Conceiving Conception:
The Bioethics of Assisted Reproductive Policy in China

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Introduction
A Co-Productionist View of Assisted Reproduction

The assisted reproduction clinic of Aixin Hospital sits in a street corner in the middle of Beijing, nestled comfortably between cheap clothing and electronic stores. Like the rest of the city, the streets around it are constantly bustling with activity, as bicycles weave in and out of cars in a busy intersection. The sidewalks are filled with people, students and street vendors selling bottles of water, magazines, or cell phone cards. Local residents sit outside their stores, chatting away a 100-degree Beijing summer afternoon.

I, on the other hand, was sitting inside the nicely air-conditioned hospital listening in on a Friday staff meeting. Every week, the assisted reproduction and gynecology departments of the Aixin Hospital organize a full staff meeting which every member – from nurses, students, and physicians to the most senior members of the departments – has to attend. Even retired members often return for this meeting, which was apparently true today, as an elderly woman wobbled in and sat in a privileged seat in the front row. At these meetings, a few select members give presentations on tricky topics related to neonatal delivery and care, after which audience members ask questions. Today, the presentation was on cesarean sections, and most of the terminology and discussion, conducted in Chinese, were completely beyond me. Unlike the others in the room, I was not intent on learning how to do a perfect operation but was waiting for an interview that had been scheduled for three hours earlier but had been postponed by this meeting.
I was about to doze off when the presentation topic changed. The end of the meeting was reserved for difficult cases physicians currently confronted. A junior physician stood up to present her situation.\footnote{The following is reconstructed from notes I took during the meeting.}

“A mother, 4 months pregnant with triplets, is having trouble with her pregnancy. She’s been experiencing periodic bleeding and I’m worried for her pregnancy. What’s the best way to proceed?”

As she spoke, I knew this was likely to be an assisted reproduction case, since triplets are extremely rare in natural pregnancies, occurring with a frequency of .01%. However, in cases of assisted reproduction, that rate rises to 2-3%. There was a high probability that assisted reproductive technologies had been used.

“What’s the placement of the fetuses?” one physician asked.

“There’s a singleton on top and a set of twins on the bottom. I know I’ll have to perform a reduction\footnote{Fetal reduction refers to a procedure when one or more fetuses are aborted to reduce the number of fetuses in a pregnancy involving more than one fetus.}, but am unsure if it’s best to reduce the twins or the singleton.”

“Why don’t you reduce the twins?” a senior physician suggested.

“I considered it, but wondered if we could preserve the two. It might be more difficult, but it’s possible to go in, reduce the one on top, and hopefully, we can shift the placement of the fetuses so that the twins won’t be affected.”

“I don’t know if that’s the best idea,” another senior physician said matter-of-factly. “In cases like these, it is difficult to reduce only one, especially given its placement near the top of the uterus.”
“I know,” the presenting physician said sheepishly. “Part of the reason I hoped to preserve the two was because I know the mother really wants twins.”

“I think you should go ahead and reduce the twins,” the head physician said. “Not only is it placed in the most ideal position, if you reduce the singlet, there’s a high possibility that you could lose the entire pregnancy. Good, meeting dismissed.”

To have such a clear-cut and fast decision on a topic that in the United States is ethically controversial was surprising to me.\(^3\) No patient representatives or ethicists were present, and at no point during the discussion did anyone question if the mother would accept this plan or if an alternative procedure could be used to preserve the twins. This is not to say that these thoughts were completely foreign to the physicians. Instead, it was striking that these physicians assumed medical concerns automatically trump a mother’s wish to have more than one child. Even more interesting is the context. Consider this conversation in a country where assisted reproduction has only been performed for a little over ten years and where conversations about birth and population are usually treated like open sores – to be touched lightly or not at all.

Since the implementation of the one-child policy, the Chinese government has maintained a firm stance on its family planning program: one child for each couple. While the state has gradually relaxed the policy in recent years, one child is still the norm in most areas. In the countryside where having a son is traditionally considered almost mandatory, the one-child policy has created severe

difficulties for many families, and some have undergone desperate measures to bear a son.⁴

In the assisted reproduction department of Aixin hospital, normal assumptions about reproduction – that it involves procreation by a man and a woman - do not always hold. Physicians and nurses, through technology, can to some extent shape the procreative process to their wishes. Here physicians have the power to make a single woman give birth, to make infertile couples fertile, to produce children whose biological parents have never met, and to decide who can and cannot have access to these technologies.⁵ In light of this power, how do physicians at this hospital manage to ethically choose between different forms and practices of assisted reproduction while still conforming to accepted cultural, political, and institutional standards?

My Approach

This thesis explores the bioethics⁶ of assisted reproduction policy in China by examining how relevant actors - academic bioethicists, policymakers, and

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⁵ See Appendix A
⁶ I refer here to “bioethics” as a branch of moral philosophy to study ethical questions that arise as a result of advances in biology and medicine. This notion “ethics” involves normative debates that occur over abstract principles and distinguishes it from Arthur Kleinman’s “local moral worlds,” as “ethics” embedded in lived experience. See Arthur Kleinman, “Experience and Its Moral Modes: Culture, Human Conditions, and Disorders” The Tanner Lectures on Human Values (Salt Lake City: University of Utah Press 1999), 357-440. Instead, I focus on understandings of bioethics as an instrument of public policy.
medical personnel - react morally to these technological practices. There are two parts to this question:

1. What are the ethical issues raised by assisted reproduction in China?

2. How do different actors react to and resolve these issues in assisted reproduction policy?

To my knowledge, this is the first study to investigate the ethical issues involved in assisted reproduction in China. I move away from a strictly philosophical approach in evaluating Confucianism’s influence on bioethics⁷; instead, I examine how cultural, historical, and institutional forces combine to shape bioethical perceptions and policy in localized contexts. Throughout my analysis, I attempt to avoid a judgmental view about China’s reproductive policies. Rather, using ethnographic and other interpretive methods, I examine the ideas behind policy creation and implementation. I suggest that in the process of accepting assisted reproductive technologies, actors must simultaneously produce new ethical and social orders. These tenuous frameworks are not only being constantly redefined and negotiated, but are also being challenged by alternative ethical frameworks, including those imported from Western sources.

Why Assisted Reproductive Technologies?

Assisted reproductive technology (ART) is any form of technology that supplements or supplants biological intercourse between a man and a woman to

aid the procreative process; usually assisted reproduction includes the help of a third-party such as a sperm or egg donor. ART is included in the larger suite of “reproductive technologies” that encompasses technologies for reproduction control (abortion, contraception), screening (sex screening, neonatal screening), and prenatal intervention (selective abortion, fetal monitoring, ultrasound). While all these techniques are widely used in assisted reproduction, I will focus on procedures that help couples who have trouble conceiving on their own.

Fertility medication is the most basic ART, usually given to women to enhance ovarian activity; this involves minimal technological interference with the procreative process. In artificial insemination (AI), semen is deposited by a syringe near the opening of a woman’s uterus. When the semen is the husband’s the procedure is termed artificial insemination by husband (AIH); when it is from a third party, usually taken from a sperm bank, the procedure is termed artificial insemination by donor (AID). In vitro fertilization (IVF) is a procedure in which eggs are removed from a woman’s body and fertilized externally, sometimes but not always with the husband’s sperm. An intermediate step in IVF is embryo transfer, in which the fertilized egg is implanted into the woman’s uterus. Expansions of IVF include intracytoplasmic sperm injection (ICSI) (a single sperm is injected into the center of an egg) and egg donation (eggs are retrieved from a donor’s ovaries, fertilized in the laboratory, and implanted into the recipient’s uterus). In an egg donation, the child is not biologically related to the intended (birth and social) mother. Surrogacy occurs when a gestational carrier undergoes pregnancy and after being implanted with a fertilized egg through IVF.
and carries the child to term. In this case, the birth mother is distinct from the social mother. As the number of procedures has increased, assisted reproduction has become increasingly complex. In some cases, more than five parties could be involved with procreation. For example, a physician could carry out a procedure involving an intended social mother, a genetic or biological mother, and a birth mother, as well as a biological father and an intended social father.

Assisted reproductive technologies introduce ambiguities into traditional ways of defining basic concepts – parenthood, family, individual. As the use of technology expands the range of possibilities for procreation, new parties enter the reproductive process and blurs long-established categorical boundaries (see Appendix A). Complex questions are further complicated through new uses of ART, such as what is “reproduction,” what is meant by “mother” and “father,” or when “life” begins. These technologies also alter our sensibilities for what is acceptable and to what extent we, as humans, should intervene in procreation. Because each of these questions can have multiple answers, discussion about the ethics of assisted reproduction can uncover underlying values that would otherwise remain latent.

ART is especially interesting in China because it not only relates to reproductive policy but also involves the family, one of the most important concepts for social organization. Whereas in many Western countries, ART policy discussion takes place in a relatively unrestricted context, in China, reproduction

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9 See Appendix A for a diagram of the parties involved in forms of assisted reproduction.
is tightly controlled. It is an extremely important process related to two socially and politically significant issues: the one-child policy and China’s household registration system (*houkou*)\(^{10}\) which relies heavily on parentage to determine a child’s residency. In addition, whereas in many democratic nations, the public opinion has a direct influence on legislative decisions, in China, policy can be decided by only a handful of people behind closed doors.

ART also challenges traditional definitions of the family, which as we will see, is a central concept in Confucian philosophy. Since important topics in Confucianism continue to exert a powerful influence on Chinese sensibilities,\(^{11}\) how do groups manage to navigate assisted reproduction to produce new understandings of traditional norms and notions? Given that ART use is relatively new in China, different groups are still struggling to accept and accommodate assisted reproduction within existing social, cultural, and institutional orders. Examining ART in China therefore necessarily means examining Chinese moral and social values in a process of change.

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\(^{10}\) *Houkou* is the Chinese household registration record which officially includes a person’s identifying information, such as place of residency, name, parents, spouse, and date of birth. Without it, a person cannot get a passport, register for school, register for a job, or even get married. The assignment of hukou type and hukou location is primarily by birth and is inherited from one generation to the next. The place of residency on the *houkou* determines the resources an individual may receive from the government. For example, a person with a Shanghai *hukou* will have access to better education, employment, and social welfare than an individual with a rural *hukou*. See Cindy Fan, *China on the Move: Migration, the State, and the Household* (New York: Routledge, 2008).

\(^{11}\) I do not imply that China is “Confucian.” Confucianism is a complex idea that is interpreted and practiced in variation with how people and institutions understand them throughout China. Instead, I suggest that topics important to Confucianism still influence the ethical perceptions of people in China today.
Toward a Co-productionist View of Chinese Reproduction

Since the 1970s, scholars have analyzed Chinese reproductive policy to understand how it formed, how it was implemented, and what its consequences were. Many scholars have focused on rural communities as loci where China’s strict reproductive policies clash with Confucian ideals, gender, and family institutions. These studies have often compared and contrasted local accounts of reproduction with accounts of official state policy.¹² Other studies have analyzed the politics of Chinese reproductive policy to understand how the state used new forms of power to control the population.¹³ In these studies, there is an inherent and unavoidable conflict between official policy rationales and social reality. Chinese reproductive policy is so tragic, these studies contend, because the government has failed to acknowledge deep-seated opposing values in society.

My thesis, in contrast, tries to examine the broader influences that bring policy into being and how state actors manage to negotiate among these influences. While internal politics and state ideology are important considerations, a thorough exploration of Chinese reproductive policy requires examining the state’s ethical assumptions. Understanding how ethical questions are shaped and defined by state actors can help us recognize how reproductive policy and practices emerge. Along these lines, I hope to examine how different state actors

¹³ Greenhalgh, Governing China’s Population.
in encountering ART used their ethical formulations to find new arrangements for the natural and social world.

In developing my theoretical framework, I draw heavily from Sheila Jasanoff’s discussion of coproduction in science and technology studies (STS). According to Jasanoff, the idiom of coproduction seeks to reveal how natural and social orders are produced together, in other words, “the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it.” Just as social structures incorporate and make use of knowledge, so knowledge is created through social practices, norms, discourses, and institutions.

Co-productionist studies, such as Jennifer Reardon’s examination of the Human Genome Diversity Project, demonstrate that the natural and social order are not created in a vacuum but are heavily influenced by historically-embedded debates. The organizers of the Project originally intended to use genetic technologies to sample and archive human genetic diversity worldwide, but they never anticipated that when they tried to reframe the natural order by “reconstructing evolutionary history,” they would run into a host of issues concerning fundamental social concepts such as the relationship between group identity, the individual, and collective rights. To study populations biologically, they first had to resolve which groups had social identity and standing to consent to the studies. In other words, the natural and social orders were coproduced.

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through processes that involved existing cultural, historical, and institutional forces.

That science and technology encompass a host of issues means that different, interrelated moments for examining co-production exist. Jasanoff identifies four main themes in coproduction. One involves the “emergence and stabilization” of new natural objects and framings, or how people create new rules to accommodate, recognize, categorize, and represent these new things. Another involves “controversy,” in which one set of ideas are opposed to or prioritized over another. The third relates to the “intelligibility and portability” of products of science and technology across different institutional contexts, while the fourth examines science’s “cultural practices” to show how supposedly universal facts function in different political and cultural contexts.16 Under each of these headings, the framework of coproduction allows us to think about the ways that ideas or objects are constantly being formed and reformed within changing social and normative orders.

This thesis approaches ethics in assisted reproduction as an example of coproduction. It examines the ethical issues involved in assisted reproductive policy in a time of emergence and how different groups manage to make sense of changing family structures within a context of redefined ethical meanings. In accepting ART, these groups have produced or adapted moral frameworks to define, interpret, distinguish, and prioritize previously unfamiliar modes of reproduction. Through historical and institutional influences, these groups have

16 Jasanoff, 38.
reordered ethical norms while at the same time reordering social and natural arrangements and practices to accommodate their ethical demands.

**Methods and Limitations**

The original research results presented in this paper arose from a mixed-methods approach. In addition to conducting in-depth qualitative interviews and engaging in non-participant observation, I consulted secondary sources for information on policy debates.

From June to July of 2010, I conducted in-depth interviews with academic bioethicists, policymakers, and medical personnel in Beijing, China. The research consisted of thirty interviews, selected through snowball sampling: thirteen interviews with leading bioethicists, two with government officials, and fifteen with hospital personnel. These interviews were held at thirteen different sites, at five academic institutions, seven hospitals, and the Ministry of Health. Because my research aims to discover the ethics behind decisions in policy, many of my interviewees were leaders in their fields, though I did interview people in a variety of positions with a range of backgrounds. For example, my interviewees at assisted reproduction clinics consisted not only of physicians, but also of hospital administrators, nurses, and laboratory technicians. The respondents narrated their experiences through semi-structured interviews which lasted one hour on average but ranged anywhere between thirty minutes to three hours. I asked them a set of

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17 See Appendix B for full methodology.
open- and closed-ended questions about a range of topics, among them educational and background information, personal history, perceptions of ethics, bioethics as a field in China, and perceptions of public ethical concerns in assisted reproduction.  

During this time, I also conducted non-participant observations of presentations and discussions among bioethicists and hospital personnel in several of the institutions I visited. All interviews were in Mandarin.

Since my thesis is related the sensitive topic of the Chinese one-child policy and I was unsure upon my arrival whether I would face restrictions on my fieldwork, I accompanied qualitative research with official reproductive policy documents and statements as well as materials from online forums, newspapers, and magazine articles to gain insights into popular conceptions of ethics and reproductive issues and to understand which areas in China receive attentive debate.

I do not intend to provide a comprehensive study of the ethical issues in assisted reproduction in China. For one, because of China’s large income disparities, conditions at assisted reproduction clinics in Beijing will be significantly different from the countryside. This is particularly true because Beijing clinics will most likely be the best regulated since they are closest to the national Ministry of Health. Income discrepancy also accounts for why my study only encompasses legal assisted reproduction in China. Throughout my stay, I heard rumors of widespread surrogacy practiced illegally in the countryside. However I had no way of substantiating these rumors or nor the resources to

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18 For a full set of topics, see appendices.
explore these issues in-depth. Due to time restraints, I could not interview patients or families who had used assisted reproduction. While this group would have been interesting to interview, because my thesis aims to explore the issues behind policy creation and implementation, I did not consider this group to be essential to my thesis.

**Thesis Organization**

In Chapter 1, I introduce the existing literature on bioethics and Chinese reproductive policy in order to frame a discussion of ethics in Chinese assisted reproductive policy. I argue that the Western bioethics has been based on conceptions of human nature that assume personal agency: individuals are seen as *a priori* self-standing entities with the ability to make autonomous, self-determined choices. As a result, Western critiques of Chinese reproductive policy have failed to understand all of its ethical dimensions. These analyses cannot fully explain the development of assisted reproductive policy in China. Instead, I present Confucianism and Chinese communism as two value systems with a significant influence on Chinese policy.

In Chapters 2-4, I show how cultural, historical, and institutional forces influence ethical structures in three groups involved in assisted reproductive policy creation and implementation: academic bioethicists, government officials, and hospital personnel. While some ethical themes recur across the three groups, groups differ in how they approach, define, and evaluate these concerns. To support what they believe to be important for policy, these groups emphasize
certain ideas while minimizing others. I also show how simultaneously, alternative conceptions of ethical priorities are developing in all three groups under the influence of an international bioethical discourse.

Chapter 2 examines how academic bioethicists understand assisted reproduction. I first examine how bioethicists perceive their roles in China and what they perceive to be the most pressing problems in assisted reproduction. While these issues are heavily influenced by perceptions of Confucian values and China’s communist ideology, informed consent forms an important part of their ethical analysis. For bioethicists, the criteria of informed consent determine which forms of assisted reproduction are naturally and socially acceptable. At the same time, the international rights discourse provides an appealing alternative that challenges these existing bioethical understandings.

Chapter 3 examines the policymaker’s role in regulating assisted reproduction. I argue that the government sees its primary duty in protecting present and future populations. This responsibility influences the government’s understanding of bioethics – that bioethics means ensuring society’s moral and physical welfare. Thus, in making reproductive policy decisions, the government relies on this bioethical understanding to determine what forms of assisted reproduction can be accepted as socially and naturally legitimate.

Chapter 4 examines the role of medical personnel in implementing assisted reproduction policy in ART clinics. While they identify many of the same topics of ethical contention as the bioethicists and policymakers, they derive what is ethically valid from what they believe is their duty to patients. For physicians
who see themselves as responsible for the physical and psychological well being of both their patients and their patients’ potential families, what is deemed “ethical” or “unethical” reflects views of patient safety and good child development. These ethical interpretations make for real differences between hospitals in clinical practice.

The thesis concludes with a summary of my results and indicates how different formulations of moral and social order contributed to a different set of policy interpretations. I discuss the implications of these results and suggest directions for future research.
1. Review

Confronting Chinese Assisted Reproductive Policy

“I’m sorry I can’t help you,” Mr. Li said, “but your topic is too sensitive.”

“No, no,” I quickly explained, trying to shy away from potentially explosive words such as ethics. “I’m not interested in the one-child policy. I’m interested in understanding assisted reproduction.”

“Oh, in that case, I’ll see what I can do.”

Reproduction is a tricky topic to explore in China and depending on its context, it can receive either violent or indifferent receptions. During my time in Beijing, even as I tried to phrase my topic in the mildest way while still staying true to my research, policymakers and leaders at top medical institutions still shied away from the word “reproduction” as though from a plague.

A discussion of bioethics in assisted reproduction in China touches on questions from multiple disciplines. On one hand, it lies within the larger context of Chinese reproductive policy, one that has been particularly controversial because of China’s strict one-child policy. On the other hand, the term “bioethics” has different connotations in different fields. The “bioethics” I refer to in my thesis is a composite of two traditions. First is the branch of moral philosophy that discusses normative ethical questions in biology and medicine. This bioethical domain has been largely influenced by Western liberal philosophy and is increasingly also being adopted in China. But I demonstrate that a complete understanding of the bioethics of assisted reproduction policy in China needs not only explore Western bioethics and medical ethics, but also the cultural and
historical influences on understandings concerning the value of reproduction, family and kinship in China. Bioethics, as used in this thesis therefore refers to the entire range of normative issues raised by assisted reproduction that I discovered during my research.

