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Suspended Autonomy: The Relational Reconstruction of Decision-Making in Chinese Women's Narratives of Assisted Reproductive Treatment

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Research Article

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Abstract

Background

Assisted reproductive treatment, including in vitro fertilisation (IVF), places disproportionate bodily and emotional burdens on women, while reproductive decisions are constituted through intimate relations, familial obligations, and clinical institutions. In contemporary China, traditional familism and individualisation intertwine within a mosaic neo-familial order, complicating the normative evaluation of women's IVF autonomy.

Methods

Drawing on 33 semi-structured interviews with women in China who were undergoing IVF or had undergone it within the preceding six months, the study examines how reproductive autonomy is practised and reconstructed within relationally constituted IVF decision-making.

Results

The findings reveal an apparent paradox at the intersection of traditional autonomy theory and IVF local practice: women experienced embodied reluctance, pain, exhaustion, or diminished desire for motherhood while continuing treatment and recognising their decisions as autonomous. Four main themes emerged from the data: continuing treatment through embodied reluctance; anticipated gaze and relational self-discipline; unequal decisional weight in familial and clinical decisions; and clinical momentum through private treatment management. At the ontological level, autonomy was articulated through a relationality-based conception in which familial responsibilities and intimate others' interests became constitutive of the ethical self. This relational constitution, however, does not itself establish the normative legitimacy of how decisional weight is allocated; such legitimacy requires epistemic and reflective examination. Even where women recognised their embodied reluctance and relational sources shaping treatment, they remained constrained in critically reassessing the legitimacy and relative decisional weight of these forces, placing their decisions at the normative boundary of autonomy even as they continued to recognise them as autonomous.

Conclusions

I conceptualise this boundary condition as *suspended autonomy*: a form of relationally constituted agency in which women coordinate treatment and reconcile responsibilities yet have a constrained capacity to reassess the legitimacy and relative weight of the forces constituting their decisions. Three structural mechanisms—devaluation, invisibility, and fragmentation—explain how this unequal weighting

is produced within the conjunction of gendered relational structures, neoliberalised self-management, and reproductive medicalisation.

Background

Over the past several decades, China has undergone an exceptionally rapid fertility transition, driven by interrelated changes in population policy, economic conditions, gender relations, and social attitudes. During this period, state reproductive governance has shifted from stringent birth limitation towards an increasingly pronatalist orientation: the one-child policy was replaced by the universal two-child policy in 2016, followed by the introduction of the three-child policy in 2021 [1]. These policy reversals have not, however, produced a sustained fertility recovery, as fertility remains well below replacement level while marriage and first childbirth are increasingly postponed, particularly among urban and highly educated populations [2–4]. Delayed marriage and childbearing have coincided with growing public-health concern about infertility and increasing demand for fertility treatment [5], especially assisted reproductive technology (ART). Following decades of development, ART has generated diverse forms of kin-making worldwide and expanded the possibilities of family formation and reproductive choice. Meanwhile, its domain-crossing character has made it a "platform" for "enterprising up" reproduction within the new bioindustrial complex [6], and has also made it necessary to remain attentive to the accompanying new ethical questions concerning how reproductive projects are planned, negotiated, and practised [7].

In mainland China, the regulatory framework governing ART has historically restricted access to legally married heterosexual couples who meet specified infertility-related medical indications [8]. As the most widely used form of ART [9], in vitro fertilisation (IVF) care is consequently organized amid traditional conjugal relations and local gendered social order. IVF treatment constitutes an invasive medical intervention involving clinical risks, and women undergoing IVF may be required to take medications with substantial side effects, undergo oocyte retrieval under general anaesthesia, and make significant adjustments to their lifestyles and dietary practices [10]. IVF-conceived pregnancies are also associated with a higher risk of adverse perinatal outcomes than spontaneously conceived pregnancies [11]. Research on reproductive ethics further indicates that formal informed consent cannot fully encompass the identities, values, and relationships through which reproductive decisions are formed [12]. Global studies have accordingly shown that women bear a disproportionate share of the bodily, emotional, and social burdens associated with treatment [13, 14]. Given the potential structural oppression that women may face in reproduction, together with the risks and gravity inherent in clinical treatment itself, autonomy in IVF is therefore a crucial bioethical concern, requiring attention to both reproductive autonomy and patient autonomy.

First, across different cultural settings, the social meaning of reproduction is closely intertwined with social institutions such as marriage and the family, as well as with constructions of femininity and masculinity [13, 15], thereby shaping individuals' understanding and practices of reproductive autonomy. In China especially, reproductive values shaped by Confucian familial ethics, including pronatalist ideals and ancestor veneration, closely associate childbearing with filial piety and confer upon reproduction a

familial moral responsibility extending beyond the individual pursuit of parenthood [15–17]. Infertility is consequently experienced through feelings of distress, guilt, powerlessness, and stigma, while the language used to describe it may reinforce these feelings [18, 19]. Some scholars even argue that infertility is better understood as a symptom or a "disease process" rather than as a disease [20, 21], partly because diagnostic requirements for infertility are sometimes broadly defined in order to minimize patients' feelings of shame. This dynamic may be particularly salient in Chinese contexts, where shame is closely tied to concerns over individual and familial face and moral standing [22, 23], while also carrying a historically significant moral function in socialisation and self-cultivation, through which individuals monitor and amend their conduct in relation to socially shared norms [24, 25]. Infertility-related shame therefore warrants particular attention as to whether, against a background of social stigmatisation, it may prompt individuals or couples to pursue assisted reproductive treatment as a strategy of shame avoidance.

Contemporary kin-making and reproductive planning in China unfold within a changing familial order increasingly characterised by neo-familism [26]. Within this order, contradictory forces shape how women perceive and navigate infertility, reproductive planning, and ART in dynamic, nonlinear ways. Processes of individualisation and women's increasing participation in paid employment may intensify work–family conflict, while foregrounding personal emotion, negotiated intimacy, and self-defined life projects over prescribed familial duty [27]. At the same time, resistance to marriage and prospective motherhood has become increasingly visible among young Chinese women amid popular narratives of "fertility fear" on social media [28, 29]. Although transformations in intimate life have challenged elements of the patriarchal family order, the only-child generation's renewed reliance on flexible, multigenerational family cooperation may restore parental authority and traditional ideologies in intimate decision-making, indicating that individualisation has not displaced familial dependence or produced a simple triumph of individualism [26, 30]. Labour-market inequalities, pronatalist discourse, and gendered fertility expectations continue to subject women's reproductive choices and trajectories to pressures from both institutional and familial domains [17, 29, 31, 32]. Neo-familism captures this coexistence of individualisation, familial embeddedness, and structural pressure. An emerging neoliberal governmental rationality further complicates this configuration, as media discourse "reprivatises" structurally conditioned struggles as matters of individual choice and responsibility [33]. These forces create a mosaic context in which women bargain with family members, manage competing expectations and ambivalence, and construct understandings of reproductive autonomy in relation to emerging reproductive medicine [31, 34].

