

Contextualizing Autonomy: Feminist Bioethical Perspectives on Family Planning in Taiwan

Özerkliğin Kavramsallaştırılması: Tayvan'da Aile Planlamasına Feminist Biyoetik Bakış Açıları

Yun-Hsien Diana LIN^a

^aInstitute of Law for Science and
Technology, National Tsing
Hua University, Taiwan

Geliş Tarihi/Received: 14.01.2011
Kabul Tarihi/Accepted: 14.03.2011

*This study was presented as an oral
presentation in the 10th Asian Bioethics
Conference, Tehran 2009, April 26-29, Iran.*

Yazışma Adresi/Correspondence:
Yun-Hsien Diana LIN
National Tsing Hua University,
Institute of Law for Science
and Technology
TAIWAN/TAYVAN

ABSTRACT Through the example of Taiwan's Family Planning Program, this article brings out the issues of autonomy in making reproductive decisions, with a focus on long-acting contraceptives, such as intrauterine devices. Facts of the program will be introduced as a backdrop in examining the autonomy of procreation; controversies of the program will be highlighted, especially how national demographic policies might affect women's control over their bodies. Next, the author will delve into the limitation of the mainstream theory of autonomy and informed consent. The theory of relational autonomy, proposed by feminists, will be introduced to provide a contrast and complement to the mainstream theory. Echoing the needs to contextualize women's choices, this article analyses social, cultural and economic factors concerning procreational decisions for women in Taiwan. Finally, it is concluded that the theory of contextualized autonomy would be helpful in establishing a biomedical environment that is more sensitive to power dynamics that might constrain personal choices.

Key Words: Personal autonomy; informed consent; bioethics; feminism; intrauterine devices

ÖZET Tayvan'ın Aile Planlaması Programı örneğinden yola çıkarak, bu makale rahim içi araç gibi uzun etkili kontraseptiflere odaklanarak üreme ile ilgili karar vermede özerklik konularını gündeme getirmektedir. Programın nitelikleri üremenin özerkliğini değerlendirmede zemin olarak ortaya koyulacak, programın çelişkilerinin ve özellikle ulusal demografik politikaların kadınların bedenleri üzerindeki kontrollerini nasıl etkileyebildiğinin üzerinde durulacak. Daha sonra, yazar özerklik ve aydınlatılmış onamın ana görüş teorisinin kısıtlılığını derinlemesine araştırarak. Feministler tarafından önerilen ilişki özerklik teorisi zıtlık sağlamak ve ana görüş teorisini tamamlamak için ortaya koyulacak. Kadınların seçimlerinin kavramsallaştırma gereksiniminin yansıması olarak, bu makale Tayvan'daki kadınların üreme ile ilgili kararlarına ilişkin sosyal, kültürel ve ekonomik faktörleri incelemektedir. Sonunda, kavramsallaştırılmış özerklik teorisi kişisel seçimleri zorlayabilen dinamiklere daha hassas bir biyomedikal çevre kurmada faydalı olacaktır sonucuna varılmıştır.

Anahtar Kelimeler: Kişisel özerklik; bilgilendirilmiş onam; biyoetikler; feminizm; intrauterin cihazlar

Türkiye Klinikleri J Med Sci 2011;31(3):509-17

Taiwan's family planning program, officially commenced in 1968 but in reality initiated in the early 50s, has been recognized as one of the most effective population control programs in the world.¹ In 1950, due to the outbreak of Korean War, President Truman of the United States established a foreign aid program in supporting developing and underdeveloped countries in an effort to thwart the expansion of the Communist influences. As other recipient countries, Taiwan had been required to control

doi:10.5336/medsci.2011-22620

Copyright © 2011 by Türkiye Klinikleri

her population growth so as to relieve the burden borne by developed countries that provided financial aid.² It was in this political climate that the family planning program in Taiwan was initiated.