**Understanding Chinese Reproductive Policy**

*History*

China’s assisted reproductive policy has developed within the larger context of its birth planning project, and any discussion of ART would be incomplete without first introducing the strict state regulations on childbearing. When the Communist Party established the PRC, there was no reason to limit its population; to the contrary, a large population was deemed beneficial to the country’s development. However, by the late 1950s, officials had already begun to doubt this pro-natalist regime. Premier Zhou Enlai was one of the first to recognize the need for population control, calling it a matter of the “health and prosperity of China as a nation.”\(^{19}\) By the early 1960s, policymakers had reached a consensus about population control but failed to translate their words into policy. The state encouraged officials to develop creative solutions for the problem while advocating for a two-child per couple, voluntary compliance formula, but the turmoil of the Great Leap Forward and the Cultural Revolution prevented any concrete plans from materializing. After a seven year hiatus, the government

\(^{19}\) Greenhalgh, Governing China’s Population, 70
launched the “later-longer-fewer” initiative in 1973, its first formal national program for birth planning. People would marry at a later age, increase the spacing between births, and reduce the number of births for all couples in accordance with specific numerical targets. Yet, these initiatives were little more than slogans. Only after Mao’s death did government intensify its population campaign.

When Deng Xiaoping came to power in the late 1970s, he saw modernization as the key to development, dependent on decreasing the quantity and increasing the quality of China’s population. Around this time, Song Jian, a prominent missile scientist and a high ranking party member, developed a mathematical model for China’s demographic future that predicted inevitable social collapse if fertility did not immediately drop below 1.75. The model served as an impetus for the party to tighten population control as part of its reforms. Thus, in 1979, the party announced the One-Child Policy to cap the population at 1.2 billion by 2000. Enforcement heightened to its peak in 1983 when national propaganda and sterilization campaigns reached a high of 58 million birth control operations, the majority of them abortions on rural women. While this was moderately successful in reducing the number of births, it had immense human costs, especially for rural citizens.

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22 Greenhalgh, Governing China’s Population, 112.
Enforcement ebbed and waned into the 1990s under Jiang Zhemin. By this time, there were signs that leaders hoped to reform birth control policy because of increasing evidence of the unexpected and undesirable medical, social and political side effects it had produced. In addition, national program leaders were becoming increasingly influenced by international practices. During the Jiang era, Chinese integration into global economics and politics intensified, and while these external relationships did not formally change Chinese population policy, the government began accepting and implementing certain foreign initiatives including international methods of reproductive planning and ethical standards for medical programs.

Under the current presidency of Hu Jintao, China has not only relaxed its one-child rule but continues to absorb international ideals of quality care and personal choice. This shift was reflected in the substitution of the National Family Planning Law for the One-Child Policy in 2001. While reaffirming a commitment to the one-child standard, the policy echoed a more humane shift by giving couples more of an “informed choice” in reproductive decisions and emphasized the ideally voluntary nature of reproductive constraints. At a 2003 party summit, Hu declared that China must “maintain stable low-level fertility” but that policy must also take practical realities into account, “to balance sex ratios and address problems of population aging, migration, and employment.” In addition to reflecting the influence of international discourse on China’s decisions, his speech also emphasized the country’s ability to adapt its regulations to meet international technical and ethical standards.
Approaches to Chinese Reproductive Policy

Much of the work on the origins and rationale of Chinese reproductive policy has come from two scholars, Susan Greenhalgh and Tyrene White, who argue for two different approaches in understanding reproductive policy. Scholars examining other areas of Chinese policy have also added to existing literature. These include the works of Borge Bakken and Frank Dikotter on reproductive “quality” and the work of medical ethicist Nie Jing-bao on Chinese abortion attitudes.

Edwin Winckler undertook one of the most comprehensive studies of Chinese reproductive policy by analyzing the family planning program within the framework of governmentalization - how reproductive policy arose, evolved, and transformed through PRC history. Winkler identified three variants of Leninism that he believed Chinese leaders adopted in policy creation and implementation: revolutionary mobilization, bureaucratic professionalism, and socialist marketization. All these approaches, Winkler argues, were “scientistic” by relying heavily on scientific theories to manage state and society.23

Susan Greenhalgh similarly identified Western science as instrumental in her study of the creation and adoption of the one-child policy. Only the government’s dream to transform a poor agrarian nation into a modern power through the absorption of science and technology could have justified the costly and radical idea of restricting reproduction. Through highly complex mathematical models, Song Jian and his allies convinced the leadership of a clear

23 Winckler, Governing China’s Population 40.
necessity for population control. Greenhalgh also identified two forms of scientific reproductive policymaking in China: one regarding population “quantity” and the other regarding population “quality.” The former refers to the strict enforcement of the number of births per couple to “bring the reproduction of human beings in line with the production of human goods” while the latter refers to the maintenance of scientific standards to ensure “quality service” and the production of “quality children” in excellent psychological, physical, and intellectual health.24

Other scholars have echoed Greenhalgh’s view of China’s leadership as obsessed with science. Borge Bakken argued that through state funded research programs, social activities, and top-quality health care and education, the government believed it could produce “quality” children who were essential for China to modernize.25 Similarly, Frank Dikotter conducted a historical study of China’s reproductive policy, arguing for what he believed represented a continuous eugenic discourse. China’s reproductive policies from 1970 onwards, incorporated what he translated as “eugenic” (yousheng) ideals to punish those who deviate from the norm – the mentally disabled or physically deformed – by preventing them from freely engaging in reproductive practices. To put it another way, China has historically sacrificed individual reproductive freedom for public health on the basis of genetic considerations. Dikotter questioned whether these “crude eugenic approaches” such as compulsory sterilization and forced abortions

24 Susan Greenhalgh, Governing China’s Population 42-44.
espoused by the PRC cast doubts on the ethical nature of scientific advances in genetic research. That geneticists were actively involved in creating “eugenics laws” represents how information about human genetics can be used in stigmatizing ways. More recently medical ethicist Nie Jing-Bao published his in-depth ethnography on abortion in China. While noting that there exists a wide plurality among the Chinese on the morality of abortion and the value of fetal life, he attributed these differences to the collectivist, statist nature of reproductive law, where official eugenic perspectives are used to justify birth control, abortion, and fetal policies.

Tyrene White discusses the other major approach to Chinese reproductive policy, one that is focused on the population control’s economic rationalizations. The logic driving the one-child policy, he believes, is one of economic necessity. When the Chinese Communist Party (CCP) came into power in the 1950s, their main goal was to transform China from a backward, agrarian society to a socialist, modern one. Initially, population growth did not seem to impede their goals, but gradually, dissenting voices led the government to believe the state needed to limit population in order to fuel economic expansion. Human reproduction, like economic production, “could and should be organized rationally through state intervention and administration; that childbearing, like grain production, should

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26 Dikotter uses this term to refer to provincial and national laws. These include “Zhejiang sheng yousheng biaojian tiaoli” (Zhejiang Province’s regulations in Eugenics and the Protection of health) as well as the national “Zhonghua renmin gongheguo muying baojianfa” (The People’s Republic of China’s maternal and infant health law). Frank Dikotter, Imperfect Conceptions: Medical Knowledge, Birth Defects and Eugenics in China (New York: Columbia University Press, 1998), 165-183.

and could be regulated according to state need and state plan.” In other words, reproduction could be economically planned.

In these studies, the Chinese government is portrayed as a cold, rational entity that will force its citizens to sacrifice themselves for an abstract greater good. In an effort to modernize, the government has made discriminatory, often unethical and sometimes brutal decisions. Under this characterization, state policy creation is divorced from social reality. The government’s failure to acknowledge the significance of cultural and historical forces within society and its complete acceptance of scientific over humanistic concerns ultimately led to the disastrous and unintended consequences of the one child policy.

I believe this representation of Chinese reproductive policy does not fully describe Chinese assisted reproductive policy. I argue instead that ethical issues make real and pressing demands on those involved in all stages of policymaking, and that these issues sometimes trump scientific analysis. In the area of assisted reproduction, bioethical discourse has had a major role in policy creation and implementation. But before I further develop that argument, I turn to a discussion of “What is bioethics and how did it develop?” After all, the framing of bioethical issues in China is not isolated from international discourse. A historical examination of the development of “bioethics” as a theoretical concept can shed light on how these ideas influence and interact with understandings of bioethics in China.

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28 White, 7
Philosophical Bioethics: The Western Liberal Tradition

“Bioethics” as a formal field began to take shape in the early 1960s, but people had debated bioethical topics much earlier. In 1927, Fritz Jahr first used the term “bioethics” to describe arguments and discussions involving biology, ecology, medicine, and human values. Prior to this, ethical issues in biology were roughly grouped under the label “medical ethics,” largely derived from a Hippocratic tradition that promoted patient welfare and medical professionalism. In 1908 the Royal Commission on Vivisection in one of the first bioethical episodes, questioned William Osler, a prominent Canadian physician, about the morality of a series of experiments he conducted on yellow fever volunteers. Around the same time, the Prussian Ministry of Health issued a government regulation that forbade all nontherapeutic experimentation without subject consent and use of standardized equipment. Yet, these were only isolated incidents.

Following the Second World War, the Nuremberg Trials exposed the serious, ethically problematic experiments Nazi physicians and scientists had performed on their unwilling subjects. During the Doctors’ Trial, more formally known as United States v. Karl Brandt et al., the Nuremberg Military Tribunal (NMT) convicted sixteen German physicians of crimes against humanity and sentenced seven of them to death. The physicians were responsible for medical experiments performed on prisoners in Nazi concentration camps. The verdict led to what would later become the Nuremberg Code, a ten-point code that established “certain basic principles that must be observed in order to satisfy
moral, ethical, and legal concepts.”29 This became the first formal international enunciation of a set of bioethical principles. Following Nuremberg, President Franklin D. Roosevelt established a Committee on Medical Research to require informed consent in scientific investigations in military medicine. Ten years later in 1964, the World Medical Association established the Declaration of Helsinki to provide a set of international ethical principles regarding human experimentation. The document contained a list of morally binding, basic principles for physicians, of which the most fundamental was that physicians needed to respect the individual by protecting the right to self determination and the right to make informed decisions.

In 1979, James Childress and Tom Beauchamp, two American philosophers, published the first bioethics textbook, *Principles of Biomedical Ethics*, which became the discipline’s most influential text. In it, they outlined what they considered to be the four basic principles of bioethics: autonomy, nonmaleficence, beneficence, and justice. These principles were held to be universal, a set of norms based on a common morality.30 Autonomy is the principle that competent people have the right to make their own medical decisions, and in a health care setting translates into the principle of informed consent. Nonmaleficence and beneficence represent complementary values to ensure that the physician avoids harm by furthering the patients’ best interest and

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by not acting against the patient’s interest. The principle of justice requires that physicians distribute goods and services fairly.

While the authors maintain that the four principles are equally important and that there is no predetermined order or preference, autonomy supplies the moral premise for the other values. Autonomy is based on the idea that “individual persons have the right to make their own choices,” that individuals through their personal values or beliefs, exercise their autonomy may choose to accept an institution, tradition, or community that they view as legitimate. In relation to others, an autonomous individual “acts freely in accordance with a self-chosen plan.”31 This idea of human nature is featured prominently in contemporary Western works32 and is heavily influenced by the writings of Immanuel Kant and John Stuart Mill. For Kant, respect for autonomy stems from the belief that people have the capacity to determine their own moral destiny and that they should not be seen as a means to an end. Mill similarly argued that autonomy requires the “individuality” of free agents. These ideas presume that autonomous actions should only be subjected to limited controlling constraints and that people should foster actions which promote autonomous decision-making. In the Western liberal philosophical tradition, one can assume that basic individual interests usually override collective goals; individuals enter this world free from relational obligations.

31 Ibid., 58.
The Helsinki Declaration and Childress and Beauchamp’s book are now foundational texts for healthcare ethics. This is true not only in the United Kingdom and the United States\(^{33}\) but also in China, where the “four principles” are widely cited by academic bioethicists.\(^{34}\) While bioethics and biomedical ethics are not synonymous\(^{35}\), because of the large overlap between these two fields, these foundational biomedical ethics texts exert considerable influence on the larger bioethical discourse. Individual autonomy forms the basis of debates whether it is on physician-assisted suicide, euthanasia, human organ transplantation, stem-cell research, assisted reproduction or on arguments about sexuality, property rights, the limits of governmental authority, the allocation of resources, or life and death.

On June 24, 2005, the United Nations Educational, Scientific, and Cultural Organization (UNESCO) adopted and issued its Declaration on Bioethics and Human Rights, a manifesto championing the need for international community to come to a moral consensus on basic human rights. At one point, UNESCO boldly proclaimed the “universal principles based on shared ethical principles” that all nations should abide by. While conceding the importance of “cultural diversity and pluralism,” it asserted that these considerations should not infringe upon the principles set out in the declaration or on the core values of “human dignity,


\(^{34}\) Benfu Li, C. Li, and Yali Cong, *Medical Ethics.* (Beijing: Beijing Medical University Press, 1996); Renzong Qiu *Shengming lunli xue* (Bioethics) (Shanghai: Shanghai People’s Press, 1987)

\(^{35}\) Strictly speaking, biomedical ethics refers to ethical questions that arise in medicine while bioethics encompasses a wider range of issues in biology, including genetically-modified food, synthetic biology, and ecological ethics.
The goal of the document was to promote a moral framework that would guide policy decisions in all countries. Put differently, it assumed and sought to articulate a universal moral consensus.

**Ethical Issues in Assisted Reproduction**

In the area of assisted reproduction, the idea of individual autonomy has shaped political and ethical debates. Ethical discussion of reproductive technologies began in the early 1970s, when techniques such as in vitro fertilization became a real possibility. Many of these early commentators were medical practitioners, so the first ethical concerns involved worries about illegitimate human experimentation. Leon Kass, an American scientist and public intellectual, noted in a 1971 article that because in vitro fertilization procedures were executed on human embryos, with the possibility of harming the potential child, there was no ethically acceptable way to perform the procedure. A scientist could not morally choose unknown hazards for the child and then give him a life in which he would have to face those consequences. Paul Ramsey, an American Christian ethicist, went even further to argue for a complete prohibition on IVF experimentation, believing that the moral hazards of experimenting on a possible future human being were unacceptable. On the other hand, John C. Fletcher, a

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leading biomedical ethicist, argued for the procedures, declaring that technology liberated human reproduction from what he termed, “reproductive roulette.”

However, governments officially began to research the ethical implications of these technologies only shortly before the birth of the world’s first IVF baby, Louise Brown in 1978. In that year, the Ethics Advisory Board of the U.S. Department of Health, Education and Welfare (DHEW) undertook a study of IVF, primarily focusing on procedural safety and efficacy to ensure that scientists were minimizing the risks to potential offspring. Following the media fanfare accompanying Brown’s birth, numerous countries, including Spain, Netherlands, Australia and the United Kingdom issued more than a dozen reports on the topic within six years. In 1982, the United Kingdom established the Committee of Inquiry into Human Fertilisation and Embryology, headed by the philosopher Mary Warnock, to examine the social, ethical, and legal implications of new and potential developments in human assisted reproduction.

In the decade that followed, the leadership of the Catholic Church sought to clarify the Church’s official position on assisted reproductive technologies in response to community inquiries. In its 1987 “Instruction in Respect for Human Life by the Congregation for the Doctrine of Faith,” the Church reaffirmed its moral prohibition on the destruction of an embryo, equating it to the destruction of human beings, and argued that any technique that separates sexual intercourse from reproduction is morally wrong, whether to avoid or assist it. The report echoed the dangers of human interference in the natural processes, that “man’s

domination over the life and death of his fellow human beings can lead to a system of radical eugenics." In reports published by other sources throughout the 1980s and 1990s, the right to procreate or reproduce, the moral status of the embryo, parenthood, the rights of patients and research subjects, intergenerational responsibilities, and confidentiality became part of the ethical debate. Surrogate parenthood was particularly troubling. It not only separated pregnancy from motherhood but also posed the danger of economic exploitation and of substantial physical and emotional risk for the surrogate.

Currently, ethical issues around assisted reproductive technologies encompass a wide range of questions including the “naturalness” of the technique, the moral status of the early human embryo, the relationships among relevant parties, and the economics of ART. Because couples substitute lab processes for procreation, some argue that the separation of reproduction from sexual intercourse is ethically dubious because it is “unnatural.” Others question whether an embryo can be regarded as a human being and if it deserves the full range of respect and protections guaranteed to citizens. In cases where ART challenges traditional boundaries of parenthood, the relationship of the genetic or birth parent to the social parent and child is unclear. There are additional problems of ART commercialization and access. Should sperm or ova providers be paid; in the case

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of surrogacy, how much should surrogate mothers be compensated and do the risks to the surrogate’s health outweigh the benefits of payment?

These debates represent different approaches to interpreting reproduction so that individuals who have no other options can choose assisted procreation in a way that is morally agreeable to society. They assume the individual to be the unit of society with the ability to make free and self-determined choices. Successful ART regulation should allow for the maximization of individual interests within the confines of society. Western debates have had an influence on Chinese bioethical discourse, but two additional sets of concerns arising from China’s cultural and political history reflect an alternative view of human nature and society than that Western liberal philosophy. The first is Confucianism, the second communism, encompassing Marxism, Leninism, and Maoism. I do not argue that Chinese bioethics is “Confucian” or “communist” in the ways I describe below. Instead, I argue that these philosophical concerns, which sometimes collude, still retain a strong hold on Chinese ethical discourse.

Confucianism and Chinese Communism

Confucian Values and Bioethics

The Confucian understanding of human nature is grounded in the idea of virtue - that a man of perfect virtue would treat others as he wishes to be treated and that in establishing himself, he would seek to establish others. In turn, virtue relies on a concept of the “self” that believes that humans are born into society automatically related to those around them and that familial roles defined from
birth (mother, father, daughter, son, etc.) prevent members from being discrete, self-serving individuals. Familial relations not only form the basis of social interaction but also provide a model from which humans can learn to sympathize with others.

Put another way, human relationships are developed from family relationships. In the Confucian conception, “Filial piety and brotherly love are the roots of jen (virtue),” and given that jen is rooted in family love, one can only achieve jen by fulfilling his familial obligations. The first virtue is filial piety, the others extend from there. To treat others as one would treat one’s family is the first step in the process of self cultivation, and this requires cultivating meaningful relationships with family members as a prerequisite. This does not imply unconditional submissiveness but rather a recognition and reverence for others’ thoughts.

Confucius applied the metaphor of the family to the community and the country. For example, family hierarchy provides a model for government, as a Confucian adage advises, “Simply by being a good son and friendly to his brothers a man can exert an influence upon government.” Because familial roles shaped relationships for all other interactions, private action within the home was politically significant. Familial roles provide a path for social order and universal peace. Just as the fathers were heads of households with decision-making authority, so rulers were the heads of society who could be exemplars for the

43 Ibid., 12.
people by governing with morality and virtue. As symbolic heads of their households, rulers have a responsibility to provide food, security, and education to the people. Law and punishment are seen as only temporary measures for peace. True social harmony can only be attained by virtue and through the fulfillment of duties and responsibilities. Thus, family structure and hierarchy is extremely important in Confucian philosophy.

If sympathy constitutes the root of human virtue, through fulfilling rites (li), people can cultivate and develop virtue to its full extent. Confucius believed that civilized humans act by following rites, or norms, set by a cooperating society. These rites include ceremonial behavior but also refer to the comprehensive system of norms that color daily life. Rites allow for human civilization by bringing harmony into human intercourse, by allowing one to achieve one’s ends while simultaneously helping to establish the goals of others. Just as family roles are relational, so societal roles are also relational, and different norms must be followed in interactions with others. Confucius best explains this in the proverb, “Do not look at what is contrary to rites; do not listen to what is contrary to rites; do not speak what is contrary to rites; and do not make a movement which is contrary to rites.”