Second, sociocultural forces also structure how women exercise clinical autonomy within IVF treatment since local cultural and ethical values shape the extent and legitimacy of family involvement in medical decisions [35]. This localization is rooted in ethical value of the "self" that shape understandings of autonomy. Confucian ethics is grounded in the roles that constitute an agent as the person she or he is: identity is understood through the roles arising from one's network of social relationships, and these roles directly influence what one ought to do [36]. Family harmony and filial piety can position relatives as legitimate participants in healthcare decisions, while ritual (li) governance may encourage patients to

defer to physicians [37, 38]. A person's judgement of their own conduct therefore depends not only on whether they have realized individual preferences, but also on whether they have fulfilled the role-based responsibilities that they themselves recognize, thereby forming a relational "ethical self" [39]. Zhai also argues that the "actual self" remains subject to the "ethical self" constituted through relational norms and must continually regulate and cultivate itself in accordance with the ethical requirements of one's role, for example, as a wife, daughter, or mother. It remains to be examined how women's embodied experiences and clinical preferences construct patient autonomy alongside their role-attached norms and the wishes of intimate others in IVF treatment.

Existing research has extensively examined how macro-level institutional forces shape the (dis)empowerment and stratification of reproductive rights [40, 41], as well as how people make reproductive decisions that challenge traditional cultural scripts and how marginalised groups reconstruct motherhood [7, 42]. Previous Chinese scholarship has also examined how IVF trajectories are negotiated within families [34]; yet little research has focused on how women come to recognize relationally constituted decisions as autonomous, and how decisional weight is distributed among the embodied and relational claims composing those decisions in relation to ART.

Drawing on 33 semi-structured, in-depth interviews with women undergoing IVF or who had undergone it within the preceding six months, this article examines how women's IVF autonomy is constituted and exercised within the modern–traditional mosaic and neo-familial configuration of contemporary China. The findings identify an empirical paradox in women’s narratives of IVF decision-making: they could experience embodied reluctance and substantial relational influence while continuing treatment and recognizing their decisions as autonomous. The article addresses this paradox at the ontological level by showing that multidimensional relational forces, including familial responsibilities and intimate others’ interests, may become constitutive of women’s ethical selves, contributing to a locally articulated relationality-based conception of autonomy, while demonstrating that such social constitution does not by itself settle normative legitimacy. It then examines the epistemic and reflective conditions under which women recognize these decisions as autonomous, showing how three structural mechanisms—devaluation, invisibility, and fragmentation—constrain reassessment and leave embodied reasons with insufficient decisional weight. I conceptualize this boundary condition as *suspended autonomy*: women retain formal rights, decisional capacity, and procedural participation, yet have constrained capacity to reassess the legitimacy and relative weight of the forces constituting their decisions, while embodied preferences remain insufficiently weighted in determining treatment trajectory. Beyond binary adjudication of choices as autonomous or non-autonomous, suspended autonomy extends relational autonomy debates, offers bioethics a framework for assessing the organisation of decisional weight beneath formal consent procedures, and contributes to the sociology of reproduction by revealing how subjectivity, relationality, reproductive medicalization, and neoliberalised self-management intertwine within reproductive decision-making.

The Relational Dimensions of Reproductive Autonomy

IVF is a sequential and medicalised reproductive process disproportionately enacted through women's bodies and biological materials emerging "eggcentrism", including in cases of male-factor infertility [43, 44]. ART consequently coordinates bodies, technologies, kinship projects, clinical expertise, and social intentions across domains carrying different forms of authority [45], with much of its embodied and social burden concentrated on women [46]. In China, ART produces coexisting hope and anxiety under conditions of sociocultural pressure and technical uncertainty [47]. ART produces liminal and asynchronous temporalities structured by waiting and the uncertain futurity of being “not yet pregnant” [48], while accumulated temporal, financial, and corporeal investments can make discontinuation itself a difficult decision requiring active reinterpretation of the reproductive future [49, 50]. Cultural and ethical values further shape the extent and legitimacy of family involvement in medical decisions: family harmony and filial piety may position relatives as legitimate participants, while ritual governance may encourage deference to physicians [35, 37, 38]. Informed consent nevertheless operates at the level of discrete interventions rather than fully encompassing the identities, relationships, and values through which reproductive decisions are constituted [12], raising conceptual questions about the conditions under which such decisions can be regarded as autonomous.

Respect for autonomy occupies a central normative position in Western bioethics and is operationalised clinically through informed consent, requiring decision-making capacity, relevant information and understanding, and voluntariness [37, 51]. Reproductive autonomy extends this normative concern to decisions about whether, when, and how to reproduce, including decisions to pursue or refuse assisted reproductive technologies [52, 53]. The "autonomous-choice concern" nevertheless questions whether women's decisions to use these technologies can be regarded as substantively autonomous when oppressive gender and reproductive norms have shaped their options, desires, and reasons for action [10]. Treating the influence of such norms as sufficient to invalidate women's choices, however, risks undermining women's agency and legitimating paternalistic judgements about those choices [10]. Assessing this concern therefore requires examining the conception of autonomy it presupposes.

Modern Western conceptions of autonomy draw substantially on Enlightenment and Kantian traditions, in which autonomy is associated with rational self-legislation and human dignity [54]. Such approaches privilege rationality, self-consciousness, and individual rights while neglecting emotion, dependency, embodiment, and intimate relationships, producing the image of an abstract individual detached from attachments [55]. Later liberal formulations have often been criticized for presenting agency in overly atomistic or socially detached terms, giving rise to interpretations of "relational autonomy" theory [56, 57]. Relational autonomy provides a comparatively cautious and context-sensitive normative starting point for understanding and evaluating autonomy in Chinese clinical practices. Within Chinese ethical traditions, emotion and reason may operate together in moral judgement, while the self acquires identity through the roles and relational contexts in which it is situated [58, p. 94; 59]. Using Hall and Ames's focal-field metaphor, the individual contributes to the surrounding social field while simultaneously taking form through the network of relationships that constitutes it [36, 60, 61]. Yet I argue that this raises a further question: might an exclusive emphasis on the constitutive role of relationships shape

individuals' very recognition of autonomy, obscuring whether every decision formed within these relations is substantively autonomous?

Mosaic Familism and the Gendered Organization of Reproduction

Assessing this possibility requires examining how the relations shaping reproductive agency are themselves gendered and organized within contemporary Chinese family life. Childbearing has historically been embedded in familial moral responsibility: filial piety links support for parents with lineage continuation, while children may also signify marital stability and provide emotional and social security in later life [15, 62–64]. Patrilineal family values have historically located women's reproductive role within the continuation of the family line, making collectively justified reproductive obligations disproportionately embodied by women [65, 66]. Reproductive decision-making therefore becomes a site where filial obligation, gendered responsibility, and individual agency converge.

