CONTESTED CONCEPTIONS:
A CULTURAL ACCOUNT OF ASSISTED REPRODUCTION

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Synopsis

This thesis addresses the changing cultural construction of reproduction at a key period in its negotiation in the context of the new reproductive technologies. These changes, occurring during the mid- to late 1980s in Britain, are analysed using materials from four separate domains of cultural production. Part One introduces feminist debates concerning the new reproductive technologies and their implications for women's reproductive rights. Using approaches developed within cultural studies, Part Two addresses the popular media construction of infertility and its treatment. Part Three presents the results of an interview-based study of women's experience of IVF. In Part Four, the focus returns to public culture by analysing recent public debate of the new reproductive technologies using extracts from parliamentary proceedings.

The main argument of the thesis concerns the contrasting representational operations at work in these different domains, which also serve as contexts for one another. Throughout, the aim is to demonstrate the means through which the technology of IVF, and women's encounters with it, are made sense of through specific representational practices. It is argued the material and analysis presented in the thesis confirm the importance of what is described as a representational politics of reproduction, through which the terms of public debate concerning the new reproductive technologies can be more effectively challenged.

Dedication

To the ex-membership, in all their anti-foundational wisdom.

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TABLE OF CONTENTS

TABLE OF FIGURES

PART ONE

WOMAN AS SUBJECT OR OBJECT?

I could not say to a woman that she should not try [IVF]. I can understand why she would want to go for it. So I would say to her: 'OK, it will be nasty and you will suffer'. But I would not say that she should not be allowed to try.

'Inge M', in Klein, 1989, p. 100

CHAPTER ONE

Introduction: Setting the Terms

A Contested Conception

Since this thesis is concerned with the changing cultural construction of reproduction, it is appropriate to begin with the event popularly associated with the origin of debate about new reproductive technologies: the birth of Louise Brown in 1978. This birth, though unremarkable in itself, received worldwide media coverage for its realisation of an event which had occurred nine months earlier in a laboratory, the conception of Louise Brown *in vitro*. The birth of Louise Brown is now enshrined as a historic watershed, in the wake of which an international public debate concerning the legitimacy and regulation of new forms of 'assisted reproduction' has emerged.

On the one hand, new forms of 'assisted reproduction' have been welcomed as evidence of scientific progress, technological enablement and human achievement.[1] They have been seen to be beneficial, and to contribute to the alleviation of human suffering. The birth of Louise Brown has been heralded as proof of the ability of medical-science to improve the lives of couples who are unable to conceive. In so doing, new techniques such as IVF have been seen to hold out hope: not only hope for the infertile, but hope for sufferers of genetic disease, and hope for greater scientific progress in understanding the mechanisms of

human reproduction. IVF is itself the product of embryo research, and with the rapid expansion of IVF programmes worldwide, and the consequent provision of a ready supply of 'spare' embryos, which were previously a scarce resource, embryo research has become not only more feasible but a rapidly expanding field of international scientific and clinical investigation. This area of research, though controversial, is seen to hold out considerable promise, and in many countries, including Britain, has been endorsed by legislators in the name of scientific progress.[2]

On the other hand, new reproductive technologies such as IVF, and also not-so-new reproductive technologies which began to receive more attention in its limelight, have been the subject of considerable ethical and moral controversy.[3] Though some forms of assisted reproduction have been officially endorsed, others have not.[4] Even those which have become officially legitimate are subject to strict regulations. This is because of the risks which are seen to adhere to the use of reproductive technologies, such as risks to the traditional family and marriage, risks to children born of the new techniques, risks of unwanted applications of the new technologies and the potential for their misuse, and risks to 'society' or 'morality' as a whole due to the transgressive nature of this form of human interference in the reproductive process.

Within these debates, and particularly here in Britain, the risks to women who undergo these new procedures, and the risks to women generally from the new forms of reproductive control they facilitate, have received little attention in mainstream public debate.[5] In no small part, this is due to the predominant tendency for these techniques to be represented in terms of their benefits to infertile women, and thus in

terms of expanding women's reproductive choice and control. In the meantime, and very much in opposition to the predominant image of benevolence, a considerable literature has been produced by feminists in many different countries concerning the implications of new techniques such as IVF, and new research initiatives such as those involving embryos. Indeed, new reproductive technologies have become a major focus of feminist attention since the early 1980s, represented by a literature the volume of which is a singular testament to the importance placed by feminists upon the political implications of new reproductive technologies. In addressing the long term social implications of the new reproductive technologies, and in documenting the many risks inherent in new techniques, the feminist literature is unique in both its breadth and depth.

Shared by participants in both mainstream and feminist debates over the social and cultural implications of new reproductive technologies is a recognition that the issues raised by this area of urgent public concern defy ready solutions. This point cannot be overstated. Even among very likeminded persons, who share considerable commonground, be that political, religious, professional, or personal, the issue of new reproductive technologies is, like issues concerning sexuality, often highly contentious. It can prove a most difficult subject upon which to reach accord, whilst at the same time it exerts a powerful fascination for many. This is hardly surprising. These technologies, and the forms of reproductive practice they enable, not only raise unfamiliar and unsettling dilemmas, *but they also challenge the very terms in which they are discussed.* Established conceptualisations of rights and choice, individuals and persons, motherhood and fatherhood, nature and

technology are disrupted by the advent of new reproductive techniques. Furthermore, such disruptions concern a vital arena of human experience, namely reproduction, which not only figures largely in our vision of the future, but is the source of key components in our identity and our imaginations, as it invokes both our personal origins and our collective future. 'Assistance' to conception not only produces 'miracle babies', it produces assisted parenthood, assisted kinship, assisted origins and assisted heredity. The question of how to understand the *meaning* of such assistance in itself is challenging enough, without also having to assess its implications, never mind having to reach firm consensus on these vital matters.

How even to think about some of these 'new conceptions' is often difficult to realise. To many, therefore, it is apparent that the question of the terms through which new forms of reproductive assistance are to be understood and debated is critical. The uncertainties in this field are often openly acknowledged, both within feminist and mainstream debate.

There are at least two major levels at which the question of setting the terms of debate over new reproductive technologies is crucial. One is the most basic level of how to develop an adequate language to address what is a deeply transgressive and, one might add, 'anti-foundational', to use the postmodernist phrase, set of phenomena. The other, equally vital, question is that of who will have the power to define the terms, both new and old, through which debate is conducted? It is a primary aim of this thesis to address both levels of concern about how the terms of debate over new reproductive technologies have been and will be developed.

Contesting the Terms of Debate

This thesis thus has a dual focus. On the one hand, it is concerned with the terms of mainstream public debate, and the ways in which new forms of assisted reproduction are defined and legitimated through them. Specifically, it is addressed to the task of analysing emergent forms of cultural representation which, it is argued, play a key role in shaping the terms of public debate. It also is informed by a feminist concern with the forms of power and control at stake in new reproductive technologies as forms of reproductive intervention. Theoretically, it draws on cultural studies and anthropology, from which frameworks for interpreting the specifically cultural dimensions of the debate over assisted reproduction have been drawn. From anthropology it takes the established recognition that models of conception, parenthood, kinship and personal origins are of profound cultural significance in the widest possible sense. From cultural studies, it invokes the equally important identification of such definitional struggles as condensed points of discursive and political contestation. It is concerned, in other words, not only with the social consequences and implications of new forms of assisted reproduction, but with the ways in which these new techniques are conceptualised, made sense of and defined. It is concerned with the systems of meaning and belief through which the significance of new reproductive technologies is constructed.

Within this, it is also concerned with a specific set of cultural representations which are central both to the terms of mainstream public debate and to feminism. This is the representation of women's experience of new reproductive technologies, specifically IVF.[6] In

mainstream debate, and in popular representations of IVF, as well as within clinical literature, women's desires for reproductive assistance play a major role in the legitimation of new reproductive technologies. The idea that women not only want new techniques such as IVF, but are indeed 'desperate' for them, has come to be a commonplace assumption in many discussions of assisted reproduction.

Within the feminist literature, the question of women's experience of the new reproductive technologies also holds a privileged place. Consistent with the longstanding importance placed upon women's experience within feminism, through which the personal is seen to be political, and upon which consciousness-raising is seen to be based, women's experiences of new reproductive technologies have been used as the basis for both feminist critiques and feminist endorsements of procedures such as IVF. Hence, while many women's experience of new reproductive technologies have confirmed feminist assessments of them as exploitative mechanisms of patriarchal control, other women's experience does not confirm this assessment. Moreover, women continue to express their desire to participate in new forms of assisted reproduction such as IVF. Thus, as is discussed further in Chapter Two, feminists themselves have been divided around this issue, and this raises many troubling questions which make any coherent feminist 'stand' on these technologies difficult.

This troubled confusion among feminists also coincides with a more general questioning process within feminism concerning the definition of 'women's interests'.[7] An increasing emphasis on recognising differences among women, while seen as an important shift away from an overemphasis on women's commonality that privileged the experiences of some women at

the expense of others, has contributed to a sense of disorientation in terms of collective strategies. The specific debates within the area of reproductive technology may thus be seen as, in part, symptomatic of broader issues for feminism.[8] In this thesis, the focus upon the specifically cultural dimensions of these debates is part of a larger argument that this level of analysis is critical to an effective re-evaluation of feminist frameworks, such as those addressed to the politics of reproduction (see Franklin, Lury & Stacey, 1991a).

This thesis was conceived in the recognition of the changing landscape of feminist politics, and the need to develop new strategies of political mobilisation, as well as to rethink certain established feminist frameworks. It was also conceived out of a concern about the implications of the new reproductive technologies both in their impact on women's lives and in their long-term social and cultural implications. Finally, it was conceived out of the conviction that both feminist and social science perspectives are essential to an informed assessment of new reproductive technologies, both in the contemporary setting and in the longer term.

This conviction is strengthened in the face of a near complete exclusion of both feminist and social science perspectives from recent public debate in Britain concerning the new reproductive technologies.[9] It is for this reason that a focus on the shaping of the terms of public debate is seen as critical. It is clear not only that the terms of current debate exclude feminist and social science perspectives, but that they are indeed *pre*cluded to a certain extent by the terms which have been set. Equally evident, however, is the widespread awareness of the inadequacy of current public debate. This point, for example, was

often raised in parliamentary debate about new reproductive technologies, in which a surprising, and in many ways refreshing degree of open recognition was afforded to the lack of any clear foundation for decisionmaking. Although these matters are explored in more depth in Chapter Eight, it is appropriate to state here simply that even amongst those currently empowered to legislate on these matters, the inadequacy of the terms available for so doing is widely recognised. Similarly, within feminism, it is increasingly accepted that the dilemmas posed by new reproductive technologies will not simply be resolved by applying outdated axioms or slogans to novel problems. Hence the need for a refashioned feminist engagement with the issues of reproductive control at stake, a task to which this thesis is, above all, addressed.

The Emergence of Public Debate

As noted above, the British context is notable for the near total exclusion of feminist perspectives from public debate of new reproductive technologies.[10] There are several reasons for the lack of greater feminist participation, or even recognition of feminist perspectives, within recent debate despite the evident attention this subject has received within the feminist literature. To begin with, debate has been structured very much around the perceived need for legislation, for some form of regulation of new techniques such as IVF. With the birth of Louise Brown, it is argued, so too was born a 'legislative vacuum' that needed to be filled. Once removed from the dark continent of the woman's body, and brought under the light of

scientific scrutiny, conception moved into the path of public scrutiny, whereupon the need for regulation became inescapable.

To accomplish this aim, the British Government duly established a Committee of Inquiry into Human Fertilisation and Embryology headed by Mary Warnock in 1982. This Committee reported to Parliament two years later, in 1984. On the basis of its recommendations, the Government published a Consultation Paper in 1986. This was follwed by a White Paper (proposed legislation) in 1987. In 1989 the Human Fertilisation and Embryology Bill was introduced into Parliament and became law in November of 1990. During the process of legislation, various other events took place. 1985 saw the passage of the Surrogacy Arrangements Act prohibiting commercial surrogacy in the wake of attempts to establish a private service industry in Britain matching prospective surrogate mothers with host clients. 1986 saw the introduction of Enoch Powell's Unborn Children (Protection) Bill, a Private Member's Bill designed to ban research on embryos, and the emergence of a powerful medical-scientific lobby in response. In the meantime, a Voluntary Licensing Authority was established by the Medical Research Council and the Royal College of Obstaetricians and Gynaecologists at the request of the Government in response to the recommendation of the Warnock Committee to provide interim regulation of embryo research and infertility services pending the conclusion of the legislative process. Presently, this function has been assumed by the Human Fertilisation and Embryology Authority which published its first Code of Practice in the summer of 1991.''

As the 'legislative vacuum' was gradually filled, so too were the pages of the nation's press, which began to carry news and features on

new reproductive technology. In the wake of the birth of Louise Brown, which initiated a new kind of media conception coverage, a 'news vacuum' was also brought into being which needed to be filled. Both media coverage of the new reproductive technologies and the debate on this topic in Parliament were key components in the emergence of public debate both here in Britain and elsewhere, comprising an important site in which the meaning and significance of scientific developments in the field of assisted reproduction are culturally shaped. Assisted conception's entry into public debate, Parliament, and the nation's television screens via the emergence of the new reproductive technologies has resulted in the emergence of new cultural constructions of its meaning. Making law and making news have required new ways of making sense of reproduction.

Public debate can thus be seen as both a process of making sense out of the 'new conceptions' produced within the field of assisted reproduction, and, because by definition it is public, a 'window' on this process, through which the foundational assumptions shaping ways of understanding are made explicit. Public debate about the new reproductive technologies has both produced and required new ways of thinking about reproduction. However, some ways of making sense are more privileged than others. Both the media coverage of new reproductive technologies and parliamentary debate concerning them were structured around particular forms of expertise. Professional medical and scientific authority were the most privileged among these. They were seen to provide the neutral, objective and factual basis for discussion. In the arena of ethical opinion, a different set of experts were privileged, those with philosophical or theological authority.

Lawyers, psychologists, social workers, and various other professionals were called upon at various points, and their contributions weighted accordingly. 'Lay' opinions, of various sorts, were generally regarded as less authoritative.

One of the reasons, then, that feminists have been so unsuccessful in making interventions into public debate is because feminism, as a critical political stance, is not recognised as a proper form of expertise. This may explain in part why feminists have written so many books about new reproductive technologies. Published work is more recognisable as authoritative. Such books often draw on the formal (professional) expertise of their feminist authors, as scientists, sociologists, psychologists and so forth.

The '-ologisation' of debate, however, is not total. There is a very important exception to this professionalisation of debate. The *only* voices which are privileged above others, in a manner similar to though not quite equalling, the privileging of experts are the voices of those who have undergone particular kinds of experience: the women and couples who have undergone IVF, or are facing the prospect of a handicapped child, or who suffer from a genetic disease they do not want to pass on. Most of all, it is the voice of the 'desperate' infertile woman which has been privileged. Who can say 'no' to her? In the face of evidence that medical science can offer assistance, in the face of Louise Brown and her thousands of similarly conceived 'siblings', who can deny her bid for hope?

Feminists, who are not proper experts as such, and whose only claim to an expertise of sorts is in terms of representing 'women's interests' are arguably *most* excluded from public debate as a result of the

privileging of infertile women's voices. This is one of the most powerful means of neutralising feminist arguments, to point to 'the women who want it'. It is, of course, important to state that this is not the result of infertile women speaking out about what they want. It is rather the result of the particular ways in which the terms of debate have been constructed, so as to selectively privilege the authenticity of the 'desperate' infertile woman's plea for medical assistance. This was even commented upon in Parliament, for example by disgruntled parliamentarians who found fault with the 'special place' such scenarios had acquired in the debate.[12]

It is now both a predictable and a well-rehearsed scenario to witness feminist expressions of concern about new reproductive technologies being met with confident reprisals from medical experts or ethicists who support the technologies that 'women want them', and that 'women have told them so', and that 'women's interests' are clearly *not* represented by feminists.[13] Indeed, it is becoming almost commonplace for IVF clinicians and researchers to argue that feminists are actually trying to define other women's interests according to their own criteria in the very same way they are accusing doctors and scientists of doing. This is an especially effective argument when put forward by a woman, be she a clinician, a research scientist or an IVF patient herself.

A slightly different version of this scenario is now familiar from feminist gatherings, where one group of women's rejection of the technologies is met with another group of women's insistance that if women want to use these technologies they have a right to do so, and that other feminists are being anti-woman and prescriptive by claiming otherwise.[14] What is indicated by both scenarios is that the issue of

who represents women's needs or desires in relation to new reproductive technologies is a highly contested one. Moreover, the forms this contestation takes are clearly impeding more effective means of addressing the implications of the new reproductive technologies for women, however various these may be. However difficult this question is, it is a critically important one, and one that is not often addressed in public debate.

