts, even if all parties entered them of their own full accord and free will. This rule must be applied with great caution, so as not to use the force of law to impose publicly accepted moral norms upon individuals in their consensual private relations (Hart 1963).

Yet, the market mentality offers a myopic, self-centered and egotistic view of an activity (reproduction) that necessarily requires collaboration between one and at least one other. This intrinsic feature of human reproduction has not been altered by technology. Even the idea of human cloning—supposedly a technique of asexual reproduction—would still require an egg cell donor and a gestational mother. Medical assistance also entails a team of medical caregivers and laboratory technicians, not to mention the administrators, the lawyers and the go-betweens. While the mentality of the market is self-regarding, the technological reproductive project is essentially relational.

Liberal theory rests upon a distinction between self-regarding and other-regarding actions. Once our actions impinge upon others, we are no longer completely free to do as we wish. Some individual choices have a profound effect upon others. Choices that we make to form and fashion the lives of our offspring are not self-regarding. Choices that we make with regard to our reproductive collaborations involve and affect others by definition.

Liberal values offer an impoverished vision of human interaction that isolates individuals, views them as essentially separate from others, abstracts

[2] The language of "right" is a misnomer. Strictly speaking, a "right" as such exists only in relation to a duty holder, for example, by virtue of contract. As for human "right"s, these have universal application regardless of personal economic resources, while the market is an arena of "privilege" for those with the ability to pay, from either personal or collective resources. Under present conditions, the use of repro-genetic technology is dependent on economic ability, and in many parts of the world, it is not accessible for most people. From a human rights perspective, the question is how to render the technologies universally accessible to those who essentially need them, and to prioritize them in relation to other much needed essential technologies, including safe child birth.

them from their relationships, and values independence and self-sufficiency rather than interdependence and cooperation. The ethos of the buyer–seller relationship does not adequately capture the moral demands of caring about the different forms of suffering that are produced by transnational practices of third-party reproduction. Ever since the groundbreaking work of Carol Gilligan, feminist ethical theorists have suggested to complement liberal theory with an ethic of care that is based on the view and understanding of human beings as social creatures and interconnected selves (Jaggar 1999). This kind of approach seems highly appropriate for reproductive collaboration. It seems we need to move on beyond the self-centered liberal ethic of individual freedom and rights, to a relational ethic of care and responsibility. Rights holders are empowered individuals. In exercising their liberty and freedom, they wield power over others who are affected by their actions. Choice carries responsibility, and in the arena of third-party reproduction, there are heavy moral stakes.

Ethic of Care

Bioethics is often thought of as the domain of moral philosophers and academic experts, who discuss the legal, moral and social implications of technological innovations so as to set the limits of permissible usage. Or, bioethics can be understood as a realm of professional self-regulation, producing codes of conduct for scientific researchers or for healthcare providers. Indeed, an ethic of care has been proposed as a relevant framework for the medical and nursing practices of care giving (E.g., Carse 1991; Benner 1997). Here, I would like to explore an ethic of care as guidance for the individual consumer of reproductive medicine and technology. Individual reproductive choices are not strictly medical, but have legal, ethical and social implications. The women who mediate the technology are in fact moral pioneers (Rapp 2000). Those who are exercising liberty and making the actual choices and decisions deserve to be regarded as moral agents, who bear responsibility for the impact of their actions upon others.

Individual repro-genetic choices are intrinsically other-regarding and necessarily impinge upon others. In the first place, the very purpose of the reproductive choice is to create an other (the child-to-be); in the second place, the activity of reproduction is dependent on collaboration with existing others. An ethic of care would require the infertile individual to transcend self-interest, to acknowledge and appreciate the relational context of his or her repro-genetic choices, and to care about and for the others whose collaboration is indispensable to realizing the desire to give birth to a child.