At the intersection of policy and culture, modernisation and individualisation have reconfigured the familial and gendered ideologies outlined above. Urban only daughters shows that one-child families expanded daughters' access to parental investment and opportunities for achievement while also enabling them to demonstrate filiality through support for parents [67]. The rise of individualisation and feminism has become entangled with, rather than simply opposed to, traditional ideology. This coexistence is captured by neo-familist accounts of contemporary family life and, more specifically, by Ji's "mosaic familism" and "mosaic gender ideology," which describe family reinstitutionalisation as a gendered hybrid rather than a linear shift towards individualism [26, 30, 68]. Neoliberal market logics and Confucian ethics can jointly moralise and naturalise motherhood responsibilities as feminine obligations, while motherhood is simultaneously framed in mainstream discourse as a matter of private choice [66]. The key question is therefore not whether individualisation has displaced familial obligation, but how gendered reproductive claims acquire weight within decisions increasingly narrated as personal choice.

The Discipline of Infertility-Related Shame

Under the social organisation of reproductive obligations, general infertility stigma can be severe and may prompt women to feel shame and manage social evaluation through concealment, selective disclosure, and social withdrawal rather than simply disclose their condition openly [69]. Women's management of such shame thus also shapes how these obligations acquire affective and moral force within women's self-evaluation and conduct. Infertility-related shame itself is strongly gendered because reproductive capacity remains tied to socially recognizable masculinity and femininity. Chinese culture has long equated fertility and potency with male strength and vitality, so that fatherhood may affirm respectable masculinity while infertility threatens men's self-esteem, social identity, and dignity [15, 70–72]. For women, pregnancy and participation in heterosexual family life may support a culturally legible feminine identity [32, 73]. Infertility can challenge women's social identities and role-attached obligations as wives, daughters, daughters-in-law, and prospective mothers. Women may conceal diagnoses, limit

disclosure, or withdraw socially to protect *mianzi* (face), understood as both the self presented to others and the self as perceived by others [74, 75].

Shame is commonly conceptualised as a self-conscious response to perceived failure to meet socially valued expectations [76, 77]. However, within Confucian-inflected moral thought, shame also carries disciplinary and ethical significance beyond its character as a conscious response. Shame (*chi*) may function as a moral resource when perceived failures of responsibility become objects of self-evaluation; in Mencian thought, the sense of shame is treated as the "sprout" of righteousness (*yi*) in *Mencius* 2A6, linking shame to moral cultivation [25, 78]. Shamelessness may be treated as an evasion of moral self-censure and a sense of shame as part of mature moral agency [79]. Calhoun [80] similarly argues that shame's responsiveness to others' judgements does not by itself deprive it of moral significance, since moral agents participate in a shared social practice in which others' viewpoints can legitimately matter. Some philosophical accounts question the moral legitimacy of shame when it tracks external standards that the agent has reason to reject. The ethical value Confucian shame is conditional when shame is situated in an interactive process between personal and communal values: vulnerability to shame marks both connection to a community and openness to its judgement, while pervasive shame generated by problematic values calls for resisting and changing those values rather than further correcting the self [25]. Some feminist critics similarly warn that shame felt under oppressive norms disciplines rather than cultivates [81]. While reproductive technologies may intensify this disciplinary potential by providing clinical means through which the perceived abnormality of infertility can be repeatedly monitored and corrected.

These literatures explain how reproductive choices are constituted through multiple and intersecting forces and become socially and morally intelligible, but leave unresolved how individuals distribute decisional authority among the relational, institutional, and embodied forces constituting those choices, and how and why women nevertheless come to understand such distributions as autonomous. This article addresses this gap by tracing how a locally reconstructed relational autonomy is ontologically constituted and epistemically recognized within the modern–traditional mosaic of contemporary family life, and by examining whether women's embodied preferences receive proportionate decisional weight among competing claims.

Methods

This article reports a qualitative interview study of thirty-three Chinese women undergoing, or preparing to undergo, IVF treatment. Reflexive thematic analysis was selected because it enables themes to be developed through sustained engagement with the dataset and treats interpretation as integral to the analytic process [82]. The analysis followed an abductive logic, moving recursively among empirical observations, anomalies that resisted initial explanation, and theoretical concepts capable of clarifying their significance [83]. Reflexive thematic analysis organized the practical work of coding and theme development, while abduction guided the movement from descriptive patterns towards conceptual explanation. Two sensitising problematics initially oriented this process: the relational and moral

organization of reproduction within Chinese family life, and the relationship between formally conferred decision-making rights and their substantive exercise. These problematics focused attention on the shifting intersections and contradictions among kinship obligations, infertility-related shame, embodied experience, and decisional authority, while allowing their relationships to be reformulated through engagement with the data.

Participants were recruited through open calls on Xiaohongshu (RedNote), a popular lifestyle-sharing social media platform with a predominantly female user base. Eligible participants were adult women residing in China who were undergoing or who had undergone an IVF cycle within the preceding 6 months, could complete an interview in Mandarin, and provided informed consent. Initial recruitment proceeded openly and without targeted sampling quotas. As fieldwork advanced, considerations of conceptual sufficiency and sample diversity led recruitment to become increasingly iterative and purposive. After 15 interviews, recruitment was adjusted to widen variation across treatment stages, cycle histories, and infertility attributions, including female-factor, male-factor, combined-factor, and unexplained infertility. Interim analysis after 25 interviews guided the recruitment of 8 additional participants whose experiences could elaborate emerging relationships and examine negative or divergent cases. Recruitment therefore concluded with a final sample of 33 participants because the additional interviews provided sufficient variation to refine and examine the developing analysis, while subsequent interviews contributed little further change to the conceptual properties and interrelations of the emerging themes. Participant characteristics are presented in Table 1.

Table 1. Demographic and IVF treatment characteristics of participants

I conducted one semi-structured interview in Mandarin with each of the 33 participants, with interviews lasting between 35 and 82 minutes. Interviews explored experiences of infertility, kinship expectations, clinical encounters, treatment decisions, responsibility, feelings of shame, disclosure and concealment of infertility between spouses, the quality of conjugal relationships, and participants' claims to and understandings of autonomy. The semi-structured interview guide was developed specifically for this study and was revised iteratively as fieldwork progressed, allowing later interviews to examine questions generated through the developing analysis. An English-language version of the interview guide is provided as Additional file 1. With participants' consent, interviews were audio-recorded, transcribed verbatim in Chinese, and de-identified during transcription. A reflexive memo was written immediately after each interview to document rapport, emerging assumptions, interactional dynamics, and emotional expressions observed during the encounter.