The Feminist Debate Revisited

As noted above, new reproductive technologies have become a major focus of feminist concern and the subject of a voluminous literature assessing their social and political dimensions. However, as is the case with much earlier feminist theory and politics, this debate is a source of considerable disagreement amongst feminists themselves. Indeed, new reproductive technologies are a subject along which feminist analysis divides in a way that reveals much about the state of feminist theory and politics more widely. The faultlines encountered in the feminist debate over this topic, in other words, underscore wider tensions within feminism as a whole.

So, for example, despite a continually expanding feminist literature on the subject, there has been little in the way of effective campaigning strategies. The contrast is distinctly noticeable indeed between the size and scope of feminist analysis of the new reproductive technologies, and the absence of actual political organisation.

There are several reasons for this gap between the feminist literature on new reproductive technologies and feminist activism aimed

at political change. For one thing, such a gap is symptomatic of feminism having become established within, indeed some would argue moved to, the academy. The feminist literature on new reproductive technologies is part of the expansion of women's studies, which, in part because it is a professional activity, is clearly thriving in a social and political climate which was in other repects quite devastating for radical movements. Hence, the gap between numbers of pages of analysis and numbers of feet on pavements in protest is typical of the broader state of feminism in the early 1990s.

However, this latter reference raises another problem which is that of what form feminist protest should take, not only in relation to new reproductive technologies, but more generally, in relation to a changing social and political climate, a changing world situation, and changes within feminism itself. In terms of reproductive technology, for example, whilst it is still possible and necessary to emphasise the ways in which it confirms much previous, and now longstanding, feminist concern about the patriarchal control of women through control of reproduction, it also raises issues that do not fit easily into familiar feminist frameworks. Moreover, the new reproductive technologies raise issues that bring some of these very frameworks into question.

One example of this are assumptions concerning choice. Whereas a woman's right to choose was, and still is for many, a basic campaigning focus for feminists active in the area of reproductive politics, the uses of this strategy have become quite problematic. The discourse of individual rights to which this slogan belongs, for example, has now been extended to embryos, fetuses, children and fathers, as well as the state itself. If women are going to have the right to choose, then so

must other parties to the reproductive process, it is claimed. If a woman's right to choose was not unproblematic to begin with, such as in relation to black women whose right *not* to choose abortion was at issue, it is even more problematic now with the proliferation of reproductive choices. The current proliferation of new reproductive technologies can be interpreted as offering women more choices than they ever dreamed might be possible.

Conclusion

In sum, then, it has been suggested that there are several ways in which feminist concern about the impact of new reproductive technologies has been excluded from public debate. This has been because of the terms through which public debate has been structured to privilege certain forms of expertise, through which certain parameters are established. In addition, there is a privileging of the voices of women who desire new reproductive technologies within public debate, and this is used to dismiss feminist attempts to make critical interventions into debate. Furthermore, the question of women's interests in relation to these technologies, and the issue of women who want to use techniques such as IVF, which are seen by other women to be damaging to women's interests as a group, is divisive within feminism itself.

It is important to note that this is by no means the only situation in which there is no consistency in women's or in feminists' attitudes and behaviour. After all, such situations are ubiquitous within feminism, in relation to marriage, heterosexuality, motherhood, etc.. Some women see some or all of these as oppressive institutions women

should resist, other women want to effect change from within them, other women think they can be a source of power to women (although there is wide disagreement about the forms, nature and limitations of such power), and certainly lots of women want to participate in them despite what other women or feminists think. A more useful way to conceive of the problem, it is argued here, is to examine the ways in which the terms of public debate are structured so as to produce particular versions of women's interests, to the exclusion of others. This is part of a larger argument that new forms of cultural representation are one of the major components of the changed political landscape in which feminism is now located. Consequently, a greater appreciation of their significance is critical to the kind of refashioned engagement with the politics of reproductive choice and control at issue in debates about the new reproductive technologies.

The concerns raised here are both multiple and intersecting. They are held together by a concern about the terms of debate over the new reproductive technologies, and the cultural and political dimensions of these. Specifically, the question of how women's experience of IVF is defined and represented constitutes the empirical focus of research.

These concerns are reflected in the structure of the thesis. In Chapter Two, a review of the feminist debate over reproductive technology is presented. Chapter Three provides a more detailed discussion of the content and methods undertaken in the collection of data and the analytical development of the thesis. Chapter Four examines popular representations of IVF and presents an analysis of how these are framed in terms of narrative and discourse. Chapters Five through Seven contain the findings of a study of women's experience of

IVF based on ethnographic interviews with women undergoing the technique, as well as observations at IVF clinics. Chapter Eight returns to the question of public debate, refocussing on the questions raised in Chapter Four concerning the way representations of women's experience of IVF played a key role in contestations over the legitimacy and regulation of new reproductive technologies. In the concluding Chapter, a brief commentary and review of the main arguments and findings is provided, along with suggestions concerning the direction of future research in this area.

References to Chapter One

1. The Warnock Report, for example, refers to IVF as 'a considerable achievement' which 'at last' had 'opened up new horizons'. It also describes the 'public excitement', 'pride in the technological achievement' and 'pleasure at the new-found means to relieve, at least for some, the unhappiness of infertility' (Warnock, 1985, p. 4).

2. *Human IVF, Embryo Research, Fetal Tissue for Research and Treatment, and Abortion: International Information*, prepared for Parliament by Jennifer Gunning (the so-called 'Gunning Report'), was published in February, 1990 (London: HMSO). It provides international comparisons of legislation concerning reproduction. Its main findings are reprinted in both *The Fifth Report* of the Interim Licensing Authority, 1990 (*infra*, pp. 28-9) and in Morgan and Lee, 1991 (*infra*, pp. 86-87), where discussions of international dimensions are also to be found.

3. Similar to the feminist literature in its recent and rapid emergence, particular in the form of anthologies, is the literature on the legal, theological and ethical dimensions of new reproductive technologies. Representative texts of this literature would include: Carter, 1983; Downie, 1988; Singer and Wells, 1984; Walters and Singer, 1982. Some of this 'ethical' literature overlaps with feminist literature, including: Chadwick, 1987; Morgan and Lee, 1989. Another branch of this literature is the theological literature on the morality of embryo research, such as: Dunstan and Sellers, 1988; Ford, 1988; and many documents produced by religious bodies, such as the Church of England Board of Social

Responsibility. For legal discussions, see McLean, et al, 1990; Morgan & Lee, 1989, 1991. For medical/medical ethics approaches, see: CIBA Foundation, 1986; Edwards, 1989; Fishel and Symonds, 1986; Grobstein, 1981. See also: Glover, et al, 1989; Snowden and Mitchell, 1981; Snowden, et al, 1983 (for a feminist approach to medical ethics in this area, see Sherwin, 1989).

4. The only assisted reproductive technique that has been refused endorsement in Great Britain is surrogacy, although only commercial surrogacy is officially banned through the Surrogacy Arrangements Act of 1985. This was the first piece of legislation to be produced in the wake of the Warnock Report, and was passed through Parliament in haste with a view to preventing the establishment of a surrogate service industry in Britain. As has been noted by Maureen McNeil, it is significant that surrogacy, one of the least 'technological' (indeed not necessarily technological at all), and therefore potentially one of the most accessible techniques included under the umbrella of 'new reproductive technologies' (although it is also not 'new'), was among the first to be banned. The argument here is that the banning of this technique constitutes part of the attempt to ensure that reproductive intervention remain the province of professional experts, rather than being made more open to 'populist' uses.

5. Although feminist arguments received little attention in public debate, it is inaccurate to claim they have been entirely excluded. It is rather the terms of their, albeit rare, inclusion which are of some interest. These are discussed at greater length in Chapter Eight.

Often, inclusion of feminist arguments is motivated by non-feminist ends, for example in the most extreme case of Sir Bernard Braine, whose arguments in Parliament were motivated by a right-to-life position on abortion, disingenuously, and wildly inaccurately, citing the work of FINRRAGE in the name of protecting 'women's interests'.

6. In vitro fertilisation, or IVF, is the technique whereby eggs are removed from a woman's body and fertilised 'in glass' before being returned to her womb. A more detailed description of the technique is provided in Chapter Five.

7. For recent feminist discussions of 'the category woman', see Butler, 1990; Riley, 1988; Spelman, 1988.

8. For a discussion of recent feminist debates concerning reproductive technology, and the divisions these have caused, see Berer, 1986; Donchin, 1988; Franklin and McNeil, 1988; Rapp, 1988; Snitow, 1990; Stanworth, 1990.

9. For a discussion of social science perspectives on assisted reproduction, in particular their absence from mainstream debate, see M. Stacey, ed., forthcoming.

10. The lack of feminist participation, or even recognition of feminist perspectives, within recent public debate of new reproductive technologies in Britain is usefully illustrated by comparison to other countries. For example in Australia and Canada, explicitly feminist

perspectives, and representatives of these, have been included in many official committees concerned with the regulation of new reproductive technologies. To a lesser extent, this is also true in the United States, particularly at the level of State government. In Western Europe also, many countries have made formal efforts to solicit and incorporate feminist perspectives, especially in Germany, Spain, Denmark and Sweden. However 'token' such efforts may have been, there has at least been official recognition of the views of feminists on this question, which cannot be claimed of Britain, where, with the exception of the Women's Health and Reproductive Information Service submission to the Warnock Committee, no such recognition or inclusion has even been attempted. The most significant example of effective feminist campaigning is that of the Forum Against Oppression of Women in the state of Maharashta in India, who successfully lobbied for state legislation to ban the use of amniocentesis for sex-selection.

11. For a comprehensive account of the Human Fertilisation and Embryology Act, and related legislation, see Morgan and Lee, 1991. For a critical feminist perspective, see Spallone, 1989.

12. As stated in Parliament for example, 'The joy of those who...achieve a baby through IVF...is developing a special place in thisargument' (House of Lords, *Official Record*, 7.12.89, c. 1028). For the full text of this extract and further discussion, see Chapter Eight.

13. An exemplary occurrence of this sort took place at the World IVF Congress in Paris in June of 1991, at which feminist author Gena Corea

was invited to address the assembled IVF professionals. Her characteristically vivid account of the oppressiveness to women of the use of IVF was met with several arguments which might be described as using feminist terms to attack feminist arguments. For example, she was met with the argument that she was herself prescribing other women's choices in the very same way she accused doctors of doing. She was also accused by 'pro-IVF' women in the audience (presumably women professionally involved in IVF in some way, as an increasing number of women health professionals are) of insulting other women's intelligence by assuming they were 'victims' or 'dupes'. In a crowning insult, Corea was accused by Australian IVF clinician Carl Wood of actively *causing* other women's infertility, under a category of Wood's own devising, entitled 'feminist inspired infertility', which included those women 'bullied' by feminists into thinking they were 'letting the team down' by attempting IVF, and therefore refusing treatment. In each of these examples are evident a reverse-discourse to that of Corea's feminism, whereby 'women's interests' are used to make feminist claims appear oppressive.

14. Indeed such divisions can become the occasion for further, 'self-inflicted' losses by feminists, who may resort to the scapegoating, 'trashing' or excommunication of other feminists with whom they not only disagree, but see as posing all the more of a threat because they speak in the name of a 'feminism' with which others disagree. The results of such episodes are often evident in published accounts of feminist work in this area (see note 8 above).

CHAPTER TWO

The Means of Reproduction: Reviewing the Feminist Debate

Introduction

As noted in the Introduction, there is a notable contrast between the near total exclusion of feminist perspectives from current public debate over new reproductive technologies and the quantity of feminist literature on this subject. The lack of attention to feminist voices, in other words, can hardly be said to result from feminist neglect of this highly contentious area of debate. The feminist literature on new reproductive technologies, to the contrary, is one of the most comprehensive and far-reaching sources of analytical and scholarly work on their social, ethical and political dimensions. This makes particularly noticeable the fact of its having been largely ignored in public debate in Britain.[1]

In addition to documenting the scope and content of this literature, this Chapter seeks to locate it within the context of a longstanding concern within contemporary western feminism with the control of reproduction as a source of women's oppression. A second aim is to examine this literature with a view to identifying in more detail the sources of divisions amongst feminists over the subject of new reproductive technologies. As noted in the Introduction, this became the subject of feminist concern at a time, in the mid-1980s, when

feminism itself had already begun to undergo major changes. In addition, the wider context within which feminist struggles took place was also altered. As a result, the sources of division between feminists on the subject of new reproductive technologies are not only significant in themselves, but are indicators of wider processes of change. In this sense, the debate over reproductive technology has become something of a barometer of changes within feminism more broadly (see Snitow, 1990; Stanworth, 1990).

The Chapter begins by reviewing early feminist approaches to reproduction before moving on to the feminist debate over new reproductive technologies. A discussion of selected texts is then used to illustrate some of the basic differences in approach developed by feminists addressing different aspects of new reproductive technology. This section is set out chronologically, in order to illustrate the development of feminist perspectives in this area, which in turn illustrates sources of both continuity and change. The Chapter concludes with a discussion of the role of 'women's experience' within the feminist debate over new reproductive technologies, and a discussion of other feminist studies of women's experience of IVF.

The Means of Reproduction

Reproduction has been a central concern within feminism, as part of a general concern with 'body politics', from the beginnings of the most recent, 'second wave', of western feminism. Central to feminist theory and politics of this period has been a recognition that specifically patriarchal forms of control over women are effected through particular

constructions of women's bodies, primarily in terms of the construction of sexuality and reproduction, which are seen as foundational to constructions of gender and sexual difference. Insofar as the construction of gender and sexual difference in 20th century western culture can be seen in terms of the deployment of a strictly bipolar classification system authenticated through the 'facts' of sexual difference, which are seen to be both bodily and embodied, and therefore 'essential' or inherent, it was virtually a foregone conclusion that struggles around the definition of women's bodies would lie at the heart of the most recent western feminist movement (see Jacobus, et al, 1990; for a challenge to this, see Butler, 1990).

Indeed, given the particular ways in which the construction of gender is founded on notions of bodily differences, the entire feminist project can be seen as 'body politics' in its broadest sense. As Gayle Rubin long ago pointed out, feminist definitions of patriarchy as a form of power concern what she describes as 'the sex-gender system', defined as the means through which sexed individuals are produced according to a bipartite gender system (Rubin, 1975). Following de Beauvoir ('one is not born, but rather becomes, a woman', 1974, p. 301), and abetted first by structuralism (Ortner, 1974; Rubin, op. cit.), and later by post-structuralism and psychoanalysis (Braidotti, 1989; Miller, 1986; Rose, 1986), the binary 'grammar' of patriarchal social relations was exhaustively deconstructed.

The ways in which reproduction has figured in the production, maintenance and enforcement of the patriarchal 'sex-gender system' have received considerable attention from feminist researchers. A major trajectory of feminist scholarship has been directed at the historical

process through which midwifery was displaced by male-dominated medical forms of intervention into childbirth (Donnison, 1977; Ehrenreich and English, 1973a, 1973b, 1978; Oakley, 1980, 1984, 1987). According to these arguments, the displacement of midwives was both motivated by, and consolidating of, a redefinition of the birth process in which the crucial actor became the doctor to the detriment of women, who became passive objects manipulated by male medical birth 'managers'. This theme has been extended in more recent studies of childbirth focussing on the ways in which 'management' of the birth process by medical professionals reduces women's control over the birth process and privileges a medical definition of what is a 'necessary' intervention, such as induction or caesarian section (Arms, 1975; Garcia, et al, 1990; Oakley, 1987; Rothman, 1985). The extent to which this remains a site of ongoing contestation is much in evidence. The recently celebrated case in Britain involving precisely this contested area of reproductive choice and control, for example, was that of Wendy Savage, an obstaetrician who was accused by her male colleagues of professional malpractice for failure to intervene 'adequately' during her patients' deliveries (Savage, 1986).

Such an episode reaffirms the central argument of feminists who claim that the forms of expertise which have come to define the reproductive process derive from a male-defined, or patriarchal, point of view which enhances the agency and authority of the male-dominated medical profession at the expense of women's ability to define their own needs during pregnancy and childbirth. This process is seen to have its roots in a number of historical factors, including the mechanistic ethos of the scientific foundation upon which medicine is based (Laqueur,

1990; Martin, 1987), the association of midwifery and healing with witchcraft (Easlea, 1980, 1981; Ehrenreich and English, 1978), the need for the medical profession to legitimate itself by establishing its authority (Donnison, op. cit.), or simply the existence of an inherently patriarchal desire on the part of men to control the reproductive capacity of women (Mies, 1986; O'Brien, 1981; Rich, 1976).