The mentality of the market is egotistic, instrumental and exploitative. One acts for one's own benefit, makes use of others and profits from that use at their expense. On the other hand, the disposition of caring is other-regarding. It is altruistic and collaborative. The other is an end and not a mere means. Care is an essential human quality and a fundamental aspect of human life. We are not only givers of care, but primarily its recipients. Acknowledgment of the roles that others have played in bringing us to where we are today, teaches us to decenter ourselves as agents and appreciate our interdependence in the world (Tronto 2010). We all have the experience of having been cared for—without having been taken care of, we would not be here at all. The ethic of care is a pillar norm of family and kinship relations. It seems particularly apt to apply it to the process of collaboration that is necessary to bring a new person into the world.

The ethics of care has developed largely from an analysis of mothering as a defining paradigm. All humans are dependent on mothering at some point in their lives. It is the first and most essential relationship all humans experience. Thus, the ethic of care elaborates a moral perspective said to arise from women's characteristic experiences of nurturing particular others, especially their experiences of rearing children (Gilligan 1982; Noddings 1984). Nonetheless, care does not necessarily have to be a gendered notion. Naturally men, too, have the capacity to care—both to be caring persons and to perform caring actions.

The idea of care as the organizing principle of an ethical theory originated in the work of Carol Gilligan. Her seminal work, *In a Different Voice* (1982), challenged the then dominant view that women were generally inferior to men in terms of their capacity for moral development. Gilligan studied the ways boys and girls reached moral decisions, and concluded that they applied different modes of moral reasoning. She termed the male mode of moral reasoning an "ethic of justice," and contrasted it with the "ethic of care" that was typical of female moral reasoning. The "ethic of

justice" is described as impartial and dispassionate; it derives particular moral judgments from abstract universal principles, and emphasizes individual rights and norms of formal equality. By contrast, the "ethic of care" is described as personally engaged and grounded in relationships, it seeks to resolve moral dilemmas in ways that preserve and maintain relationships, understands moral judgments as responsive to the needs of others in a concrete situation and emphasizes personal responsibility for particular others above impersonal principles of rights, equality and justice.

Care and caring are about relatedness, receptivity and responsibility (Noddings 1984). The traits involved in care—concern, empathy, compassion and kindness—are facets of an outgoing disposition that is emotionally sensitive to the needs of others and is concerned with their good. Empathy is the capacity to imagine oneself in the position of others and to appreciate how they experience their circumstances (Carse 1991). Compassion is the ability and willingness to be present and abide in a nonjudgmental manner with the discomfort of another, and to respond to discernable needs. These skills are related to the understanding of mutual interdependence and vulnerability as characteristic of human relationships. Kindness comes from an innate impulse to help others, because they matter to us and we want to matter to them.

> "Morality is not about serving others' interests through the process of disserving one's own interests. Rather, morality is about serving one's own and others' interests simultaneously. When we engage in ethical caring we are not denying, negating, or renouncing ourselves in order to affirm, posit, or accept others. Rather, we are acting to fulfill our fundamental and natural desire to be and to remain related." (Tong 1998, 148)

The capacity to care is a skill of emotional intelligence. Its essence is to see beyond one's narrow self-interest and act out of altruistic motivation, to acknowledge the suffering of others and respond to their needs, because we truly care about their welfare.

Caring about Fragmented Reproduction

Let us return now to the subject of third-party reproduction and consider one particular scenario in light of the ethic of care. Let us assume that a 30-year-old married woman (whose name is Ann) cannot have a child because she does not ovulate and is also unable to carry a pregnancy. She lives in a country where the law does not allow either egg cell donation or surrogate motherhood arrangements. She and her husband are economically well-off and can afford to travel to other countries where these services can be accessed and purchased through medical practitioners offering their clinical services in the private market. What are the ethics of the relationship between Ann and Barbara, the egg cell donor, or Carol, the surrogate mother, whose services she needs in order to birth a child?