Analysis proceeded alongside data collection through repeated reading, initial coding, code comparison, thematic mapping, and recursive review. Coding was conducted in Chinese at semantic and latent levels, with early codes remaining close to participants' language. These included "being selfish by failing to repay the debt of being raised," "sequencing marriage and childbirth as tasks," "protecting my husband's self-esteem," "anticipating relatives' judgement," "signing without receiving a full explanation," and "redefining autonomy as having chosen." Cross-case comparison connected these codes to broader

processes involving anticipated social evaluation, gendered concealment, embodied reluctance, procedural participation, and the unequal weight accorded to different considerations within treatment decisions. Two recurring anomalies drove abductive refinement: women described pressure, fear, or poorly understood procedures while affirming their autonomy, and responsibility for infertility was sometimes attributed to women despite clinically established male-factor infertility.

I returned successive formulations to the dataset multiple times and assessed them against cases in which women rejected shame, challenged familial expectations, or exercised substantive refusal. Through this recursive dialogue between coded data and relevant theoretical literature, I progressively developed the anticipated gaze, unequal decisional weight, suspended autonomy, and the clinical processes of devaluation, invisibility, and fragmentation as analytic concepts. As the sole researcher, I conducted all coding and did not pursue intercoder reliability because reflexive thematic analysis treats themes as situated interpretive constructions [82,84]. All surnames used below are pseudonyms. The Duke University Institutional Review Board approved the study (Protocol #2025-0310).

Results

The analysis traced how women's embodied responses to IVF acquired meaning and practical force within conjugal, intergenerational, and clinical relationships. Many women demonstrated, in differentiated ways, how their embodied preferences, including pain, reluctance, exhaustion, and diminished desire for motherhood, were negotiated and weighed against others' expectations, social stigmatization, and the broader environment of reproductive medicalization. Almost all nevertheless described themselves as autonomous decision-makers despite these tensions. Four interconnected patterns emerged, linking embodied reluctance with claims to autonomous decision-making.

Continuing Treatment through Embodied Reluctance

Participants frequently combined explicit reluctance with continued treatment and retrospective endorsement of the eventual decision, especially when motherhood was desirable but not indispensable. Responsibilities towards a spouse or nuclear family often motivated continuation because women incorporated these considerations into their own evaluative reasoning. Some of them explicitly resisted interpretations that classified their eventual decision as non-autonomous, thereby asserting and exercising self-agency from an alternative dimension.

Lin (Participant 28), a 32-year-old primary-school teacher in Wenzhou, had pursued treatment for five years and undergone three egg-retrieval procedures and nine embryo transfers. Repeated implantation failure and pregnancy loss left her open to a future without children, while she sensed that her husband continued to regard parenthood as essential. Lin described the psychological damage of treatment alongside her continuing identification with the original decision:

“To be honest, from my own perspective, I never felt that I absolutely had to have a child. I was thinking more about the family, including my husband’s happiness. . . . Each time a cycle failed, my husband

encouraged me. What I wanted him to say was, ‘It is all right; it would also be all right for us to have no child,’ but I knew he would never say that. . . . The physical pain can be forgotten, even when my body was covered with painful lumps and bruises, but the psychological pain cannot be repaired. . . . I regarded what I was doing as a responsibility. . . . Standing at that crossroads again, I think I would still make the same choice.”

Lin located her decision within marital responsibility rather than an overriding desire for motherhood. Because her well-being had become tied to her husband's aspirations and their conjugal future, her psychological suffering carried limited authority to alter the established treatment trajectory. Zhao (Participant 29), a 38-year-old woman living in Shanghai, described a related tension through the language of being "pushed" towards treatment. She had stopped working after a career in procurement and had undergone one stimulation cycle and two transfers. Her husband repeatedly invoked their age and the declining possibility of pregnancy, creating pressure around the timing of treatment. Zhao nevertheless defined autonomy through her practical control over the process:

“I felt as though this matter was pushing me forward; I did not arrive there naturally by myself. What pushed me was the pressure from my husband. . . . When I felt that I had not recovered enough and did not want a transfer that month, he would say that I was getting older and age would become an even greater obstacle. . . . Yet I still felt that most of the process was autonomous because I was the person managing the whole process.”

Her husband's repeated references to age narrowed the postponements she regarded as acceptable, while Zhao derived and sustained her sense of procedural control from exercising discretion over appointments, hospital visits, and immediate scheduling. Hao (Participant 26), a 34-year-old freelancer in Beijing, was preparing for a second transfer after an unsuccessful first attempt. She recalled refusing childbearing when she felt unready, despite her parents-in-law's desire for a grandchild. Her position changed as her marriage became more emotionally secure:

“In earlier years, when they wanted me to have a child and I did not want to, I simply would not do it… At first, I felt as though I was completing a task for my husband. Later, as our relationship became closer, I began to feel that I was also creating another family member for myself… By then, the child was something I felt I wanted, regardless of what might happen between my husband and me.”

Hao's earlier refusal showed that relational expectations did not automatically determine her reproductive conduct; conjugal intimacy subsequently changed the meaning she assigned to motherhood, allowing a goal once experienced as a task for her husband to become part of her own imagined future. Across these narratives, embodied reluctance remained present within deliberation, while relational responsibility and anticipated well-being often acquired greater practical weight. The decisive variation concerned whether changes in women's bodily experience or personal aspirations could revise the reproductive goal after treatment had begun.

The Anticipated Gaze and Relational Self-Discipline

Many participants, especially those from non-urban areas, often expressed shame about their own use of ART and typically emphasised that their husbands' sense of shame was even stronger. Women accordingly voiced concerns that such shame would damage their families' reputations and injure their husbands' masculinity and self-esteem through anticipated evaluation rather than explicit commands. This fear arose because their own understanding of what should occasion shame substantially coincided with prevailing social judgements: they imagined relatives discussing infertility, parents losing face, or husbands receiving blame for reproductive problems, and such anticipation shaped disclosure, self-evaluation, and bodily conduct.

Wu (Participant 11), a 28-year-old former editor in Tianjin, had experienced one failed transfer and was preparing for another cycle because her husband carried a dominantly inherited genetic condition. She remained uncertain about her desire for motherhood and described childbirth as one task within a socially sequenced life course:

"I am not sure whether I even like children… But I feel that once marriage is completed, the next task should be childbirth… I think this comes from a traditional idea that relatives will talk if a married couple has no child. I worry particularly about my husband's relatives… He and his family would also face a round of gossip… I have no evidence that they have said anything. Perhaps nobody has; perhaps I imagined it… I cannot tell others it (doing IVF) is because of my husband. I am afraid they will gossip about him…Even when the doctor says it is my husband's issue, my mother-in-law still tries to find reasons in me, like saying I have a ‘gong-han’ (cold womb)."

The harsher social or individual constructed stigmatisation of male infertility and the imperative to protect masculine self-esteem shaped Wu's concealment of her husband's diagnosis. Disclosure could expose him to hostile comments from relatives, while telling her own parents might lead them to resent a husband whose condition required their daughter to undergo injections, medication, and embryo testing. She therefore managed information across both families to protect her husband and preserve relations between parents and spouse.