A more recent trajectory which extends the male-medical-takeover-of-the-birth-process literature is that concerning fetal personhood. According to these arguments, the fetus has emerged as a patient in its own right during the process of pregnancy and childbirth, leading to an even greater diminishment of women's agency during the birth process. The emergence of the fetus as an 'independent' entity is also seen to create the potential for (or indeed inevitablity of) conflict between the fetus and its 'host', and a view of the fetus as threatened by its 'maternal environment'. Court cases in which women have been forced to undergo caesarian sections against their will, in the interests of the fetus, have been seen by feminists as evidence of the dangers to women's reproductive rights posed by the emergence of fetal rights (Gallagher, 1985).

The concept of fetal personhood has also been analysed in relation to the abortion struggle, in which it has been argued that the image of the fetus is used to bolster patriarchal definitions of fetal interests at the expense of women's reproductive rights (Duden, forthcoming; Franklin, 1991a; Hartouni, 1991; Petchesky, 1985, 1987; Raymond, 1987; Taylor, in press). Importantly, the feminist analysis of fetal personhood locates the emergence of the fetus-as-patient in the same matrix of patriarchal control over reproduction through medicine

identified in the earlier literature about midwifery. The 'fetalisation of reproduction', in other words, is seen as both a symptom and a product of its redefinition through the powerful expert language of patriarchal medicine. Both technologically and discursively, in terms of monitoring and surveillence, the birth of 'fetology' has been seen by feminists as a variation on the familiar theme of medical management of pregnant women. As women are increasingly subject to pressures to modify their behaviour while pregnant, in the interests of their fetus (see McNeil & Litt, 1991), so reproductive control can be seen to have been extended back from the moment of childbirth itself into the earliest stages of pregnancy, and even pre-conception (see Figure 1, *infra* pp. 28-9).

Reproductive Technologies and the Politics of Knowledge

The emergence of a feminist literature specifically concerned with new reproductive technologies also has its roots in the feminist critique of science. Because of its importance to the definition of gender and the construction of sexual difference, biology has long been subjected to criticism by feminists who have challenged its deterministic models of 'woman's nature' and 'woman's proper place' in society (Birke, 1986; Bleier, 1984, 1986; Brighton Women and Science Group, 1980; Fausto-Sterling, 1985; Haraway, 1978a, 1978b, 1979, 1981, 1983a, 1983b; Hubbard, et al, 1982; Keller, 1984; Liebowitz, 1978; Lowe and Hubbard, 1983; Sapiro, 1985). Many of the earliest feminist critiques of science focussed upon biology and the critique of biological determinism in various branches of science including genetics

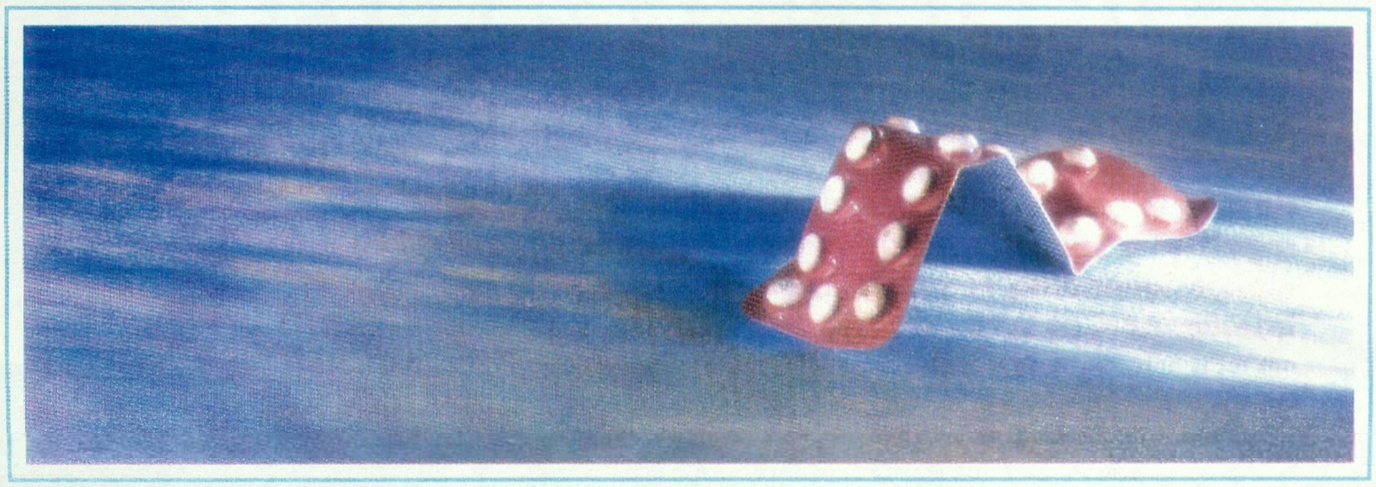
Figure 1 (see overleaf)

Figure 1 'Starting a Family...'

As the management of reproduction is extended to include pre-conceptive monitoring products such as this one, pregnancy is increasingly seen as dependent upon the assistance provided by technology, and as something to be achieved.

Many women find that becoming pregnant isn't as simple as just stopping contraception - in fact, it can take one couple in six a year or more. That's because you can only conceive around the time you ovulate. And if you don't know when those crucial 2 or 3 days are, your chances of getting pregnant may be reduced.

STARTING A FAMILY ISN'T ALWAYS THIS EASY



IMPROVING YOUR CHANCES CAN BE

Now there's a new home ovulation prediction test that can precisely identify your fertile days.

Clearplan One Step monitors the level of the special hormone that triggers ovulation. But unlike any other home ovulation test it's amazingly easy to carry out; without the need for recording charts, separately collecting urine or messing around with test tubes.

You just hold the sampler in your stream of urine for a few seconds. Replace the cap and, after 5 minutes, compare the lines in the two windows:

If the line in the large window is paler or not visible, you're not about to ovulate.

If the line in the large window is a similar or darker blue, you should ovulate in 24-36 hours.

In this way you'll know, in advance, which is your most fertile time.

Clearplan One Step is 98% accurate in detecting the hormone rise that precedes ovulation. And it's also extremely convenient to use since you can test at any time of the day.

You can get Clearplan One Step from Boots and other leading pharmacies.

Because, if you're trying to become a mother, Clearplan One Step could bring you a step nearer.

The simplest, fastest way to know when you're most likely to get pregnant.

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(Hubbard and Lowe, 1979; Tobach and Rosoff, 1978, 1980); primatology (Haraway, op cit; Herschberger, 1970; Tanner, 1976; Zihlman, 1978); gynecology (Bart, 1977; Daly, 1978); and obstetrics (Ehrenreich & English, op. cit.). This continues to be an important focus of the feminist critique of science as is evident in recent studies of gynaecology (Laqueur, 1986; Moscucci, 1989); embryology (Duden, forthcoming); primatology (Haraway, 1989, 1991); and skeletal morphology (Schiebinger, 1989).

Alongside this literature on biological science has developed a related and overlapping literature on the epistemology of science. Whereas biological science has largely been criticised in terms of the extent to which it serves patriarchal interests by *authenticating* a patriarchal worldview (ie through biological determinism), the critique of scientific epistemology is often expressed as a critique of patriarchy *itself*: that is, its mode of *defining* 'reality'. The privileged standpoint of objectivity, for example, is seen by some feminists as a definitively masculine mode of knowing, premised upon a detached, separate vantage point and defined primarily in terms of vision (Jordanova, 1989; Keller, 1983, 1985). Objectification, as the foundational practice of scientific inquiry, is seen to be replicated by, and implicated within, other patriarchal practices of objectification, such as the sexual objectification of women (MacKinnon, 1982). Objectification as a form of control, (mis)represented as a form of neutrality or impartiality, is not only seen as a symptom of patriarchal culture, but as a crucial means through which patriarchal power 'makes itself true' (MacKinnon, op. cit.). In other words, objectification has come to be seen as a form of patriarchal power in

and of itself, and science to be seen as one of the key sites of its legitimation and deployment.

Scientific knowledge as a form of patriarchal power, even its quintessence, is also a view expressed in historical accounts of the emergence of patriarchal science. In these accounts (Fee, 1981; Haraway, op. cit.; Easlea, op. cit.; Jordanova, 1980, 1989; Martin, op. cit.; Merchant, 1980; Schiebinger, op. cit.; Shiva, 1988), science is seen as an instrumental expression of an Enlightenment ethos characterised by a polarised construction of reality, in which masculinity is equated with rationality and defined by control over 'feminine nature' (see Harding, 1986; and Schiebinger, 1987 for reviews of these debates). The Baconian view of nature in terms of a mechanistic analogy, and knowledge in terms of masculine power or potency, are seen as evidence of a conflation between knowing and dominating which is seen to be definitively patriarchal (see Franklin, 1987 for a selected bibliography emphasising the links between the feminist analysis of new reproductive technologies and the feminist critique of scientific knowledge).

Yet another trajectory of feminist analysis concerned with the ways in which patriarchal reality is enforced through control of knowledge and bodies is that which emerged out of the early women's health movement. An exemplary parable here is that of the Boston Women's Health Collective. Originating in the mid-1960s, this collective began as a discussion group concerned with women's experience of medical treatment. Dubbed 'the doctor's group', the lack of control women experienced over basic health issues, and their anger at the male-dominated medical profession, led to an identification of 'women and

their bodies' as a focus. In the attempt to challenge male-medical control of information related to women's health, and to increase women's autonomy from the medical profession, the collective began to compile a basic feminist health primer. This was eventually published in 1971 under the title *Our Bodies, Ourselves*, and has ever since remained a much-valued feminist resource which continues to be kept up-to-date and in print through serial re-editions, whilst also having been translated into many other languages. This evolution, from 'women and their bodies' to *Our Bodies, Ourselves* illustrates succinctly the process through which 'body-politics' became increasingly central to early, 'second wave' feminist theory and politics (see further, Corea, 1977; Dreifus, 1977; Gordon, 1976; Roberts, 1981).

The enormous feminist literature addressing women's health issues continues to be based on the link between control of knowledge and control of women's bodies. In the power to name and define women's anatomy is seen to lie an essential component of contemporary patriarchal structures. Hence, the move to empower women both through challenging patriarchal constructions of women's bodies, and through giving women access to alternative, more empowering, constructions, has a long history within recent feminism (for a selected bibliography on women's health literature, see Henifin and Amatniek, 1982). From the feminist-inspired artwork of Judy Chicago; to consciousness-raising groups, equipped with speculums for collective self-examination; to feminist health campaigns and organisations, the politics of women's health was a politics of body-knowledge as power.

The most important single issue within the women's health literature is control of reproduction. It is therefore closely linked not only to

the critique of biological determinism, and the analysis of scientific epistemology, but to the campaign literature devoted to reproductive rights. Abortion, sterilisation abuse, and population control programmes were and remain key issues in the feminist analysis of reproductive politics (see Fried, 1990; Hartmann, 1987; Lovenduski and Outshoorn, 1986; Petchesky, 1984). Reproductive politics, and reproductive health were the lynch-pin issues linking feminist theory and practice across a range of diverse issues.

New Reproductive Technologies

All of these trajectories converge in the feminist literature on reproductive technology. Two edited anthologies published in the early 1980s, *Birth Control and Controlling Birth* (Holmes, et al, 1980) and *The Custom Made Child* (Holmes, et al, 1981) were the first feminist volumes to focus attention specifically on reproductive technology. But it was not until a few years later, in the mid-1980s, that this literature began rapidly to expand. 1984 saw the publication of *Test-Tube Women* (Arditti, et al), subtitled 'What Future for Motherhood' and containing thirty-three short contributions from a range of feminist perspectives. In 1985, Gena Corea published *The Mother Machine: From Artifical Insemination to Artificial Wombs*, the first major feminist study of reproductive technology, and in 1986 Barbara Katz Rothman published *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*, the first feminist analysis of women's experience of a particular technology (ammiocentesis).

Together, these and many other feminist critiques of reproductive technology launched a major debate within feminism which continues to expand. In these early texts were also evident the major themes which would come to define this area of feminist debate (for review articles, see Donchin, 1988; Franklin and McNeil, 1988). *Test-Tube Women*, the most well known early 'feminist primer' on the subject of new reproductive technologies, illustrated in its very composition the dilemmas that were to beset feminists in this field. A forceful introduction, in which 'the *real* message for women' (p. 5, original emphasis) of reproductive technology is stated ('we are *all* at risk of becoming *Test-Tube Women*', p. 6, original emphasis) opens the volume. Finishing with an equally trenchant conclusion charting the way forward (separatism), the framing of the volume is unequivocal in its stress on the need for feminist opposition to the new reproductive technologies. Yet, the contents of this volume are far from unanimous or certain about 'whether we as feminists should endorse [these technologies] or [whether they are] just one more way to keep women subordinated to male control' (p. 1). In spite of all of the reasons women are cautioned about the dangers of new reproductive technologies by the contributors to this volume, little by way of consensus is evident about what should be done about them. Indeed, the strategies on offer are not only multiple, but contradictory. From the argument that 'new reproductive technologies may be the key to more positive, functional ways of raising children' (Breeze, 1984, p. 397), to the argument that reproductive technologies exemplify the reification of man-made femininity (Raymond, 1984, p. 433), and with several shades of gray in between, the anthology is a primer in more than one sense. It contained not only the

earliest seeds of feminist analysis, but it also expressed in its very structure, in the contrast between the certainty of the framing chapters and the far less certain or unified content in between, the character of feminist debate in this arena -- an arena in which the paradoxical reality of women's enmeshment in the very culture many of us hope to change is everywhere apparent.

Barbara Katz Rothman, in her contribution to *Test-Tube Women* concerning pre-natal diagnosis, shows a particular sensitivity to the paradoxes created by the new reproductive technologies. On the one hand, she argues, they undoubtedly create more reproductive choices for women. Yet they also both diminish and change the character of reproductive choice. In the face of the possibility of having much more information about the fetus, women are suddenly made aware of the need for the right *not* to have information, such as undesired information about the sex of the fetus, or traumatic information such as an ambiguous diagnosis. In the face of prescriptive choices, where a woman may be held responsible for the outcome of, for example, not having chosen amniocentesis, choice becomes a means of women's subordination rather than empowerment. Rothman argues for a continuing emphasis on the need for information and choice, whilst at the same time a need critically to deconstruct the context in which information and choice are situated. She argues that it is a continuing necessity to fight for women's right to choose, and to define their own needs in relation to childbirth. She concludes:

> We must not get caught into discussions of which reproductive technologies are 'politically correct,' which empower and

which enslave women. They ALL empower and they ALL enslave, they can be used for or against us. (Rothman, 1984, pp. 32-3)

This claim is elaborated in Rothman's subsequent study of women's experience of amniocentesis (1986). Using interview data, she provides a detailed account of the ways in which pre-natal screening and diagnosis transform the experience of pregnancy. Her title, *The Tentative Pregnancy*, refers to the way in which women's experience of pregnancy is rendered ambivalent by undergoing amniocentesis, as a result of which they must live with the possibility of a termination until late in their pregancies. She also raises a number of other issues, such as the experience of having to make difficult choices based on inadequate or partial information; the taxing demands of 'risk assessment' in the context of new and to a certain degree experimental techniques; the impact of learning the sex of the fetus during pregnancy; and a range of other issues.

Her conclusion is itself also 'tentative'. For some women, she insists, 'pre-natal diagnosis and selective abortion are the best answer', yet, she continues, this solution is 'costly' (p. 238). Even if these technologies do offer 'solutions', Rothman argues, it is also necessary to evaluate how such a 'solution' comes to be seen as such. Hence, on the one hand, women's choices to opt for new technologies such as amniocentesis need to be supported, as Rothman does in her appendix, providing 'Guidelines for Personal Decisionmaking'. Yet, on the other hand, the costs of the technique and the reasons why it comes to be seen as desireable must continually be subjected to critical scrutiny. Rothman's conclusion is composed of two elements: support for women in the short term through established means of feminist intervention, i.e.

in the provision of information and support for a woman's right to choose what she defines as in her best interest; and a more long term process of challenging the terms through which women's choices are constructed.

A far less equivocal account is presented by Gena Corea in *The Mother Machine* (1985), an investigation of the other side of reproductive technologies, that is, its producers rather than its consumers. In this account, the beneficent and therapeutic 'foreground' of new reproductive technologies is portrayed as veiling a far more sinister 'background' of corporate profiteering, reckless experimentation and abuses of women and animals. In her account, Corea provides a disquieting tour of the institutional and professional infrastructure supporting the development of reproductive and genetic engineering. Critical to Corea's account and analysis is the embeddedness of new reproductive technologies within an emergent bio-industry in which control of the means of reproduction has become a fiercely competitive futures market. Descriptions of 'bombing' ovaries with fertility drugs to produce 'ovulation to order' (p. 109); of 'recruiting', 'harvesting' and 'capturing' ova in women (p. 103); of sending embryos into outer space (p. 116); or of 'the biological manufacture of a human being to desired specification' (p. 133) directly contradict the image of benevolence and concern for the infertile through which reproductive technologies are publicly legitimated. Deftly utilising the words of the new 'reproductive pioneers' themselves concerning the new 'frontiers' they are busily engaged in colonising, Corea's aim is to expose both the scale of what is at stake in terms of

new reproductive technologies and the unsavoury character of the ethos motivating 'progress' in this field.