If virtue is the ultimate moral goal, and familial relationships contain the potential for realizing that virtue, ritual is the path by which one could obtain virtue. Virtue both strengthens and forms the pillars of human civilization.

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In Confucian philosophy, the development of one’s moral virtues nurtures relationships with others. Yet, this self-cultivation by the individual is not a choice but rather a responsibility, arising from the nature of one’s social roles. When taken into a medical context, these responsibilities create a “Confucian bioethics,” espoused by scholars Fan Ruiping and Julia Tao Lai Po-Wah of the City University of Hong Kong. As opposed to Beauchamp’s Western liberal bioethics, Confucian bioethics sees the family as the fundamental unity of society, with personal responsibilities and duties prioritized over autonomous, self-determined choice. Assigned roles have more pressing moral significance than the realization of individual desires. In response to Beauchamp and Childress’s biomedical principles, Fan and Po-Wah criticize the supposed universality of the “patient-centered decision model” in a clinical setting. Instead, they call for a “family-centered decision model” that gives the family authority for giving medical consent. In this model, patients are always attached to families. “Families are the locus of responsibility to look after and protect the patient…Under this model, decisional authority is unambiguously vested with the family,” Lai Po-wah writes.45

Chinese Communism: Marxism, Leninism, and Maoism

The second philosophical tradition with a strong influence on Chinese bioethics comes from Marxist ideology, heavily altered by Leninism and Maoism. It provides a conception of the relationship between market, state, and society and how people should act in relation to these institutions. Chinese Marxism differs from classical Marxism in many respects that require clarification.

Marxism supports a critical materialist conception of human history. Classical Marxists hold three main convictions: dialectical materialism is the proper method for understanding humanity; historical materialism reveals that capitalism creates class relations; and socialism, or communism, presents a better alternative to “bourgeois liberalism.” As opposed to Western liberalism which emphasizes individual differences, Karl Marx in his “Economic and Philosophic Manuscripts of 1844” poses an alternative construction of the human condition:

What is to be avoided above all is the re-establishing of “Society” as an abstraction vis-à-vis the individual. The individual is a social being. His life, even if it may not appear in the direct form of a communal life carried out together with others – is therefore an expression and confirmation of social life. Man’s individual and species life are not different.

Current capitalist society destroys this relationship by separating man from his labor to create divisions and conflict among men. This is particularly true because market conditions make class relationships inherently unequal. Ideally, the capitalist buys labor with money and workers sell their labor to the capitalist for money in a balanced exchange. However, this exchange is always unequal.

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because the worker must sell his labor to live and must sacrifice an aspect of his life in the process. Theoretically, both parties can leave this contract at will, but in a capitalist society where worker competition grows increasingly fierce, possible means of employment for the worker decrease proportionately. The worker must depend much more on the capitalist for his subsistence, allowing the capitalist to exploit the workers’ labor. Communism is the state in which man can return to his natural state, regaining his equality with others in society. Communism, through its transcendence of private property, allows man to become a social being by resolving the conflict between man and nature and between man and man. In this ideal state, distinctions between man and his “species” disappear; what is desirable for society is equally desirable for each person in it. It follows that, on this theory, a socialized society is the best society.

While China retained the fundamental economic tenets of Marxism, the nation ideology is different from classical Marxism. Chinese Marxism is heavily influenced by Leninism and Maoism, as Leninism provided the structural foundation for state-society relations while Maoism became official ideology. Leninism calls for an organized party to display strong leadership by representing the most progressive forces in society and by dictating the direction of societal progress. PRC government structure and Maoist thought reflects this ideal. In an article elucidating the relationship between the government and the people, Mao explained the concepts of democracy and freedom by saying:

This freedom is freedom with leadership and this democracy is democracy under centralized guidance, not anarchy…Within the ranks of the people, democracy is correlative with centralism and freedom with discipline. The
people enjoy broad democracy and freedom, but at the same time they have to keep within the bounds of socialist discipline.\textsuperscript{47}

The ruling party practices “democratic centralism” by consulting the needs of participants lower in the hierarchy and centralizing that information into party statements. Communities can regulate their members’ conduct collectively by prescribing general rules which dictate what is allowed and intervening when people violate those rules. To ensure compliance, fairness, and equity, Leninism heavily favors societal over personal needs.

The early PRC was heavily influenced by Maoist interpretations of Marxism. These were in turn influenced by Confucian ideals. Mao believed that a correct understanding of dialectical materialism emphasizes the “law of contradiction in things.”\textsuperscript{48} Society is dominated by a wide range of contradictions, the most important being those within socialist institutions and between the masses and their enemies. Contradictions within institutions can be smoothed out through discussion, while incorrect beliefs of enemies should be demolished.

Ultimately through these processes society should achieve a state of unity. In describing this state and in promulgating it to the public, Mao and early communists used the word “datong” to describe this final state of unity. Datong, a term borrowed from Confucian philosophy means the “grand union,” a final natural state of harmony characterized by meritocracy and egalitarianism.

Similarly, the datong of Maoism was the final, ideal societal state, characterized


by egalitarianism, communalism, the disappearance of private property. In order to reach this state, the entire society needed to help overthrow the vestiges of capitalism. To do this, Mao and the government implemented a comprehensive propaganda program to instill what they believed were ideal values, embodied by model workers and solders. Chief among them was Lei Feng, a soldier in the People’s Liberation Army in the early 1960s. Characterized as a selfless and modest person devoted to the Communist Party, he personified the moral integrity and values the government hoped to nurture, including those of self-improvement, self-cultivation, selflessness, and dedication to the government.

In recent years, the government has more explicitly attempted to fuse traditional Confucian elements with communist ideology. This was prominently featured in Deng Xiaoping’s “socialism with Chinese characteristics” and has continued into the Hu Jintao regime’s call for “harmony.” After Mao’s death when China began gradually transitioning to a market economy, Deng Xiaoping coined the concept “xiaokang society”49 as an intermediate goal to datong. Xiaokang, also borrowed from Confucian terminology, signified a temporary period characterized by a competitive class system, private property, and manageable contradictions that could culminate in datong through good governance. The Hu regime has similarly borrowed from Confucianism in its “harmonious society” campaign. Achieving a harmonious socialist society has been the ultimate mission throughout PRC history, Hu asserts, and describes the goals of this society as follows:

49 Ibid., 110.
To realize social equity and justice is the Chinese Communists’ consistent position and a major task of developing socialism with Chinese characteristics. In accordance with the general requirements for democracy and the rule of law, equity and justice, honesty and fraternity, vigor and vitality, stability and order, and harmony between man and nature and the principle of all the people building and sharing a harmonious socialist society, we will spare no effort to solve the most specific problems.\(^5^0\)

These ideas are now constantly referenced by the Chinese government\(^5^1\) and emphasize their continuous reliance on Marxist and Confucian values to articulate their goals. While official ideology doesn’t automatically guarantee government action or public acceptance of these goals and values, it nevertheless presents a forceful vision of morality. The combination of a centralized Leninist structure with Marxist and Maoist ideology does suggest an alternative view of society from the liberal democracy advocated by Western governments. At the very least, an emphasis on collective, egalitarian values over individualistic, self-determined desires provides a challenge to the view of a person with relatively unconstrained autonomy, as presumed by dominant international bioethical discourse.

My thesis reveals how different perceptions of these cultural and political influences bring about ethical frameworks, which are then used to create, guide, and implement assisted reproduction policy in China. These bioethical interpretations diverge from those commonly cited by formal philosophical


bioethics and encourage other ways of understanding ethics and reproduction than the prevailing literature suggests.
2. Consent to Conceive

Bioethics and Academic Bioethicists

I was twenty minutes early to an interview with Ms. Ai, an influential bioethicist at a leading university, and it was so early in the morning that university personnel had not yet arrived. Standing outside Ms. Ai’s office, I took note of the surroundings around me. A large poster in the hallway introduced in both English and Chinese the founding of the bioethics department, while the hallway was cluttered with bookshelves of old Chinese journals. Displayed like historical relics, long-forgotten newspapers and booklets from past symposiums were neatly stacked and encased in glass bookshelves. As I sifted through the bookcases what surprised me most was the breadth of content. Publications ranged from books on Marxist dialectics and medical ethics to prominent international genetics journals, essays on Confucian philosophy and Chinese legal theory.

It was only after I returned to the United States that I realized how those bookshelves nicely represented the influences on bioethicists in China. In this chapter, I discuss the role of bioethicists in assisted reproductive policy and how bioethicists use the discourse of ethics to naturalize assisted reproduction. Using the theoretical framework of Chapter 1 as a starting point, I show how bioethicists in China accommodate assisted reproduction under existing cultural, political, and institutional constraints. Rather than providing a simple reflection of the international assisted reproductive technology (ART) discourse, assisted reproduction presents Chinese bioethicists with a different set of concerns, issues
with deep roots in Chinese cultural and political history. I further show how bioethicists rely on informed consent as an ethical principle to solve these problems, defining which assisted reproductive forms and processes should be allowed. By adopting a unique set of bioethical principles to accommodate assisted reproduction, bioethicists present new ways of restructuring natural and social order through a form of co-production.

History of Bioethics in China

Bioethics in China arose as an extension of “medical ethics.” Since the economic reform period of the 1980s, Chinese medical schools have required their students to take a course on ethics. Yet, few teachers at the time were qualified to teach the subject; most were specialists in other fields such as philosophy, psychology or law, while some were only hospital administrators. By 1981, some medical ethicists were publishing articles related to “medical ethics,” but these were exceptions. By the mid-1980s, only a handful of professionals nationwide seriously devoted themselves medical ethics research.

Two events triggered the formation of formal “bioethics” in China. The first was the 1986 Hanzhong euthanasia case, the second, the publication of Qiu Renzhong’s *Bioethics* (1987). The former involved Xia Suwen, an elderly woman at the Infectious Disease Hospital of Hanzhong City who suffered from late stage hepatic cirrhosis. At her son’s and daughter’s request, a physician and her duty nurse injected her with toxic amounts of chlorpromazine. On the day of her second injection, Xia Suwen died. Shortly after, two of Xia Suwen’s other
children accused the physician, the duty nurse, the son and the daughter of murder. The case became the first euthanasia trial in China and immediately attracted the attention of the press and the public. Preceding the verdict, scholars and the public intensely debated issues involving the proper boundaries of life and the physician’s duties over a patient. 52 Eventually, the Hanzhong city court ruled that while the defendants had deliberately infringed on Xia Suwen’s shengming quan (living right), because their actions did not lead to any severe, unavoidable consequences, they could not be penalized. A year later, Qui Renzhong, a philosophy professor, published Bioethics, a general introduction to ethical issues in reproductive technologies, birth control, eugenics, euthanasia, organ transplantation, and genetic modification. This publication formally introduced the concept of “bioethics” into China.

From this point on, two groups of bioethicists emerged: those with backgrounds in medicine, and those with backgrounds in philosophy, specifically in Marxist dialectics. Those who were physicians by training specialized in clinical ethics, while those who were previously philosophers specialized in theoretical ethics. While these groups occasionally exchanged ideas, the academic fields remained separate, with independent publications and academic appointments in different kinds of institutions. 53

53 Biomedical ethicists were usually affiliated with medical universities while theoretical bioethicists were usually affiliated with the social sciences departments of universities. In recent years, these two fields have begun to blend together.
It wasn’t until the 1990s that the Chinese government became interested in bioethics. By this time, scientific and technological research was beginning to flourish, and policymakers quickly realized that the country needed ethical research guidelines to gain international recognition for its researchers’ scientific achievements. The ethical review requirements of European Union’s Ethics Committee and United State’s Institutional Review Board (IRB) ethical review requirement was one of the main reasons policymakers wished to develop a similar set of ethical guidelines in China. In 1998, the Ministry of Health (MOH) issued its first ethical regulations, the *Interim Regulations or Ethical Review of Biomedical Research Involving Human Subjects*, defining protocols for ethical review of human biomedical research in China. Research institutions would establish ethical committees to safeguard procedures in human subjects research, while all large certified hospitals would establish medical ethics committees. In addition, the MOH established a national ethics committee and provincial ethical committees to supervise and monitor research and healthcare in their jurisdictions. These committees would also serve as a forum for discussion on ethical issues, provide ethical training, and offer expert advice to the state.

Following this, the MOH and other organizations issued additional ethical guidelines. In 1999, China’s Food and Drug Administration issued *Regulations for Clinical Trials of Drugs*, standardizing clinical trial requirements, subject protection, and researcher responsibilities. In 2001, the MOH issued ethical guidelines on assisted reproductive technology, which was later revised in 2003. In 2007, the State Council passed the *Human Organ Transplantation Act* which
set guidelines and established an ethics committee to oversee ethical issues related to organ transplantation.

Bioethics is now an area of concern at the national, provincial, and local levels of policymaking. While “medical ethics” and “bioethics” are still separate fields, constant communication between specialties have blurred their boundaries. Universities now promote bioethics domestically and internationally by organizing symposiums hosted in collaboration with organizations such as UNESCO, WHO, and the International Association of Bioethics. Fostered by top Chinese bioethicists who have been educated and trained in Western universities\(^{54}\), bioethics professors from prominent foreign universities come to China to give workshops. Through these exchanges, the Chinese bioethicists have internalized many of ideas promoted by foreign scholars.\(^{55}\) In China’s attempt to modernize, learning from the leaders in the field means learning from first-world, Western examples.

**A Second Sense: The Role of the Bioethicist**

The bioethicist as an expert is not a unique phenomenon in China, but in the Chinese one-party system, where there is no formal system to solicit for public opinion, expert opinion has even more weight in policy decisions. Whereas in many other political systems, the government balances the interests of the

\(^{54}\) When I say “Western,” I mean those countries which have been largely influenced by a certain philosophical mode of thought, meaning the United States, Great Britain, Germany, and to a lesser extent, Australia, New Zealand, and France.

\(^{55}\) The First Workshop Report of Ethical Governance of Biological and Biomedical Research: Chinese-European Cooperation (Beijing: Peking University Health Science Center, 2007).
advisers with the voiced concerns of the public,\textsuperscript{56} in China, the state relies more on better-educated, elite scholars than on public opinion. Thus when the government decides which policy questions are relevant, which advisors are important, and which issues should take greater priority, the answers depend more on the personal experiences of the leaders and the opinions of those who advise them than on public consensus.

The role of bioethicists to some extent represents the role that bioethics currently plays in China. The importance of international collaboration in science has led policymakers to recognize the value of “ethics” for purposes of global recognition. The government’s awareness of subject has improved the respectability of bioethics as an academic discipline. Part of this respectability comes from the perceived semi-scientific nature of bioethics. Scientific journals publish bioethical research, international conferences discuss bioethical issues, and international guidelines set ethical standards for basic and clinical research while hospitals and schools require ethics as a part of a complete medical education. Yet, for some bioethicists, this recognition is still inadequate. As Mr. Bo, a physician-turned bioethicist explained, “In the United States, one of the things that surprised me most was the fact that even high school students were exposed to bioethical issues. Well in China, the basic foundation is not there.” Nevertheless, there is no doubt that ethical questions regarding biotechnology are gaining wider acceptance in China.

With this greater acceptance comes a rise in the popularity of bioethics an academic field. According to the bioethicists I interviewed, more and more students are now drawn to the discipline, despite how small it remains in relation to other subjects. This development has helped increase the accessibility of bioethics. Ms. Ai, a leading bioethicist with many connections to the government, described this change. Whereas “bioethics” in the 1980s and early 1990s was largely a philosophical subject and an abstract topic of discussion, now “applied bioethics” attracts students from various backgrounds - medicine, experimental science, and law. The earlier gap between bioethicists and policymakers is decreasing as bioethicists and their audiences share more of a “common language.” Medical professionals are more likely to relate to, respect, and better understand bioethicists who have had medical training whereas earlier both sides may have attributed differences in opinion to ignorance.

In addition, the number and popularity of new technologies has increased and with this comes a host of problems which call for the increased role of bioethicists. With regard to ART, infertility is on the rise. This increase has led the government to reflect more on how assisted reproduction might threaten the existing reproductive regime. As Ms. Du, a younger bioethicist critically observed, “In China, it’s only when government realizes ‘Oh, there’s a problem’ that people pay attention to the issue.” With infertility on the rise and new technologies becoming more accessible to the public, the government has had to decide how best to incorporate these technologies in existing social, political, and institutional structures.
To assist in this decision, bioethicists have adopted the role of expert, responsible for educating the public, the government, and those in other institutions (e.g., doctors) of bioethical norms. Ms. Ai explained, “Before, when the media wanted to talk to me, I refused. But then one day my professor chastised me and said, ‘You shouldn’t refuse to speak to the media because as scholars we have a responsibility towards the public to educate and to allow them to understand these things. It is easier for me to say these things than for officials, because when I say certain things, my ideas can be wrong because I am a scholar. I see these interviews with the media as opportunities that will allow us to understand and to solve problems.’” Only the bioethicist as the expert scholar has any recognized power to speak authoritatively on these issues. Mr. Gu, an up-and-coming bioethicist at a leading university, put the point in this way, “You [bioethicists] need to lead the public because you can’t just make the policy based on the attitude of the public. 99% of the people don’t have the opportunity to learn about these issues in depth.” Thus, bioethicists feel a responsibility to learn about bioethics from international collaborations and to disseminate this knowledge to government officials. Similarly, bioethicists have a duty to educate the public on the proper bioethical discourse and to convince other institutions, especially medical institutions, of the importance of their version of bioethics. Ms. Fei, a bioethicist with a philosophical background, most strongly expressed this sentiment by stating, “While some people may not believe in those [universal] values now, it should be changed and we should teach them bioethics.” In China’s major cities, academic bioethicists both run and supervise bioethical training
sessions for physicians and nurses in hospitals. Older bioethicists serve as advisers to both the government and to the younger generation of bioethicists who are raised to lead bioethics training and disseminate bioethical knowledge at other institutions.

Given that there is still a dearth of bioethicists in China and that many current bioethicists are still young and have not developed powerful political connections, a handful of older generation bioethicists wield a dominant influence on government opinion and the public’s perception of bioethics. In light of this monopoly on ethical authority, academic bioethicists have a great degree of power to decide which questions are relevant in “bioethics.” This is especially true for academic bioethicists with connections to important government officials. Of course, this does not mean that all of their suggestions are taken as given. Bioethicists often have to fight for the position of bioethics in policy against other priorities and the experts of other subjects. Yet, all the bioethicists I interviewed expressed the sentiment that bioethics has been given increasing priority and that policymakers have been more receptive to their suggestions. These suggestions not only influence which issues are debated, considered, and discussed by policymakers but also determine how these issues are implemented throughout the nation.

In assisted reproductive policy, what topics do bioethicists believe are the most ethically pressing and how do they go about settling them? Taking into account the wide range of opinions, I specifically focus on the major themes that
bioethicists identify as “ethically problematic” and the rationales that they use to resolve them.

**Formal Bioethical Issues in Assisted Reproduction**

*Informed Consent*

On the most basic level, bioethicists believe that ART needs informed consent regulations similar to those for other medical procedures. This idea of informed consent not only involves a physician’s or researcher’s obligation to disclose information to the subject or patient but also includes the quality of a patient’s understanding and consent. Informed consent derives from the conviction that “individuals should be treated as autonomous agents”\(^57\) to protect and preserve individual autonomy and rights. While Chinese bioethicists generally agree that individuals possess a certain degree of autonomy, they are less comfortable with the idea of rights. Bioethicists primarily express concern about vulnerable populations who may not understand the risks involved in ART or who may be adversely harmed through unfair agreements. This three part concern center around information - that physicians should provide patients with complete information they can understand so that patients can act in a way that does not cause them harm.