Because spouses' reproductive identities are interdependent, couples may manage threats to masculine status through concealment, diagnostic ambiguity, or wives' assumption of public responsibility, rendering infertility-related shame conjugally entangled while women undertake more of the emotional and reputational labour of protecting partners and families. The anticipated gaze required no confirmed act of criticism; its plausibility already organized her reproductive responsibility and silence.

Beyond Wu’s case, infertility-related shame acquired practical force through an "anticipated gaze" operating across relational networks consistent with the differential mode of association (*chaxu geju*): from community opinion and relatives' gossip, through parental and affinal expectations, into conjugal allocations of responsibility and women's bodily conduct [85,86].

Zhou (Participant 6), a 31-year-old corporate employee in Shanghai, had experienced several implantation failures and a pregnancy loss after one retrieval. Her family presented themselves as accepting the possibility of remaining childless, yet their everyday comments continued to orient her towards bodily preparation for another attempt:

“My family tries to sound as though they mean, ‘It is fine if it never works,’ but in practice they mean, ‘Rest for a few months and try again.’ … If I wear a skirt or eat watermelon, they say it is bad for the uterus. I do not believe wearing trousers for one day changes anything, but when I go for examinations with my mother, I wear trousers to avoid another argument… I understand her concern, and I still find it irritating.”

Zhou changed her clothing to pre-empt disagreement and preserve family harmony, despite rejecting her mother's narration of reproductive health; repeated reminders gradually shaped how she presented and managed her body. She also described stomach pain whenever she entered the hospital, as though her body had developed a conditioned response to the clinical environment, while continuing to ask why an otherwise healthy body had "failed" at reproduction. Her rational resistance to self-blame coexisted with persistent self-scrutiny and minor acts of bodily correction.

Sun (Participant 33), a 35-year-old forensic examiner from north-western China, had originally envisaged a childfree marriage and was preparing to begin her first IVF cycle. She connected the change in her reproductive plan to the emotional difficulty of disregarding her parents' expectations:

“If I could ignore my parents’ feelings, I would not be doing IVF… When I tried to tell my mother that I did not want a child, she cried while caring for my grandmother. At that point I could no longer continue the conversation. Whether I truly wanted a child became impossible to say… My father-in-law once told my husband not to return home for the holiday because, without a child, people would ask questions.”

Sun understood remaining childlessness through its anticipated effects on parents whose previous care remained emotionally present to her, while her father-in-law's concern about whether the couple could appropriately return to their hometown connected childlessness to family reputation and social exposure. The shame generated by construing infertility or childlessness as abnormal thus linked relational obligation to self-scrutiny and self-regulation. Within Confucian ethics, *chi* (shame) renders such self-correction culturally intelligible as part of self-cultivation, yet its ethical value depends upon the legitimacy of the norm against which the self is evaluated [25,79]. Its dependence on social evaluation therefore leaves women vulnerable to standards of self-assessment whose ethical legitimacy remains uncertain, particularly where patriarchal relations supply those standards. Reproductive technologies may further intensify this disciplinary potential by creating less visible spaces in which monitoring, protocols, and repeated intervention translate social expectations into the clinical management of women's bodies.

Unequal Decisional Weight among Relational, Clinical, and Embodied Forces

Women carried substantial responsibility for gathering information, arranging appointments, and completing treatment, while spouses, parents, and medical institutions retained considerable influence over the reproductive goal. The division between practical responsibility and decisional authority became especially visible when women's bodies enacted projects negotiated across several relationships.

Gao (Participant 30), a 32-year-old woman working in the clothing industry in Jiaxing, was preparing for a second stimulation cycle after chromosomal testing identified abnormalities in the embryos from her first cycle. Both she and her husband had reproductive conditions relevant to treatment. Gao described intense fear before egg retrieval alongside a belief that withdrawal would constitute selfishness towards two families:

“Three days before egg retrieval, I was terrified and my heart was racing. I kept thinking that I could not be selfish and disregard two families… When you ask what I could decide for myself, the answer is very little: perhaps my own view of childbearing and the choice of hospital… My husband and I did not decide to use IVF by ourselves. Both families made that decision together.”

Gao exercised authority over hospital choice and treatment management, while two families participated in defining IVF as the appropriate reproductive course. The prospect of appearing selfish changed the significance of her fear, turning an embodied preferences for hesitation into a concern that she expected herself to overcome. Clinical procedures then supplied the practical route through which the collective reproductive objective could proceed through her body.

Clinical communication further influenced how couples allocated reproductive responsibility. Xu (Participant 27), a 40-year-old marketing professional in Shanghai, had undergone five retrievals and four transfers. Her husband had received a diagnosis of severe male-factor infertility, yet Xu described continuing ambiguity in family discussions and clinical communication:

“When the doctor spoke to me alone, he said the problem lay mainly on the male side. When both of us were present, he became much more cautious… The final record still attributed infertility and ovarian insufficiency to me, although I believed my indicators did not support that… My husband and his parents continued to say that nobody knew whose problem it was. I found this deeply unfair because the report already contained the diagnosis… My husband already has a child of his own, so I am the one who wants a child. I feel incomplete without one… If I divorced, I would still have to expend effort finding someone else with whom to have a child.”

Xu described the clinician's caution as protecting masculine standing, speaking with a mixture of resignation and anger. Whether or not the clinician intended that consequence, diagnostic ambiguity allowed her husband and in-laws to preserve uncertainty around causation while treatment continued to focus on her body. Clinical communication therefore shaped more than the circulation of biomedical information; it influenced whose condition became publicly discussable, whose reputation required protection, and whose suffering could justify reconsidering treatment. At the same time, Xu asserted her reproductive autonomy by presenting the desire for IVF and childbirth as primarily her own. Yet this claim

drew upon an indistinct narrative of "incompleteness" that exceeded any simple or clearly articulated affective desire for motherhood and reflected a broader social construction of reproduction.

Luo (Participant 12), a 33-year-old financial-sector employee in Shanghai, began IVF after doctors raised concerns about her husband's sperm motility and had recently received confirmation of pregnancy. She demonstrated how family influence could remain substantial while women retained reflective endorsement of the reproductive goal:

“I was never someone who especially liked children, but I wanted one because I thought a child would open another perspective on life when other possibilities begin to narrow. . . . My mother was very firm that I should have a child, so I probably absorbed some of that unconsciously. . . . Still, when I made the decision, about eighty per cent of the consideration concerned the life I wanted for myself.”

Luo differentiated her mother's influence from her own anticipation of future life while recognizing that both formed fragments of the same decision, resisting a categorical distinction between externally imposed expectation and internally generated desire without erasing the distinct presence of either. Across these cases, participants differed in how they understood the sources of the considerations entering deliberation: some sought to distinguish reasons they regarded as their own from heteronomous influences originating in other agents, whereas others viewed such separation as overly idealised and impracticable, emphasising the inevitable entanglement of these sources.