Seen through the lens of an ethics of care, I can acknowledge the suffering of Ann, the infertile married woman, and empathize with her desire to have a child. I can see how her suffering is the result of an unfulfilled desire that is produced by a combination of certain social and technological conditions. I can also respect the choice that she makes to engage as an actor in the field of reproductive tourism, even if I myself might not have done so were I in her shoes. I realize that there is a dilemma that has no absolute right or wrong outcome, and so I will withhold judgment.

At the same time, and because I respect Ann as a moral agent, I would like her to reflect upon her options, including the possibilities of self-restraint and inaction. Also, I would like her to reflect upon the manner in which her motivations, her actions and her manner might impact upon the needs of Barbara and Carol, the other women who will fill certain essential roles of mothering in the process of bringing a child into the world for Ann to raise as her own.

Ann might feel that she is a victim of her infertility, but in relation to Barbara and Carol, she has power and moral agency over its exercise. She has a liberty-right to buy services in the unregulated market place of transnational reproductive tourism, and she has the privilege of being able to afford to do so. If Ann were a consumer of mere goods, she might act out of greed and harm no one save herself. But she is not buying an extra pair of high-heeled shoes or one too many pieces of apple strudel. She is activating a process and initiating relationships that are intended to culminate in the birth of a child. I would like her to care about the process and about the welfare of the other women who will be part of it, as well as that of the future child. With the power of

privilege and the wherewithal to make one's choices materialize, there comes responsibility.

Market practices and technological logic have fragmented and depersonalized the delicate and intimate process of mothering children into the world. They make it all too easy to deface the images of Barbara and Carol and erase their personae, to regard them as providers of mere bodily functions and to reduce them to egg cells and wombs, as if "the lady vanishes" (Dickenson 2007). Notwithstanding the hi-tech innovations of medically assisted reproduction, the essential nature of reproduction remains the same—it is relational, and the child-to-be is the connection that forms the relationship. All the women collaborating as mothers in the reproductive process are in active relationship vis-a-vis the future child, even though it does not yet exist. It is not difficult to imagine the need for a loving, caring and harmonious passage into the world.

The relationship between the women who collaborate as mothers in third-party reproduction practices is one of mutual interdependence and vulnerability. Ideally, they would be connected in a web of seeing and responding to each other's needs. Sometimes all that caring takes is human touch. Comfort measures that are central to nursing care can appear trivial when compared with powerful technological interventions. But holding a hand, bringing food and drink or simply listening and being present are the kind of care that makes human beings connect in relationship (Benner 1997). But in the impersonal anonymous model of transnational reproductive tourism, distance makes it nigh impossible to discern and respond to need. Viewed from the approach of an ethic of care, we need to ask who is responsible for what caring and to whom? It is not surprising that the disconnection and detachment between the women in current practices of transnational third-party reproduction precludes any one of them from taking responsibility. As if all the mothers relinquish responsibility toward one another and toward the child-to-be.

Conclusion

One characteristic of moral dilemmas is that no right answer appears readily. Whichever way we look at it, we appear to be in trouble. This is one reason why I hesitate to impose my opinion or view on someone else. I might be wrong; therefore, I respect her choice and empower her to make her own decision. In liberal discourse, the individual's right to autonomy includes the right to make mistakes, and at this point, we move into the sphere of responsibility. The autonomous person is responsible for the consequences of her choices, including her mistakes.

Responsibility is more, however, than the right to make erroneous choices. It also reflects the interdependence of human beings, because our choices have impact on others. We are not isolated atoms and do not live on desert islands. We come into the world connected by an umbilical cord to another human being. We are social creatures by our nature. My right to make decisions and to be free from coercion in doing so does not release me from the responsibility to reflect upon the probable effect of my actions upon others with whom I am in relationship.

Repro-genetic medicine is a testimony to the marvelous achievements of human reason. It is seductive and irresistible, but it has also produced much suffering. We need now to cultivate emotional intelligence, so we are able to use the technologies at our disposal in a skillful way. We need to cultivate a wisdom of the heart rather than the head. We need to understand that we cannot control life, that our desire for gratification is a greed that can never be fully satisfied, and that our lives are interconnected in relations with others. An ethic of care and responsible self-restraint requires a shift in consciousness: from calculation of self-interest and benefit to contemplation of our mutual vulnerability and interdependence; from observation of others as external objects and instruments for our own ends, to inner awareness of the seamless web of life and relationship in which we are implicated by our very nature as human beings.