Thus, bioethicists believe that regulations need to provide basic guidelines so assisted reproduction clinics can meet criteria for informed consent. On one hand, hospitals need to maintain standards of care to ensure that patients are receiving the care they expect. Quality control concerns extend to adequate equipment and physician qualifications in assisted reproduction clinics. Mrs. Ai, a prominent bioethicist, explains, “For doctors, they think that as scientists they should know what the safety considerations are, but this includes not just an acknowledgement of the risks but also if the conditions of the hospital meet the standards of quality.” Quality standards can promote the patient’s ability to make informed choices between clinics. Bioethicists believe that the need for hospitals to maintain certain success rates is necessary so that the public will not be deceived when they rely on the hospital to provide them care. The market, some argue, is inadequate to provide this sort of guarantee for patients.

On the other hand, patients should also be given adequate information and be allowed a wider range of choices about their health care. China has recently seen an increased interest in IRB review and proper procedures to ensure that patient choices are safeguarded. Indeed, most of the training sessions that bioethicists implement are targeted towards creating greater awareness among medical personnel and physicians of the issue of informed choice and voluntary consent in medical procedures. Mr. Gu, a younger bioethicist from a leading university, cited an instance in which bioethicists interceded in a hospital procedure and corrected certain unethical practices. “Previously in an ART clinic in Shanghai,” he observed, “there was one consent form for both the ART
procedure and for the donation of the extra embryos. In actuality, this is a form of coercion, an unjust situation. If the two consent forms are put on one sheet, then of course the choice for one procedure would influence that of the other. Some people might believe that they would not be provided the procedure if they do not donate their embryos.”

In these two areas, in quality control and informed consent, all bioethicists expressed the optimistic belief that China has improved dramatically even within a span of ten years. As Mr. En, an older bioethicist remarked: “I think now China is realizing more of these things. So for example, whereas before the doctor had no respect for the patient and said, ‘You have to listen,’ now, the doctors respect the patient, and medical procedures and research entail consent and have to be voluntary to make sure that the laws are respected.”

But what was unexpected was that in the process of accommodating ART, bioethicists have extended the criteria for informed consent into other social concerns. Whether it involves ART commercialization or changes to the family structure, bioethicists’ beliefs about how assisted reproduction should be administered depends on how well parties can obtain adequate information, how well parties can process that information, and how well parties can act on the information to prevent undue harm. In cases where these criteria are not met, bioethicists believe that technology’s disadvantages in causing potential harm to certain populations outweigh its advantages. Put differently, whether assisted reproduction is allowed under certain settings depends, in bioethicists’ views, on how well those situations meet the standards for informed consent. In order to
accept assisted reproduction as a naturalized form of reproduction, bioethicists rely heavily on their formalized ethical framework of informed consent to set a socially acceptable baseline for the use of ART.

Commercialization

In order to integrate assisted reproduction into the economy, bioethicists use the framework of informed consent to define how assisted reproduction should be received – not as a standard commodity. Instead, their concern about the safety of “vulnerable populations,” specifically the indigent and the uneducated, makes them averse to commercialization of ART. This is most vehemently expressed in the case of surrogacy but extends to other assisted reproductive procedures. The bioethicist’s worries reflect not only the large income disparity within China and between China and first-world nations but also skepticism that the market adequately signals people’s preferences. In deciding that assisted reproduction should not be commercialized, they have roped off certain activities reproductive processes as illegitimate. Methods of reproducing can only be accepted as natural if they meet bioethical standards of informed consent and thus of social legitimacy.

Many bioethicists express skepticism that commercialization and quality assurance can coexist in China’s current market. Their concern is not without reason. There is a common Chinese adage that “The sky is high and the emperor is far away.” Even in areas with strict regulations, the best intentioned policy measures can go awry when local authorities or professional do not comply, often
due to corruption. In some areas, this is worsened by inadequate education and a
general lack of awareness of dangers associated with biological practices. The
best example is the AIDS epidemic in Henan, which drew international attention
in the late 1990s. In Henan and a handful of other provinces, AIDS was spread by
large numbers of poor farmers illegally selling their blood to people known as
blood heads, whose collection methods, including the reuse of contaminated
needles and the pooling of donated blood, have spread blood-borne diseases to the
donors.\textsuperscript{58}

In order to resolve these issues, it is best that some forms of assisted
reproduction be prohibited to prevent harm to vulnerable populations. This is
especially true in the case of surrogacy: all Chinese bioethicists I consulted
oppose the commercialization of surrogacy, regardless of whether or not they
support its national prohibition. Mr. Bo remarked, “I think now there are some
things which are prohibited under the guidelines, but maybe later when the law is
more stable it could be allowed. From an ethical point of view, I’m not against
surrogacy for those people who really need it, but I am ethically opposed to
surrogacy under market controls.” Surrogacy itself is not problematic, only the
way it interacts with society under current conditions. Given that surrogacy has
the greatest potential for harm to the third party, and given that current institutions
cannot adequately ensure that hired women will be acting under free will instead

of coercion, the bioethicists believe that surrogacy should be banned until it can meet criteria for voluntary, informed consent.

This aversion to commercialization was seen in other areas of assisted reproduction where coercion may be present. Ms. Fei, a younger, theoretically-grounded bioethicist, was very vocal on this issue. “The body should be respected,” she declared, “but when ART is commercialized, the body is used as a tool, and it is usually the most vulnerable populations which get exploited because of it.” Placing biological materials on the market is ethically wrong not only because it could be extremely harmful to the seller but also because it represents an unequal transaction that favors one party over the other, more vulnerable party. Commercialization of ART, Chinese bioethicists fear, would not be seen as a free exchange between two willing parties, but a coerced exchange in which one party is forced to undergo the transaction due to external circumstances. Thus, even if both parties felt that the exchange was in their best interest, it would be a false impression. Ms. Ai explained,

For example, if it [ART] were regulated by the market, then some hospitals might allow patients to use ART even though it might not be the best hospital or the best for the patients. And this is an ethical problem because if it were under market conditions, the patient wouldn’t know which hospital was the best…

On this account, tight regulation and state control of ART facilities could maintain standards to ensure that the patient can truly choose what is best. However, it is interesting to note that while market pressures do not represent a proper form of persuasion for the patient, the government does have the authority to guide or direct the patient to what it believes are the best choices. With its
narrow variety of options for clinical facilities and sperm banks, the government allows the patient to “choose” by offering fewer choices to choose from. Yet, bioethicists believe that under these conditions, patients can be provided with correct information, and given that he has the ability to understand the procedure and that he can undergo the procedure without significant risk of harm, assisted reproduction can be accepted.

ART commercialization is not an ethical issue unique to China, but the strong reaction I received from bioethicists to the possibility of commercialization is unique. All the bioethicists I interviewed considered this topic a major ethical issue, one that which the government was right to bring under state control. In the late 1990s before the first guidelines were passed, ART was largely regulated by the market. Bioethicists frequently used the term “chaotic” to describe this period when assisted reproduction had just begun to thrive. For the bioethicists, unregulated ART means the potential for unethical exploitation through lack of informed consent. Many couples will go to extremes to have a child, and ART commercialization would allow swindlers to enter the market. Mr. Bo explained that currently “there are still some areas where there are private clinics that might not meet these regulations and ART is done illegally, but these things are always hard to control. Right now there are reviews across the entire country, and perhaps later when standards are raised, it may be more acceptable to have these private clinics.” Strictly speaking, commercialization is not the problem. Rather, ART under current market incentives would create an exploitative environment
that bioethicists deem unacceptable. Complete prohibition of certain activities seems to serve individual interests better than inadequate regulation.

Bioethicists’ standards of informed consent heavily influence the extent to which they believe assisted reproduction should be accepted and practiced by society. For them, ART is useful but should be prohibited in situations with a high chance for exploitation and should only be allowed if mechanisms protect parties from physical or psychological coercion. In labeling some practices of assisted reproduction as illegitimate and others as legitimate, bioethicists imply that ART commercialization, through violating standards of informed consent, perverts the natural reproductive process. In defining how assisted reproduction fits in society, bioethicists use their understanding of bioethics to partition reproduction into natural and unnatural forms.

*Traditions: The Individual and the Family*

The effect of ART on the traditional family structure is a heated topic in China but it has received less attention elsewhere. Contrary to expectations, bioethicists’ largest concerns were not about multiple births (sometimes made in an attempt to circumvent China’s one-child policy) or the use of ART for gender selection. Instead, the greatest ethical concerns uncovered in my interviews center on assisted reproduction’s effects on traditional conceptions of the family.

The traditional Chinese family is defined by blood relationships and lineage. Birth defines motherhood while marriage legitimizes the mother’s relationship to the father. Traditional definitions of the family assumed that
children were direct biological descendants of their parents, related “by blood.”
Assisted reproduction destabilizes this natural order by disrupting these
established methods of defining heredity. Because ART can produce children who
are genetically unrelated to their parents, it splits the natural category of
parenthood and upsets the traditional family structure. In trying to resolve these
issues, bioethicists needed to produce an alternative framework for evaluating and
redefining “family” and “parenthood” – to create in a sense a “new natural.”

Bioethicists have achieved this through their standards of informed
consent; assisted reproduction is acceptable when all parties meet the criteria for
informed consent assuming that it does not present any significant risks.
Bioethicists are divided on this last assumption; those who come from a medical
background believe some disruptions to the family structure are too harmful for a
potential child, while younger, more theoretically based bioethicists do not see
these same disruptions as harmful. Thus, the first group uses ethical frameworks
to prohibit ART in cases where it severely interferes with family structure to
advocate for a more traditional family, whereas the second group uses these same
frameworks to argue for family structures outside of the traditional father-mother-
child triad to claim that single-women should also have access to ART.

Many of the most visible public controversies around assisted
reproduction have arisen because of conflicts related to the family. In May 2001,
Mrs. Zheng’s husband was imprisoned for murder, and in August of that year, he
was sentenced to death. Mrs. Zheng wanted to have a child with her husband so
she requested permission for use of ART with semen from her jailed husband,
first asking the city court, then the High Court of her province. Her request was first rejected, then circumvented on appeal so that Mrs. Zheng did not receive permission before her husband was executed in January 2002. Her request was widely discussed around China as a case questioning the morality of single-parenting. In another case, a woman and her parents-in-law pleaded for artificial insemination by husband (AIH) following a car accident that left the husband in a coma. She was eventually granted permission. In these cases, traditional conceptions of the meaning of the family and of reproduction were violated mainly because newly naturalized means of reproduction had been made possible by ART.

Infertility presents a major problem for Chinese couples. In the classic Confucian adage, “having no descendants is one of the most unforgivable and unfilial deeds.” In the Confucian tradition, “gentlemen pay great attention to marriage that unites two families into one in order to serve ancestors in the temple of the family and to extend the family to future generations.” Filial piety requires people to extend their family continuously through generations. Thus for couples, infertility brings many negative social consequences including individual unhappiness, family disharmony, and the stigmatization of infertile women as violators of filial piety; these consequences often result in domestic violence and

61 The First Workshop Report of Ethical Governance of Biological and Biomedical Research: Chinese-European Cooperation, 10.
62 Ibid., 10.
divorce. ART has the unique potential for infertile couples to use technology to provide them with a child through “natural” reproductive processes.

Yet, ART is not perfect, and bioethicists have voiced concerns over conflicts that may arise due to the procedures. One involves the discontinuation of the blood line in cases where the child is not genetically related to both parents. As Mr. En noted, “The difference between assisted reproduction in China and those in other places, is that there are certain traditional influences. Because in China, there is a great emphasis on blood relationships so ethical issues arise with people who are completely infertile and need the sperm or egg of other people for them to have children.” He recounted the story of a couple who had successfully undergone artificial insemination by donor (AID). Conflict arose between the wife and the husband’s parents after he disclosed to them that his child was conceived with the help of donor sperm. Upon the husband’s death, his parents rejected his child’s inheritance rights, in disregard of proper legal procedures. While some bioethicists simply see this ethical issue as arising from people’s lack of understanding about the technology and traditional views of parenthood, others believe the continuation of the blood line is important because it underpins other traditional practices in China. Mr. Bo explained,

In China, the problem of ART and the family is definitely big, or at least larger than in some other countries. In China, if you undergo this procedure, the parents won’t tell, for example, if the father was from the sperm bank. I think this is because of the need to take care of the elderly. Part of the reason they have children is so that they can care for their parents in their old age. Perhaps it is because if the children find out that the parents who raised them are not their own, they won’t care for them, and maybe they’ll find their own parents.
ART’s potential to disrupt the blood line interferes with traditional methods of demarcating the boundaries of parenthood. Given the traditional definitions of heredity and lineage and social obligation based on blood relationships, it is understandable that people are uneasy about ART when it interferes with classic notions of the social relations between the parents and the child.

This problem is further deepened by ART’s disruption of traditional definitions of the “mother” or the “father,” and this issue is especially pronounced in surrogacy. When the biological parent and the sociological parent differ as in the case of sperm banks, there was a general agreement among bioethicists that this was an ethical issue that could eventually be overcome as the public gradually becomes accustomed to these new technologies. However, in the case where the birth mother and the genetic or sociological mother differ, there are real objections to the practice. The separation of motherhood from the physical act of birthing a child is an issue that some bioethicists found uncomfortable. Motherhood as defined by birth is accepted by tradition and is further reinforced by Chinese law. Thus, surrogacy presents a greater ethical challenge for bioethicists because of their tendency to include the physical act of pregnancy and birth as an inseparable part of motherhood.

A final aspect of the family presents the gravest challenge to assisted reproduction in China. Bioethicists heatedly debate the proper structure of the family and the challenge that assisted reproduction poses to this traditional structure. Because ART can allow those who ordinarily could not give birth,

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specifically single parents and homosexual couples, to use technology in lieu of normal procreation to bear a child, an acceptance of assisted reproduction requires bioethicists to reconceptualize the family. Bioethicists were divided as to how to resolve this issue.

Some bioethicists I interviewed seem to have serious problems in recognizing the legitimacy of alternative family structures. Their opinions vary by age; those who were older, and thus had greater political influence, were more likely to be opposed to uses of ART that would allow for these possibilities, while those who were younger seemed more open to other family structures. This was shown most clearly in a discussion between one older bioethicist, Mr. Bo and the younger bioethicist, Ms. Cai. I had asked them to elaborate on cases that highlighted ethical conflicts in ART. Mr. Bo began narrating a case in which a couple had already begun the ART process. Before completion the husband was fatally injured in a car accident. The wife still wanted to undergo ART since the husband’s sperm had already been preserved, and the hospital debated whether to complete the procedure.

“For example,” Mr. Bo began, “there was a case in which the parents were involved in a car accident and the husband died, but the wife still wanted to undergo the procedure. In this case, it was allowed. Why is this a special case? Because the couple had both agreed before the husband died. You need to have the agreement of both sides before a procedure can be undergone. If the couple divorces, the couple doesn’t agree, and usually it’s the man who doesn’t agree to the procedure.”
“They think that single family might cause disruptions, but who says that single parenting is necessarily bad?” Ms. Cai countered.

“We think that if there is only a single mother, there is something lacking on one side of the parenting. A lot of people who are raised in these households are criminals, so we think it’s a single-parent problem.”

“But it’s not just single parent, it may just be that the family is not suitable.”

“The main thing is that you lack love,” Mr. Bo declared assertively.

“Without the proper amount of love, then psychologically, it might create some problems. So for example, some children who under ART procedures might ask, ‘Who is my father?’ Also if the couple is divorced, the child may also want their father. You can’t lie to them forever. Well, definitely single parenting does have an influence from a psychological point of view. Having a single family is not normal for the natural development of the child.”

In this exchange, both bioethicists agree that ART procedures need the consent of both sides. This also happens to be the going rule in other countries as well; in the United Kingdom, there is no obstacle to using AIH after the husband’s death if agreement took place in advance. However, the bioethicists disagree about the assumptions that underlie that consent. Mr. Bo seems to believe that there are grave dangers to children who are born outside of the traditional heterosexual marriage. For him, assisted reproduction is acceptable as long as it does not cause

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undue harm to the potential child. In doing so, he uses the principle of informed consent to define a proper family – a family that should not cause harm to the vulnerable potential child. For him, only the traditional mother-father-child structure meets the criteria of being an acceptable, natural family. Any other formulation is illegitimate and thus should not be made possible through the use of ART. Ms. Cai seems more open to the possibility that other family structures may not be as harmful as Mr. Bo assumes and seems ready to accept the single-mother formulation as legitimate. For her, single-mother families do not violate the belief that ART procedures need to meet the criteria of informed consent that will prevent undue harm.

These sentiments were echoed by Ms. Fei, a younger, more theoretically-grounded bioethicist than Mr. Bo. “There should be basic rights for single parents, and the guidelines should be changed because they’re not ethical,” Ms. Fei asserted. “The reason it may be in the regulations could be because of the experts who where there at the time it was made. Perhaps it is because the experts are all a bit old; they have more traditional ideas about the family and assumed that single parenting would not be good for the child. I definitely believe that there is a generational gap for the experts, which is reflected in cultural values.”

Coincidentally, this was also the only bioethicist I interviewed who explicitly mentioned the concept of “rights” in an ethical context. Thus, even as bioethicists use the same criteria in evaluating how assisted reproduction should affect the family, their different opinions on what is harmful leads to understandings of the proper family structure. For some, these moral frameworks
lead to new ways of conceptualizing the natural family while for others, ART serves to bolster traditional demarcations. The younger the bioethicist, the greater the chance he or she is more open to changes in social or natural order. In the process of accommodating ART, bioethicists coproduce the natural and social order as bioethical principles replace blood-based relationships to redefine a natural family.

A Creeping International Discourse

In line with international discourse, a rights discourse is emerging, though it is emphasized and articulated mainly by the younger generation of theoretically-inclined bioethicists. This rights discourse recognizes the need to place greater value on human life and, subsequently, to respect people’s rights. But more importantly, it serves as an alternative ethical framework that could restructure ideas about society. Instead of limiting assisted reproduction by its potential for harm, why not limit it by how well it respects the individual rights? Bringing “reproductive rights” into the ART debate could lead to very different answers for whether government should legitimize surrogacy or whether single-mother families.

This alternative rights framework is slowly gaining traction. In one faculty discussion at a leading Beijing University, scholars debated whether there needs to be a greater recognition of patients’ rights, particularly in reproduction. In the discussion, some bioethicists emphasized the need to develop a robust rights discourse while others acknowledged that a discussion of rights in China is tricky
because the Chinese government doesn’t formally acknowledge rights or the 1948 United Nations Declaration of Human Rights. Yet, in my interviews, the fact that a concept of rights is appearing among younger bioethicists suggests that “rights” are being incorporated as an ethical issue. For example, Ms. Fei stated, “I believe there should be basic rights for the single parents, and the guidelines should be changed because they’re not ethical.” She was the only bioethicist who explicitly labeled “rights” an ethical approach in assisted reproduction.

When bioethicists discuss the ethical concepts mentioned above, they explicitly note that these ideas originate from foreign sources (either the United States or Europe) and that China needs to learn to appreciate these ethical values. Bioethicists assume that China can never become a developed nation without acknowledging these issues. This was most clearly expressed by Ms. Fei in her statement, “I think there are still many things that need to be learned from the West. For example, the issue of life is not a problem for most people when I think it should be.” “Life” and “rights” and to a lesser extent, standards of quality and the concept of “informed consent” are foreign concepts adopted from international conventions. Bioethics in this sense is to be learned and emulated from the more developed nations so that China would become more “cultured.” To adopt these concepts would be necessary for China to become a world leader in the scientific realm. Whether China decides to adopt these alternative ethical frameworks could have implications for how China evaluates policy.

Not only are issues in assisted reproduction important for our understandings of order in the natural world, they are also central to our
conceptions about how we order the social world. Because assisted reproduction
confuses conventional categories of commodity and of family, normal ways of
defining what is social and what is natural do not work well in the context of
assisted reproduction. Thus, in trying to accommodate ART into society,
bioethicists have used bioethical frameworks to establish new ways of redefining
social and natural order.
3. Republic of Reproduction
Bioethics and State

The building that houses the national Ministry of Health (MOH) seems at first insubstantial. Finding it was difficult. Whereas other main government buildings stand prominently on Chang An Road, the Ministry of Health is tucked away in Beijing’s northwest corner, almost past the second ring demarcating the city center. But as I approached the building, it grew more imposing. Two guards standing erect guarded the glass-door entrance, and the people walking by cast stern, questioning gazes my way as I approached the building.