Clinical Momentum and the Private Management of Treatment

Once treatment began, its temporal and institutional organization often made continuation easier to enact than reconsideration of the reproductive project as a whole. Women accumulated sunk costs as IVF became embedded in careers, private schedules, and bodily routines, while consent remained attached to successive procedures. Autonomy was consequently enacted largely through private treatment management, and the resources consumed by such practical competence could weaken women's capacity to reconfigure their reproductive trajectories.

Huang (Participant 18), a 33-year-old woman living in Qingdao, had left an administrative career and spent three years preparing for pregnancy. After two retrievals and two unsuccessful transfers, she described how treatment occupied her time and altered her position within the marriage:

“After I started IVF, I realised how difficult this road was. I have not worked for three years because I have been trying to have a child. . . . For one third of every month I am at the hospital, often waiting for an entire day, so I cannot look for work. . . . Yet my husband does not see this labour and thinks I make no contribution to the family. I want to return to my former position, but that has become almost impossible.”

Huang's bodily and temporal labour sustained the reproductive project while paid employment remained the more visible measure of household contribution: IVF reduced her occupational and economic resources while expanding the labour she performed for the family. Her husband's limited recognition of that labour weakened the force of career loss and exhaustion as reasons for pausing treatment and reinforced its detached sense of obligation and necessity, even though those consequences had completely reorganized her daily private life.

Tang (Participant 7), a 36-year-old internet professional in Beijing, was undergoing preimplantation genetic testing after two pregnancies ended following chromosomal abnormalities. Although she and her husband had relatively high incomes, Tang managed treatment as an undisclosed private obligation:

"I told nobody at work that I was doing IVF. I did not want them to know because I felt this was a very private matter, and I did not want my boss to know either. Sometimes I got up at 5:30 in the morning, went to the hospital, and arrived at work on time as though nothing had happened… I kept wanting everything to move faster because I needed to control the timing and spend less time on treatment… Eventually, as you can see, I placed my career planning behind reproduction… Having a job was still important because it sometimes allowed me to forget the anxiety and pain of treatment."

Tang experienced intensive self-management as a form of control: she concealed treatment, preserved workplace performance, and coordinated clinical schedules around employment, demonstrating substantial procedural agency while keeping the occupational consequences of IVF within private life. She added that labour law protected pregnant women yet gave no attention to those undergoing IVF before pregnancy, obliging women in her position to safeguard their rights indirectly through caution and secrecy. The reproductive project could therefore reorder her career while her ability to manage that disruption continued to signify competence and autonomy.

Fang (Participant 34), a 40-year-old woman in Guangzhou who had left clerical employment, had undergone four stimulation cycles and four transfers and was awaiting a final transfer after a miscarriage. She entered treatment with limited knowledge and later struggled to establish a clear stopping point:

“We did not really understand the IVF process before entering it. Once inside, I felt stuck, and we received very little information; the only thing we could do was continue. . . . I had already resigned, so my career had stopped, but there had been no breakthrough in treatment either. . . . If I stopped after investing so much, I thought I would regret it. If I continued, the price also seemed too high. I felt trapped between those two directions.”

Sunk costs and sequential procedures nudged Fang towards continuation without resolving her ambivalence, leaving her to exercise agency within the narrow domain of managing her treatment plan and her own body. Each clinical stage presented another immediate decision, while the broader question of whether she wanted to pursue biological motherhood received less structured consideration, since confronting it would have required the difficult work of reorganizing her life.

Across these narratives, women's pain and exhaustion remained visible as expected experiences of IVF, while concealment, scheduling, and bodily management stayed concentrated in private life. Successive procedural decisions preserved participation and formal consent, yet accumulated embodied judgements often lacked sufficient authority to redirect the reproductive project as a whole. Women narrated their eventual decisions in ways that reduced relational conflict and protected the perceived legitimacy of their choices by connecting them to their original reasons for undertaking IVF, rendering their conduct intelligible and defensible to themselves through a comprehensive balancing that encompassed their own interests and those of intimate others in pursuit of harmony and well-being.

Discussion

The discussion begins from a paradox in contemporary Chinese IVF decision-making. Although individualisation, educational expansion, and women's employment have altered orientations towards childbearing, some women who express exhaustion, hesitation, pain, or reluctance to begin or continue IVF nevertheless proceed through successive cycles and describe persistence as "my own autonomous decision". They present continued treatment as a considered outcome of weighing conjugal responsibility, familial harmony, shame, and personal well-being. These narratives exceed a simple opposition between free choice and passive obedience: formal decisional rights and procedural opportunities for consent remain present, while relational, clinical, institutional, and embodied claims are entangled over the direction of the decision.

These decisions remain situated within a neo-familial order in which individualised aspirations coexist with intergenerational dependence and enduring reproductive obligations [26,30,31]. Even amid rapid socioeconomic development, as members of the only-child generation renew their dependence on intergenerational family support, individualised aspirations increasingly enter into negotiation with inherited familial expectations, which associate a meaningful individual life with family harmony and a meaningful family life with raising successful children. Childlessness still extends beyond the domain of private preference and becomes vulnerable to construction as abnormal and shameful, thereby producing what may be experienced as a socially produced "atmosphere of abnormality". Within this atmosphere, infertility may be always experienced as instead of a biological bodily condition but a perceived sense of shame arising from the constructed failure of role fulfilment and socially recognizable masculinity or femininity.

Berkson [78] argued that Confucian ethics distinguish morally productive shame from pathological shame and treat the former as internally connected to self-cultivation rather than reducible to external concerns over face. Even though building on this distinction between morally constructive and pathological forms of shame, infertility-related shame **within the cultural context** may often be socially repositioned between these two registers, instead of experiencing as solely an individual pathological response to bodily impairment. When infertility is recoded as a perceived failure of responsibility, the resulting shame may be situated within a moral rather than merely pathological register. Yet moral intelligibility should not be conflated with normative legitimacy: where the standards generating shame

are gendered or oppressive, this moralisation may transform shame from a resource for self-cultivation into a disciplinary force. The narratives of women who expressed reluctance to undergo IVF remained unable to escape the affective entanglement of such shame, experiencing ideational conflicts with traditional and socially established norms, including obligations associated with repaying parental care (*yang'er fanglao*) and responsibility for lineage continuity.

This configuration echoes what Thompson [45] calls an "undifferentiated hybrid mess", which describes the coordinated convergence of elements belonging to different ontological orders within assisted reproduction (see also [6]). ART's domain-crossing character therefore warrant reconsideration of both the social ontology of autonomy and the epistemic conditions under which women recognize their decisions as autonomous. The autonomous-choice concern cautions against treating gendered or reproductive norms as sufficient evidence of non-autonomy, since excessively demanding standards may diminish women's agency, portray them as passive products of patriarchal socialisation, and legitimise paternalistic interference [10]. A more adequate analysis must therefore examine how locally specific relational norms participate in constituting autonomy while also shaping the epistemic terms through which autonomy is normatively evaluated.