Through the example of Taiwan's family planning program, this article brings out the issues of autonomy in making reproductive decisions, with a focus on long-acting contraceptives. In the next part, facts of the program will be introduced as a backdrop in discussing the autonomy of procreation. In part III, problematic dimensions for family planning in Taiwan will be highlighted, especially how the national demographic policies affected women's medical decision making. Part IV will focus on mainstream principlist theory of bioethics while elaborating on the limitation of informed consent. In part V, the feminist bioethics perspectives will be introduced to demonstrate the inadequateness of the mainstream theory of autonomy step by step. Echoing the needs to contextualize autonomy, part VI of this article provides and analyzes social, cultural and economic factors concerning procreational decisions for women in Taiwan. Based on the theory of contextualized autonomy, part VII draws the conclusion that this theory is helpful in forming more friendly medical settings for women, and the next step will be to empower women to become autonomous agents.

FAMILY PLANNING PROGRAM IN TAIWAN

In retrospect, it can be argued that the time had come for family planning, although it was far from obvious to contemporary observers. This chapter introduces how Taiwan's family planning program worked, particularly the powerful intervention that came from national policies. Attention will be drawn to the interactions among the State, non-governmental organizations (NGOs) and women in Taiwan. By examining the controversies of intrauterine contraceptive devices (IUD), the problems of informed consent and other issues of autonomy will be discussed in depth.

HISTORICAL BACKGROUND

By the time the family planning program was implemented, Taiwan's crude death rate had fallen

steadily from about 33 per thousand in the early years of twentieth century to around 7 per thousand by 1960.³ By contrast, the crude birth rate fluctuated in the range of 37 to 46 per thousand during the Japanese colonial period between 1895 and 1945. Starting from 1950, the birth rate began to fall, but not as rapidly as the death rate. The combined effect was a gradual acceleration of natural population growth rate from less than 1% in 1900 to nearly 3.7% annually in the mid-1950s.³ Accordingly, when the Nationalists were defeated by the Communists in Mainland China in 1949, the arrival of about 1.6 million refugees and the baby boom after World War II exacerbated the mounting pressure of population on resources. In absolute numbers, the population of Taiwan soared from about 6.9 million in 1945 to 11.4 million in 1960.¹

Despite worrisome demographic trends, family planning initially failed to gain support from the official authorities. Opponents of the program were mainly centered in the military and the conservative wing of the Nationalist government while supporters were concentrated in the disciplines of public health, agronomy, engineering and economics. Huenemann referred to the contradictory opinions within the government as the "ideologues versus technocrats" dichotomy.⁴ The ideologues adhered to Dr. Sun Yat-sen's lectures on the "Three Principles of the People" in 1924, which embraced the idea that "if other countries' populations increase but China's does not, China will inevitably be swallowed up and at the end the race will disappear".⁵ Moreover, major obstacles arose from the sacred crusade for the Nationalists to recover the mainland. A salient example emerged as early as 1950 when a pamphlet on the rhyme method of contraception was denounced as a Communist plot to weaken the military.¹

It was amid the hostile circumstances toward family planning that the technocrats in the Nationalist government began to rely on NGOs. Before the "Regulation on the Implementation of Family Planning in Taiwan" was promulgated in 1968, which signaled the official approval to the family planning program, a few NGOs had already launched a series of activities for fertility control. Among

them, the Sino-American Joint Commission on Rural Reconstruction (JCRR) that received funding from U.S. foreign aid money had been advocating for reducing reproduction since 1950. Family Planning Association of China (FPAC), which was sponsored and advised by JCRR and was organized by privileged women who were well-connected to the Nationalist government, started making numerous home visits to disseminate information on contraception in the late 1950.⁶ At the beginning of 1960, the technology of birth control changed dramatically with the development of the Pill and a new intra-uterine contraceptive device (IUD) named Lippes loop. The Pill was slow to be accepted due to the cost and doubts on medical safety, but the IUD was quickly adopted.⁷

In 1963, an experimental but nonetheless intensive birth control program was initiated by the Taiwan Provincial Healthcare Office in the city of Taichung. The Maternal and Child Health Association (MCHA), another NGO, was responsible for carrying out the actual distribution of contraceptive materials to hospitals and clinics.¹ It is to be noticed, however, that the three NGOs mentioned above were actually boarded by government employees and sponsored by governmental funding, although all members acted in a private capacity so as to circumvent potential complications caused by ideologist opponents. The Taichung program was successful and one of the most important findings was that there was a strong demand for such services.⁸ This experimental program became the basis for a later island-wide expansion of the program.