References

Abrams, F. 2006. The misery behind the baby trade**.** *Daily Mail*, 17 July 2006. http://www.dailymail.co.uk/femail/article-396220/The-misery-baby-trade.html.

ASRM (American Society for Reproductive Medicine). 2007. Financial compensation of oocyte donors. *Fertility and Sterility* 88: 305–309.

ASRM (American Society for Reproductive Medicine). 2008. Ovarian tissue and oocyte preservation. *Fertility and Sterility* 90: S241–S246.

Baran, A., and R. Pannor. 1993. *Lethal secrecies: the psychology of donor insemination, problem and solution*. Cambridge: Amistead Press.

Benner, Patricia. 1997. A dialogue between virtue ethics and care ethics. *Theoretical Medicine* 18: 47–61.

Birman, Zviya, Eliezer, Witztum. 2010. *To bear a child.* Tel Aviv: Aryeh Nir Publishers (Hebrew).

Buchanan, A., et al. 2000. *From chance to choice: Genetics and justice*. Cambridge: Cambridge University Press.

Carse, Alisa L. 1991. The voice of care: Implications for bioethical education. *Journal of Medicine and Philosophy* 16: 5–28.

CEDAW. 1979. *Convention on the elimination of all forms of discrimination against women*. United Nations.

Cwikel, Julie, Y. Gidron, and E. Sheiner. 2004. Psychological Interactions with Infertility among women. *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 117(2): 126–131.

Dickenson, Donna. 2007. *Property in the body*. Cambridge: Cambridge University Press.

Fine, Michael, and Caroline Glendinning. 2005. Dependence, independence or interdependence? Revisiting the concepts of 'care' and 'dependency'. *Ageing and Society* 25: 601–621.

Franklin, Sarah, and Celia Roberts. 2006. *Born and made*. Princeton: Princeton University Press.

Gilai-Ginor, Hannah. 2010. *The desire for a baby: On the emotional price of infertility treatment*. Accessed 25 Sept 2010. http://www.horuta.co.il/article03.html (Hebrew).

Gilligan, Carol. 1982. *In a different voice*. Cambridge: Harvard University Press.

Greil, Arthur L. 1997. Infertility and psychological distress: A critical review of the literature. *Social Science and Medicine* 45(11): 1679–1704.

Greil, Arthur L., Kathleen Slauson-Blevins, and Julia McQuillan. 2010. The experience of infertility: A review of recent literature. *Sociology of Health & Illness* 32(1): 140–162.

Groenhout, Ruth. 1998. Care theory and the ideal of neutrality in public moral discourse. *Journal of Medicine and Philosophy* 23(2): 170–189.

Hämmerli, Katja, Hansjörg Znoj, and Jürgen Barth. 2009. The efficacy of psychological interventions for infertile patients: A meta-analysis examining mental health and pregnancy rate. *Human Reproduction Update* 15(3): 279–295.

Hart, H.L.A. 1963. *Law, liberty and morality*. Stanford, CA: Stanford University Press.

Hudson, Nicky, et al. 2011. Cross-border reproductive care: A review of the literature. *Reproductive Biomedicine Online* 22(7): 673–685.

Ikemoto, Lisa C. 2009. Reproductive tourism: Equality concerns in the global market for fertility services. *Law and Inequality* 27: 277–309.

Israel IVF Regulations. 2010. Public health (Extra-Corporeal Fertilization) regulations (Amendment). *Kovetz Takanot* 6931: 51.

Jaggar, Alison M. 1999. Feminist ethics. In *The blackwell guide to ethical theory,* ed. Hugh LaFollette. Blackwell Publishing. http://www.scribd.com/doc/7455115/Alison-Jaggar-Feminist-Ethics.