Conceptions of the self condition what self-determination can mean and, therefore, what counts as locally intelligible autonomy. Within the modern–traditional and collective–individualistic mosaic of Chinese family life, women's incorporation of intimate others' interests into IVF decisions reflects a hybrid process of self-making in which personal desire and familial responsibility are interpreted, coordinated, and negotiated together. The important variation is not simply whether relational considerations enter decision-making, but how women assess their relative decisional weight and whether their embodied standpoint is treated as authoritative within deliberation. Relational autonomy provides a useful theoretical starting point because it treats values and agential capacities as socially constituted rather than as properties of an already isolated subject [56,57,87,88]. This account partly resembles the role-based self in Confucian ethics [61], although the two are not identical. Feminist relational autonomy emerged from critiques of atomistic agency and emphasises how relations of dependency, recognition, and power constitute ethical subjects. The Chinese relational self, by contrast, is more explicitly organized through established kin-made roles and social identity with their attached duties and affections. Both reject an atomised conception of the person but differ in the sources, structures, and ethical significance they attribute to relationality.

This distinction between the ethical subject of Western relational autonomy and the Chinese relationality-based local articulation of autonomy helps to clarify how individuals reconstructed autonomy in certain degree at the ontological level. It recognizes more in the dimension that subjects develop self-understandings within concrete relationships as social or familial role and its attached duty and affection, thereby explaining how conjugal relations, parent–child relations, intergenerational obligations, and familial attachments shape an individual's understanding, in decision-making, of the multidimensional positional attributes of the "subject"—as oneself, daughter, wife, daughter-in-law, and so on—which together compose the ethical self. I therefore first argue that women's reproductive plans

and IVF clinical trajectories that take relational forces such as familial responsibility into account should not necessarily and absolutely be judged as non-autonomous, as though an originally independent personal preference had been coerced by collective demands.

However, although I acknowledge that women's relational (ethical) selves are formed within an intersubjectively constituted ethical order of decision-making, this order is one in which internal and external relational forces acquire differing degrees of decisional weight through role understandings and relations of recognition whose legitimacy requires examination. It is therefore crucial to distinguish further between the social constitution of the self and the normative conditions of autonomy: a self may be socially constituted, yet the manner of that constitution may still be shaped by oppressive power relations [57]. Recognizing relationality as constitutive of the self therefore does not, by itself, settle the normative authority of the claims entering decision-making [89]. Where such claims are shaped by potentially illegitimate norms or habitus, the normative boundary of autonomy depends not simply upon whether women incorporate relational considerations into their self-understanding, but upon whether they can identify different subject-positioned origins of those claims, critically assess their legitimacy, and distribute their relative decisional weight without structural oppression.

Identifying the sources of relational claims, assessing their legitimacy, and distributing their relative decisional weight are capacities that recent bioethical discussion increasingly locates at the epistemic and reflective dimension of autonomy beyond informed consent. Autonomous choice depends upon access to relevant information and adequate understanding, but also upon capacities for deliberation, critical reflection, authenticity, and the evaluation of reasons guiding action [87,88,90]. These capacities are socially situated, since relational conditions such as dependency, interpersonal relations, and broader social contexts can enable or constrain their exercise [91,92]. The argument of dialogical answerability emphasises the capacity to answer for one's commitments and reasons in response to external critical perspectives [87,93], while Benson [94] argues that reflective authorisation alone does not secure agency because agents must also possess “a certain sense of their own worthiness to act, or of their status as agents”. These discussions are particularly relevant where women reflectively endorse reproductive commitments while experiencing relational expectations primarily as role-based obligations to be managed rather than claims whose authority can itself be critically assessed.

Although reproduction is a joint conjugal decision and responsibility requiring both sperm and egg, IVF interventions are performed primarily upon women's bodies, imposing labour and bodily burdens asymmetrical to those borne by husbands. Women's embodied preferences connected to bodily integrity therefore have a prima facie claim to proportionate decisional weight. That women's final decisions are constituted through relationships does not mean that claims arising from different subject positions possess equivalent normative weight, nor does it establish that women can regard themselves as authoritative participants in practical reasoning. A woman may fully understand treatment information, possess reflective capacity, and sincerely say "this is my decision", yet still lack adequate interpretive resources or social conditions to distinguish the subject-positioned origins and intersubjective relations of competing claims and assess why each acquires its corresponding decisional weight. Her own

subjectivity and the interests of others may consequently become unequally weighted within relational decision-making.

Epistemic injustice offers one way of understanding situations in which women lack shared interpretive resources for making sense of embodied experience or encounter identity-based credibility deficits [95]. Yet the interviews also reveal a distinct problem: women may recognize both their embodied reluctance and the relational sources of competing claims while those embodied preferences remain deprived of sufficient decisional weight. Suspended autonomy therefore cannot be reduced to epistemic injustice. Its central problem is not necessarily whether women can identify or articulate their experience, but whether they possess sufficient interpretive, relational, and normative resources to reassess the authority accorded to competing claims. This article accordingly asks whether women can distinguish the subject-positioned origins of relational claims and whether unequal decisional weight marginalises their embodied preferences.

To capture and critically reflect upon the recognition and realisation of women's autonomy under a relationality shaped by illegitimate norms and unequal but stable ideological structures—one that threatens this legitimate boundary—I conceptualise the improperly weighted condition as "suspended autonomy". Suspended autonomy describes a condition in which agents remain formally endowed with autonomous powers, while the normative force of those powers remains substantively unrealised. Under the shelter of a self-claimed relational autonomy, women may consequently bear asymmetrical burdens that threaten bodily integrity. This limitation is reinforced and reproduced through a neoliberalised form of self-government in which the distribution of decisional weight among competing intersubjective claims remains insufficiently differentiated, as the following analysis shows.

Xiang [96] uses "suspension" to describe a condition produced within a highly mobile social world, where people remain engaged in continuous activity while lacking the capacity to alter the conditions organizing that movement. Suspended autonomy similarly separates continuing activity from transformative authority: women's agency is channeled towards managing and reconciling ambivalence rather than towards revising the role-structured reproductive objectives that generate this ambivalence.

Suspended autonomy is accordingly defined as a structure satisfying four conditions: 1) the agent retains decisional capacity, formal rights, and procedural participation; 2) the agent's agency manifests primarily in coordinating the interests and responsibilities of multiple parties; 3) structural conditions constrain the agent's ability to critically reassess the normative authority accorded to competing claims, even when their subject-positioned sources are recognizable; and 4) the agent's final decision exhibits the suspension and deviation of her embodied preferences.