“Do you have approval to be here?” one guard asked me.

“Yes, I have a scheduled meeting with Ms. Li,” I answered.

“Well, you’ll have to go to the registration building,” he said, pointing to a small marble building a few hundred yards away. “No people allowed in this building except on official business.”

At that moment, Ms. Li came down from her office. I had eagerly awaited this interview. Ms. Li was a current official in the Ministry of Health, involved in implementing assisted reproduction regulations. I had spent the previous night preparing for the interview, trying to phrase my questions to sidestep sensitive issues. However, my efforts were in vain as even my most trivial questions were received with the same cold indifference that I received from the guards.

“Can you please tell me your name and occupation?” I asked.

“Let’s skip that part,” she answered bluntly, setting the tone of the conversation.
From then on, she met every one of my questions with the same answer, “We do everything as dictated by the regulations.” What I had anticipated to be an hour long conversation lasted a mere twenty minutes as she used the official line to evade providing any hint of an opinion.

In a sense, my unsuccessful attempt at interviewing an official at the Ministry of Health is characteristic of Chinese policymaking. Whereas in Western democracies, multiple groups provide input at various stages of policy formation, in China, policymakers debate behind closed doors, with only a select handful of people allowed access. Even if the state does consult other opinions, government officials hold absolute sway on policy’s final form. Policymaking in China is a black box, with no way of distinguishing for certain which considerations determine a policy’s final formulation.

We saw in the prior chapter how bioethicists used their ethical principles to coproduce a new social and natural order around ART, but how well do their concerns get translated into national policy? How well does the state internalize bioethicists’ framing of “natural” assisted reproduction? A close reading of ART regulations and my conversation with an important member of the MOH reveal the considerable role that moral concerns play in ART policy formation. While policymakers are concerned about the same ethical topics as bioethicists – ART commercialization and assisted reproduction’s impact on the family – they have devised different methods of understanding ART. In the process of
accommodating ART, policymakers rely heavily on traditional values to define what should be commodified and what constitutes a legitimate family.

**China’s Assisted Reproductive Technology Policies**

On February 20, 2001, the Ministry of Health issued Orders 14 and 15 the *Human Assisted Reproductive Technology Administrative Guidelines* and the *Human Sperm Bank Administrative Guidelines*. On May 14 of the same year, the Education and Technology Department of the Ministry of Health issued Orders 143, the *Human Assisted Reproductive Technology Guidelines* and the *Human Sperm Bank Standards* and the *Practical Principles and Ethical Standards for Human Assisted Reproductive Technology*, abbreviated as *Technology Restrictions: Basic Standards and Ethical Principles*. These first sets of guidelines were very basic, focusing mainly on ART clinic registration procedures, facilities requirements, and basic prohibitions. The ethical principles in ART regulation added a more abstract component by listing official ethical guidelines for assisted reproduction, including principles of informed consent.

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69 Ministry of Health Education and Technology Department, (15 May 2001) *Shishi renlei fuzhushengzhi jishu de lunli yuanze* (Practical Principles and Ethical Standards for Human Assisted Reproductive Technology).
voluntary donation, and donor anonymity. These principles also prohibited ART use for single women.

In March 2002, the MOH held multiple meetings with experts in different fields to reexamine China’s ART policy, taking account of regulations in other countries. At these meetings, the state encouraged experts to evaluate what sorts of technology regulations, standards, and ethical principles would best meet China’s practical needs and to consider adapting parts of foreign regulations to include them in a set of revised Chinese ART regulations. In an official policy document, the government stated that through these revisions, it hoped to create guidelines that would provide the right technologies “in accordance with society’s ethical, moral, and legal needs to respect life and to protect future generations from harm.”70 The edited draft seriously expanded the scope of government control by providing more detailed ethical and technological requirements, including standards for multiple embryo implantations and embryo reduction, access to ART, and prohibitions on embryo and sperm commercialization.

On October 2003, the Ministry of Health issued the final draft of the revised Human ART Regulations, Human Sperm Bank Regulations, and Human ART and Sperm Bank Ethical Guidelines and Principles, replacing the earlier provisions.

An Examination of Policy

The last set of regulations issued by the MOH contains a comprehensive space, facilities and equipment requirements as well as quality standards and specific prohibitions for ART clinics. It also lists background and training needed for medical personnel in offering ART. Two separate parts which have similar provisions address IVF and artificial insemination, respectively. The first section details requirements for the clinics, including the types of rooms and the equipment required in them. Given large amounts of space and high technological capabilities are required, the regulations imply that only large hospitals can legally operate ART clinics. Because clinical operations and laboratory work must take place in the same building, only a hospital with significant research and clinical resources can operate an ART clinic. Each ART institution must also establish a working Reproductive Medical Ethics Committee.

The second section of the regulations concerns clinic management - that hospitals must carefully check the identity cards of potential couples for proof of a marriage certificate; couples must also qualify for pregnancy under national population and family planning laws. Even foreigners must present passports and marriage certificates before they are allowed to undergo the procedure. In addition, physicians may not transfer more than three embryos per IVF cycle and for women under 35, physicians may not transfer more than two embryos in the first cycle.

The third section of the policy provides specifications for couples who can undergo certain procedures, including which couples qualify for IVF treatment.
Physicians can perform a preimplantation genetic examination if a couple is highly likely to produce a child that might have “single-gene related genetic diseases, chromosomal abnormalities, sex-linked genetic diseases, and reproductive abnormalities.” Under these circumstances, a woman is also eligible for an egg donation. Egg donation is also an option if the woman cannot produce eggs or if the woman is carrier of a serious genetic disease. There are additional specifications for women who wish to donate their eggs. To prevent the commercialization of gamete donation, only women who have leftover eggs after undergoing assisted reproductive treatment can be egg donors. Certain people are also prohibited from IVF procedures, including individuals “suffering from severe mental disorders, acute urogenital infections, or sexually transmitted diseases.” These regulations additionally bar hospitals from performing IVF procedures on those with hereditary genetic diseases for which there is currently no cure or on those with a history of drug addiction or substance abuse.

The regulation’s fourth section lists quality standards for ART clinics, measured by their success rates for procedures. These rates are high even compared to international standards. In this area, one provision reads, “Multiple pregnancy fetal reduction must be used to avoid twinning and to promote the strict prohibition of the birth of triplets or more than three children in a birth.”

The final section provides a list of guiding principles for all medical personnel. These guidelines mandate that all personnel must strictly adhere to national population and family planning laws and regulations. Medical personnel

71 Order 14, Ministry of Health
72 Ibid.
must comply with informed consent and voluntary informed choice procedures and respect a patient’s right to privacy. It prohibits non-medical use of sex selection, surrogate technology, embryo donation, and genetic manipulation, and bars single women from ART. The last few provisions forbid the use of ART for human cloning, chimeras, or unspecified research purposes.

The Human Sperm Bank Policy has similar detailed specifications for facilities, equipment, and personnel qualifications. In addition, there are specific instructions for how the facility should be managed, how information should be processed, and how records should be maintained. Sperm banks must keep thorough information on each sample that discloses “the recipients of pregnancy, the status of the development of the offspring, and whether these offspring were born with birth defects.” There are strict confidentiality requirements for the people in charge of the data. The guidelines then provide an exhaustive list of donor eligibility restrictions which are similar to the egg donation stipulations, except that sperm donors do not need to have provided sperm for other assisted reproduction purposes.

In addition to these guidelines, the Department of Medical Technology and Education of the Ministry of Health also issued a set of “ethical guiding principles” regarding ART. These principles were to provide “a safe, effective, and rational implementation of human assisted reproductive technology, the protection of personal, family, and health of future generations and interests, and
to safeguard the social welfare." Seven overriding principles govern these areas: benefit to patients, informed consent, protection of future generations, benefit for social welfare, confidentiality, prevention of commercialization, and ethical oversight. The largest numbers of restrictions relate to informed consent, the protection of future generations and the benefits for social welfare. With regard to the protection of future generations, medical personnel have a duty to stop ART implementation if “there is evidence that the implementation of human assisted reproductive technology will have serious physical, psychological, and social damage to future generations.” The MOH explicitly gives medical personnel the responsibility for implementing these ethical principles in assisted reproduction. Thus, while the government broadly defines what “bioethics” entails, hospitals need to ensure that these principles are rigorously carried out.

From Individual to Political Subjects: What Do “Ethical Principles” Mean?

According to official statements, the guidelines will promote and limit assisted reproductive technologies for the protection of social welfare and “for the active promotion of progress.” In 2003, the MOH revised its “Technology Regulations: Basic Standards and Ethical Principles,” to officially “ensure the safety of ART and sperm banks in light of realistic practices, to protect society’s health benefits, to raise the standards of material and institutional requirements,

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73 Practical Principles and Ethical Standards, Ministry of Health Education and Technology Department
the structural requirements, and the technical skills of the staff, to meet a standard of quality in practice, and to better clarify the details of the ethical principles involved in this technology."

Aware of these lofty but vague goals, I interviewed with Mr. Xu, a senior policymaker, to obtain more specific information on the government’s intentions. To understand how bioethical concerns transfer from the bioethicists to policymakers, it is necessary to examine not only the policy itself, but the opinions of policymakers who make policy.

While one official may not provide a comprehensive view of how ethical issues are incorporated into policy, his words do provide some insight into how well that information is conveyed and utilized.

Mr. Xu is the former director of Health Technology Management and the former director general of the Bureau for Science and Education at the Ministry of Health. He was very involved with the development and implementation of ART and multiple sources credit him as the main promoter for the establishment of ART regulations. Incidentally, he has the closest ties with the Chinese bioethicists and often speaks at bioethics conferences in China. He is also a member of the Chinese Genetic Resources Management Office, established under the Ministry of Health and the Ministry of Science and Technology, which creates regulations for genetics research, and stipulates prohibitions on the use of genetic materials use.

Thus, Mr. Xu is heavily involved with all topics related to assisted reproduction and is knowledgeable about genetic materials regulation.

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74 No. 176, Ministry of Health
Prior studies have tended to focus on the scientific and data-centric nature of policy considerations and political contests in China. The actual provisions of the policy and my subsequent analysis of a key policymaker’s explanation for ART policy provide an alternative view of Chinese policymaking. While Mr. Xu accepts some of the bioethicists’ concerns, his understanding of assisted reproduction relies on another framework, one that views ethical matters from a collectivized standpoint. For Mr. Xu, this means insuring the physical and moral integrity of China’s citizens. Whether certain ART procedures can be allowed depends not on whether they meet the criteria for informed consent, but on how much they violate the government’s understanding of traditional Chinese values.

Mr. Xu believes the government’s role is to protect present and future generations. On issues concerning ART, this responsibility is even greater for future generations. Mr. Xu uses the word houdai to represent the concept of “future generations.” Houdai in Chinese is synonymous with the word “offspring” and depending on whether it was uttered in a private or public context, it could mean “later generations”, “descendents”, or “progeny.” The phrase “for the sake of future generations” (wei houdai zhexiong) is often used to describe an action that is taken within the family for the benefit of those who are born later-on in the same blood line. Even when used in the public sphere, houdai retains an intimate private undertone. Thus when the government uses the phrase “for the sake of future generations,” houdai is not simply an abstract concept but implies to the listener a private interest in his own offspring.
Multiple scholars have commented on the Chinese concept of “future generations.” As mentioned in earlier chapters, the Chinese government has often been criticized for its “eugenic policies” in regulating houdai. Lisa Handwerker, a professor at California State University, reflects this concern in her 1998 ethnography of Chinese assisted reproduction clinics. Chinese assisted reproduction, she believes, is part of a larger “new eugenics movement” created by the Chinese government to produce “perfect” children. These children would ideally be physically, intellectually, and morally superior to others born through “natural” reproduction. The problem with this campaign, she argues, is that “the right to reproduce and even the right to exist are determined by ill-defined and partial ideas about genetic fitness.”

Similar to other academic works on Chinese reproductive policy, she believes the Chinese government is oversimplifying social problems by framing them in strictly scientific terms.

While this eugenic interpretation is compelling, Chinese assisted reproductive policy is more nuanced. To criticize the government for interfering with “the right to reproduce” or “the right to exist” is premature when the state sees them as foreign, unfamiliar concepts or overrides them with what it believes are more pressing ethical concerns. Because the Chinese state has a duty to care for its citizens, similar to the way a father has a responsibility to care for his family, the government must fulfill its obligation to “protect future generations” in assisted reproduction policy. This “protection” comes in multiple parts.

On one hand, protection means ensuring the overall well-being of society so that the technology results in no negative unintended consequences. Mr. Xu presents sperm bank regulation as falling under this category. Mr. Xu explains, “After pregnancy, how do you control the fact that there may be multiple people who have one father and they may get married? In China, our regulations solve all these problems so that in China with these guidelines only 5 people maximum can have access to one sperm donor so that it prevents generations of people with the same genetic father from intermarrying.” Regulations are necessary to ensure that future generations do not accidentally commit incest. For the government, this requires sperm banks to keep close records on sperm donors and to track the children as they grow to ensure they do not eventually marry another of the same parentage.

Another part of this protection lies in guaranteeing that the technology is safe. This means ensuring that assisted reproduction does not spread sexually transmittable diseases to unknowing patients. Safety also means ensuring that the procedure does not compromise the mental or physical health of the potential child. Thus, Mr. Xu feels it is government’s responsibility to maintain close records of children born through ART to ensure that there are no health issues associated with the procedure. For Mr. Xu, it is the government’s responsibility to “properly track the 30,000 children who have been born through assisted reproduction in order to assess the possible harms and risks of the technology. We would need to measure their height, weight, etc. to see if there were any abnormalities. For example, how is their intelligence, and are there any gender
discrepancies within the children who are born? This is because for a society to function properly you need a balance of men and women.” Mr. Xu does not even consider the possibility that some of these children may not want to participate in the state’s ART studies. Even if closely monitoring and assessing these children does infringe privacy, the MOH acts more irresponsibly if it fails to closely follow these children. The protection of present and future generations means collectivized, not individual protection.

But given that assisted reproduction has not shown evidence of harm and that it is relatively easy to properly maintain accurate records for sperm banks, what other regulations need to be enacted for assisted reproduction? From my conversation with Mr. Xu, it seems that protection of present and future generations also extends to “moral” caretaking.

Even before the interview began, Mr. Xu launched into what he believes are the ethical issues in assisted reproduction. He proudly stated, “We formed our guidelines after we had researched the guidelines of 36 different countries and managed to integrate an international ethic with China’s culture because China is different from Africa or Europe or the United States; we have over 2000 years of Confucian thought. This ART regulation is good because it allows for both individualism and traditionalism.” Mr. Xu’s explanation of the guidelines is as follows: regulations can be adapted from foreign sources provided that they do not violate what the government perceives as Chinese traditional values. These traditional values guide the ministry’s decisions about what forms of assisted reproduction can be naturalized.
Whereas Mr. Xu acknowledges the importance of informed consent, he is more passionately opposed to the commercialization of assisted reproduction. At first, he was unclear on why he believed market regulation is unethical, but as the conversation progressed, his primary concern became apparent: commercialization of gamete donation. Put differently, assisted reproduction procedures should not be commercialized because of the complications it brings to gamete donation. Commodification of reproductive materials entails selling the body for profit, an act he equated with prostitution. This in part accounts for why China allows and even encourages sperm donation but strictly restricts embryo donation to women who have undergone IVF and have spare embryos. Mr. Xu elaborated on this point:

Now the donation of embryos, that’s illegal in China because giving embryo poses a risk for the girl. For example for a single girl to donate an embryo, she needs to be injected with all kinds of medicine and then the embryo must be extracted from her which is a violation. Of course, tradition could be wrong, but is necessary for girl because want to respect her health. Because if you get the embryo from the woman, we think that it may affect their future and it wouldn’t be right for their safety because you don’t know if those medicines could give them cancer or whatnot.76

Mr. Xu cites safety concerns as a reason for the prohibition of egg donation, but his explanation - that the medication could cause cancer - has insufficient scientific backing and was added as an afterthought. From the conversation, it seems that his primary rationale for prohibiting egg donation is related to tradition; embryo extraction “may affect their [women’s] future,” especially for unmarried

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76 Interview with Mr. Xu
women. Mr. Xu believes the act is a “violation” of a woman’s reproductive sanctity. Commercialization has less to do with exploitation or consent, but pertains to the morality of commercializing reproductive materials, particularly a woman’s reproductive materials. The goal of ART regulations, Mr. Xu explains, is to help infertile women while supervising the process to ensure that “natural principles” are applied. These “natural principles” do not primarily rest on safety or biological concerns but on how severely commercialization conflicts with what he perceives are traditional moral values, specifically traditional ideas of female chastity.

This moral framework extends to the family, the outcome of reproduction. Because assisted reproduction complicates traditional ways of defining the family, Mr. Xu believes that government needs to ensure that outcomes of assisted reproduction do not alter family structure. For Mr. Xu, a complete family consists of a heterosexual married couple; this is not only socially appropriate, but also “natural.” He further elucidates this belief by claiming that the ART policies of other countries “break the regular institution of marriage and harms children when they’re small because they don’t have a complete family.” This is especially true in the United States where the single-parent family “is not really ethical and breaks the natural way of things.” What he defines as “natural” here is not based on biological or genetic relationships but by prior understandings of what is a “complete family.” ART may interfere with blood relationships, but a family is legitimate as long as it resembles the traditional “complete family.” Mr. Xu explains, “We think that having natural parents is better because it applies to
natural law and so our regulation does not allow those out of wedlock and thus we can continue to promote those traditional forms of relationships to avoid these societal problems and it can continue people’s natural and social relationships.”

For Mr. Xu, definitions of “natural” and “social” run together. Counter-intuitively, what is “natural” is better represented by traditional social norms than by biological markers.

Mr. Xu did not justify the ART age limit prohibition on the basis safety concerns or the “natural” birth range, but on what he believes are traditional duties. “In China,” he declared, “there’s a tradition of providing for your parents in their old age, but if they have you when they’re old, but the time you’re ten they’ll be old, and there would be no way to provide for them. On top of that, they’d also have to provide for your schooling as well.” If couples have children in their fifties or sixties, raising a child would be economically unsustainable because their children could not fulfill what Mr. Xu believes is their filial obligation to take care of their elderly parents. Admittedly, since filial obligation serves as a substitute for the government’s poor provision of welfare to senior citizens, Mr. Xu may have ulterior motives by appealing to tradition. However, Mr. Xu’s reliance on Confucian morality rather than on safety, rights, or quality concerns illustrates that ethical concerns do play an important part in ART policy formation. For Mr. Xu, accepted forms of reproduction should exist to reinforce traditional family norms; thus, the government prohibits ART in situations where it might jeopardize the “complete family.” Assisted reproduction should try to be as faithful as possible to traditional reproductive contexts; what forms of “natural”
reproduction creates a “complete” family is defined not by blood relationships but by traditional moral norms and obligations. In the process of accommodating ART, Mr. Xu redefines the “natural” and socially acceptable reproduction by applying “bioethical principles” derived from conceptions of Confucian morality.

Mr. Xu, as noted above, is only one policymaker in the Ministry of Health and in no way serves as a complete representation of the entire bureau. Indeed, his comments may not represent his true personal beliefs but could simply mimic the party line or be hedged by political constraints. However Mr. Xu’s role as a central figure in the development, drafting, and promotion of ART policy along with his current role as a retired official with less substantive power and few future political ambitions help buttress his statements. In addition, his unique understanding of “bioethics” in assisted reproduction does provide insight for a better understanding of Chinese policy within the international bioethics discourse. A Western bioethical perspective may be insufficient for understanding Chinese policy, for as we have seen here, when formal bioethics conflicts with traditional ethical concerns, the latter usually overrule the former.