THE CONTROVERSIES OF IUD

The Taichung program was rapidly duplicated by 361 townships throughout Taiwan and was operated via two ways simultaneously. First, incentives were created for citizens. The spread of information on fertility control was carried out through extensive publicity in a variety of mass media, mailing brochures to married women, door-to-door rounds made by full-time prenatal health workers both in villages and urban households, and education in factories, schools and armed forces.⁹ Contraceptives were made available to women on

a subsidized low-cost basis by licensed physicians of Obstetrics and Gynecology. Second, incentives were provided for medical practitioners. Physicians received 60 NT dollars for each insertion, half from the patient and half from MCHA. A network for promoting Lippes loops was thus rapidly developed through the collaboration of the government-controlled NGOs and medical professionals. In 1964, more than 70% of physicians of Obstetrics and Gynecology in Taiwan had undergone a one-day-training for the insertion and contracted with MCHA for Lippes loops supplies.¹⁰

Although methods other than IUD were provided in Taiwan's family planning program, including the Pill, sterilization, and condom, the IUD initially was set as the priority partly because it was based upon the assumption that once inserted, the device could remain in place for years and thus did not require recurring decisions for using the device. According to statistics, among women who used contraceptive methods offered by the family planning program, the utilization of IUD reached as high as 57% in 1967. Although the use of IUD later substantially decreased and accounted for only 25% of program method users in 1985, a total number of more than 615 thousand married women in Taiwan had IUD insertion from 1965 to 1985.⁹ As estimated, around five million births that would otherwise have occurred had been averted by the program-supplied methods during 1965 and 1988, which reflected upon the drop of the natural population growth rate from 3.3% to 1.1%.⁹

In the beginning of the IUD insertion program in Taiwan, however, Lippes loops had only been introduced in the U.S. for two years. The program involved such wide application of the new IUD that FPAC, one of the NGOs, declined to participate in this "human subject experiment" and was ultimately cut out of funding by JCRR.¹¹ Information about the side effects of IUD was not made available to Taiwanese women when the merits of fertility control were extensively promoted through a variety of media. For some reason, reports under-publicized the fact that IUD can cause longer, heavier, and more painful menstrual periods, that the increased blood flow may cause anemia,

and that weight gain, headaches, depression, increased blood pressure and even pelvic infection may occur.

It soon became clear that in Taiwan as elsewhere, despite its claimed advantages, IUD was far from a perfect method of contraception. An IUD follow up study surveyed 2000 cases drawn from the 71 016 acceptors of Lippes loops in Taiwan during the period between January 1964 and March 1965.¹² The total termination rate, including three types of termination as pregnancy, involuntary expulsion, and voluntary removal, amounted to about 38% one year after insertions; and 48% at the end of 18 months after insertions.¹² The high termination rate was alarming. Among those who ceased to use IUD one year after first insertion, more than 60% had it voluntarily removed due to various side effects. The termination rate could be higher than as estimated, however, because like other sample surveys that depend on users' reports of whether the IUD is still in place, unnoticed expulsion would not be reported. Furthermore, some women may not feel comfortable reporting removals that occurred outside of the program.

CHOICES AND CONTROL: ISSUES OF AUTONOMY IN THE FAMILY PLANNING PROGRAM

Behind the impressive result of population control, the family planning program in Taiwan is problematic in the following ways. First, information conveyed to Taiwanese women on IUD was not complete because the side effects of Lippes loop were not fully revealed. The nondisclosure of information of such significance, either caused deliberately or negligently, constituted a substantial obstacle for women in making autonomous choices. From the mainstream bioethics perspectives, Taiwanese women's consent to insert IUDs in the family planning program was far from an informed one.