In Corea's account, the new reproductive technologies, the bioindustry of which they are a part, and the ethos underlying the development of both are seen to be the product of an essentially male desire to control the reproductive process. This is based on the work of Mary O'Brien (1981), who draws a distinction between women's continuous reproductive experience and men's discontinuous one to locate the source of the male quest to control reproduction and to refashion it in their own image, as it were. This argument in turn invokes the kind of critique of Baconian science encountered in the feminist literature on science discussed earlier.[2] According to this view, reproductive technologies are themselves, like gynecology and obstetrics, not only *products* of a patriarchal society, but *expressions* of patriarchal male desires, that is, *inherently* patriarchal. Such an argument is difficult to reconcile with Rothman's view that feminist support for women who choose reproductive technologies is a continuing necessity. From the point of view articulated by Corea, such support is facilitating patriarchal control of reproduction not only by endorsing it, to whatever limited degree, but by providing it with the 'raw material' it needs through women's continued participation in patriarchal experiments.

Technology, Culture and the Paradoxes of Patriarchy

The only way to reconcile these two positions is to argue for a paradoxical appreciation of women's relationship to patriarchy, whereby

short-term strategies of accomodation may well contradict long-term struggles for change but are nonetheless still necessary. This is more Rothman's position than Corea's. However, it is also useful to note the different models of patriarchy suggested by the two accounts. In Corea's account, patriarchy is seen to be of a piece, continuous and more or less unified. It has purpose, direction, motivation and goals. It is seen as a historical process which would reach its 'culmination' in the establishment of 'the reproductive brothel', 'the capture of maternity' and 'the defeat of the womb', which are the titles of chapters 14, 15 and 16 in *The Mother Machine*.

Rothman argues precisely the opposite. In her account, reproductive technology is not inherently patriarchal, indeed it is not inherently anything, it is merely an avenue of possibility. She writes:

> I am not claiming that the technology is itself harmful. I think that the new technology of reproduction offers us an opportunity to work on our definitions of parenthood, of motherhood, fatherhood, and childhood, to rethink and improve our relations with eachother in families. Freed from some of the biological constraints, we could evolve better, more egalitarian ways of relating to ourselves and eachother in reproduction. The technology is a promise, beckoning us with new possibilities...giving us new control. (Rothman, 1986, p. 3)

New reproductive technologies are thus, according to Rothman, no more 'inherently' patriarchal than abortion is 'inherently feminist' (see p. 31). If prenatal diagnosis is, for Rothman as for Corea, 'very much part of the history of patriarchy, [of] men's struggle to gain control

over their "seed", and thus...over women's reproductive capacities' (p. 23), it is also for Rothman, *unlike* Corea, equally 'part of feminist history, [and] women's increasing right to control her reproductive capacity' (p. 23). Hence, while both Rothman and Corea argue that reproductive technologies are patriarchal, both their models of technology and of patriarchy differ, as, correspondingly, do their conclusions. For Corea, for whom patriarchy and reproductive technology are synonymous, the one is the expression of the inherent principles of the other, and the means of implementing the other, and the two are part of one whole. For Rothman, reproductive technology is *part* of patriarchy, but not an expression *of* it, and though interrelated, the two are separate.

In addition to different models of technology and different models of patriarchy, Rothman and Corea also need to be distinguished in terms of their concerns and foci. It is not suprising in many ways that Corea's analysis is much more deterministic, conspiratorial and monolithic given her focus. In other words, the powerful, male-dominated, professional corporate industry Corea investigated *is* to a large extent more deterministic, conspiratorial and monolithic. Compared to women undergoing amniocentesis, whose minimal agency and power Rothman sought to maximise, both in terms of how she represented them and what her book aimed to do, the power-brokers of Corea's account are of a different order altogether. Any recognition of patriarchal power must see both sides of patriarchy in this sense: how it is determining and monolithic, and how it is partial and contradictory.[3] Feminist change is inspired by both recognitions: of patriarchy's strength, and of patriarchy's weakness. It is likewise inspired by the

well-worn recognition that women do make their own choices, if not always on their own terms.

Nonetheless, these two accounts, arguably the two most important 'groundbreaking' feminist accounts of reproductive technology, exemplify, as do the contrasts in *Test-Tube Women*, the tensions and potential conflicts which have beset the feminist debate over new reproductive technology since its inception. Addressing opposite sides of assisted reproduction, providing very different accounts of patriarchal power and technology, and offering very different strategies for change (and represented in chapters back to back in *Test-Tube Women*) these two 'germinal' feminist accounts provide a microcosm of the many paradoxical characteristics of the feminist debate over reproductive technology. Clear too is the extent to which these differences between feminists can be read as either oppositional or complementary. The one can be seen as the flip side of the other, or they can be seen as irreconcilable positions -- the one (Rothman) as 'pro-NRTs' and as 'colluding' in their routinisation; the other (Corea) representing a more radical 'anti-NRTs' stance. In Rothman's challenge to eschew such polarised readings is evident the same potential polysemy: on the one hand it can be read as a wet form of feminist relativism, a wishy-washy liberalism, a naive optimism or a lack of political rigour; on the other hand it can be read as precisely the opposite, as a necessary caution against the simple certainties of 'naming the enemy', a hard won lesson of feminist activism, a cogent warning against the destructive consequences of 'political correctness', or a sound conclusion based on sensitive analysis.[4]

Before turning to consider one final, more recent account, of reproductive technology, it is useful to note another distinction between the accounts offered by Rothman and Corea: this is their models of culture. Neither account is specifically addressed to the cultural dimensions of the new reproductive technologies, however both can be seen as contributing to their elucidation.[5] In Corea's account, the main form of cultural analysis is best described as the analysis of *patriarchal* culture. This is not particularly distinguished from patriarchal society or patriarchal technology. Indeed Corea's analysis could well be described as a cultural analysis in this respect; in which reproductive technology is seen as an expression of patriarchal culture. It could be said her account describes reproductive technology as a quintessential expression of patriarchal culture, representing as it does the culmination of what she and other feminists perceive as an age-old trajectory of increasing patriarchal control, rooted in the discovery of paternity, and consolidated at its most potent moment in the conquest of women's reproductive capacity.[6] Corea's mode of analysis, in describing the language used in the subculture of the 'technodocs' and 'pharmacrats', in highlighting the 'logic' that makes certain possibilities 'thinkable' and 'desireable', and the subsequent means through which this worldview is implemented, can be seen as a cultural approach in this sense. It is concerned with the production of meaning, which is seen as a primary locus of power, connecting otherwise disparate social domains, such as industry, the state, the professions, the economy and technology.[7]

Rothman's analysis can also be seen as a cultural account of reproductive technology, though in a different sense. Hers could be

described as a cultural account insofar as it is ethno-methodological, that is, concerned with the ways in which actors 'make sense' of their experience in their own terms. It is also concerned with a 'subculture' of sorts, constituted by the parameters of a clinical practice, which is in turn defined by its own rules and meanings. In her concern with the ways in which women negotiate this 'subculture', Rothman's account can be seen to address the production of meaning, which in turn can be seen as a cultural focus.

In sum, then, a comparison of Rothman and Corea's accounts is illustrative of a number of differences which characterise feminist analysis of new reproductive technologies. At one level, these accounts illustrate different 'positions' or 'stances' in relation to the politics of reproduction at stake in the deployment of new reproductive technologies. These differences can, in turn, be traced to underlying assumptions concerning power, culture and technology in the context of patriarchal social relations.

The Politics of Embodiment

Emily Martin's major study of women's encounters with the medicalisation of reproduction, entitled *The Woman in the Body: a Cultural Analysis of Reproduction*, was published in 1987. As its subtitle indicates, this study represents the first major feminist account of women's experience of reproductive technology (perhaps more accurately described in this case as the 'technologisation' of reproduction) to foreground a specifically cultural focus, and to employ a method designed to foreground this focus. Martin's account is the

most ambitious feminist work to date in its attempt to combine elements from a wide range of previous feminist scholarship on the politics of reproduction.

In the first major section of *The Woman in the Body*, Martin investigates the medical construction of reproduction, with a particular focus on the metaphors through which reproduction is defined. Entitled 'Science as a Cultural System', this section contains a detailed analysis of the two definitive analogies of the medical-scientific construction of bodies in general, and reproductive processes in particular, which are those of industry and the machine. Tracing the emergence of these meta-metaphors from the classical era, through the seventeenth century Scientific Revolution to the present, Martin charts the rise of the mechanistic and industrial construction of the body to its contemporary state of predominance and ubiquity. Analysing the resultant model of reproduction, Martin argues it is organised around a specific definition of reproductive purpose and teleology, constructed in terms of a hierarchy of functions, conceptualised in a mechanical fashion, and consequently subject to continual medical prescriptions for adequate 'management'. Moreover, Martin argues, women's bodies, according to this account, are defined as badly designed and inefficient to begin with, and prone to malfunction even when they are performing their primary purpose, which is to reproduce. Finally, these models of reproduction are seen as fragmenting women's bodies into separate parts, and separating the woman from her body, both in terms of agency and identity.

The analysis of medical metaphors in the cultural construction of menstruation, menopause and birth, through which the woman's body is

described as a machine, the woman herself as a labourer, the baby as the product and the medical professional as the essential manager, leads Martin to her central question: 'How do women as they lead ordinary lives respond to scientific metaphors about their bodies?' (Martin, 1987, p. 67). In the second major section of the book, Martin explores 'Women's Vantage Point', through interviews with women about their self-image and reproductive experience. A total of 165 interviews were conducted with women of different ages, races and classes focussing mainly on menstruation, birth and menopause, or other aspects of women's reproductive identities, depending upon their experience. These interviews provide the basis for an evaluation of the extent to which women internalise or resist dominant medical constructions of their bodies. Martin's study thus brings together the two vantage points elaborated by Rothman and Corea, that is, of dominant patriarchal definitions and of women's relationships to them. It addresses both the powerful determining force of cultural (patriarchal) ideology, and the ways in which this ideology is always contradictory, and is negotiated by individual women, who are not merely passively positioned by it. Culturally, the theme of how reproduction is made sense of holds the two parts of the book together, in the first section through a focus upon the analogies which shape powerful forms of medical expertise and discourse, and in the second section in terms of how women themselves interpret their bodies and their reproductive experience.

Through the interviews, Martin demonstrates a wide range of ways that women make sense of their reproductive experience, and to these she adds her own analytic interpretations. Pre-menstrual tension, for example, is analysed in terms of women's challenges to imposed work

disciplines and women's 'inchoate rage' (p. 137). In contrast to the medical imagery of deterioration and decay, menopause is accounted for in terms of providing a 'milestone' for women, enabling transitions to be marked in women's lives and identities that may be positive and affirming. Birth stories collected by Martin and her assistants provided accounts both of the alienating and fragmenting effects of medical definitions on women's reproductive experience, but also of the ways in which women resist medical 'management' of their pregnancies. Correlating her findings about women's reproductive experience to the effects of racial and class-based social divisions, Martin emphasises the variety in women's understandings of their bodies and selves.

In concluding, Martin argues that women's reproductive experience, across the range of forms it takes, constitutes an 'embodiment of oppositions', whereby women's bodies are seen to contradict the prevailing social and cultural order, thus creating a site of potential resistance.[6] The way in which women inhabit their bodies, in other words, constitutes a form of practical consciousness from which to question 'the shape of society as a whole' (p. 201). Martin writes:

> Because their bodily processes go with them everywhere, forcing them to juxtapose biology and culture, women glimpse every day a conception of another sort of social order. (Martin, 1987, p. 200)

Women's bodily experience, Martin argues, belies the foundational oppositions of contemporary western culture: public/private; reason/emotion; mental labour/manual labour; biology/culture. She argues women's bodies also produce different meanings of time and space, confounding the distinction between linear and cyclical time, or private

and public space. These embodied contradictions are also seen by Martin to be most likely to become possible origins of resistance for women most excluded from the dominant social order, that is, the women 'at the bottom of the heap'. Such women, claims Martin, 'tend to see more deeply and clearly the nature of the oppressions extracted by those at the top of the heap' and consequently 'to gain relatively greater critical vision' (pp. 202-3). This hopeful conclusion strongly echoes the work of Adrienne Rich, whose publication *Of Woman Born* which appeared in 1976 is arguably the most substantial early feminist analysis of reproduction. It is this powerful book which provides the following headnote to Martin's account:

> I know no woman -- virgin, mother, lesbian, married, celibate -- whether she earns her keep as a housewife, a cocktail waitress, or a scanner of brain waves -- for whom her body is not a fundamental problem: its clouded meaning, its fertility, its desire, its so-called frigidity, its bloody speech, its silences, its changes and mutilations, its rapes and ripenings. There is for the first time today a possibility of converting our physicality into knowledge and power. (Rich in Martin, 1987, p. viii)

Despite the close parallels between Martin's conclusion and that of Rich, in which women's bodies are also seen as potential sites of alternative meanings and resistance, a substantial divide separates the two in terms of theory. Whereas Rich's early account of reproduction in *Of Woman Born* is concerned with motherhood and reproduction as *patriarchal* institutions (and how these are related to experience), Martin's account is primarily grounded in the analogy between control of

the means of production and control of the means of reproduction. Indeed, 'patriarchy' does not even appear as an entry in the index to Martin's book, and is not a central framework in her analysis.

True to her orientation towards analysis of political economy and 'management', Martin relies heavily on the concept of ideology, through which the 'obviousness' of oppressive and often contradictory belief systems is explained as a form of false consciousness. Martin's approach is ecclectic, drawing upon a range of approaches, and so is not meaningfully pigeonholed in any simple sense. Yet, the overall structure of her analysis, in which dominant cultural representations are analysed in terms of the extent to which they are internalised by individuals, indicates the traces within her work of a traditional (Marxist) model of ideology. Likewise, in her conclusion, which emphasises forms of 'practical consciousness' in which women's alienated *reproductive* labour are linked to forms of women's alienated labour as paid workers, the influence of Marxist-inspired frameworks is also apparent.

This influence is problematic for two reasons. Most significantly, it de-emphasises the specifically patriarchal elements in the control of reproduction. Second, though it might seem to offer a framework through which such an analysis *could* be pursued, this becomes problematic because of certain features of the methodological approach. These are twofold. On the one hand, Martin's model of culture is, again, eccelectic. It is at once anthropological, feminist and marxist. Dominant ideas are analysed in terms of their representation as texts. The reading of these texts is seen to be a cultural reading insofar as it examines the particular ways these representations are constructed

and 'make sense' through particular forms of imagery, analogy, metaphor, and so on. The texts, read as culture, are then *themselves* metonymically positioned to 'stand for' culture more generally, in the sense of dominant culture. Arguably a discursive reading might better have accomplished this task, but, although Foucault is mentioned by Martin on two occasions, his more detailed analytics of power/knowledge are not pursued in any depth. The result is a certain degree of reductionism, resulting from the limits of equating cultures with texts, and the emphasis on whether or not dominant 'ideologies' are 'internalised' by 'ordinary women'.

Martin counters this reductionist tendency through her investigation of how women selectively consume the 'messages' produced by dominant culture about their bodies. She thus avoids the kind of textual determinism often encountered in the work, for example, of Corea, in which a text is read as confirmation of a cultural process that is undoubtedly much more complex and contradictory than a simple textual extract can convey. The dangers of textual determinism are of constructing a more monolithic, unified and powerful version of dominant culture than is, in fact, possible to see through a more multi-layered analysis. Yet although Martin does not assume that texts automatically determine subject positions, and although she attends to the ways in which women actively negotiate their relationship to dominant ideas, the problem remains in the 'gap' between these two sites of cultural production. It is the way Martin structures her argument, in terms of investigating the relationship between two very distinct sets of cultural formations, which limits the kinds of conclusions she can draw. This is compounded by her strong reliance upon the concept of ideology,

as a result of which the question is reduced to that of whether women internalise dominant ideas or not.

As an anthropologist, Martin does not restrict her account to merely substantiating the degree to which women do or do not resist dominant ideology. To the contrary, she is consistently sensitive to the range of ways in which women make sense of their reproductive experience from an ethnographic point of view, and in this sense combines an anthropological model of culture, in which it is seen as an end in itself, with the idea of dominant culture, which is seen more in terms of distortion, 'veiling' or 'conjuring'. Again, Martin's is a sophisiticated and accomplished account which provides a convincing approach to a difficult problem and is thus impossible to categorise.