Could the ART single parent prohibition be the natural result of complying with national laws? The specific provision regarding this prohibition in the ART guidelines reads, “Prohibits those women and single women who do not meet the requirements of the national population and family planning laws from using human assisted reproductive technology.” By coupling ART regulations to the family planning program, the MOH seems to imply that the one-child policy

77 Order 14, Ministry of Health
allows for only father-mother-child families. However, a further examination of Chinese provincial ART regulations reveals that this is not the case. An examination of the Jilin ART Regulations, passed only one year after the MOH regulations, suggests a plausible alternative approach to understanding assisted reproduction within the context of China’s birth planning program.

The Right to Reproduce: Jilin Regulations

On November 1, 2002, Jilin province passed *The Regulation on Population and Birth Control*. A provision in subsection thirty read: “Women who have reached marriageable age but have decided not to marry, may make use of assisted reproductive technologies to help them bear a child.” A Jilin Province representative from the Legislative Affairs Committee introduced this provision by announcing, “There are some people who do not wish to marry, but want a child. This circumstance is rare but the right of reproduction for this part of the population should be respected. The right of people to reproduce is innate, and should take precedence over the power of the country and the law.” This regulation created uproar in the blogosphere. Some in academia and media hailed the regulation for respecting and protecting the woman’s right to

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reproduction by giving single women the ability to have a child, while others believed it violated national family planning laws.\textsuperscript{80 81}

Earlier drafts of this provision reveal the legislators’ concerns and provide interesting insight into how China is currently grappling with ethical choices. Whereas Mr. Xu emphasizes the good of the collective in assisted reproduction regulations, the Jilin legislative committee focuses on the “rights” of the individual. Yet, these “reproductive rights” also have limitations, meaning that rights are allowed so long as they do not violate certain moral principles. While these moral principles are also based perceptions of traditional moral values, the Jilin legislature allows more flexibility in their interpretation.

The first meeting on September 27, 2002 of the Jilin Legislature produced a draft that included the provision, “Those people who are of married age, who chose not to marry but wish to have a child, may make use of reproductive methods to bear a child.” However, legislators later decided that the phrase “reproductive methods” was not tight enough and that some may interpret “premarital sex” as a “reproductive method,” so “reproductive method” was replaced with “medical reproductive methods.” Then, others mentioned that “medical reproductive methods” should be restricted to only those technologies approved by the national government, thus, for example, outlawing clones, and so

\textsuperscript{80} Jieren Chen, “Guojia jishengwei fuzeren biaotai: bu tichang yi falu xingshi guiding dushen nuzi shengyu quan” (Representative of the national family planning commission expresses: we don’t promote regulations that allow single women reproductive rights) \textit{China Youth Daily}, 13 Nov. 2002

\textsuperscript{81} Yumei Xu and Xianlian Liu “Guanyu dushennuxing shengyuqugan de falu sikao” (Regarding the law granting reproductive rights to single women), \textit{Chinese Medical Ethics} 2 (2003): 31-32.
the provision was changed to “those medical reproductive methods that the national government endorses.” Finally, legislators considered future implications; if in the future, technology permits males to become pregnant or give birth, this provision should not allow such practices, so the committee changed the word “persons” to “women.” Then it was considered that some women may have once been married, are now divorced, and no longer wish to marry, but do not have children. If Jilin gives single women a right to reproduce, it is illogical to deprive formerly married women of their reproductive rights; the wording was changed from “those women who in their whole life decide not to marry” to “those women who in their whole life decide not to marry again.” When the provision finally came to a vote, of the 47 members attending, only one member voted against it.

These changes present a perfect example of coproduction; in debating how assisted reproduction should be accepted by society, legislators redefine “reproduction” while simultaneously producing ethical principles to support these definitions. They had to define not only which processes but also which forms of reproduction are allowed, as socially accepted extensions of “natural” reproduction. Jilin’s combination of “reproductive rights” and their perceptions of traditional morality produce an interesting way of understanding reproduction. For the Jilin legislature, reproduction is considered “natural” as long as it is medical and not out of wedlock, which is ironic considering that biologically speaking, premarital procreation is a much more “natural” method of reproduction than biotechnological procreation. What is or is not natural depends on an

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82 Shanguo Li, Fuzhushengzhi jishu yanjiu (Research on Assisted Reproductive Technologies), (Beijing: Law Press China, 2005), 73-80.
understanding of bioethics that includes as its primary focus “reproductive rights” and a more flexible understanding of “traditional morality.” Of course by adding the words “that the national government endorses,” legislators did ban commercialization of assisted reproduction, but as shown above, this phrase was added as an afterthought.

Because Jilin legislators use the concept of “reproductive rights” to ethically guide their regulation, they accept a wider range of family structures as “legitimate.” As opposed to the strict national standard of the mother-father-child trinity, they accepted as “natural” forms of reproduction that can result in a single-mother family. Their debate revealed more concern about the motives of the parties involved than about the final form of reproduction. For example, some legislatures worried that the line “those who choose not to marry” would encourage mistresses to take advantage of the regulations. These mistresses may have decided to stay unmarried but some may seek reproductive clinics to “prepare a husband” by inseminating themselves and giving birth. To address this concern, others responded that the assisted reproduction clinics must abide strictly by national regulations, using the double blind method, so that the donor doesn’t know who receives his sperm, the mother doesn’t know whose sperm has been donated, and the clinic must keep the identities of each in strict secrecy. While the government places moral prohibitions on reproduction, the Jilin legislature was more lax because it was guided by the bioethical principle of “reproductive rights.” Reproduction is defined as natural by the Jilin legislature as long as it
respects the reproductive rights of women and does not infringe on what they perceive to be traditional moral principles.

In fact, this rights language was so strong that legislators supported the regulation even if it creates a loophole in national family planning law. During the debate, one legislator worried about the people who use assisted reproductive technologies to have a child but later decide to marry. To this, legislators did collectively admit there needs to be more research, but generally believed that the government could not take away people’s right to marriage. Women can only have one more child in the event that their husbands were not previously married or did not have a child in a prior marriage. In this case, the husband’s individual rights trumped even the one-child policy.

Following this meeting, some Chinese scholars hailed this regulation as a sign of progress. They believed these legislative results were caused by popular demand, interpretations of the National Population and Birth Control Law that emphasized the right to reproduction, and the desire to provide a good rights image to improve relationships with the international community. The head of the Chinese Law School Research on Marriage Law Committee, a Chinese politics and law professor, observed during an interview with the media: whether or not women who are unmarried can give birth was discussed at great length. While “right of reproduction” was a novel concept, she believed that China could experiment with this right by allowing certain exceptions in the family planning guidelines.\(^{83}\) Many scholars equated the rights discourse as influenced by the

\(^{83}\) Li, 75
government’s greater awareness of international regulations, and argued that an adoption of this discourse was an example of “progress.” It would be impossible for China to modernize without adopting a robust rights discourse, but adopting a rights discourse may mean altering earlier conceptions of natural and social order.

The Jilin Province regulations and subsequent discussions was the first case in which Chinese legislators seriously considered reproductive “rights,” as a legal and moral issue and incorporated it into reproductive policy. Whereas talk of “rights” is often banned as a sensitive topic in relation to the one-child policy, its debut on China’s legislative stage represents the impact that international influences can have on Chinese ethical beliefs. In addition, this discussion provides an alternative to the ethical principles in the Ministry of Health’s national guidelines on assisted reproductive policy, creating a very different set of regulations reflecting a different set of concerns. Whether these provincial regulations can be practically implemented is another matter. While they may in theory provide for single women to make use of ART, the procedure may still be prohibited in practice because the regulations conflict with national MOH.

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84 Liu Linping, a professor in the department of sociology at Sun Yatsen University noted, “This progressive set of guidelines demonstrates the protection of women’s reproductive rights…While there will not be a large number of people who will become single mothers, the Jilin Province’s protection of their reproductive rights under law is a sort of progress.” Lian Xinhuan of the National Center for Gender Studies similarly stated, “The current differentiation of lifestyles requires the modern society’s flexibility. If the government is too strict, then the laws and guidelines will lag behind and will bring many problems to the lives of many people.” Li, 74-76.

85 My conversations with people close to policymakers in Jilin revealed that these regulations currently only exist on paper and that so far, no single women have taken advantage of these guidelines. However, as this could not be substantiated with further proof, I present this only as conjecture.
Currently, marriage is a strict requirement for couples who hope to use ART not only in China but also in Egypt, Hong Kong, Iran, Jordan, Korea, Morocco, Saudi Arabia, Singapore, Taiwan, Tunisia, and Turkey. In all other countries, only a stable relationship is required.\textsuperscript{86} This list can further be separated into two categories: countries with a strong Islamic tradition and East-Asian states with a strong Confucian tradition (Korea, Hong Kong, Singapore, and Taiwan). This evidence only reinforces a conclusion about Chinese assisted reproductive policy: cultural norms can be as influential as religious convictions in bioethics, and in the process of coproduction, different bioethical understandings can contribute to different policy outcomes.

The next question then is: how well do these ethical values function when practiced? How well are they translated into action, in the clinics where physicians and nurses have the duty to abide by the policy? As can be seen from the drafting of the nation ART guidelines, in China, physicians are explicitly responsible for abiding by the government’s ethical principles. In the next chapter we will examine how those ethical values are understood, interpreted, and implemented on a daily basis in Beijing’s assisted reproduction clinics.

4. Prescribing Procreation

Bioethics and Medical Personnel

In March 1988, the Beijing Review announced the birth of the China’s first “test-tube baby,” born to a 39-year-old peasant woman. The media presented the official announcement as a technological success story, a symbol of science and medicine ushering in a modern China:

This healthy little girl, 3900 grams in weight and 53 cms in height, was born at Beijing Medical University at 8:56am. Zou, a peasant from a rural southern province and now a first time father at 42, clapped his hands and wiped away his joyful tears when he saw his daughter. The twelve members of his family had already arrived in Beijing several days earlier to wait for this happy moment. Professor Lizhu Zhang, the famous scientist and head of the in-vitro research program, took the baby in her arms and happily said, “I am a grandmother again.”

In 2006, almost twenty years later in a televised interview, Professor Zhang recounted her emotions and experiences during the early stages of China’s assisted reproduction program.

“Many people believe that China’s population is too great. Why, then, should China have an assisted reproduction program?” the interviewer asked.

“When we first started the program, many people asked me this question,” Professor Zhang admitted. “They also said that we were going against the birth planning program; what benefits do test-tube babies provide for China? But I believed that the country and its people cannot be separated; the problems that afflict its people also affect the country. At the time, thousands of women wrote

letters to me, narrating their pain. They said they felt inferior to others; ‘Other people all have children,’ they thought, ‘but I have none.’ They recounted their tales of marital strife, sometimes resulting in divorce; some were even contemplating suicide. Thus, I decided that we should solve the infertility problem.”

“What emotions did you feel when the first series of test-tube babies were born?”

“I was very happy” Professor Zhang confessed, “but I also felt tremendous pressure. Once, when a gynecologist announced the birth of a successful test-tube baby to the couple’s family, the mother in law shouted, ‘What test-tube baby? It’s not our family’s child. Throw it away!’ I was terribly hurt when I heard this, almost like I too had been thrown away by her words. She completely didn’t understand assisted reproduction.”

The hopes and worries Professor Zhang expressed during the interview reflect perfectly the challenges that medical personnel in assisted reproduction must tackle on a daily basis. As employees of the state, they are responsible for implementing official policy but must balance these policy considerations with their patients’ needs. Physicians are not passive agents of the state but must deal with a variety of emotionally fraught situations. To obey state commands while functioning within a hospital setting is not an easy task.

As seen in previous chapters, Chinese bioethicists formally define bioethics in assisted reproduction as a matter of informed consent. However, the government uses another interpretation of “bioethics” to decide which forms of assisted reproduction are naturally and socially acceptable. How do hospital personnel understand bioethics, and how do their perceptions guide daily decisions in assisted reproduction clinics? As I will argue below, physicians use neither the bioethical principles of the bioethicists nor those of policymakers but rely on yet another understanding of bioethics to underpin their decisions about which forms of assisted reproduction are naturally legitimate. These interpretations are not identical for all hospital personnel. Instead, even as medical professionals receive standardized ethical training, hospitals still deviate on which topics are considered “ethical” and on how medical personnel should resolve them. These differences lead to no practical consequences on issues related to commercialization, but on issues related to family structure, these differences allow hospitals to offer a diverse array of assisted reproduction practices.

**Assisted Reproduction Clinics in Beijing: An Introduction**

There are currently fourteen state-controlled institutions in Beijing licensed to use assisted reproductive technologies (ART); these institutions significantly differ in practice, experience, and reputation. Some hospitals can perform all procedures while other more recent licensees can only carry out simpler procedures. Some hospitals have been using ART since its debut in China, while others have only lately opened clinics to meet the growing domestic
demand for ART. In this section, I will briefly introduce the six institutions I visited and interviewed.  

Aixin Hospital is one of the leading assisted reproduction clinics in Beijing as well as in China. It currently staffs over 120 personnel and performs roughly 100,000 procedures a year. Unlike some other clinics, its assisted reproductive department is separate from its gynecology branch. It is licensed to do all procedures requiring the use of ART and has been performing these procedures long before many other clinics opened. Due to its reputation, thousands flock to the clinic each year, some traveling from as far away as Guangzhou in southern China. The hospital staff is considered to be among the most experienced in the country, and its facilities are immaculate and first-rate.

Beijing East Institutional Hospital (BEIH) houses an assisted reproduction clinic as a branch of the gynecology department. While the hospital has offered assisted reproduction services for well over ten years, BEIH is better known for its superior general practice. Thus, many of its assisted reproduction patients have been transferred from other branches of the hospital. However, its facilities are noticeably worse than those of Aixin Hospital with smaller, cramped rooms, fewer operation rooms, less office space and fewer clinical personnel. Nevertheless, its physicians are well respected, and the hospital has a long waiting-list of patients.

89 The descriptions I give are obtained from conversation with regular Beijing citizens and physicians, my observations, and information they distributed at the hospitals and on their websites.
Changan Hospital is a reproductive center, which also serves as a
department of a larger, well-respected hospital, though it is less well-known than
BEIH. Founded after the regulations were passed, it began performing ART
procedures only relatively recently. It currently houses a staff of fourteen
personnel, including four main doctors who perform the major operations. While
it is licensed to offer all ART procedures just as in Aixin Hospital and BEIH, its
facilities are not as extensive as the other two, with only one major operating
room and one office with no air conditioning in the waiting area. Nevertheless,
because of the respectability of the larger hospital, the ART clinic still maintains
an excellent reputation, keeping a busy schedule and a moderate patient waitlist.

Beijing Dongbu Clinic is located in a larger hospital specifically known
for its obstetrics and gynecology practice. Its ART practice is not as popular as
that of Aixin, BEIH or Changan Hospital but its facilities are immaculate. To
avoid contamination, even visitors who did not go near operating rooms must
wear protective clothing and footwear. The center currently staffs 16 personnel,
four of whom are its main physicians. It has been practicing ART since before the
guidelines were passed and is licensed to perform all ART procedures. The
hospital is known for its Genetic Diagnosis Center, established in 1979, which
provides prenatal screening and genetic counseling to couples. While it does have
a good reputation, the expertise of its personnel is publicly perceived to lag
behind those of the other hospitals.

National Hospital is also located in a larger, general practice hospital.
While it started using ART before the regulations, these technologies were
utilized on a small scale, and it only recently began to focus on its ART center. The hospital is less popular than many others, with fewer patients, in large part because it is not licensed to do all ART procedures, including IVF. Thus, medical personnel consider National Hospital to be a small player in the Beijing ART world.

The Beijing Reproduction Center is the only sperm bank in Beijing with very limited assisted reproduction services. It is also an unconventional place for an ART clinic because unlike the other clinics, it is not located in a large hospital, but is a subdivision of a research institution. While it was a major player in reproduction technology during the early stages of ART development in China, recent lack of funding has caused it to fall behind others in ART applications. Primarily because it is not associated with a larger medical institution, it is only licensed to perform the most basic assisted reproduction procedures; it currently does not meet the facilities requirements for more complicated procedures such as IVF. However, its role as the only sperm bank in Beijing attracts a large number of potential donees who must wait more than two years for sperm. The institution sees its primary role in conducting reproductive research, with its sperm bank playing a secondary role even though that is what makes it distinctive.

The daily routines in each of these clinics are almost identical. In the morning, physicians operate and perform assisted reproduction procedures, and in the afternoon they complete outpatient checkups and pre-treatment tests; mornings are usually the busiest while the afternoons tend to be more flexible. Each hospital also provides for its patients a similar timeline for ART treatment,
excluding the waiting period. Diagnosis and treatment lasts a minimum of 6 months but may extend to several years depending on the treatment’s initial success. These hospitals implement systems to ensure that couples seeking assistance are indeed infertile and that they only receive the proper treatment. These tests often take several months to complete. Once a couple is admitted for treatment, each of these hospitals carefully provides the patients with adequate information to meet the principles of informed consent and voluntary donation. This is especially true when sperm or egg donation occurs. As specified by the guidelines, they also have strict rules for who is eligible for assisted reproduction.

Nevertheless, in many cases, often the most difficult, physicians in different hospitals provide varying accounts and use distinct approaches to ensure that the hospital meets the ethical principles outlined in official guidelines. These opinions sometimes lead to different practices among the ART clinics.

**Medicalization as Naturalization: The Role of the Physician**

Physicians categorize valid and invalid ethical issues according to how well they hold up against scientific facts. Many doctors believe their primary responsibility lies in ensuring the safety and health of both the patients and the possible child. They also see themselves as medical experts who are responsible for addressing the patients’ concerns, respecting the patients’ wishes when possible, and correcting their misunderstandings about the technology. One misunderstanding that all the physicians I interviewed hope to debunk is that the process of assisted reproduction is “unnatural.”
Whether assisted reproduction can be considered “natural” has been in continuous debate since Paul Ramsey, an American ethicist, opposed artificial insemination by donation because it dehumanized parenthood and made reproduction a process of the laboratory. Some scholars believe that professional assistance in lieu of procreation is ethically dubious because it separates reproduction from sexual intercourse. The Catholic Church has argued that ART interferes with the “sacred process” of life that is God’s will. While many of these arguments come from religious groups that place an importance on conception and disapprove of the medical interference in procreation, they nevertheless carry significant moral weight.

For the hospital personnel I interviewed, the “unnatural” process argument has limited ethical significance. This was made clear from physicians’ explanation of the growing popularity of ART, to the concerns of their patients, to stories of physicians’ own acceptance of assisted reproduction. As hospital staff explained to me, assisted reproduction is in greater demand because more people were beginning to “realize” that ART is indeed natural. As a physician from Changan Hospital explained, “In the beginning people thought that it was not natural, but then we explain to them the whole process. I mean basically it’s pretty close to natural. People are slowly accepting this because from their Chinese traditional views, they still want children.” For physicians and hospital staff in all

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92 Ratzinger.
the hospitals, the “naturalness” comes from the process of reproduction; given that assisted reproduction is medically certified as a “treatment” that leaves “pregnancy” and “birth” largely intact, it is unjustifiable that assisted reproduction should be considered unnatural.

When speaking about the “unnatural” nature of assisted reproduction, many of them believe the idea comes from an incomplete understanding of the technology. This incomplete understanding also accounts for why some people decide to opt out of assisted reproduction treatment after an initial consultation. A physician in Beijing Dongbu Clinic explained to me how before the regulations, few people came to the clinic for infertility treatment and those who did usually kept their ART procedure secret. This has been slowly changing, she noted, as China becomes “more developed,” and more economically successful. She assumes that as soon as people gradually understand that assisted reproduction is a medical “treatment,” the feeling that ART is “unnatural” would dissipate. This connection between “medicine” and “nature” was most clearly articulated by a nurse at Changan Hospital who explained, “As for myself, I don’t believe it’s unnatural. I think it’s the same as other sorts of medical treatments. Perhaps at the beginning people were not clear about the technology but slowly people are beginning to accept this.”