Next, as feminists are concerned about the safety of IUDs, they are even more disturbed by women's lack of control over their uses. Unlike many older means of contraceptive methods such as condoms and the rhythm method, newer methods usu-

ally require the skilled service of physicians or other healthcare practitioners. In particular, oral contraceptive pills must be prescribed by physicians, and IUDs such as Lippes loops must be inserted by a physician. The fact that women must rely on physicians for access to contraceptives means women are increasingly dependent on the medical establishment for their procreation choices. Taking Taiwan's family planning program as an example, only married women were provided with subsidies to insert Lippes loops. Unmarried women were subject to the discretion of individual physicians, who were free to deny them contraceptives on the ground of "preventing promiscuous life styles." On the other hand, married women in Taiwan might be pushed to insert IUD that was deemed effective but with burdensome side effects. The abuse of power by physicians was exacerbated under the combined effect of the network promoting Lippes loops and physicians' professional authority.

The third controversial dimension of Taiwan's family planning program was that, due to the high termination rate of Lippes loops, women turned to sterilization as their main method of birth control. Statistics indicated that in the first two decades of the program, during 1965 and 1985, the use of IUD far surpassed other contraceptive methods such as sterilization, condom and oral pills. The prevalence of IUD, especially Lippes loops, was attributed to the promotional network composed of NGOs and physicians. The percentage of women who resorted to sterilization, however, began to grow rapidly since 1975 and finally prevailed over IUDs after 1987.⁹ It is not at all clear if all or even most of the sterilization done at that time involved what would legally and ethically constitute informed consent. Similar to the scenario of IUD, many women in Taiwan did not have the opportunities to thoroughly discuss the advantages and disadvantages of sterilization or other contraception options with physicians.

Fourthly, technological development on birth control in fact imposed new burdens upon women in Taiwan. Since contraception and sterilization make sex without procreation possible, the new reproduction controlling technology supposedly has

generated new rights and responsibilities pertaining to sex and reproduction. Unfortunately, the rights and responsibilities were not fairly distributed between women and men. In Taiwan's family planning program, IUD and sterilization were used far more commonly than Pills and condoms. While IUD was solely for women, sterilization acceptors were mostly women as well.¹¹ This phenomenon showed that an unwanted pregnancy was still deemed a "woman's problem." As opposed to IUD and the Pills, using condoms is much less risky and intrusive in terms of medicine. Moreover, since a vasectomy is a minor surgery whereas a tubal ligation is a major surgery, Taiwanese women's "choosing tubal ligation over IUD" reflected the fact that vasectomy for men was not common.

Finally, as feminist bioethicists noted, the history of contraceptives is a tale not only of scientists developing safer and more effective means of birth control but also of women being used as nonconsenting research subjects.¹³ Interestingly, knowing more about the risks and side effects of IUD may not stop most program participants from inserting such devices, because they have been told that no better options were available. A majority of participants might decide that the benefits of Lippes loops far outweighed the risks of pelvic inflammatory diseases or repeated pregnancies. Women in Taiwan might have made a non-coerced choice in accepting IUDs. However, is a non-coerced medical decision equivalent to an autonomous one? To provide an answer, it is imperative to look into the definition of autonomy and the context of women's reproductive decisions, which will be elaborated in the following chapters.

THE MAINSTREAM THEORY OF AUTONOMY: INFORMED CONSENT AND ITS LIMITATION

According to the mainstream theory of bioethics, four substantive principles are especially relevant to bioethics debates: autonomy, nonmaleficence, beneficence and justice. These principles are derived from the influential "principlist" approaches to bioethics advocated by Thomas Beauchamp and James Childress.¹⁴ Among the four principles, auto-

nomy has been elevated to become the first among equals.¹⁵ According to Beauchamp and Childress, the principle of autonomy declares that everyone should be in control of his or her own person, including body and mind. The respect for autonomy requires respecting those choices made by individuals whose decisions are free from external interference or personal limitation, such as inadequate understanding.¹⁴ Because bioethics is concerned with the proper conduct of health care providers, the principle of autonomy primarily focuses on actions such providers shall take to avoid undue interference with a patient's capacity to choose.