It is, in addition, a pioneering account in several respects. In terms of feminist scholarship it is unparalleled, and marked a certain coming of age of feminist scholarship in this area, and more generally. It is sensitive, scholarly, well-written and, in many places, both elegant and moving. It is also a pioneering account in terms of anthropology, attempting as it does to provide an account of contemporary North American culture through traditional anthropological approaches combined with methods unfamiliar to anthropology. Finally, it is a unique contribution to theories of the labour market and the debates about women's work, providing as it does an innovative thesis linking productive and reproductive labour.

Like many ambitious and groundbreaking volumes, Martin's work also serves as a transitional study. Its failings are in this sense as productive as its successes insofar as it put to the test one of the most well-established feminist models of women's relationship to

dominant constructions of reproduction.[9] One reason this volume has been considered in depth is the degree to which it informs this thesis, for example, and the productive influence of Martin's example has set for other researchers concerned with the relationship between dominant cultural constructions of reproduction and the ways these are negotiated by individual women in contemporary society.

The Expansion of Debate

The feminist debate over reproductive technology has now expanded from its early stages in the mid-80s to comprise one of the most substantial areas of contemporary feminist scholarship. Several anthologies succeeded *The Custom Made Child* (Holmes, et al, op. cit.) and *Test-Tube Women* (Arditti, et al, op. cit.). 1987 also saw the publication of *Reproductive Technologies: Gender, Motherhood and Medicine*, edited by Michelle Stanworth, and *Made to Order: the Myth of Reproductive and Genetic Progress* edited by Patricia Spallone and Deborah Steinberg. Though often contrasted as representing opposing views on reproductive technology, the former being seen as taking a more nuanced and the latter a more deterministic stance, it can as well be argued that, like the anthology *Test-Tube Women* which preceeded them, these anthologies both articulate the paradoxical dimensions of the feminist debate on reproductive technology in their overall content. If any contrasts are to be drawn, it is more between the introductory statements to these volumes than their contents as a whole, in ways not dissimilar to that discussed in reference to *Test-Tube Women* above.

1988 saw the launch of a feminist journal entitled *Reproductive and Genetic Engineering*, which provided an international feminist forum for discussion of the new reproductive technologies, and was particularly successful in widening the debate to include perspectives from Third World feminists (a process which was initiated by *Made to Order*). In 1989, the results of an extensive feminist consultation project on proposed legislation concerning the new reproductive technologies, organised by the Women's Rights Litigation Clinic of Rutgers University Law School, was published under the title of *Reproductive Laws for the 1990s*, edited by Sherrill Cohen and Nadine Taub. Several more anthologies have appeared in recent years (Bartels, et al, 1990; Baruch, et al, 1988; Corea, et al, 1985; Homans, 1985; Klein, 1989; McNeil, et al, 1990; Overall, 1989; Purdy, 1989; Scutt, 1990) as well as single and multi-authored volumes addressing a range of issues (Birke, et al, 1990; Hartmann, 1987; Overall, 1987; Rothman, 1989; Spallone, 1989, 1992). So too did the debate about reproductive technology begin to develop as a specialised literature within medical ethics, socio-legal studies and the burgeoning field of bio-ethics, which sometimes overlapped with feminist analyses, though more often remained within a framework of liberal humanism, heavily informed by notions of rational progress and individual rights.[10]

It could also be noted that the past ten years have seen the rise of a veritable cottage industry of infertility guidebooks, and the emergence of a substantial professional literature on infertility counselling.[11] Fewer feminist interventions have been made in these areas, although they are beginning to be initiated. While most feminist analyses have focussed on the analysis of reproductive technology, far

fewer have addressed the experience of infertility. There are, however, some notable exceptions to this, which are discussed briefly here.

The Experience of Infertility

The singular exception to the feminist lack of attention to *The Experience of Infertility* is the book by this name published in 1983 by Naomi Pfeffer and Anne Woollett. It is based on the authors' own experience of infertility and infertility treatment, as well as interviews with other women sharing this experience. Essentially a feminist handbook for coming to terms with infertility, it is written to provide both information and advice, and to break the silence surrounding infertility. In time-honoured feminist tradition, the authors write:

> We believe, like Adrienne Rich, that in the realm of sexuality and reproduction, 'it is crucial that women take seriously the enterprise of finding out what we do feel instead of accepting what we have been told we must feel'. (Pfeffer and Woollett, 1983, p. 1)

Hence, this is a book in which detailed medical information and practical advice are interspersed between frank, open and direct chapters describing various aspects of how infertility feels, what the emotional and psychological effects of it can be, and what can be done about it. The book thus accomplishes its aim of 'speaking out' about a difficult personal crisis in a manner that is characteristic of the feminist health movement, combining personal testimony and discussion of personal experience alongside basic factual information which can aid

women in gaining a greater sense of confidence and control over their bodies and selves.

Pfeffer and Woollett are not uncritical of techniques such as IVF, which, they argue, raise questions in terms of ethics, resources and the social conditioning of women to feel that having children is essential to their identities. Though they are critical of some aspects of the medical profession, such as the assumption that infertility is more likely to be the woman's fault, they do not advocate the view that reproductive technologies are part of an extension of patriarchal control over women's reproductive capacity. Their book, not suprisingly, is instead written from the point of view of enabling women to come to terms with infertility to the best of their ability, and is sympathetic to the reasons women are willing to undergo costly and invasive forms of treatment.

Written before the new reproductive technologies began to be the subject of much more critical feminist attention, *The Experience of Infertility* was able, relatively unproblematically, to extend pre-existing and well-founded strategies of the feminist movement to break the silence surrounding a critical issue effecting women's reproductive identity. Such an approach has since become much more problematic for feminists, and it is likely this is the reason no successor project to this pioneering volume has been undertaken.[12] The closest candidate to a contemporary companion volume to *The Experience of Infertility* are in fact quite different from it. Birke, Himmelweit and Vines' volume, published in 1990 and entitled *Tomorrow's Child: Reproductive Technologies in the 90s*, is, like Pfeffer and Woollett's volume, a Virago 'feminist handbook' of sorts. Like its predecessor, it gives up-

to-date practical information about a range of infertility treatments, as well as types of infertility and their diagnosis. Unlike the earlier volume, however, it does not address the experience of infertility as such. Instead, the opening chapters address recent feminist debate, arguing against the need entirely to reject reproductive technologies, and instead for a greater appreciation of the extent to which women can make technology work in their interests. In the concluding chapters they argue that what is necessary in order for women to use technological solutions more effectively is a greater accountability for science and technology, and an improved quality of public debate surrounding the ethical issues they raise. This focus, upon very general issues of science and technology, and the character of current public debate, as well as criticism of feminists who are seen as too quick to reject technological solutions, and too ready to see them as patriarchal plots, is a succinct indication of the degree to which the character of feminist discussions around this issue have changed since 1983.

An even more illustrative difference can be seen between *The Experience of Infertility* and Renate Klein's 1989 anthology, also published as a 'feminist handbook' of sorts by Pandora, entitled *Infertility: Women Speak Out About Their Experiences of Reproductive Medicine*. This volume is much more similar to *The Experience of Infertility* than is *Tomorrow's Child* in its foregrounding of experience as a basis for feminist understandings and feminist change. However, it could not be further from either of the other volumes in its assessment of the technology itself. Like *Test-Tube Women*, the contents of the anthology are framed by a polemical introduction and conclusion. The

message is 'clear': '[IVF] is a *failed* technology' (Klein, 1989, p. 1, original emphasis). It has 'dangerous health hazards for women' (p. 1), involves women being used as 'living test-sites for drugs and new techniques' (p. 2), 'often severely violate[s] a woman's sense of dignity' (p. 4), and invokes a 'brutal ideology which sees women as mere breeders who need to be controlled' (p. 6). In sum, 'it fails women' (p. 7). The aim of Klein's book is two-fold. On the one hand, she is seeking to expose the 'hidden truth' of IVF, the reality behind the image of benevolent medicine and happy media portrayals. On the other hand, she is seeking to enable women 'to have a *real* choice to say "No" to conventional fertility treatment as well as to IVF' (p. 7. original emphasis).

Following Klein's emphatic introduction are four sections exploring various aspects of infertility and its treatment.[13] These sections include chapters by women who have experienced IVF and other forms of infertility treatment, feminist researchers, feminists who have attempted to develop alternative ways of coming to terms with infertility other than by conventional treatment, and women who have acted as surrogates. Though largely critical of the techniques, few of the contributors are as certain as Klein about the viability of alternatives to conventional treatment, or the possibilities of large numbers of women saying 'No' to them. To the contrary, many of the contributions indicate that *despite* having considerable reservations about the techniques, women were, for various reasons, willing to undergo them in pursuit of a child. Even the women who are *most* critical of the techniques in retrospect do not oppose treatment. As one woman is quoted as saying:

> I could not say to a woman that she should not try it. I can understand why she would want to go for it. So I would say to her: 'OK, it will be nasty and you will suffer.' But I would not say that she should not be allowed to try. (Winkler, 1989, p. 100)

The dilemma expressed by 'Inge M.', whereby she says for herself that she would never go through IVF again, that she 'would not like to be part of their machinery ever again' (p. 100), yet that she could not say to another woman that she should not try it, far less that she should not be allowed to try it, presents the feminist dilemma in a nutshell. On the one hand, feminists are critical of the new reproductive technologies as extensions of patriarchal control over reproduction -- as 'Inge M.' states, she will not be part of '*their machinery*'. On the other hand, for feminists to prescribe other women's reproductive choices for them is difficult to reconcile with any notion of sisterhood. This is complicated by the views of feminists, such as Klein, who argue that 'The tragedy lies in women's cooperation with the experimenters' (p. 246). Or, as she puts it later, 'women taking part in IVF do not realize that, unwittingly, they contribute to this sick scenario of interfering with human reproduction' (p. 279). According to this view, women who participate in IVF are not only 'victims' but 'colluders', to use Klein's terms (p. 246).

Neither are the solutions straightforward. Though Klein argues that 'there are no better spokeswomen against these technologies than women who have actually gone through the procedures, and survived' (p. 286), such women themselves, as is evident in Klein's book, do not endorse Klein's own imperative 'to be firm and advise women not to use these

technologies' (p. 287). Not to do this is considered by Klein as yet another form of 'collusion with the promoters of reproductive technologies' (p. 287). Yet even her 'best spokeswomen' cannot do this themselves.

The gap opened up in Klein's book is similar to that in Martin's, whereby there is an attempt to bring together two most extreme ends of the spectrum. The testimony of the women 'at the bottom of the heap', to use Martin's phrase to describe how Klein sees her spokeswomen, is meant to measure the effects of dominant ideology. Yet, precisely the negotiating process so well identified by Martin, and the power of the voices of the women in Klein's anthology, are obscured by this approach. There is an uneasy fit. The answers are not so simple. Klein far more than Martin can be accused of badgering the witness, indeed of 'framing' her, quite literally, in terms of the way the book is framed by forceful interpretations of the very voices Klein sought to liberate. There is a rich equivocality to the voices of the many women in Klein's book, affirming the varied strengths of women to come up with solutions. They do not fit into an overall plan. To attempt to make them do so only lessens the power of their voices, their own eloquence in stating the very same concerns as Klein, indeed often in a far *more* convincing and sensitive manner.

Though Klein's work is similar to that of Pfeffer and Woollett in its emphasis upon women's experience, her book lies in a different feminist tradition of 'speaking out'. Klein's account is more in line with the model of an international feminist tribunal of crimes against women, such as those organised around sexual violence (Russell and Van de Ven, 1976; Bunch, 1982). She is not herself an infertile woman

seeking to break the silence in order to share experiences in a manner which will enable women to cope with their bodies and selves in whatever way they see fit. She is rather seeking to publicise the voices of women who have undergone the technology and rejected it, in order selectively to foreground those dimensions of women's experience which will dissuade other women from using conventional fertility treatments, and to attempt to promote alternative means of resolution. Aside from the manner in which she unconvincingly, and at times quite offensively, 'frames' her subjects, Klein's work is an important contribution to the feminist critique of new reproductive technologies, highlighting as it does a neglected aspect of treatment, which is the extent to which it fails, degrades and exploits women.

The problem with Klein's approach is that its reliance upon experience is double-edged. Just as the women she has included in the anthology are not entirely unequivocal, so too is 'women's experience of infertility treatment' a highly contradictory area. For every woman who adamantly denounces these technologies as patriarchal machinery, there are other women who are keen to try the procedures, and women who are grateful for having had the opportunity to do so, not to mention women whose 'dreams have come true' because of them. This is a problem inherent in the use of women's experience as the basis for any argument. The 'evidence' it provides is, by definition, diverse and therefore inconsistent. That the experiences described in Klein's book do not conform to her own position on the subject of new reproductive technologies compounds this problem further. Though integral to feminist theory and practice, 'women's experience' is not in itself a sufficient

basis for effective political mobilisation, nor is it an unproblematic basis for theoretical understandings.

Women's Experience of IVF

Other feminists who have specifically studied women's experience of IVF have, in the main, been far more equivocal than Klein in their conclusions, and far more concerned with the broader context in which women's choices are constructed, rather than the specific forms of 'coercion', as Klein puts it, specific to the field of assisted reproduction. Christine Crowe, the first feminist researcher to conduct a study of women's experience of IVF, the results of which were published in 1985, emphasised the way in which IVF is a socially constructed choice designed to further traditional social priorities, such as biological motherhood. Entitled 'Women Want It', her article explores the reasons women give for wanting to try IVF, and argues that given these desires, and a medical technological means of fulfilling them, it is not suprising women's 'choices' follow this route. In so doing, Crowe problematises the concept of 'choice' from a social constructivist standpoint, locating the need for change in relation to social expectations and definitions of women, rather than women themselves.

Linda Williams, in a Canadian study, also focussed on women's reasons for undergoing IVF. In her study, entitled 'It's Gonna Work For Me' (1988a), she sought to explain why women continue to try IVF after failing. Her analysis thus focusses more than Crowe's upon the features of the IVF procedure itself which increase women's desires to succeed,

such as the way in which it enables women to feel they are 'getting closer to success'. In her doctoral dissertation, Williams (1988b) focusses on the desire to parent, described as 'parenthood motivation', which she charts in terms of both individual and social factors. Given that the IVF 'market' cannot survive without willing participants, she argues, the reasons why couples are not only prepared to undergo the procedure, but indeed eager to do so, are an essential component in its evaluation.

Lene Koch, a Danish researcher, also investigated women's experience of IVF in terms of their reasons for choosing to undergo the procedure and the ways in which the procedure itself affected their perceptions of it. Like Williams, Koch was struck by the counter-intuitive nature of the way women's desire to pursue treatment appeared to increase the more they learned about how likely the procedure was to fail. 'Somehow', she states, '*information did not matter*' (Koch, 1990, p. 225, original emphasis). In her article entitled 'IVF -- An Irrational Choice?' she explores the reasons for this discrepency. In the face of passionate feminist denouncements of the technique of IVF, and considerable evidence about the shortcomings of the technique, women who opt for the technique appear not only not to be listening, but indeed to be among the most passionate supporters of IVF. Klein's answer to this, that if women really knew what was involved in IVF they would never go through it to begin with, is contradicted by both Koch's and Williams's studies, which indicate that the more women know about the problems with IVF the more at least some women appear to be determined to pursue it.

Koch makes sense of this dilemma, as her title indicates, by arguing that the reasons women want to undertake IVF, or want to continue it

despite serial failures are not 'irrational'. The reason for this is very simple: they want a child. If this is a socially constructed wish, she argues, it is no less an authentic one, and seeking to realise this desire is the foundation of the rationality underpinning women's choices to continue IVF, no matter how unlikely it is to succeed or how painful it is to fail. Koch therefore argues for an appreciation of the specific worldview of women who undergo IVF, which is structured by its own rationality, instrumentality, logic and purpose. Koch argues that appreciating the 'different rationality' inhabited by women who undergo IVF is necessary both to understand why 'women want it', and to respect their reasons for doing so. To understand and respect other women's reasons for wanting to undergo IVF, Koch argues, does not mean necessarily agreeing with them. Indeed, respect and understanding for other women is a better standpoint from which to openly disagree with them, for all of the reasons feminists have for opposing these technologies. Most importantly, she argues, 'The belief that some views are "right" and others are "wrong" will not bring us closer to a better world for women' (p. 231). It is not helpful, according to Koch's analysis, to pigeonhole women as dupes, victims or colluders. Even to think of women in such a manner, never mind to make a political platform out of it, diminishes the meaning of feminist-inspired change. It is a divisive, antagonistic and politically counter-productive way of thinking about differences between women. Moreover, it is unnecessary, as there is no need to show disrespect for other women whose choices one disagrees with. To the contrary, effective dialogue between women who have opposing views, like any dialogue between oppositional parties, is most likely to succeed when it is based on mutual respect and openness.