This article then seeks to answer a further question: how are the epistemic conditions of suspended autonomy structurally produced? These narratives can be situated within a neoliberal rationality that valorises individual responsibility, coordination, and self-management; reproductive medicine supplies the institutional setting in which this narrative is rehearsed and stabilised. The structural shaping of women's epistemic conditions must therefore be traced into the clinical structures and institutional

environments of reproductive treatment, where macro-governance meets individual bodies. Drawing upon Fisher and Tronto's analysis [97] of the devaluation, invisibility, and fragmentation of feminised care work, I identify three structural mechanisms through which the decisional authority of women's embodied reproductive preferences is suspended beyond the reach of women's individual agency. These mechanisms show how the improper weighting that defines suspended autonomy is structurally produced rather than merely personally chosen.

The first structural mechanism through which suspended autonomy takes shape is the devaluation of embodied and affective labour within reproductive medicalisation—a devaluation that, I argue, is further reinforced when neoliberal governmental rationalities recast the management of such labour as evidence of women's individual competence and responsibility. Operating through subjects' active pursuit of responsibility, choice, and self-management, neoliberal governmental rationalities organise personal life through individualisation and responsibilisation [98–100]. Neoliberal feminist discourses similarly recast gendered constraints as problems to be managed through women's ambition and individual effort, including the pursuit of what Rottenberg [101, p. 422] calls a “felicitous work–family balance”, thereby displacing attention from structural inequalities [102,103]. In post-socialist China, mainstream media have reframed gender inequalities through rhetorics of rational individual choice and responsibility while reprivatising women's family roles [33]. Such governmental rationality operates selectively alongside state-led individualization, heteropatriarchal norms, and persistent socio-familial relations [26,100]. Their conjunction contributes to ambivalent forms of subjectivity in which aspirations to independence and self-management coexist with familial dependence and gendered reproductive obligations.

Within IVF, this ambivalent subject position manifest when women's capacity to absorb and manage relational conflict is itself rendered intelligible as “independence”. The flexible yet effective organization of the mutually embedded relationship between relationality and women's own subjectivity constitutes the sphere within which they can exercise agency. Meanwhile, keeping the conflictual dimension of relationality from surfacing beyond private life therefore becomes a personal accomplishment: the harmonious decisions women devise for themselves are rendered defensible while distancing them from patriarchal representations of dependent femininity. The experience and articulation of suffering are reorganized into a detached, inevitability-laden medicalised discourse—treatment cycles, follicle counts, embryo grades, and success rates—naturalised as necessary costs. Neoliberal rhetoric then completes the devaluation by revaluing the labour and management of both decisional and treatment burdens as marks of modern subjectivity and independence.

The second mechanism, invisibility, reveals how infertility-related shame acquires ethical significance within the gendered distribution of concealment labour. Concealment operated at multiple interconnected levels. First, because virility and fertility are typically tied to manhood, male infertility constitutes a potentially emasculating condition that men may manage through secrecy [104], and husbands commonly avoided disclosure or refused to acknowledge infertility diagnoses in wives' narratives. Second, the long-standing construction of reproduction as a female domain, reinforced by

what Almeling [43] identifies as the biomedical non-knowledge of men's reproductive bodies, channels diagnostic attention and public accountability towards women. Wives consequently performed additional concealment labour for male-factor infertility yet received no comparable protection when infertility was attributed to themselves, reflecting their unequal position within a patrilineal reputational order [105,106]. Consistent with Mann's account [107] of gendered shame as a mechanism through which feminine norms extract labour and value from women, concealment here became a form of feminised reputational labour protecting masculine standing. The deeper implication of these concealment practices is an effort to maintain, or return to, “normality” without “abnormality” becoming socially visible, thereby avoiding labels that may be difficult to shed. The movement from anticipated judgement to self-surveillance and bodily correction is consistent with Foucauldian accounts of gaze and norm as intertwined technologies of normalisation [108]. Pursuing the invisibility of abnormality may, in turn, reinforce the stigmatizing and gendered environment that makes such concealment necessary.

The third mechanism, fragmentation, arises from the temporal and procedural organization of reproductive treatment itself. IVF proceeds through testing, stimulation, retrieval, transfer, pregnancy testing, and further cycles, while informed consent remains attached to each discrete intervention. Women receive information and sign repeatedly, yet the overarching objectives, including motherhood, treatment continuation, patrilineal reproduction, and non-treatment, never become genuinely revisable at any single decision point. Meanwhile, the identities enacted within kin-making and familial ethics are dispersed across patient, wife, daughter-in-law, daughter, and prospective mother, so that each consent moment demands a fresh round of the ontological choreography [45], coordinating these positions with bodily experience, embodied reproductive preference, familial obligation, and clinical authorization. Women remain continuously active, deliberating and consenting at every stage, while the conditions organizing that movement stay suspension. The formal apparatus of autonomy thus operates at full procedural strength precisely where its normative force, that is, proportionate authority for embodied preferences over the direction of the reproductive project, remains substantively unrealized.

Conclusion

This article examined how reproductive autonomy is constituted and exercised within the modern–traditional mosaic of Chinese family life, and how decisional weight is organised among the embodied, relational, and clinical forces shaping IVF treatment. It began with an empirical paradox: women could experience embodied reluctance, pain, exhaustion, or a diminished desire for motherhood while continuing treatment and sincerely recognizing the resulting decisions as autonomous. Rather than treating this coexistence as evidence either of hidden coercion or of unconstrained choice, the analysis distinguishes the ontological reconstruction of relationality-based autonomy from the assessment of its normative legitimacy. The article conceptualizes this boundary condition of autonomy as *suspended autonomy*. It shows how formal rights and procedural participation can coexist with insufficient weight accorded to embodied reasons, extending relational autonomy and illuminating how neo-familial

relations, reproductive medicalization, and neoliberalised self-management shape reproductive decision-making.

Abbreviations

ART: Assisted Reproductive Technology

IVF: In Vitro Fertilisation

IUI: Intrauterine Insemination

PGT: Preimplantation Genetic Testing

DOR: Diminished Ovarian Reserve

POI: Primary Ovarian Insufficiency

Declarations

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Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available because they contain sensitive qualitative information concerning infertility, reproductive treatment, intimate relationships, and family dynamics, and public disclosure could compromise participant confidentiality. Appropriately de-identified data are available from the corresponding author on reasonable request.

Ethics declarations

This study was approved by the Duke University Institutional Review Board (Protocol #2025-0310). The study was conducted in accordance with the Declaration of Helsinki and all relevant institutional guidelines and regulations. Participation was voluntary, and informed consent was obtained from all participants before the interviews. Interviews were conducted in Mandarin and, with participants'

consent, were audio-recorded, transcribed, and de-identified. Pseudonyms are used throughout the manuscript, and identifying information was removed to protect participants' privacy and confidentiality.

Clinical trial number

Not applicable.

Consent for publication

Not applicable. The manuscript contains no identifiable personal information. All quotations from participants have been de-identified.

Competing interests

The author declares no competing interests.

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Table

Table 1 is available in the Supplementary Files section.

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