Other than passively avoiding interference with a person's autonomous choices, mainstream bioethics also emphasizes actively providing information necessary for making such choices, which is understood as informed consent. Informed consent seems to be favored by all; it is only the specific details and application of the doctrine that arouse debate.¹⁶ In order to map this debate, it is useful to distinguish two camps of commentators on informed consent: idealists and realists. Informed consent idealists, primarily judges and medical ethicists, advocate a relatively expansive concept of the physician's obligation to disclose and elicit information about risks and alternatives. Specifically, idealists insist that physician-patient interactions be dialogic rather than authoritative, tailored to the individual patient's emotional needs and cognitive capacities, and sensitive to the distortions that can be created by power differentials between physician and patient.¹⁷ On the other hand, the realists, primarily practicing physicians, hold a different opinion on informed consent. Although they do not contest the principle and goals of informed consent, they do question whether most patients really desire the kind of dialogue that the idealists propose. They also question whether the gains in patient autonomy produced by the dialogue are worth the additional time, money, and unnecessary patient anxiety and confusion that informed consent may involve.¹⁷

In a real sense, informed consent idealists and realists argue past one another, producing a debate that is oblique and inconclusive rather than poin-

ted and fruitful. One thing to be sure, focusing on informed consent as the sole locus for autonomy has worked to constrain the deliberation on autonomy in medical settings. For example, if the emphasis of autonomy is whether the physician gives full and adequate information, whether the physician has unduly influenced the decision of the patient, and whether the physician explains the information clearly, ethical concern is directed to the actions of physicians to obtain consent instead of the decision making process of the patient. By identifying respect for autonomy merely with informed consent, other factors influencing the development and demise of patients' capacity to choose for themselves are likely to be ignored.

■ A FEMINIST ANALYSIS OF AUTONOMY ON REPRODUCTION

Based on the discussions above, this chapter explores a theoretical framework of autonomy that may better suite the situations faced by women in general. Since the focus on informed consent would inevitably generate a physician-centered medical ethics, scholars of feminist bioethics have expressed concerns.¹⁸ The concept of autonomy in bioethics assumes that the patient is rationalistic, atomistic and individualistic, and is able to make choices wholly for himself or herself once given adequate information. It ignores the social circumstances and power relations that affect the context of decision making and thus seems to be ill-suited to choices concerning reproduction, including abortion, sterilization and long-active contraceptives.¹⁹ More specifically, the Western concept of autonomy as independent, informed and rational choice free from any influences is not compatible with many women's experiences in medical settings, especially in the issues of reproduction.

In general, women's options in medical settings are frequently constructed in two undesirable ways. They may exercise the limited autonomy that is identified with informed consent and preserve partial control over their bodies; or they may attempt to reject those limitations but also risk being viewed as incompetent in making decisions for themselves. Feminist scholars have challenged tho-

se notions and practices that inadequately respond to women's experiences in health care.

Under the celebrated success of family planning program in Taiwan, women's bodies and capacity of reproduction were utilized and medicalized. Susan Sherwin, among other feminists, believes that women as a group are oppressed, and since oppression is objectionable on both moral and political grounds, they shall be eliminated.²⁰ It is to be noticed that oppression, often compounded by factors such as race, sexual orientation, economic class and nationality, takes different forms. According to Sherwin, the mainstream understanding of autonomy that pictures "a rational individual, making choices from available options, based on adequate information, and free from explicit coercion" may associate with various forms of oppression that contribute to women's subordination.¹⁸

Firstly, as the core of autonomy, rationality is in fact not a neutral concept because the rational competence of women and other minority groups is frequently questioned.¹⁹ For example, in facing a significant number of Taiwanese women complaining about various side effects of IUDs, some physicians chose to believe that the symptoms were either mild from the medical viewpoint, or were merely psychological.¹² Since oppressed groups often appear to lack sufficient emotional distance and objectivity to act rationally, they are left dependent on medical patriarchy to decide for them.