Judith Lorber, whose studies of infertile women and couples undergoing IVF were conducted in the US (see Lorber 1987, 1988, 1989), has brought a phenomenological approach to bear on similar questions to those raised in other studies. Like Koch, Williams and Crowe, her aim was to elicit the 'rationality' of women choosing to undergo IVF. A key term for Lorber is that of 'the patriarchal bargain', a concept which borrows from theories of social exchange and locates women's choices in relation to the subordinate status imposed on them by the marital relationship. She writes: 'The impact of the hegemonic moral imperative that women must be mothers and that children should be biological, and the manipulation of women by the Western medical system make the use of IVF in female, male or couple infertility a patriarchal bargain for women' (Lorber, 1989, p. 31). Her work also identifies female altruism as a key factor in women's decisions to undergo IVF, especially in cases of male infertility, for which Lorber provides the analogy of organ donation, in the sense of providing 'the gift of life'.

Whilst the approach developed by Lorber, like those of Koch, Williams and Crowe, emphasises the functionalism of the logic informing women's choices to undergo IVF, thus challenging the patronising assumption that they are merely duped or pressured into it, her account in no way answers the question of why other women resist. Like many phenomenological accounts, the attempt to foreground the point of view of the actor may create a sense of the context being more fixed and rule-governed than is, indeed, the case. Though particularly suggestive in relation to the question of how women create reproductive identities out of altruistic acts, and the role of these in women's negotiation of relationships with men, her analysis presents something of a monolithic

picture of women bargaining their way through patriarchal social relations.

These studies, by Crowe, Williams, Koch, Lorber and Klein, play a particular role in the larger feminist debate about reproductive technology insofar as they address the 'problem' of women who choose to undergo IVF.[14] As IVF is the most controversial of the new reproductive technologies, because of the way it is linked to embryo research, genetic modification technologies and pre-implantation diagnosis, and because it is therefore the technique which serves as a kind of lynchpin between reproductive and genetic engineering, the numbers of women worldwide who are eager to undergo it and are demanding more IVF clinics, constitute a politically charged area for feminism. In addition, it is the desires of women who want to undergo IVF which are critical to the public legitimation of the technique, as well as the medical-scientific justification of it. Providing feminist frameworks for understanding the experiences of women who undergo IVF is thus critical in relation to feminist struggles to challenge the validity of the procedure.

Conclusion

This Chapter began by describing the centrality of reproduction to feminist concerns since the inception of the current 'wave' of western feminism and tracing the politics of reproduction through different fields of feminist theory and practice. These include the feminist critique of biological determinism and scientific discourse, the male-

medical 'takeover' of the birth process, the women's health movement and campaigns for reproductive rights.

The discussion then moved on to the emergence of the feminist debate of new reproductive technologies, tracing chronologically its development, and using selected key texts to illustrate some of the main arguments and methods which have been utilised. By comparing the ways in which patriarchal power, technology and culture have been theorised by different feminist researchers, the aim has been to identify some of the central points of disagreement in the feminist debate on this subject.

The final section introduces other feminist research addressing women's experience of IVF. This is discussed in relation to the 'dilemma' for feminists of reconciling an appreciation of the reasons women opt to undergo procedures such as IVF with the feminist assessment of these same technologies as consolidating certain forms of patriarchal control over reproduction.

As noted at the outset, it is these issues within the feminist debate over new reproductive technology which are seen as particularly significant, insofar as they constitute a site of conflict which I feel has much wider implications. My emphasis on these divergences derives from both an intellectual and political struggle to make sense of what I have described as the 'changing landscape of reproductive politics' (see Franklin, 1990b). I believe it is imperative to develop more effective feminist strategies in relation to the unprecedented degree and scope of reproductive control represented by new reproductive technologies (which are, increasingly, aimed at direct manipulation of human genetic material rather than fertility).[15] However, I believe it is also clear

that feminists have not succeeded in achieving this aim. This state of uncomfortable uncertainty leads me to ask if it is necessary to rethink, or even unthink, some feminist certainties. It is largely to this question that the present study is addressed.

What would such a rethinking process entail? For one, it must engage with the question of patriarchal power, and how it operates. A major theme of this study is to identify the ways in which *representations* comprise a means through which power is deployed. Another question concerns women's relationship to patriarchal power: how is it mediated, negotiated, inhabited or embodied? A related set of questions concern technology. A major aim here has been to identify the cultural dimensions of technology, in terms of how our relationships to technology are culturally shaped through the meanings, values and belief systems with which we not only employ, but *think* technology. For conceptive technologies, such a question is vital, given their importance to how we 'conceive' the future, our origins, or humanity, our relationships, and much else.[16]

Finally, a concern in this study is with the meaning of feminism, and collective feminist strategies, in a time of considerable change in how these are understood, both more widely and by feminists themselves. This is not to overemphasise the loss of certainties, for there are many issues about which feminist opinion and conviction have changed very little. Likewise, there are many issues about which feminist convictions have been strengthened in the face of mounting opposition, such as unrestricted access to abortion. Cut-backs in many countries to spending levels in public provision have also underscored the importance of feminist concerns regarding safer contraceptive methods and basic

reproductive healthcare. However, new reproductive technologies pose new political questions, and to some extent undermine longstanding feminist strategies, such as the emphasis on reproductive rights and reproductive choice. In the face of proliferating 'rights', for fetuses, embryos and donors, and conflicting rights, such as between women who serve as surrogates and commissioning parents, such strategies are less effective. Likewise, in the face of proliferating reproductive choices, choice itself may become the problem rather than the solution. Hence, one might speak of proliferating reproductive dilemmas in the context of new reproductive technologies, producing difficult questions concerning women's relationship to the medical profession, to new technology, to motherhood and to the state.

Most importantly, these new dilemmas present questions to feminism which parallel an increasing emphasis within feminism itself, upon differences between women, and the foundations (and foundationalisms) of feminist theory and practice (Butler, op. cit.; Haraway, 1985; Hirsch and Keller, 1990; Riley, 1988; Spelman, 1988; Wittig, 1980, 1981). These include a questioning of the 'we' of feminism, the category 'woman', the concept of 'gender' or 'sexual difference' and other concepts or 'certainties' feminism may have relied upon in ways that contradict its own stated aims and objectives (see Fraser and Nicholson, 1988).

Reproductive technology occupies a significant place in these debates. It is, on the one hand, an explicit confirmation and instrumental realisation of many of the most deep-seated patriarchal attitudes and constructs with which feminism has, since its inception, been politically engaged. In an ironic sense, new reproductive, and especially genetic, technologies have made much more publicly viable,

and visible, the fundamental feminist precept that reproduction is a political issue. The politics of reproductive control now extends from seed patents to genetically-engineered contraceptive vaccination programmes. The politics of fertility are increasingly seen as the politics of survival, not only in economic, but in literal terms, as land, animals, plants, people and species are assessed according to their reproductive viability. The 'gene gap' has replaced the 'missile gap' in the post-Cold War politics of national security. The current global quest to map the human genome, and the daily news of yet another genetically-engineered marvel'[17], comprise essential components in the 'changing landscape of reproductive politics'. It is through control of reproduction -- the reproduction of plants, humans, animals and micro-organisms -- that new forms of technological 'progress', new forms of economic growth, new forms of capital and new forms of 'nature' are also being created.'[18] These developments also create new forms of regulation and surveillence, new forms of social and environmental control -- in short, new forms of power.

Hence, if the picture remains unchanged in many respects, it is unrecognisably altered in others. The longstanding importance of the politics of reproduction to feminism gives it a 'head start' in engaging with the many new dimensions of reproductive politics. The politics of reproduction has been so integral to so much of feminist analysis that it is uniquely well-equipped as an intellectual and political force to raise critical questions and mobilise public opinion in relation to the many and proliferating guises in which it has moved onto the public agenda. The more specific set of questions surrounding women's relationship to new technologies such as IVF is thus quite rightly

invested with an emotive and contested significance. The means of assessing the 'changed landscape' instantiated in and through these kinds of reproductive choices and decisions by definition involves a degree of reflexivity concerning the terms upon which they are assessed. It is thus to the assessment of both that the present study is directed.

References to Chapter Two

1. See Steinberg and Spallone, 1987. See also note 9, Chapter One, for a discussion of feminist interventions in other countries.

2. O'Brien's encompassing framework is best understood in relation to a set of feminist evolutionary accounts of human history based on control of reproduction (see note 7 below). The way in which control of reproduction was both central to, and continues to be derivative of, an 'enlightenment ethos' also characterises the work of Easlea, 1980, 1981; Griffin, 1978; Merchant, 1980; Mies, 1986 and Shiva, 1988.

3. The model of patriarchal power which informs this thesis is also drawn from Rich. She states:

> "Women have always been divided against each other."
>
> "Women have always been in secret collusion."
>
> Both of these axioms are true. (Rich, 1979, p. 178)

The emphasis in this brief extract, taken from Rich's influential essay on 'Women and Honor', is on the paradoxical and contradictory nature of women's relation to both patriarchal power and to one another.

4. This is a basic question at stake in all political movements directed at social change. It is, again, for this reason the conflicts surrounding women's choices to opt for new technologies are so important. They occur at a particularly significant faultline in feminist debate.

5. The term 'cultural dimensions' is used here to refer to 'culture' in the anthropological sense, emphasising the production of meaning and its circulation in the form of belief systems, values, commonsense assumptions, and so forth.

6. Not discussed in the earlier section, but an important set of feminist approaches to the politics of reproduction worth mentioning here are the evolutionary accounts which posit control over reproduction as a definitive factor in the historical emergence of patriarchy. These derive in part from the early studies of Bachofen and Briffault, positing an early matriarchate, in part sustained through ignorance of physical paternity. Such studies were the basis, for example, of many of Engels' claims in *The Origin of the Family, Private Property and the State* (1972). Feminist theorists who have employed similar types of argument include Davis, 1971; Diner, 1973; Morgan, 1972; Mies, 1986; and Rich, 1976.

7. For a discussion of the relevance of models of culture to feminist debates in various areas, see Franklin, Lury and Stacey, 1991a.

8. This interpretation is derived, in part, from Martin's reliance on Rich's (1976) model, as is discussed below.

9. For a detailed account of the strengths and weaknesses of Martin's study from the point of view of feminist anthropology, see Rapp, 1988.

10. Eg. *The Hastings Center Bulletin.*

11. See Lorber, 1989, for an extensive bibliography of this field.

12. Examples of recent volumes written by women addressed to a 'consumer' audience of IVF users (or potential users) include Andrews and Biggs. The closest contemporary analogue to Pfeffer and Woollett's study is perhaps Lasker and Borg's *In Search of Parenthood: Coping with Infertility and High Tech Conception* (1987), but this is neither largely experiential nor concertedly 'feminist' (but is a Pandora 'Women's Health' paperback). It is, however, much more explicitly feminist than either *Making Miracles: In Vitro Fertilisation* by Tilton, Tilton and Moore (1985), or Glazer and Cooper's *Without Child: Experiencing and Resolving Infertility* (1988), an anthology edited by two members of RESOLVE, the infertility support network. Robert Winston's (1989) *Getting Pregnant* represents yet another category of publications in the burgeoning market for reproductive 'wannabes': that of the infertility specialist offering advice and information to couples seeking reproductive assistance.

13. A significant difference is that Klein's book is not so much about the experience of infertility, as the experience of infertility *treatment*.

14. A unique, to my knowledge, anthropological study of an IVF clinic has been conducted by Judith Modell (1989), and bears many resemblances to the present study in its emphasis upon the changing cultural constructions of pregnancy and parenthood at stake in the field of assisted reproduction. Like this study, it involved both observations

in the clinic and interviews with women undergoing IVF and is self-described as ethnographic. Whereas the present study explicitly engages with feminist debate of the new reproductive technologies, Modell's study extends her previous work (1986) concerning the negotiation of social and biological facts in the construction of kinship definitions, an undertaking that is in many ways quite closely related to the present study.

15. See Spallone (1992) for a more detailed account of the relationship between reproductive and genetic engineering.

16. The perspective developed here is also that informing a recent, collaborative study concerning 'The Representation of Kinship in the Context of the New Reproductive Technologies' undertaken in the Department of Social Anthropology at the University of Manchester, 1990-1 and supported by the ESRC (see acknowledgements).

17. During the final completion of this thesis (April 1992) I encountered the example of sheep who will be bred next year in Australia to be 'self-dipping', that is, to secrete their own pesticide supply from their skin. As is characteristic, the account provided emphasised the *environmental* benefits of this procedure to consumers, who are otherwise exposed to undesireable quantities of pesticides in meat and wool.

18. For further discussion of changes in the cultural construction of meanings of 'naturalness', 'knowledge' and 'progress', see Franklin, 1991b; Strathern, 1992, in press; Haraway, 1989, 1991.

CHAPTER THREE

Investigating 'Women's Experience'

Introduction

Although this thesis is concerned with women's experience of IVF, the origin of this concern lies in a broader set of issues related to the advent of new forms of technological assistance to reproduction, and the feminist analysis of these, particularly in terms of their cultural dimensions. Hence, as discussed in the previous Chapter, the specific concern with 'women's experience of IVF' is informed by a much wider set of questions, which in turn is reflected in the structure of the thesis. In this Chapter, the various concerns informing this study, and its developmental transformations, are discussed with reference to the wider feminist debate described in Chapter Two. Beginning where the last Chapter left off, with other feminist studies of women's experience of IVF, this Chapter moves on to consider some of the wider conceptual issues, specific methodological approaches and emergence of the final structure of the thesis.

As will become apparent, the findings of this study confirm much of what previous feminist researchers have identified in terms of women's experience of IVF. Its contribution to these studies is apparent at several levels. It seeks to amplify Koch's (1990) recognition of the need to appreciate the specific components of the 'different

rationality' which informs women's choices to opt for IVF. Like William's (1988a and b) studies, it seeks to explore the motivations behind this choice and like Klein's (1989) study it seeks to identify points of resistance by women to the terms set for them by the IVF procedure, and ways in which the procedure 'fails women'. Like all of the studies described in the last Chapter, it seeks to foreground the socially constructed nature of the context in which women's choices to opt for IVF are formulated (Crowe, 1985; Holmes, 1987; Lorber, 1987, 1988, 1989; Modell, 1989).

The main difference between this study and those conducted by other feminist researchers is that it seeks not only to investigate the question of 'women's experience of IVF', but also to be critical of how and why this topic has come to be seen as a site of such importance. In a sense, then, it seeks to problematise this focus. This is achieved both through contextualising 'women's experience' in and against a range of contrasting cultural fields (eg. the media, public and parliamentary debate, feminist debate, etc.); and through problematising the question of 'women's experience' by analysing *how* it is *represented.* The reasons for this shift in focus, away from 'women's experience of IVF' itself, and towards a consideration of how it is constructed in a series of different contexts, has already been touched upon, and is further explicated below.

Beyond the immediate focus upon 'women's experience', therefore, the aim is both to connect, *and to contrast*, the ways in which 'women's experience' is represented or constructed in public debate to legitimate the technologies, and the ways in which women represent or construct their experience themselves. Both of these aims are pursued through a

cultural focus, that is, through an emphasis on the culturally constructed nature of *representations* of 'women's experience of IVF' as ways of 'making sense' of the procedure itself, or the wider questions raised by this form of technology. In the preceeding review of feminist approaches to the question of women's experience of IVF, for example, is evident one set of cultural representations of it. As has been shown, these representations are constructed in accordance with particular aims and purposes according to which they are shaped. In Part Two, a very different set of representations of infertility treatment and women's desires to pursue it are analysed. These are the popular media accounts of new reproductive technologies. This is contrasted in Part Three, comprising three Chapters based on interviews with women undergoing IVF, in which the focus shifts to the ways in which women themselves make sense of their experience of treatment. Finally, in Part Four, the questions raised throughout the thesis concerning the representation of women's reproductive experience and desires are located in a broader frame of reference, investigating the changing cultural construction of reproduction by considering parliamentary and related public debate.

The Investigative Trajectory

As noted above, this thesis attempts a similar task to that undertaken by Martin (1987) in that it seeks to contrast 'dominant' cultural constructions of reproduction with the ways in which women themselves make sense of their reproductive experience. Also like Martin, it seeks to accomplish this task by contrasting a set of textual

readings against a set of interview data. Some important differences, however, also characterise this study. Martin's study is important for having, in a sense, tested the limits of a textual reading against a more ethnographic approach. Beginning with a well-established feminist position concerning the forms of patriarchal control effected through the discursive representation and technological 'management' of women's reproductive capacity, Martin and her assistants 'took this to the field', where they examined the extent to which women themselves internalised or resisted these constructions of their bodies. Their conclusion, put most simply, was that some women internalised these more than others, correlating in part to their social position in terms of race and class. They also discovered many forms of resistance to dominant medical constructions of women's bodies, and Martin's conclusion builds on these to emphasise the inherent capacity to resist built into the very fact of inhabiting a female body that is by definition at odds with the dominant cultural values of contemporary Euro-American society.