Joint SOGC-CFAS Guideline. 2006. Pregnancy outcomes after assisted reproductive technology. *Journal of Obstetrics and Gynaecology Canada* 28(3): 220–233.

Katz Rothman, Barbara. 2000. *Recreating motherhood*. New Brunswick, NJ: Rutgers University Press.

Kuhse, Helga, Peter Singer, and Maurice Rickard. 1998. Reconciling impartial morality and a feminist ethic of care. *The Journal of Value Inquiry* 32: 451–463.

Lloyd, Margaret. 2001. The politics of disability and feminism: Discord or synthesis? *Sociology* 35(3): 715–728.

Motluk, Alison. 2010. The human egg trade. *The walrus*. Accessed 24 Sept 2010. http://www.walrusmagazine.com/articles/2010.04-health-the-human-egg-trade/.

Nahman, Mical. 2008. Nodes of desire: Romanian egg sellers, 'dignity' and feminist alliances in transnational ova exchanges. *European Journal of Women's Studies* 15(2): 5–82.

Noddings, Nel. 1984. *Caring: A feminist approach to ethics and moral education*. Berkeley: University of California Press.

Ombelet, Willem, et al. 2006. Perinatal outcome of 12021 singleton and 3108 twin births after non-IVF assisted reproduction: A cohort study. *Human Reproduction* 21(4): 1025–1032.

Parks, Jennifer. 2010. Care ethics and the global practice of commercial surrogacy. *Bioethics* 24(7): 333–340.

Rapp, Rayna. 2000. *Testing women, testing the fetus*. New York: Routledge.

Remennick, Larissa. 2006. The quest for the perfect baby: Why do Israeli women seek prenatal genetic testing. *Sociology of Health & Illness* 28(1): 21–53.

Robertson, John. 1996. *Children of choice: Freedom and the new reproductive technologies*. Princeton, NJ: Princeton University Press.

Rogers, Lois. 2010. IVF doctors to raffle human eggs. *The Sunday Times*. Accessed 24 Sept 2010. http://www.timesonline.co.uk/tol/life_and_style/health/article7061155.ece.

Sacks, Jonathan. 2002. *The dignity of difference*. London: Continuum.

Sandel, Michael J. 2007. *The case against perfection*. Cambridge, MA: Belknap Press.

Shalev, Carmel, Gabriele, Werner-Felmayer. 2012. Patterns of globalized reproduction: Egg cells regulation in Israel and Austria. *Israel Journal of Health Policy Research* 1 (forthcoming).

Storrow, Richard F. 2006. Quests for conception: Fertility tourists, globalization and feminist legal theory. *Hastings Law Journal* 57: 295–330.

Tong, Rosemarie. 1998. The ethics of care: A feminist virtue ethics of care for healthcare practitioners. *Journal of Medicine and Philosophy* 23(2): 131–152.

Tronto, Joan C. 2010. Feminist ethics, care and the politics of immigration. In *Ethics—gender—medicine: Questions about health in political reflection*, vol. 6, ed. Waltraud Ernst, 165–185. Germany: International Women's and Gender Studies in Lower Saxony.

Veatch, Robert. 1998. The place of care in ethical theory. *Journal of Medicine and Philosophy* 23(2): 210–224.

Verhaak, C.M., et al. 2007. Women's emotional adjustment to IVF: A systematic review of 25 years of research. *Human Reproduction Update* 13: 27–36.

Whiteford, Linda M., and Lois Gonzalez. 1995. Stigma: The hidden burden of infertility. *Social Science and Medicine* 40(1): 27–36.

Author Biography

Carmel Shalev (JSD) is a human rights lawyer and ethicist in the field of health, medicine and biotechnology. She works as a consultant for local and international public interest organizations, and teaches at academic institutions in Israel and abroad. Her major current interest is in repro-genetics. She is the founding head of the Department for Reproduction and Society, International Center for Health, Law and Ethics, at Haifa University, Israel.