One nurse from Aixin Hospital told me of her changing views, from initial skepticism about ART to comprehension of the “naturalness” of assisted reproduction. “At first I thought ART was very mystical,” she said. “I thought, ‘How can you just get a baby out of nowhere?’ I thought it was a high technology.
But then I understood and realized that it would bring couples happiness and do a lot of good so I think it would be a good thing to help the patient.” While she was originally fearful about the unfamiliar technology, after she realized that ART could allow previously infertile patients to reproduce, assisted reproduction no longer seemed an unnatural process but rather an extension of the natural desire to have children. The nurse naturalizes ART because it socially produces the same state of happiness in parents, not as a biological extension of normal reproduction.

These statements illustrate that while hospital personnel may have initially expressed reservations, this is a stage they can easily overcome with additional information. In their view, the “unnaturalness” framing does not stem from ethical principle but is an emotional reflex in response to novelty. Thus, the role of the clinic and its personnel is to “demystify” the process by providing patients with knowledge, primarily scientific knowledge, to debunk the “unnaturalness” myth. Hospitals have adopted multiple strategies to help patients overcome this initial uncertainty. Some hospitals provide a health care class while others painstakingly talk through every stage of the process with their patients. Others explain the scientific basis behind assisted reproduction in private consultations.

Physicians express no qualms about whether the use of science in reproduction is a violation of “natural” reproduction. Instead, physicians view “infertility” as more abnormal than procreation through assisted reproduction. Since medicalized assisted reproduction allows couples to “normally” reproduce, the use of technology in lieu of procreation is no more “unnatural” than
prescribing drugs to treat a bacterial infection. Medicine both socially legitimizes and naturalizes assisted reproduction.

However, this is not to say that physicians believe all forms of medicalized assisted reproduction to be acceptable. Assisted reproduction should be prohibited when it cannot guarantee the health and safety of the patients or the potential family. Their perceived responsibility to guarantee benefits (li) for patients and family underpins their opposition to non-medicalized assisted reproduction and even commercialized medicalized reproduction. Under uncontrolled assisted reproduction, parents in non-hospital settings may have difficulty ensuring that their baby is actually the intended child; untrained professionals may misidentify or labeling gamete samples; this confusion perverts the “natural” process and outcome of reproduction. Under current conditions in China, when commercialized assisted reproduction and even some forms of state-controlled, medicalized assisted reproduction cannot guarantee the safety and health of patients and their families, physicians believe it is their ethical responsibility to prevent these forms from being practiced.

**Donation and Surrogacy: Few Practical Consequences**

Physicians were divided as to how to resolve ethical issues in gamete donation and in surrogacy which they believed were the most ethically problematic issues in assisted reproduction. While physicians believe that commercialized gamete donation should be prohibited, other believe it poses relatively little risk to the donor but is hugely beneficial to those who need it.
Physicians approach surrogacy more warily, whether in commercialized or medicalized contexts. Because pregnancy is perceived as a substantial risk, physicians are more cautious about advocating for surrogacy, even in medicalized, strictly-regulated hospital settings.

Gamete donation is widely recognized as a process that can give rise to ethical concerns. One set of concerns centers on whether this act divides parenthood – that the division of biological and social parents destroys the traditional mother-father-child trinity. Separation of these roles is not only harmful to the parents but can also deprive a child of the ability to develop a personal identity.93 Another set of concerns involves the commercialization of gamete donation; anxieties are particularly prominent in egg donation. Some in the medical profession have even labeled clinicians who advertise for paid egg donors as little more than pimps.94

The hospital personnel I interviewed expressed concerns about heredity, commercialization, and patient benefit in gamete donation. One set of objections relates to genetic lineage; people are uncomfortable with the idea that the possible child will not be biologically related to one of the parents. Dramatic examples often gain media attention. One report in the China Daily described a doctor’s recollection of an outburst from the operating room where a mother-in-law shouted at her son, “The baby cannot be considered as having the blood of our

family! I won’t accept it as my grandchild!”95 To avoid such messy scenarios, physicians take lengthy measures to ensure these issues are resolved before a child’s birth.

Some hospitals provide counseling to the couple when donation is involved. As a doctor from Aixin Hospital stated, “In cases where the sperm is not the husband’s and is donated, the husband must promise that he will fulfill his responsibility to support the baby.” Other hospitals provide legal documents to ensure that both parties understand the child is their mutual responsibility, even if not biologically related to both parents. These precautions are even stronger in cases involving egg donation. “In the case of egg donation, some patients who don’t have the ability to produce oocytes in their ovaries have to pay much to undergo this procedure. But the patients understand that all children they will have are their own. In some cases, patients do forego the procedure, I think, because if they believe “it’s not my own,” then they don’t want to undergo the procedure,” a BEIH physician stated. Even if the child might be biologically related to one part, infertility is not a strong enough burden to convince parents to undergo assisted reproduction. Because assisted reproduction requires serious financial sacrifices and significant bodily risk, the broken genetic link is the tipping point for some patients who are initially skeptical about the new technology.

The administrator of the clinic at Aixin Hospital articulated the genetic relationship issue in an interesting manner, as the “right to descendents (houdai).”

<http://www.chinadaily.com.cn/life/2010-10/20/content_11433049.htm>
When the potential child is not biologically related to both parents, Aixin hospital takes great care to ensure that the couple understands that the child is their own. This is a tedious process, but because the couple has a “right to descendants (houdai),” she explained, the hospital goes to great lengths to ensure the procedure’s success. This “right to descendants” is not framed as a right to reproduction or a right to a child, but as a right to houdai. In choosing this word, the administrator implies that the hospital’s interest is to ensure that patients can maintain their ancestral line, whether or not their offspring are genetically related. Patients should have the possibility to generate offspring to ensure the continuation of their family lineage, a social rather than a strictly biological concept.

Others physicians believe that the ethical dangers in gamete donation, specifically egg donation, lie in its commercialization. A closely related issue in commercialization is the issue of the vulnerability of the donor. This was explicitly stated by a physician at Aixin hospital who believes gamete donation should be tightly regulated by the government: “The government may be afraid that people will exploit it, and they it wants to make sure that the donation is voluntary because if people do it for the money, it’s like prostitution. The women might make money, but a lot of money would be given to the pimps.” Because China’s AIDS epidemic was exacerbated by exploiters who illegally collected the blood of large numbers of poor farmers,96 the government worries that something similar could occur with egg donation.

96 See Rosenthal.
Patient benefit is another ethical issue in gamete donation. As a BIEH physician explained,” while egg donation may be beneficial to the couple who wants a child, it may not be advantageous to the third-party woman involved.” Egg donation does entail a certain degree of risk, greater than the risk involved in sperm donation. For example, egg donation requires hormonal changes through medication and an operation to extract the eggs. Because of the physical risks involved, physicians are divided as to how strictly egg donation should be regulated. Some physicians intensely oppose commercial egg donation on the grounds that China lacks proper structures to safely regulate it. Others lament that government regulations are too severe. A BIEH physician explicated, “While in China, people are allowed to exchange embryos, the rules are too strict, and because of this, it is very hard to do. So for example, in this clinic maybe 100 people or so may need a donated egg, but probably only 1 or 2 actually get it. We currently lack the ability to adequately ensure for egg donation.” Other physicians similarly felt that government regulations prevented them from adequately treating many of their infertile patients.

Surrogacy is another matter. Most doctors I talked to did oppose surrogacy, even medicalized surrogacy, under China’s current legal and economic circumstances. On one hand, some patients truly need surrogacy; perhaps they have had a hysterectomy or their uterus is too thin to undergo pregnancy. On the other hand, pregnancy and childbirth is risky while providing little benefit for the surrogate. Thus, some doctors remain undecided on this issue because of the difficulties in properly regulating surrogacy. Some of these difficulties come from
guaranteeing the surrogate’s safety. A physician from Aixin Hospital stated, “Before when surrogacy was allowed the people who were surrogates were those who did not have a lot of money. And surrogacy carries a high risk because if there’s pregnancy involved there’s a lot of risk between the labor and the birth.” Other difficulties come from a lack of proper legal structures to handle surrogacy. In the case of egg donation, the birth mother is still the intended social mother, but in surrogacy, the birth mother is different from the intended social mother. Since under current Chinese law, the birth mother is recognized as the official legal mother, surrogacy could create problems for the potential family. An Aixin administrator stated:

   It’s a complex ethical safety issue. In China, from my point of view, people for example who do not have a uterus would give up their right to descendants (houdai). By should this be so? The mother is not the birth mother. What if the birth mother has emotions and doesn’t want to give up the child, what will happen? Legally what will happen? Who do I support? I think that if law hasn’t resolved this issue, I don’t support surrogacy.

The general sentiment among physicians is that minimal societal harm at the expense of benefit for a few is preferable to the harms that could result from improperly regulated assisted reproduction. Given China’s current social, economic, and legal situation, physicians generally do not support surrogacy, even in medicalized contexts.

Despite the difference of physicians’ opinions on the ethics of gamete donation and surrogacy there seemed to be little practical difference in its implementation in the hospitals I visited. This is in large part because of the explicit government stipulations on sperm and egg donations, covering who is
eligible to be a donor, hospital measures for sperm or egg quality, and the conditions and procedures for gamete donation. Given that the regulations unequivocally limit egg donation to patients who have already gone through IVF, there is little room for interpretation. However, in both gamete donation and surrogacy, physicians use the ethical principle of patient benefit to decide which assisted reproduction procedures should be medicalized – and thus naturalized. Whereas in this case, divergent opinions hold little practical consequences for the assisted reproduction implementation, this does not hold true in other contexts.

Uncertain Families

Kinship remains a contested analytic concept in anthropology. In their 1987 anthology, Jane Collier and Sylvia Yanagisako argued that much of what was thought to be the norm in kinship has been rooted in Western assumptions such as the universality of the family and the centrality of the mother-child bond. More recently in her work on kinship in infertility clinics, Charis Thompson demonstrated how technology is used to transform traditional kinship structures. Intended parents of ART children can legitimize their claim as the real parents by emphasizing certain ways of kin differentiation while minimizing others, particularly in situations where there is no biological relationship between parents and children. In other words, “the clinic is a site where certain bases of kin differentiation are foregrounded and recrafted while others are minimized to

make the couples who seek and pay for infertility treatment – the intended parents – come out through legitimate and intact chains of descent as the real parents.”

Certain behaviors, traits, or substances are emphasized while others are rendered irrelevant to prevent a conflict over who the child’s parents are.

In the previous chapter, I illustrate how the government uses what it perceives to be traditional family values to define what constitutes naturally and socially legitimate reproduction. This understanding of bioethics is not fully shared by physicians. The medical personnel I interviewed do see changes to the family structure as ethically problematic. However, they present an alternative bioethical framework for evaluating who can access ART. Physicians view their primary ethical responsibility in guaranteeing the health and safety of patients and their potential families. This understanding makes possible a variety of interpretations for who is eligible for ART to start a family, despite regulations that the government believes are clear and explicit.

As already noted, the physicians I interviewed often pair descriptions of family with the concept *houdai*. One doctor explained, “I think that ART and gynecology are very special because only in these fields are there issues related to *houdai*.” The physician’s role, then, is not only to provide the best treatment for patients but also to mediate potential conflicts between benefits for the present generation (the patient) and for the future generation (the potential child). In assisted reproduction, when the patients’ wishes may raise safety concerns or

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bring possible harm to the development of the child, the physician has the duty to evaluate whether those risks to the child outweigh the interests of the patient. In cases of direct conflict, some physicians admit that they “usually think about what would be best for the child.” For example, when a mother’s wish to have multiple children might bring slight risks for the possible child’s healthy prenatal development, medical staff will usually perform a reduction to ensure that the child is delivered under optimal conditions. Medical staff feel a duty to prohibit the use of ART in cases in which it might cause physical or psychological harm for the child.

The ART regulations prohibit ART use for certain groups of people, including single mothers. These are the same regulations that Mr. Xu, the official at the Ministry of Health, claims protect the “natural” and socially accepted “traditional family.” Yet, for physicians, the definition of an adequate “family” depends on what they believe are necessary conditions for a child’s proper development. These opinions are not only idiosyncratic, differing from one physician to another, but also lead to different practices in the hospitals I visited. This is most clearly indicated in examples from four clinics around the city.

At Aixin Hospital, maintaining bioethical standards means ensuring that the potential child is protected. This requires that an interested couple needs a marriage certificate and valid proof that their marriage is stable. In addition, physicians must deem the couple to be free from serious medical problems so that they have the capability to raise a child. As an administrator explained, “It’s about protecting the patient but also about protecting the children.” For the medical
personnel at Hospital A, the “single parents” provision extends to those who are divorced, so that previously married couples cannot undergo assisted reproduction. Aixin Hospital has also created self-imposed age limit requirements for potential fathers. Even if the mother is legally eligible and the sperm comes from a sperm donor, the intended father must be younger than 60 for the couple to be considered for treatment in the hospital. A physician justified this rule: “Because we should protect the baby’s right, if the father is too old, when the baby grows up, the father would be gone.” Being ethically responsible means not only protecting those who are currently present but also those who may arrive in the future. To avoid depriving future generations of a complete family, physicians believe that they must sometimes place restrictions on freedoms of those now living. At Aixin Hospital, a complete family requires a stable, heterosexual marriage with the mother under fifty and the father less than sixty years of age.

Physicians at National Hospital expressed similar concerns, but are more lenient in their eligibility requirements. While there are no age limits imposed on the intended father, couples must endure a long evaluation process to ensure they meet the standards for parenthood. “To do a legal procedure, we have to check the mother’s age and their living arrangements. We consistently contact them to see if there are problems with the marriage.” When physicians discover that the couple has marital discord or are considering divorce, medical personnel arrange a psychiatrist for the couple to see if they can resolve their issues. If these marriage problems persist, the hospital will refuse to proceed with treatment. Physicians at
National Hospital act as the ultimate moral arbiter in determining whether parents are capable of successfully raising a child even if they are legally married.

Medical personnel at Beijing East Institutional Hospital articulated the family structure problem in a legal framework. Physicians I interviewed see single parenting as ethically unreasonable because it deprives a child of necessary care. One doctor describes a typical ethically problematic scenario: “There are cases in which one person in the couple, usually the male does not want to undergo ART. It may be the case that when they first started the process, the couple was married, but divorced before the embryo was implanted, but the mother may still want the embryo to be implanted because she wants a child. In this case, you have to consider the best interests of the child.” For physicians at BEIH, the “best interests of the child” do not require a stable emotional marriage, only a stable legal marriage; it is enough that couples are legally married. This understanding of marriage is reflected in the eligibility requirements, as revealed to me by a BEIH nurse: couples must present a marriage certificate before and after the procedure to qualify for assisted reproduction. Emotional marriage stability is less important for a child’s development than formal, legal marriage recognition. Thus, BEIH devotes no attention to an examination of the dynamics of marital relationships; the government’s recognition of a couple’s legal status suffices.

Single parenting was also an ethical issue at Changan Hospital. “There are some single mothers who may want children, but we do not allow it. I don’t think that single parents are good for the future generation. Perhaps it may not matter to the single parent, but one person’s ability is not more than two people’s ability,” a
physician explained. For physicians at Changan Hospital, a complete family does not require legal marital status but only that two able-bodied, heterosexual adults are available to care for the potential child. Less emphasis was placed on emotional or legal definitions of marriage. Instead, the hospital denies requests if one member of the couple has a mental disability or dies before procedures are completed. The harm done to the potential child is a lack of a living parent, not of a lack of having married parents. On this reasoning, the hospital accepts divorced couples for assisted reproduction. A nurse clarified, “We do ART where the couple is divorced, but both parents are around. One side may be childless and want a child, and we do allow it because in that case, the child will have both a father and a mother, and it wouldn’t be like the child was lacking something. So as long as both parents are around, we allow these procedures.” This interpretation of the national regulations contrasts sharply with versions in Aixin, National, and Beijing East Institutional Hospital: marriage in this case is an irrelevant factor in defining what should be considered a proper family for a child’s healthy development.

Single parenting is seen as a psychologically and culturally corrosive force. One of the most forceful statements came from a physician at National Hospital. “We think that single parenting is not ethical because it’s like you’re taking something away from the child,” he asserted. “It’s culturally against our beliefs, but now it is becoming more of a problem as China comes under more of Western influences.” This is not to say that “single parent” has a definite meaning. The ethical principles embedded in policy are insufficient to give a single, universal
interpretation for what counts as single parenting. State promoted ethical understandings about family lead to physicians’ deviating views which in turn, develop into divergent hospital practices. For physicians, reproduction is only considered natural when it results in a certain type of family, one defined by their bioethical standards.

During these interviews, I was surprised that gender discrimination and fetal reduction arose very little in the conversation. Part of this may be attributed to the nature of the field site. Since these clinics were located in Beijing, a cosmopolitan, modern city, gender preferences are less important than they might be in the countryside. In addition, ART clinics are not fully representative of the public perceptions. Since many parents have been infertile for years before coming to the clinics, the possibility of any child is a joy regardless of the child’s gender. Fetal reductions are different matter. China’s one-child policy is unpopular even in the cities, and the assisted reproduction regulations require fetal reductions in the case of triplets and strongly encourage them in the case of twins. Before my interviews, I had heard rumors of wealthy couples going to ART clinics with the sole intention of giving birth to twins. While physicians did mention the rare case when extreme conflict occurred between the couple and the hospital when fetal reduction was advised, these cases are relatively rare. A nurse at BEIH related a case where the patient had disappeared after her physician advised her several times to undergo reduction for her triplets. “But in my three
years here, this was the only case where a patient did not listen to doctor.” That fetal reduction is not more common is a mystery.

I believe that this lack of conflict can be attributed to physicians’ relaxed attitudes towards the number of children born to one patient as well as a sense of ethical obligation towards the safety of the potential child. For the most part, hospitals strongly discourage triplets but are amenable to twins unless significant safety risks arise. A nurse at Changan Hospital described their policy: “The government will not allow multiple pregnancies. Triplets are rare, but in ART, we will advise a reductive procedure if there are two or above. In the end, it’s up to the patients to decide, but usually the patients will accept the advice of the doctors.” The nurse assumes that patients and physicians have a mutual goal to primarily ensure the safety of the child even at the cost of some restrictions to the patient. It was assumed that with proper explanation by physicians, patients will understand the medical risks tied to multiple pregnancies. For physicians, minimizing the harm done to the future child was more important than the number of possible children patients could have. Physicians implied that patients felt a similar responsibility for the well-being of their offspring. This may be true, but because I did not interview patients, I cannot substantiate this claim.

Summary of Hospital Results

While it is not clear if the same ethical questions arise in reproductive clinics outside of Beijing, the views described above illustrate that moral questions have significant weight in medical institutions, affecting how official
rules are validated, interpreted, and transformed into action on a daily basis. Even when instituted through government regulations, ethical principles can become cloudy when implemented in localized settings, revealing ambiguities in meaning. By actively shaping, defining, and evaluating their understandings of bioethics, hospitals engage in coproduction when they decide how assisted reproduction is accepted by society – how reproduction is practiced, what forms of reproduction are naturalized, and what families are formed through ART.
Conclusion

Still leaning against the incubators he gave them, while the pencils scurried illegibly across the pages, a brief description of the modern fertilizing process; spoke first...some account of the technique for preserving the excised ovary alive and actively developing; passed on to a consideration of optimum temperature, salinity, viscosity; referred to the liquor in which the detached and ripened eggs were kept; and, leading his charges to the work tables, actually showed them how this liquor was drawn off from the test-tubes; how it was let out drop bydrop onto the specially warmed slides of the microscopes; how the eggs which it contained were inspected for abnormalities, counted and transferred to a porous receptacle; how (and he now took them to watch the operation) this receptacle was immersed in a warm bouillon containing free-swimming spermatozoa— at a minimum concentration of one hundred thousand per cubic centimetre, he insisted; and how, after ten minutes, the container was lifted out of the liquor and its contents re-examined; how, if any of the eggs remained unfertilized, it was again immersed, and, if necessary, yet again; how the fertilized ova went back to the incubators; where the Alphas and Betas remained until definitely bottled; while the Gammas, Deltas and Epsilons were brought out again, after only thirty-six hours, to undergo Bokanovsky's Process.