The aim of this study was more specific, and built on a less well-established feminist position. Rather than taking to the field a feminist certainty, this study involved fieldwork as a means of engaging with the sources of *uncertainty* described in the preceeding Chapter. On the one hand I shared many of the reservations, and sense of outrage, towards the rapid routinisation of IVF and the ubiquitous portrayal of it as a beneficial form of 'treatment'. On the other hand, I was conscious of a major problem for a feminist understanding of IVF to encompass women who sought this form of treatment. Most of all, I felt particularly conscious of the problem this discrepency between critical

feminist voices and the voices of women who sought access to IVF created in terms of mobilising effective feminist strategies to make visible the less benevolent, indeed oppressive, dimensions of new reproductive technologies.

I was not alone in my confusion and desire for clarification on this matter. It was my impression that many feminists found the subject of new reproductive technologies, and particularly the question of the extent to which women could make productive use of them, troubling. I also sensed in this confusion parallels to wider feminist uncertainties about the place of feminist politics in an increasingly conservative context, and in the wake of feminism having 'peaked' as a visible political movement.' It struck me as deserving of much more attention that despite feminism having established itself so successfully in many ways, and having accumulated such a powerful array of analytical frameworks with which to challenge patriarchal attitudes and structures, feminists had made minimal interventions into public debate about new reproductive technologies.

I have a full-sized filing cabinet in my office in which I have a virtual archive of press clippings on new reproductive and genetic technologies. These are arranged in a filing system that runs from familiar territory ('IVF', 'embryo research' and 'surrogacy') to the extremes of debate ('postmodern body practices', 'bio-weaponry' and 'cows'), but I have no file entitled 'feminist perspectives'. Instead, I have two other filing cabinets, filled to the brim with feminist materials on the subject of new reproductive technologies. I have papers and letters and articles from women all over the world on this subject, most of whom, like me, have similar collections of material

related to developing feminist resistance strategies to the relentless pace at which reproductive and genetic enginering are becoming more invasive and widespread.

It was therefore with several overlapping concerns that research on this project was initiated through a combination of methods aimed at providing evidence and analysis which might clarify certain issues related to a feminist assessment of new reproductive technologies. Following a textual analysis of popular media accounts of infertility and its 'treatment' via new reproductive technologies, the ethnographic component of the project was undertaken. Unlike Martin, I eventually abandoned the aim of correlating 'women's experience of IVF' to dominant cultural constructions of it. While both could be seen to draw on similar sources of cultural meanings and belief, particularly those concerning scientific progress and traditional family values, and their conjoined realisation through the technology of IVF, I became less convinced of the value of attempting to establish a *determining* relationship between them. They were, in essence, overlapping and interrelated cultural domains, the analysis of each of which having distinct features that were neither dependent upon, nor particularly enhanced by, their being in any way causally linked.

I was thus returned to my initial concerns with a range of findings that did not cohere around a central argument. Such an argument eventually emerged through reconsideration of both the aims of the project and the structure of the study in relation to the original concerns regarding feminist politics, and feminist interventions in this arena. In addition to my own initial reservations about interviewing women in the midst of IVF, given my own scepticism about this form of

'treatment', I came to feel they had not told me very much I might not have been able to discern without having invested an enormous amount of energy in researching their experience. They wanted a child, they saw IVF as their only hope of having one, and they chose it knowing full well it probably would not work, but hoping that it would. Yet, I did feel I better appreciated the complexities of the experience of undergoing IVF, such as the ways in which women's lives were 'taken over' by the technique, the ways in which their 'hope' is motivating at the outset but often disabling in the longer term, and the reasons women felt they 'had to try' IVF. I also appreciated better the partial nature of media representations which foreground a woman's needs and desires going into treatment but neglect the rest of the story, and the irony that it is precisely these needs which can be so disabling to a woman in the wake of 'failure', which is precisely what is left out of the media accounts. I felt this demonstrated the extent to which such accounts are not really 'about' women at all, but merely use their experience as a framing device for what is apparently much more interesting, which is the novelty of reproductive technologies themselves.

While such findings were not insignificant, I did not feel they brought me closer to my original aim of bridging the 'gap' between feminist accounts of IVF, and those provided by women who underwent the procedure. Neither did it serve my aim of tying together ethnographic and textual accounts. This led me to some thoughts about ethnography.

It should be stated that this study is not 'fully' ethnographic, and My use of this term is in some senses misleading. I use the term for several reasons despite these shortcomings. For one, I use it to

emphasise not only the structure of the interviews I conducted, which were open-ended, but also the intent of the interviews, which was, in traditionally anthropological fashion, to come to understand the 'insider's point of view'. I do feel the research was successful in this respect, and more valuable for my not having adopted a more confrontational approach, by asserting my own misgivings toward the technique of IVF, or my own knowledge of its potential dangers.[2] Whilst I felt ambivalent at times about my own silence on these matters, I did not feel I would have been able to engage as fully as I intended with women's own definitions of their experience were I to have challenged their accounts. I knew what I thought, I was not in women's sitting rooms to tell them but to listen. Significantly, in the end, I realised it was not my reservations about IVF, *but my own uncertainties about these*, which caused me the greatest degree of self-consciousness and ambivalence during the interviews. It was as well, I feel in retrospect, I did not attempt to explore or reconcile my conflicting feelings at the time. The entire purpose of the interview component of the study was to provide a space in which to explore these further.

Another problem with describing this study as 'ethnographic' is that it was largely based on interviews, which do not in themselves constitute 'fieldwork' in the strict anthropological sense. It was for this reason I also spent quite a bit of time in an IVF clinic, different to the one attended by the women I was interviewing, observing the day-to-day routines involved in the procedure.[3] For this component of the project, my point of view was more that of the ward sisters with whom I spent my time. This proved an illuminating experience on several levels, particularly in appreciating the hierarchical structure of the

clinic. The nurses were beneath the all-male tier of consultants and doctors. They were, however, above the patients. This produced a paradoxicial situation for me to observe. On the one hand, I very much appreciated the nurses outrageous sense of humour towards their male-superiors, whom they teased and ridiculed, often using sexually explicit and extremely lewd innuendoes of a kind I had not come to associate with the English. The young male sperm donors were a target of particular hilarity, and incidents, such as the donor who got bacon sandwich in his sample, were endlessly repeated. A complex social interaction characterised the life of the clinic, saturated by an explicit and rather fascinating sexual politics.

On the other hand, I was often appalled in equal measure to my admiration for the nurses' fiestiness towards the doctors by their treatment of the patients. Particularly when I was observing, they would discourse about the woman lying on the table as if she were an object, as in: 'Oh yes, and here we have Mrs So-and-so, and I'm afraid she really isn't producing her eggs they way she should be, and yes she has been trouble for us all along, really, haven't you Mrs So-and-so, and I do hope you won't be disappointing us again this time 'round', which were the more extreme examples of condescending and insensitive language. It did not appear to be a lack of empathy or compassion which created this nurse-patient interchange, so much as the situational context. Standing at the ultrasound control panel, looking at the screen, and speaking to me, a 'professional observer', it was as if the 'objective facts' on the monitor determined the nature of communication: 'Yes, you can see here Mrs So-and-so's eggs really just aren't growing the way the should be, and she has only got two, and this one doesn't

look very well-developed', and so forth. I also observed counselling sessions where I saw the same nurses deal very professionally and reassuringly towards couples who came into the clinic to discuss their treatment or proposed treatment options. In these situations, the nurses seemed like different people.[4]

Hence, the study is described as ethnographic despite the reservations I have about using this term for a variety of reasons. Although the study was based on interviews, they were very open-ended and conducted in a manner I would describe as ethnographic in intent. I also supplemented these interviews with observations in a clinic, which comprised more of a traditional 'fieldwork' element to the research. Although I have not drawn explicitly on the observation sessions elsewhere in the thesis, since the workings of the clinic were not a major focus of analysis, they greatly enhanced my understanding of the interviews, and provided much useful background information as to precisely what the techniques involve.[5]

Out of the variety of methods, approaches and data combined in the pursuit of this study, an overall structure eventually emerged in conjunction with the overall argument. As I came to appreciate the lack of fit between the interviews and the media analysis as a significant finding, rather than simply as a failure, I began to see a different approach to what I had originally envisaged.[6] I began to see the value of the study might lie precisely in the fact that the different representations of women's experience I had encountered, in the feminist literature, in the media, and in women's own accounts, did *not* match up. After all, why should they? Each was drawn from a very different domain of cultural production, why should they have to be neatly sewn together?

Each set of representations also had its own instrumentalism: in feminist accounts to bring about political and social change; in media accounts to engage readers and sell newspapers; and in women's own accounts to construct a particular version of themselves and their experience to a professional interviewer. In sum, I came to feel the differences in the representation of 'women's experience of IVF' in each of these doimains was best appreciated as a set of *contrasting* fields, rather than a set of neatly-interwoven ones.[7]

The same could also be said of other discursive domains I had wanted to include in the thesis but ended up developing elsewhere, such as medical and legal discourses concerning the new reproductive technologies.[8] Most importantly, this way of seeing things enabled me to see my own contribution to the analysis of 'women's experience of IVF' as yet another instrumental representation, aimed, among other things, at securing a professional title. Of course, none of these aims were quite so straightforward, and all, including my own, were marked by contradictory impulses. However, it was in this way I found it most appropriate to present the findings of this study: as a set of representations. I added to this a final 'discursive field', that of public and parliamentary debate which comprises Part Four of the thesis and attempts to draw the arguments together in relation to the particular ways 'women's experience of IVF' can be seen to have functioned as a condensed signifier of much else.

It is hoped this mode of presenting the findings of this study is also useful insofar as it gives the multiple, various and complex interconnections between the four sets of representations discussed their full scope by not drawing them too tightly. In the end, a looser

structure felt much more appropriate to this material. There are several strong themes running through the material, and these are made explicit at various points. There is much that is left to be filled in by way of interconnection, however, and in this sense it is hoped the reader will find ample room to reach conclusions in addition to those I have made explicit.

Methodological Considerations

Data for Part Two of the thesis were drawn from newspapers, magazines, infertility guidebooks and clinical literature concerning infertility and IVF.[9] They are 'read' in terms of their construction as narratives and as discourse, identifying the ways in which they perpetuate certain dominant cultural systems of knowledge and belief. Data for Part Three are drawn from 20 interviews with women undergoing IVF, observations at IVF clinics, IVF clinic publicity material and informal discussions with clinic staff.[10] Extracts from the interviews are presented in order to illustrate the reasons women choose to undergo IVF, the demands of the procedure, the ways in which women change as a result of the experience of treatment and the difficulties encountered by women in resolving both their infertility and their experience of treatment.[11] In Part Four, extracts from parliamentary debate accompanying the passage into law of the Human Fertilisation and Embryology Act are used to explore the representation of 'women's experience' as part of public debate.

In the four Parts of this thesis, then, four contrasting sets of representations of 'women's experience of IVF' are presented. These are

drawn from different sources, or sites, of cultural production, and are therefore both overlapping and discordant to varying degrees. Such an approach derives from an overall concern with the many layers of cultural meaning which work to produce both individual subjective and more mainstream 'public' understandings of technological 'assistance' to the reproductive process. It derives from a model of culture that does not presume a 'neat fit' between 'dominant' or normative values and the way individuals are positioned by them. Likewise, it derives from a model of power that owes more to the Foucauldian assumption that it is dispersed, 'capillary' and productive than to more narrowly deterministic versions. Finally, it both relies upon and seeks to foreground an appreciation of the paradoxical and contradictory nature of women's relationships to patriarchal attitudes and structures, which in turn marks the whole of the feminist enterprise.[12]

As has been noted, the initial aim of the study, like that of Martin's, was to trace the effects of dominant cultural constructions of infertility and infertility treatment in the ways in which women articulate their experience. *Given* that women are positioned in certain ways by these dominant cultural constructions, how did they negotiate their relationship to them? However, as has also been noted, in analysing the data, it soon became apparent that most everything to do with the dominant cultural construction of infertility treatment, such as the way it is defined by medical discourse, the way it is shaped by social conventions, the way it is legitimated in public debate, the way it is regulated by the law, and so forth, seemed to be largely irrelevant to women undergoing treatment and were certainly peripheral to their understandings. What I discovered was a consistent single-

mindedness and determination which rendered all else secondary. This was the desire to have a child. As in Koch's study, the extent to which the desire for a child serves as the foundation for a worldview or *mentalite* specific to the experience of IVF, became forcefully apparent.

My interpretive focus shifted in relation to this appreciation. Instead of focussing on how women do or do not acquiesce to the demands made of them as a result of their enmeshment in the IVF procedure, in all its condensed discursive and technological modes of deployment, I focussed on the ways they define their path forward through it according to their own understandings of their location and their corresponding 'choices'. In particular, I focussed on the difficulties women encounter in following the IVF 'road', the ways they make sense of their 'journey', the strategies they employ to empower themselves, and the paradoxical nature of the ways in which some of the strategies produce new and unexpected dilemmas.

By pursuing this 'route' myself, of charting women's paths through a demanding process fraught with hurdles, as part of pursuing a PhD, there were times I felt I inhabited a very similar world to that of the 'obstacle course' of IVF. Though interviews in no way capture the ethnographic scope of traditional fieldwork, where the anthropologist lives with the people whose culture is the subject of analysis, there is nonetheless a degree of immersion produced by the interviews, the observations, and the long hours of manual transcription, sorting, selecting and retyping of interview data which creates a distinctly ethnographic depth or 'thickness'. It is for this reason that I often felt I had little to add to women's descriptions of themselves, as certain of them expressed succinctly the thoughts and feelings of many

other women, and neatly articulated the condensed nodes of the experience of 'living IVF'.

The Interviews

Twenty interviews were conducted in the academic year 1988-9, and worked up over the next three years, along with the remainder of the thesis (see Appendix A). The women interviewed were contacted through a participating clinic in the West Midlands, as my aim was to interview women who were in the midst of undergoing IVF. Women were contacted through a letter describing the study and filled in a reply sheet if they chose to participate. They were then visited in their homes for the interview, lasting between 1 and 4 hours, covering a range of issues in an open-ended fashion, and tape-recorded with their permission. Their partners were present if they wished them to be. This leads to some terminological confusion in the thesis, as I was sometimes interviewing women, and sometimes interviewing couples. Likewise, some women thought of themselves as women undergoing treatment, whereas others thought of themselves as part of a couple undergoing treatment. To have explored this issue in more depth would have been revealing. However, I have attempted to deal with it here by simply referring to 'women' as much as possible, since the focus is on their experience, and to refer to 'couples' only where it is the frame of reference employed by the woman herself.

The interviews began with questions about when women first became involved in infertility treatment, how it effected them, who they told, and how they got to IVF. The experience of IVF was discussed in terms

of various aspects of the treatment itself, how it effected their relationships, their jobs, and other aspects of their lives. The decision to opt for IVF was discussed in terms of what other possibilities they considered, how they found out about the technique, whether they had reservations about it, how much they knew about it beforehand and what they thought about its risks and low success rates.

This study did not concern a subject women found entirely pleasurable to discuss. The subject of infertility treatment is often not a happy one, even for women who have been successful. However, one of the difficulties of infertility is how hard it can be to discuss the subject even with close friends and family, or even with other people in the same position. This is not necessarily the case, of course, but it can be a more difficult area to be open about than other subjects, and in some ways it has no analogy in terms of the problems associated with disclosure. It is for this reason that the interviews sometimes provided a welcome opportunity for women to relate their experiences to an outsider unconnected to their day-to-day life. As assuredly confidential discussions, no risk of exposure was involved, and many women used the interviews to clarify their own thoughts in a comparatively protected space.