Next, those options available for women to choose from are usually influenced by health care policies and priorities of government financial support, which may be biased against women. Although some women in Taiwan explicitly consented to the insertion of IUDs, the consent was not informed because the side effects were not explained to them. Even if women were aware of the potential risks of IUDs and still gave consent, the consent was at most a non-coerced one. Other less risky contraceptive options, such as condoms and vasectomy, were never given due concern or equal opportunities to be presented as their options. The appeared available choices are limited by the wrongful assumption that women alone are responsible for unwanted pregnancies.

Furthermore, due to the major gap between medical professionals and patients in both medical knowledge and experiences, it is doubtful that information provided to patients will actually meet their needs. As mentioned earlier, when the public health network was utilized to promote IUDs, information on the possible complications of Lippes loops was never as widely accessible as the efficiencies and conveniences that were publicized.

Finally, echoing the views of radical feminists, Sherwin asserts that the absence of coercion at the time of decision does not make the choice free, because forces contribute to the oppression of women may not be easily identified.¹⁸ Among various types of contraceptives, the mass insertion program of IUDs for women in Taiwan was preferred because of various reasons. For example, compared to the Pill that requires cooperation from women, IUD is entirely controlled by medical practitioners. Other possible reasons include the following: the easy insertion process for physicians; only one necessary visit to the clinic; the IUD in place for a relatively long term; no need to inform the husband; and the free and stable supply of Lippes Loops. The above reasons all point to one conclusion: IUD insertion was chosen primarily not because it best contributed to women's welfare, but because it was the most convenient and economic method for policy makers.

CONTEXTUALIZING AUTONOMY: FACTORS AFFECTING PROCREATIONAL DECISIONS FOR WOMEN IN TAIWAN

The feminist analysis exposes the inadequacies of the mainstream theory of autonomy as well as indicates the importance of social context in the application of autonomy. This chapter focuses upon significant factors that influenced Taiwanese women's decisions of procreation, including whether or not to participate in the family planning program. Exploring how these internal and external elements interact with one another is helpful in rethinking the theory of autonomy described in mainstream bioethics. It may also help to shed some light on our understanding of how women's decisions in procreation coincided with various

political social, economic, and medical factors as well as how their options were actually shaped.

The traditional Taiwanese culture that highly values fertility and male heirs is the first important factor. Broadly speaking, the Confucian cultural traditions deeply rooted in Taiwanese people's minds seemed to offer little support to a family planning program. Confucian teachings emphasize filial piety, or being obedient to one's parents and to continue the family line. A famous Chinese maxim that is still quoted and believed by many people in Taiwan goes, "Of the three types of unfilial behaviors, the worst is to have no male heirs".

Nonetheless, the traditional Chinese distaste for small family size was offset by other factors, such as the advance of public health and the prevalence of education. In statistical terms, the life expectancy of a new-born male grew from 28 years in 1906 to 62 years in 1960.²¹ Accompanied by the decline in infant mortality, the improvement of average life expectancy had a direct effect on parents' attitude toward fertility control, because it was no longer necessary to have many children in order to reach a target number of survivors. The prevalence of education is also relevant in public attitude on family size. During the 50 years of Japanese colonial period (1895-1945), although only a handful of Taiwanese received education, basic literacy was widespread on the island. By 1960, as a result of the Nationalist government's vigorous expansion of education, only 27% of those over six years old remained illiterate.²¹ Widespread literacy allowed information on fertility control to be easily accessed by Taiwanese, and women began to benefit from advanced education through the increase of employment opportunities, which in turn became an important factor in their decisions on reproduction.

Another noteworthy factor is the strong grip of governmental control. The governmental support for family planning was mainly based on the assumption that the oversize national population would seize the fruits of economic development. By emphasizing the benefits of fewer burdens to family economy, the policy of family planning aimed to win the support from men, the head of fa-

milies. Other than the policy tactics that successfully changed the focus from medicine to economy, another efficient way of control was also cultivated through policies. As mentioned earlier, NGOs such as JCRR, FPAC and MCHA played a particularly important role in Taiwan's family planning program. Most deeds done by these NGOs were actually directed by the government in order to accomplish the most pressing goal, namely the control of population growth. In the 1950s when social atmosphere was still conservative, female field workers who conducted home visits with married women were rather common. With the information provided by Household Registration Offices in every township, such mobile teams effectively established networks for distributing knowledge of birth control, and the same network was utilized in evaluating the efficacy of prior visits and issuing funding to local task forces accordingly.²² Therefore, the influences of the government on individual woman were rather concrete and profound.