- Aldous Huxley, Brave New World

In Brave New World, Aldous Huxley envisions a future world in which people are bred by the state into separate castes: Alphas, Betas, Epsilons, and Gammas who are biologically distinct from one another. In this state, the government has abolished disease and social conflict, depression, madness, loneliness, and emotional distress through a host of biotechnological processes such as the one described above. People appear healthy and happy, but as John the Savage, the book’s protagonist finds, a world devoid of religion, family, or Shakespeare seems as grotesque as the mass-produced people themselves, who

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rely on drugs to keep themselves content. After finishing the book, Huxley leaves
readers pondering, “How can people in that world view their lives as normal?”

On a hot summer day as I sit in Aixin Hospital’s waiting room, procedures remarkably similar to the ones Huxley described above are being carried out on the floor above me. In some rooms, physicians are extracting eggs from women, inspecting them for abnormalities, and placing them in receptacles filled with chemical fluid to freeze them at precise temperatures in carefully monitored appliances. In other rooms, physicians are delicately fertilizing sperm and eggs in incubators or diligently injecting a single sperm into an egg under a microscope. Other physicians are meticulously examining these eggs to ensure that they are fertilized into embryos. Yet as I sit in Aixin Hospital’s waiting room, everything seems so normal. Some patients quietly sit in pale green chairs, watching the dashboard dish out medical reminders or flash the numbers of patients who are ready to be seen. Others read biographies of important hospital personnel, many of them pioneers of ART development in China, now fixed in institutional memory by thick plaques that hold their names on hospital walls. However, this is not a dystopia, just a normal, summer day in Beijing, 2010, in a clinic that is responding to people’s deep desire to have a family.

It was no coincidence that Huxley began *Brave New World* with a description of reproduction, as some consider it to be the most fundamental process of human biology. Every year in the United States alone, thousands of people passionately debate issues of abortion, the right to life, and the status of the embryo. Because reproduction is so vital to our understanding of personal and
human identity, it is no surprise that it arouses such ardent emotions and opinions. In China, reproductive debates are also taking place with similar zeal, but in a considerably different manner than in the United States.

In my thesis, I have tried to highlight some of these debates by examining how China is normalizing technologically assisted reproduction. Reproduction lies at the root of human survival and continuity, but in the People’s Republic of China unique facets of culture and politics have intertwined to set the stage for a particularly fascinating study. The first facet is the central role of reproduction and the family in Confucianism, a philosophy which still retains a prominent place in public morality. Second is the power of the Communist Party which can decree and quickly implement almost any guidelines it sees fit to enact, no matter how burdensome for individuals. Third is the strict one-child policy which maintains its presence in the daily reproductive decisions of Chinese citizens. Because assisted reproduction transforms the process and end result of reproduction, prior ways of controlling reproduction or family size no longer work precisely as they use to. In light of these changing circumstances, how does China manage to accommodate assisted reproduction into existing cultural, social and institutional contexts? In other words, how does assisted reproduction go from being a “foreign” and “strange” procedure to being completely natural?

I argue for an understanding of Chinese reproductive policy in what science studies scholars have called the framework of coproduction. Because assisted reproduction disrupts existing definitions of the family, to accommodate

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100 Jasanoff, States of Knowledge.
the uses of new technologies, state actors must simultaneously redefine natural and social order, so that the “artificial” is no longer seen as strange. Through bioethics, the state can once again stabilize ideas about reproduction and society.

Yet, the ideas used for this purpose are not homogeneous but vary widely as the different actors in Chinese assisted reproductive policy have found multiple ways of understanding “bioethics.” Because these localized interpretations produce distinct conceptions of what is or is not natural, they have led to different practical reproductive consequences. Who is or is not allowed to undergo assisted reproduction, what forms of reproduction are legitimate, what forms of parenthood are considered natural – all these questions have different answers depending on the actors’ bioethical perspective. By examining three different groups involved in assisted reproductive policy, I have shown how each manages to create a different way of managing the changes caused by ART in natural and social order.

Academic bioethicists, I have argued, are officially recognized as defining formal bioethics in China. Their focus on commercialization and the family as ethically problematic topics was driven by influences with deep roots in Chinese cultural and political history. Yet, their Western training and early work on informed consent has contributed to their understanding of bioethics. Informed consent is an important part of their analysis. Which forms of assisted reproduction are natural, which are socially legitimate, and how those procedures should be carried out depends on how well they meet certain criteria: that the
people involved can understand the process, that they can choose what is in their best interest, and that they are not harmed in consequence.

Policymakers however, deviated from “formal bioethics” and relied on another understanding. For them, bioethics proceeds from government’s responsibility for society’s moral, social, and physical welfare. In metaphorical terms, the government is the “father” who cares for the Chinese “family.” In the case of assisted reproduction, this has meant not only ensuring that present and future society would not be physically harmed but also that reproduction remains in line with what are perceived to be traditional Confucian moral values. Thus, commercialized reproduction and certain forms of assisted reproduction are considered unnatural because they violate traditional family values. The naturalness of reproduction hinges on its effect on the physical and moral welfare of society.

The bioethics embraced by medical personnel deviates from both bioethicists’ and governmental interpretations. ART clinical personnel, all of whom are medically trained, see bioethics from the standpoint of what they believe are their patients’ best interests. Reproduction that is considered natural should benefit the physical and psychological well being of their patients and their potential families. Medical personnel primarily worried about patient safety and child development in assisted reproduction. Because definitions of “best interest” varied from hospital to hospital, different hospitals also came up with different definitions of which reproductive processes and which forms of assisted reproduction they considered natural. In a certain sense, Chinese reproductive
policy is in reality multiple policies with localized interpretations about how the natural and social world should be ordered. This is why ultimately different sites have implemented Chinese ART policy differently despite the state’s best efforts to standardize it.

**Implications for Policy**

Michel Foucault in his famous *History of Sexuality* described the rise of a new form of power, biopower, whose claims to authority rests on a mastery of nature through its regulation of the population and of the individual body. Reproduction through population growth lies at the heart of modern governmental concerns. Thus, reproductive control becomes the subject of governmental interests as the state seeks to preserve the health and purity of the population. In the People’s Republic of China, where reproduction and the family are not only social entities but also have symbolic political meanings, a change in what is considered natural reproduction or a legitimate family has important ramifications for the state-society relationships. Not only do proper methods of reproduction dictate how Chinese family planning policy is defined (by redefining understandings of *family* and of *reproduction*), but because China has a tradition of seeing the state as an extension of the family, it can also alter the state’s understanding of its citizens as legal and political subjects. If the rigid family hierarchy is substituted for alternative family structures – the single-mother

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family, the lesbian family – where the father has no real role in family affairs, how will it change the state’s view of itself or the citizens’ relationship to the state?

Susan Greenhalgh’s *Just One Child* draws on Foucault’s idea of biopower and uses co-production to describe how the state created China’s one-child policy. Yet, for her, co-production describes how in the 1980s Chinese scientists produced a cybernetic regime of truth about the population problem that ruled out other, more flexible policy alternatives from other fields. This scientific population model “became the only way to think about the population question in the PRC.”102 Because of this, many more moderate and compassionate voices were silenced for the sake of a scientific solution. Chinese citizens, she argues, were unfortunate, passive objects of the government’s attempts to regulate life.

However, as I have demonstrated, a co-productionist view of reproductive policy requires a more nuanced view of the Chinese situation. In the process of co-production, it is rarely the case that one way of ordering the natural and social world triumphs to completely obliterate other possibilities. Instead, multiple views often coexist and continue to compete even after policy is made. In fact, while policy makers may adopt one way of perceiving a problem and one solution to fit those perceptions, the views of other relevant actors often influence policy implementation. Thus, while policymakers supported a very restrictive view of reproduction, assisted reproduction as it was practiced in Beijing clinics remains open to an acceptance of a wider range of possibilities. Co-production is not the

102 Greenhalgh, *Just One Child* 324.
sole property of the state but occurs at multiple levels of policymaking, often in localized forms.

What do these findings in ART policy tell us about policymaking? New technologies are constantly changing the way we think about and order the world. In the twenty-first century, as technology negates old distance divides, radically different versions of understanding the world are frequently colliding. As this happens, it will be interesting to see how these distinct visions interact and how governments, experts, and the public manage to negotiate this complicated terrain. We can see this happening today with the emerging rights discourse in China. While it has not yet been a major determinant of reproductive policy, the rights tradition provides an interesting alternative to more traditional Chinese ways of understanding the world. As we saw in Jilin, a reproductive rights model provides a very different idea of what is natural reproduction and what is a legitimate family than the Confucian model does. As technology disrupts ways we see and know the world, it encourages us to produce new alternatives to stabilize our world, alternatives that can change fundamental assumptions about humanity.

Recently, the Chinese Communist Party began promoting a return to traditional Confucian family values. On January 2011, legislators proposed an amendment to the Law on the Protection and Rights and Interests of the Aged (the Elderly Law). Under this amendment, elderly people who are ignored by their children can go to court to claim their legal rights to be physically and mentally cared for. The purpose of the amendment, the government states, is to “promote
the traditional filial duty for children to take care of their aged parents.” This interesting mix of rights with Confucian moral obligations represents to a certain extent the Chinese government’s response to change. Like its approach towards assisted reproduction, the state seems to be accepting new ideas and concepts, but not at the expense of traditional moral values.

While some may argue that this call for a return to traditional morality is only a façade for the government’s true economic motives, I believe differently. For a state that has extensively used the metaphor of a “harmonious family” to describe the relationship of its citizens to the state, discarding traditional family values could be politically disastrous and threatening to for the Communist Party’s perceived mandate to rule. If filial piety becomes a symbol of China’s backward past, how will people perceive a party that has consistently portrayed itself as the symbolic, caring father of the metaphorical Chinese family? It is no wonder then, that China has paid such close attention to new developments in reproduction and has taken such care to regulate it properly. Reproduction forms the basis for understandings about the family, and drastic changes could mean serious problems for the government’s relationship to its citizens.

Appendix A. Parties Involved in Forms of Assisted Reproduction

# Females

- 0
  - #10 (Sperm donation + surrogacy)
  - #7 (Surrogacy and egg donation)
  - #11 (Surrogacy + egg donation + sperm donation)

- 1
  - #6 (Sperm Donation)
  - #3 (Surrogacy AND/OR egg donation)
  - #8 (Surrogacy or egg donation + sperm donation)

- 2
  - #2 (Sperm Donation)
  - #1 (Female (birth, social, genetic) + Male (social, genetic) (Natural Reproduction))

- 3
  - #5 (Surrogacy and egg donation)
  - #9 (Surrogacy and egg donation)
Chart Explanation

#1 One female is the birth, social, and genetic mother and one male is the social and genetic father. This form is what people usually associate with “natural reproduction” but some technological assistance may still be involved. For example, hormonal therapy, artificial insemination by husband (AIH) or IVF may be used by the couple to help them reproduce.

#2 One female uses the sperm of an anonymous donor to create a child. This is a single-mother family. There is technically a “father” involved but he plays a non-existent role in the child’s life.

#3 The male is the social and genetic father, but there are two females involved, with different roles depending on the method of assisted reproduction. If surrogacy and egg donation are used, one female is the birth and genetic mother while another is the social (intended) mother. If only surrogacy is used, one female is the birth mother while the other is the genetic and social mother. If egg donation is used, one female is the genetic mother while the other is the birth and social mother.

#4 The male is infertile and needs to use sperm donation. While one female is the birth, genetic, and social mother, there is a genetic father and a social father.

#5 Surrogacy and egg donation is used to make the male a single-father. The surrogate and the egg donor can be one person or separate people. The female plays little to no role in the child’s life.

#6 Two females, usually a lesbian couple, use sperm donation to start a family. The sperm donor plays little or no role in the child’s life. One of the females is the birth, genetic, and social mother while another is also a social mother.

#7 Surrogacy and egg donation are both used by the couple. While one male is the social and genetic father, one female is a genetic mother, one is the birth mother, and one is the social mother.

#8 One male is the social father while another is the genetic father. There are two females involved, with different roles depending on the method of assisted reproduction. If surrogacy and egg donation is used, one female is the birth and genetic mother while another is the social (intended) mother. If only surrogacy is used, one female is the birth mother while the other is the genetic and social mother. If egg donation is used, one female is the genetic mother while the other is the birth and social mother.
#9 Two males, usually a gay couple, use surrogacy and egg donation to start a family. In this case, the mother(s) play little to no role in the child’s life after birth.

#10 The sperm donor plays little to no role in the child’s development. In one possible situation, a surrogate is used to bear a child for a lesbian couple. Alternatively, an egg donor is used while one female in the couple bears the child.

#11 See #7, except there are also two males. One is the social father while the other, the sperm donor is, the genetic father.
Appendix B. Data and Methods

Research Site

As indicated in my Introduction, I conducted my research in thirteen different sites – five academic institutions, seven hospitals, and the Ministry of Health. While there were a variety of locations that I could have chosen from, I selected Beijing because of my familiarity with the city and its proximity to the national government. A scan of Ministry of Health symposium lists reveals that more than 50% of participants are affiliated with institutions located in Beijing. Because my overall research design and my selection of interviewees depended on my knowledge about policymaking in China, before I describe my methods in detail, I’ll briefly introduce how policy is made.

Chinese law subdivides into four main categories: national statutes, national administrative regulations, regional regulations, and regional and local “administrative rules and orders.” Legislative power resides with the National People’s Congress (NPC) and its Standing Committee (SCNPC). The NPC is the highest organ with three thousand members, chosen by provincial people’s congresses and the army, and it only meets once a year. The State Council is the highest administrative organ in China which oversee the ministries and commissions. These branches may, in their respective policy fields, make administrative rules in accordance with the Constitution, the laws, and the administrative rules and regulations of the State Council. Immediately below the national level is the provincial level, then the lower levels of county, city,
municipal district, township, and town. Provincial Congresses can issue regional regulations as long as those regulations do not conflict with the national Constitution, laws, and administrative regulations. Thus in China, primary legislation lies in the statues (fa\l u) while secondary legislation covers the regulations (fagui) issued by the state council and covers the main bulk of regulations issued by the national Ministries and the provincial authorities.

In his book, *Law-Making in the People’s Republic of China*, Jan Otto, a Dutch professor of Law, describes eight phases in the process of law-making: agenda-setting, writing and drafting, wide discussion, interdepartmental consultation, approval “in principle” by political leaders, formal legislative approval, publication and registration, and implementation. In my thesis I focus on the agenda-setting, writing and drafting, discussion, and implementation aspects of assisted reproduction policy. In agenda-setting, a particular subject finds its way onto the agenda of the important legislative bodies. Sometimes it is simply a single person, a “legislative entrepreneur,” who takes the initiative. In the case of assisted reproduction policy, this was rumored to be the case by several informants, though I did not verify this. In the second and third phases, the draft is written in the Ministry and then discussed by experts in the field, such as academics. This phase is usually paired with the writing and drafting phase and is the phase where bioethics academics are most involved. After the final draft is prepared, it is usually sent to political leaders who usually approve of the regulation. Then, it is published and implemented in conjunction with other laws.
In this area, medical personnel are the people primarily responsible for carrying out policy.

**Research Design**

I used a variety of methods in this investigation: in-depth qualitative interviews, non-participant observation, consultation of secondary sources for provide me with information on ethical debates in provincial and national reproductive policy.

During a six week period from June to July of 2010, I conducted thirty interviews, thirteen with leading bioethicists, two with government officials, and fifteen with hospital personnel. Because my research aimed to discover the bioethical debates among those closely involved with assisted reproduction policy and implementation, I interviewed mostly those who were leaders in their fields. This criterion made random sampling difficult if not impossible, considering the high concentration in Beijing of leaders in both medicine and academia. Because these leaders were often busy and hard to reach, my interview length varied and I could not contact some key people. However, my use of snowball sampling provided me with a connected network of interviewees.

Over the research period, I first used secondary sources to get a good grasp on who were the leaders in bioethics and in assisted reproduction clinics. I then used existing contacts to ask for recommendations for new interviewees. To ensure my sample was unbiased, I not only relied on contacts from Harvard University professors but on multiple sources of friends and family. To ensure
that I interviewed bioethicists and medical personnel with different views, I made sure to visit multiple universities and hospital sites. I fortunately had the ability to do this through the robustness of my contacts; for example, I was fortunate enough that one of my prior contacts had friends in high positions at most medical institutions in Beijing. While I cannot guarantee that my interviewees provide a complete representation of bioethics, because of the close-knit nature of leading academic bioethicists in China, especially those who have the most influence in policy, my interviewees do provide a fairly good representation of the ethical opinions heard by policymakers.

Respondents participated in semi-structured interviews that lasted from thirty minutes to three hours. I conducted all interviews in Mandarin, translating as I transcribed and writing in Mandarin when necessary. I asked them a set of open- and closed-ended questions about a range of topics which varied between the groups. For bioethicists, I asked them about academic and background information, the history of assisted reproduction in China, the history of bioethics in China, perceptions of ethics in assisted reproduction, and their views on the one-child policy. I then modified my questions depending on which areas seemed most important to my interviewees. For medical personnel, I began by asking them about their education and background, their patient demographics, the ethical issues they faced in clinical practice, their perceptions on ethics in assisted reproduction, their views on assisted reproduction technology, and how assisted reproduction relates to society, again modifying questions based on the discussion. For policymakers, the interview was completely open-ended around the topic of
“ethics” in assisted reproduction. Because I did not feel comfortable audio-recording the interviews, I usually took notes on my computer or on a notebook and filled in missing information from memory afterwards.

In addition to conducting qualitative interviews, I also engaged in non-participant observation in a variety of settings. I took a notebook of field notes each time I traveled to my research sites and took down observations on the setting, atmosphere, and material conditions of the institutions I visited. I attended two meetings - one at a staff meeting at one of the reproduction clinics I visited and one at a presentation and discussion at a university - and multiple informal meals with my interviewees.

In addition, I relied on secondary sources for general information about institutional structures and administrative processes in China. At the time of my research, I was not aware of a set of the Jilin provincial reproductive regulations, which provided an interesting alternative to national assisted reproductive regulations. Fortunately, through internet forums and Chinese publications, I gained indirect access to some of the debates that had occurred at the time of the policy’s creation. I also consulted official policy documents.

**Interview Sample and Limitations**

As necessitated by the research question, all interviewees were affiliated with leading institutions in Beijing. Respondents who were academic bioethicists were generally balanced by age, experience, and political influence as well as by gender. Respondents included retired senior figures, currently office-holders in
positions of power, and beginning bioethicists. All respondents were Mandarin
speakers of the Han nationality. As for the hospital personnel, the respondents had
a variety of professions – physicians, nurses, researchers, and hospital
administrators. I tried to interview at least two people from each institution to
ensure I have a more accurate understanding of hospital conditions. While most of
my respondents were female, this reflects the gender bias in the gynecology
profession in China. As noted in my study, some of these differences proved
significant while others contributed less to differences in ethical understandings.

It is important to note a few limitations of my research. Because I spoke
only to those in Beijing and visited only assisted reproduction clinics in this city,
my research cannot provide a comprehensive overview of assisted reproduction in
China. On one hand, there is the difference between legal and illegal assisted
reproduction. The latter is more prominently practiced in the countryside, and
during my stay, I heard rumors of couples traveling to rural China to “buy”
surrogates in Sichuan, a province in south-western China. Multiple web sites also
support this rumor. However, because of time and resource constraints, I was not
able to follow-up on these reports. In addition, I only explored bioethics and
assisted reproduction practices in Beijing; these can differ between provinces
since China is an area with large demographic variations. Nevertheless, I do not
believe this significantly reduces the validity of my conclusions. Because
bioethicists and hospital personnel are located close to the national political center,
their opinions tend to be conservative and more closely aligned to policy opinion
their proximity. The bioethical differences I observed among the three groups, I
hypothesize, should be even greater in other provinces because of distance and lack of communication. That there are such pronounced differences even within Beijing highlights that these distinctions do exist.
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