The last but not least important factor concerning women's choices in the family planning would be the increasingly authorities of physicians. It was during the Japanese colonial period that Western medicine was first introduced to Taiwan. Nevertheless, as for pregnancies, Taiwanese women had long counted on local midwives for prenatal and postpartum care. Obstetricians, mostly male, who went through modern medical trainings, were not widely accepted by Taiwanese women in the beginning.²³ This was partly due to the deeply-rooted influences of Confucian teachings that discourage physical contact between people of different sexes. In spite of that, modern obstetricians in Taiwan gradually gained significance over traditional midwives when they became the sole licensed profession to apply modern technology of forceps, to perform abortion and sterilization, and to insert IUDs. Consequently, in 1950s and 60s, although women were still inclined to turn to midwives for childbirth, they had to visit obstetricians for insertion of IUD.

During the family planning program, through collaboration with the Taiwanese government on

policies on IUD, obstetricians in Taiwan rapidly gained professional authority over midwives, received benefits derived from U.S. financial aid, and extended their influences to more women via public health network established under the program. Unsurprisingly in 1970, the number of births attended by obstetricians was already equal to those by midwifery; and after 1970, giving birth in hospitals and being cared by obstetricians had become the norm.²³ It is to be noted, however, that governmental intervention was rather powerful at that time. For example, to achieve preset goals for IUD insertion, behavioral guidance was issued to discourage obstetricians from removing IUDs for women complaining about side effects.¹¹ Although obstetricians were limited by governmental policies, they had in fact benefited significantly from family planning program in general.

In the example of Taiwan's family planning program, the consent from women in Taiwan was actually influenced by the Confucian tradition, the growth of economy, the prevalence of education, the authority of physicians, and the control of the government. To construct a patient-centered theory of autonomy, it is important to examine autonomy in the social, economic, cultural and historical context. Only by contextualizing autonomy, it is possible to transcend the "idealist vs. realist" debate on informed consent and shift the focus of bioethics from physicians to patients.

CONCLUSION

In general, the wide availability of birth control contributed to women's freedom and well-being. For instance, contraceptives and sterilization afforded women more or less the same opportunities men have always had: to pursue a career without worrying about pregnancies thwarting school or employment. For Taiwanese women back in the 1960s, participating in the family planning program gave them the chance to be free from their mothers' and grandmothers' fate of repeated pregnancies. However, this article summarized problematic dimensions of Taiwan's Family Program: incomplete information on IUD and other alternatives, safety concerns, the high termination rate

and the demographic policy that constructed family planning as women's responsibly. It is therefore suspected that the benefits experienced by women were only "collateral effect" of population control, rather than the intended goal.

The principlist theory emphasizes the physician's responsibility to protect the patients' autonomy, but the feminist approach shifts the focus to factors shaping one's decision making process. Respecting for autonomy should be understood not merely as non-coerced choices but as contextualized informed choices. By recognizing that mere consent is insufficient for making an autonomous choice, this article further identifies factors that indeed affect procreational decisions for women in Taiwan. The theory of contextualized autonomy would be helpful in establishing a biomedical environment that is more sensitive to various power dynamics that have the potential to constrain

personal choices as well as in forming friendlier medical settings for women. For policies that significantly affect women's bodies and health on a massive scale, such as the family planning program in Taiwan, women's participation in the forming of policies was far from sufficient. The next step, therefore, will be to cultivate women's ability in the path of becoming autonomous agents who are able to actively participate in medical decisions and even policy making. It is hoped that a contextualized theory of autonomy may help to empower women in the process of forging mutually agreeable policies that in fact reduce gender oppression.

Acknowledgements

The author expresses gratitude to the Bioethics and Law Center of National Tsing Hua University, Taiwan, for supporting this research; and to Daisy Chou for English proofreading.

REFERENCES

1. Kuo-ting L, Guoding L. *The Evolution of Policy Behind Taiwan's Development Success*. 1st ed. New Heaven and London: Yale University Press; 1988. p.189.
2. Guo Wen-hua. Politicizing Family Planning and Medicalization of Reproductive Body: US Backed Population Control in 1960s Taiwan. *Taiwan: A Radical Quarterly in Social Studies* 1998;32:39-82.
3. Ho S. *Economic Development of Taiwan 1860-1970*. 1st ed. New Haven: Yale University Press; 1978. p.461.
4. Huenemann RW. Family planning in Taiwan: the conflict between ideologues and technocrats. *Modern China* 1990;16(2):173-89.
5. Sun Yat-sen, San Min Chu I. *The Three Principles of the People*. Translated editor: Price FW. Shanghai: The Commercial Press; 1929.
6. Shi-Chu H, Liang-Pin C, Tze-Kuan SK. Field study on the effectiveness of various contraceptive methods in Taiwan. *Taiwan J Public Health* 1961;1(2):64-75.
7. Taiwan Province. *The Bureau of Health. Studies in Family Planning*. New York: the Population Council; 1970.
8. Freedman R, Takeshita J. *Family Planning in Taiwan: An Experiment in Social Change*. 1st ed. Princeton: Princeton University Press; 1969. p.501.
9. Freedman R, Ming-Cheng C, Te-Hsiung S, Maxine W. The fertility transition in Taiwan. In: Thornton A, Lin HS, eds. *Social Change and the Family in Taiwan*. 1st ed. Chicago and London: The University of Chicago Press; 1994. p.264-304.
10. Tung-Ming Lee. *Early Development of Family Planning in the Area of Taiwan*. Taichung: National Institute of Family Planning of the Province of Taiwan; 1995.
11. Liu Chung-Tung. [Women's medical sociology]. Taipei: Fembooks; 1998.
12. Chow L-P, Freedman R, Potter RG, Jain AK. Correlates of IUD termination in a mass family planning program: the first Taiwan IUD follow-up survey. *The Milbank Memorial Fund Quarterly* 1968;46(2):215-35.
13. Tong R. Nonfeminist and feminist perspectives on contraception and sterilization. *Feminist Approaches to Bioethics: Theoretical Reflections and Practical Applications*. 1st ed. Colorado: Westview Press; 1997. p.101-24.
14. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 4th ed. New York: Oxford University Press; 1994.
15. Donchin A. Understanding autonomy relationally: toward a reconfiguration of bioethical principles. *J Med Philos* 1998;26(4):365-86.
16. Kuczewski M. Reconciving the family: the process of consent in medical decision making. *Hasting Cent Rep* 1996;26(2):30-7.
17. Schuck P. Rethinking informed consent. *Yale Law J* 1994;103(4):899-959.
18. Sherwin S. *A relational approach to autonomy in health-care. The Politics of Women's Health: Exploring Agency and Autonomy*. 1st ed. Philadelphia: Temple University Press; 1998. p.19-47.
19. Dodds S. Choice and control in feminist bioethics. In: Mackenzie C, Stoljar N, eds. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. 1st ed. New York: Oxford University Press; 2000. p.213-35.
20. Sherwin S. *Feminism and Bioethics*. In: Wolf SM, ed. *Feminism & Bioethics: Beyond Reproduction*. 1st ed. USA: Oxford University Press; 1996. p.47-66.
21. Sun TH, Lin HS, Freedman R. Trends in fertility, family size preferences, and family planning practices: Taiwan, 1961-76. *Stud Fam Plann* 1978;9(4):54-70.
22. Sun TH, Chen CN, Lee TM. *The Transition of and Lessons from Taiwan's Family Planning Program. Economic Prediction and Policy of Taiwan*. 2001;32(1):25-76.
23. Fu DW. *Midwife tales and the rise of modern obstetrics-gynecology. Assembling the New Body: Gender/Sexuality, Medicine, and Modern Taiwan*. 1st ed. Taipei: Socio Publishing; 2005. p.81-152.