It should also be noted that the interviews took place in women's homes, and if they did not want to discuss a particular subject they did not feel unwilling to say so. Indeed I often said very little other than an occasional query once the interview started. The way women told their stories with confidence and assuredness, and often with a very moving amount of courage, impressed me and led me to feel the women I spoke with felt very much in control of the interview situation. Even

when becoming upset, for example reliving a painful memory which brought them to tears, I had a sense that the women I spoke with were on very familiar ground in which they 'knew what they were about'. Thus, despite being a painful and personal subject, the women who spoke to me were on the whole very open, in control and directive of discussion. It is likely women who did not feel as confident talking to an outsider or a researcher would not have agreed to participate in the study.[13]

The main point to be made about undertaking interviews and analysing them is that it is exhausting and overwhelming. I travelled to women's homes in an ancient and unreliable vehicle, often over distances of 50 to 100 miles, and often at night, to obscure destinations, on a road system to which I was then a novice. After this the interview took place, during which several levels of concentration are required, to listen to what is being said, whilst noting what is not being said, or how one thing that has been said contradicts something else, or does not make sense, and so forth, often for several hours. Following this I would inevitably return in a state of exhaustion.[14]

A different kind of mental exertion accompanies transcription and analysis of the interviews. Again, there are demands of concentration, as transcribing the tapes involves re-hearing the interview, with the luxury of simply listening, rather than having to interact, which enables a keener attention to detail. Likewise, transcription itself, though tedious, creates a sense of having taken in every word, every half-completed sentence, every shift in direction, and, sadly, every misjudgement or missed opportunity during the interview. During the analysis and writing-up process, large amounts of data must be

systematised, in order for the large quantity of disjointed information to be transformed into a coherent account.

The results of these interviews, presented in Part Three, comprise a portrait of 'the IVF experience' well worth the arduous task of their collection in their detailed depiction of IVF not only as an encounter with new reproductive technology, but as a process of reproductive decisionmaking and personal transformation. It is argued not only that such accounts are essential to an appreciation of the full extent of the effects of IVF treatment, but that such a portrait can only be compiled through the kind of careful listening and attention facilitated by an 'ethnographic' approach.

The Interview Pool

Systematic data on personal characteristics of the women interviewed, such as age, class, religious preference or educational level were not collected for this study. Since this was not a quantitative study, such data were not considered to be necessary. Nonetheless, a general portrait of the interview pool can be sketched as follows.

On the whole, the women interviewed were in their mid- to late-thirties, or early forties, and all were married. In addition, all of the women interviewed were white and, if not of a middle-class background, were living with what would be considered a middle-class degree of material wealth. Given that women were contacted through a private fertility clinic, such characteristics would be the norm. Most of the women had significant experience of paid work outside the home

and many had professional careers that were ongoing as teachers, nurses, social workers and secretaries. 85% of respondents claimed that paid work outside the home had helped them cope with the demands of infertility treatment.[15] However, a majority of 75% had either already left full-time employment or were planning to as a result of treatment. The women interviewed also worked, or had worked, as child-minders, assembly-line workers, managers and saleswomen and thus as a group represented a wide range of work experience, as would also be expected. The average number of years spent in previous infertility treatment was five, with a total of over a century of treatment amongst the group as a whole. The average number of years the women had been married at the time of the interview was nine.

Not all of the women interviewed were childless. Two had biological children, three had adopted children and one had a GIFT baby by donation. Neither were all of the women infertile, with three undergoing treatment because of their partner's infertility. In the remaining cases, reasons for treatment varied: in seven cases resulting from blocked tubes; seven from unexplained infertility and three with multiple factors that were shared. The average number of attempts already undertaken was three, with ten being the highest and one woman having become pregnant on her first attempt. Five of the women interviewed were pregnant at the time of the interview, producing a 25% pregnancy rate overall. Although higher than expected, this percentage of pregnancies for a group which on average had undergone at least three attempts is not significantly at odds with the broader clinical picture. This figure may also reflect a greater tendency for women who have been successful to agree to an interview, although not all of the women who

were pregnant at the time of the interview knew so at the time of their initial consent to participate in the study. It has also to be assumed that not all of the women who became pregnant would necessarily give birth, and there was no follow-up to this study to confirm the live birth rates.[16]

A very high percentage, 95%, of the women interviewed were well aware of the low success rate of IVF before they decided to attempt it. Few, however, knew very much about potential side effects or health hazards of the drugs or the technique.[17] When asked about side effects, only four women reported any at all, all of which were considered minimal and discounted. Similarly, when asked about the risk of multiple births, although all were aware of this possibility, no concern was expressed by any of the respondents, which is again consistent with what one would generally expect. In terms of alternatives to IVF, only one respondent had not considered adoption, with the remaining 95% having given it serious thought but having either encountered or anticipated difficulties, in particular their age. A significant majority, 95%, of the women interviewed praised the clinic where they were undergoing treatment, and had a high opinion of both their medical care and the clinic staff.

As a group, therefore, the women interviewed could be described as white, married and middle-class, well-informed and very positive about the clinic and their treatment. All had considered the option of IVF carefully before attempting it, and a majority had considered alternatives such as adoption.[18] This group therefore represents what might be described as very 'pro-IVF'. By definition, women who rejected the option of IVF would not be among this group, unless they rejected it

after trying it, which was not a decision taken by any of the women I interviewed. Again, follow up research, which might have revealed such decisions, was beyond the scope of the study.

The point to keep in mind about this group, therefore, is that they were articulate, well-informed and, at least initially, felt very positively towards their treatment. They would constitute a 'typical' British user-group of IVF in this respect.'[19] That despite being very 'pro-IVF' this group expressed many reservations about the technique, and, ultimately, some doubt about its validity or effectiveness as a means of resolving their infertility, is therefore a more significant finding than would have been the case had a group of less favourably inclined women been selected.

One of the most striking findings to result from the interviews was the consistency, in 100% of cases, of women stating that they felt they 'had to try' IVF. This finding, of nearly identical statements to this effect in *every interview*, clearly formed a strong common thread connecting what were, in other respects, quite disparate experiences of IVF. The exploration of what was meant by the phrase 'had to try' in turn became a major feature of the analysis of the interviews, and is elaborated in the Chapters in Part Three. Why women felt they 'had to try' IVF, and how this was related to their attempts to resolve their infertility (as a couple if not their own), became key questions structuring the analysis of the interviews presented here.

IVF as Part of 'Public Culture'

The question of why women felt they 'had to try' IVF is also significant in terms of the wider social context in which women's decisions about their reproductive futures are determined. The pressures on women to become mothers, to 'complete' a marriage through the bearing of children, and to realise their identities as adult women as wives and mothers are well-known and well-documented. It is these features of the social context of women's reproductive decisionmaking, for example, which are highlighted in studies such as those of Crowe and Williams discussed above. A more immediate social context is the increasing awareness of the rate of infertility[20], and wider public recognition of new techniques, such as IVF, which are available as forms of fertility assistance[21]. It is this, more recent, social context which is analysed in Parts Two and Four of this thesis, in which the representation of 'women's experience' of assisted reproductive techniques, and particularly IVF, are argued to have become condensed signifiers of wider cultural beliefs, such as those concerning scientific progress and traditional family values.

Rather than arguing that representations in the public domain have a directly determining effect on women's choices (which view is partly challenged here), the relationship between these sets of representations and women's representations of their own experience is more loosely drawn. Instead, an emphasis is placed upon the ways in which all of the representations of 'women's experience of IVF' presented here draw on similar sets of cultural meanings, in ways that are both mutually reinforcing and discordant. Hence, for example, it is suggested by some of the interview material that part of women's 'investment' in IVF as a 'solution', *even when they know it will most likely fail them*, derives

from a similar belief in scientific progress and the capacity of technological enablement to that portrayed in popular media accounts of the technique and in public debate. A major argument of the thesis is that IVF is a 'hope technology', uniting hope for a conventional family with the hopes invested in science and technology as means of enablement and progress.

Contrasts and Connections

The importance of 'hope' to the processes of making sense of IVF described in the four different contexts considered in this thesis is a strong thread connecting them together. However, there are also important contrasts in the ways in which 'hope' functions in these different contexts. As noted earlier, a significant component in the evolution of the argument presented here was a move away from an emphasis upon how the 'same' message was being re-articulated across a range of domains, and towards a recognition of how common themes were enunciated differently. The former approach is not so much inaccurate or misplaced as simply obvious. There is a self-evident link between the media celebration of joyful couples with their miracles babies and the increasing numbers of women and couples who are willing to undergo IVF. It is in some ways, therefore, more revealing to consider what is less obvious about the relationship between 'dominant' representations of IVF and women's choices to opt for it, such as the differences in how 'hope' functions in these domains.

In the context of women's own accounts of undergoing IVF, for example, hope plays a prominent role as a motivating factor. It is hope

for a child which leads women to opt for IVF. This hope is described as what makes IVF 'worth it', even when it fails. 'Keeping the hope alive' becomes an end in itself in the context . It is seen as an essential and rewarding component of the experience of undergoing IVF.

This is hardly surprising given the extent to which the hope motivating participation in an IVF programme is over-determined. The hope is not only for a technological miracle (a 'miracle baby'). It is for conjugal fulfilment, a sense of individual completion or accomplishment, or a resolution to a woman's or a couple's reproductive uncertainty. Needless to say, the hope is for a child, but also for a family, as there are no families without children. The hope therefore stands for everything a baby represents, in terms of the woman's or the couple's futures, identities, and so forth.

Yet this hope also comes to mean something else that is specific to the experience of undergoing IVF, and something quite different. Over time, in the wake of serial failures, and in the face of physical, emotional, financial or other impediments to continuing treatment, hope can become the major obstacle to a reproductive resolution. The extent to which 'keeping the hope alive' has motivated progress forward through IVF, for all of the over-determined reasons it has the force to do so, is one of the most difficult features of the 'aftermath' or the 'other side' of IVF. The very hope that 'kept you going' is what then needs to be 'abandoned'. In this context, hope takes on a set of meanings in the context of the experience of IVF that are absent from media accounts and public debate.

The meaning of hope in the context of public debate, by contrast, and as is discussed at greater length in Chapter Eight, is quite

different. In this context, hope is similarly over-determined. However, what it 'stands for' can be seen as more refracted and diffuse. The hope of women undergoing IVF itself becomes a 'condensed signfier' of much wider cultural hopes and beliefs, symbolised by the 'miracle baby' which unites faith in scientific progress with traditional family values. In contrast to the context of personal experience, there is little attention in public debate to the scenario encountered when hope has run out, or has itself become an obstacle to progress. Rather, the exclusion of such consequences is one of the definitive features of the way in which 'women's experience of IVF' is represented in public negotiations of new reproductive technologies.

Yet another set of meanings attached to hope are evident in popular media representations of infertility and IVF. In these accounts, a dichotomy between 'happiness' and 'hopelessness' is key to the structuring of accounts of 'desperate' infertile couples opting for a 'technological miracle'. Women's hopes for success are foregrounded in accounts of IVF, from which the woman then disappears and is replaced by a technical description. Her hope is essential to both the narrative and discursive structuring of these accounts, which proceed from hope for a technological miracle to joy in a 'miracle baby', and, as in public debate more widely, foreground the joyful union of scientific progress in the service of family values.

Hence, across a range of domains are evident similar themes and shared signifiers. These are the 'condensed nodes' of cultural meaning through which new reproductive technologies are coming to be made sense of in particular ways across a diversity of sites and locations. The aim here has been to examine each of these sites in terms of the specific

processes that differentiate them, as well as those through which they are interconnected.

Conclusion

A frequently encountered criticism of representational analysis is its tendency to reduce cultures to texts, and to reduce politics to meanings and ideas. A similar criticism of cultural studies approaches, which are often, like this study, ecclectic in their use of evidence and theory, is that they practice an opportunistic hermeneutics in selectively drawing upon disparate contexts to produce a semblance of coherence. This problem is often described as one of evidence. Neither of these criticisms are wholly undeserved, and they are concerns which have informed the discussion presented in this thesis.

In contrast, the strength of both cultural studies and cultural anthropology, in both intellectual and political terms, is their shared emphasis on the importance of underlying conceptualisations and assumptions to individual and social practices. Crudely put, something has to be 'thinkable' before it can become 'do-able'. The marxist critique of idealism can in this sense itself be seen as ideological, premised as it is upon an assumption this 'level' can be seen as distinct from others.

This is a particularly important feature of what is occurring in the context of the development of new forms of reproductive technology, which not only involve literal conceptions but imaginative ones. To undertake IVF, this procedure has to be seen as desireable, practicable and legitimate. It is by no means self-evident that it should be so.

Likewise, for IVF to be publicly applauded and valorised, this technique has to be seen as beneficial, desireable and legitimate. Its transgressive and unsettling potentials must somehow be rendered acceptable. Such processes are of profound political and cultural significance. Their implications cannot be underestimated. With new ways of 'thinking' reproduction and doing reproduction also come new forms of reproductive control. It is for this reason that a better understanding of the underlying cultural constructs through which they come to make sense in particular ways is essential.

Correspondingly, this thesis addresses a number of different levels of conceptualisation, and attempts to loosely sketch the ways in which they interrelate. It began as a project aimed at exploring a source of feminist uncertainty, namely, women's relationships to new reproductive technologies. This focus derived from the way in which women's choices to opt for IVF condensed, or appeared to condense, an array of longstanding feminist concerns into an overdetermined instance, or moment. The aim was therefore to conduct interviews with women undergoing IVF to attempt to locate their understandings of their choices in relation to the wider context, and to explore this 'problem area' as a means of clarifying feminist understandings.

Yet, as has been described, both the wider context and women's representations of their own experience led to a reconceptualion of these aims, and, at once a more narrow, and a more diffuse object of inquiry. It was through this focus that I both arrived at a different understanding of the research 'problem', and the overall structure of the thesis.

The thesis presented in these Chapters is thus a record of several levels of transformation, both internal to the project itself, and in relation to wider changes. It is informed by major changes within feminist theory and politics, which reflect a continuing effort to recognise the multiple and contradictory dimensions of both women's lives and the wider context in which they are lived. It is aimed at effecting better means of feminist engagement with public debate over new forms of reproductive intervention, which has grown rapidly in the years during which this project was researched and written. It is a record of changes in my own personal understanding of feminism, what it can achieve, and how it is likely, in my view, to effect social and political change. It is also an important record of changes in the lives of women who have chosen to undergo IVF, and sources of uncertainty in their accounts which closely parallel those of feminists regarding the technique of IVF.

Perhaps most importantly, this thesis is an attempt to analyse a critical period in time when new reproductive technologies began to be much more widely known and more widely available. These technologies, the choices they offer, the dilemmas they pose, and the risks they bring, cannot simply be added in to existing understandings. By the very fact of their existence, they alter certain previous assumptions about what is possible, what is imaginable, what is 'real', and what is desireable or legitimate. It is for this reason new frameworks must be developed in order to assess their social, political and cultural significance. It is in this context that 'the politics of reproduction' takes on a huge and incomparable significance, which, by definition, is almost beyond our comprehension.

Inevitably, therefore, new reproductive technologies require new ways of thinking about reproduction. The Chapters of this thesis address several ways in which new forms of reproductive intervention require new ways of 'making sense' of reproduction. The media accounts discussed in the next Chapter comprise one example of this: how new forms of reproductive intervention have resulted in new forms of media representation -- new forms of 'news'. The experiences of women undergoing IVF discussed in Part Three also document a process of 'making sense' out of reproductive choices, which until recently did not exist. Likewise, the public debate already discussed and returned to in Part Four is an important site of contestation over the meanings, values and definitions through which previous assumptions about reproduction will give way to new and different ones. In all of these sites and locations can be documented the emergence of new means of understanding the relationship between human reproduction and technology. It is to the analysis and documentation of these that this thesis is addressed.

References for Chapter Three

1. See, for example, Faludi (1991) for a discussion of the current 'backlash' against feminism.

2. This knowledge, of the dangers of IVF, was always a particularly worrying issue for me during the interviews. In fact, a woman died from IVF at the clinic where I did the interviews shortly after I finished them. It was quite obvious to me from the interviews that such a possibility would never have occurred to most, if any, of the women I spoke with.

3. I should note the clinic I observed in, unlike the clinic the women I interviewed attended, was based in a large public hospital which did not subscribe to the same level of service ethos associated with private medical care.

4. Some of the differences in the conduct of staff in the hospital I observed as opposed to the clinic attended by the women interviewed can be attributed to the differences between the public and private sectors of health provision described above. Significantly, such contrasts are oftne noted in the interviews and contribute to the sense of 'good fortune' dewscribed by many of the interviewees concerning their experience of IVF treatment.

5. Although beyond the scope of this thesis, an ethnographic study of this clinic would have been revealing in several respects. The gender

politics of IVF as a clinical practice are quite interesting in that it is a procedure that depends on highly developed teamwork, and thus breaks down some of the more traditional medical hierarchies. It is also increasingly a 'women's field' in various senses. Infertility treatment is also of interest in that it has emerged in Britain as a practice that is in between the public and the private health care systems (see Pfeffer and Quick, 1988).

6. By 'lack of fit' is meant in part the impression I gained that even if there were no media coverage of IVF whatsoever, it would still be desired by the women who choose it, for all of the reasons they did so. For all of the ways the media representations might have influenced them, the main reasons they desired to undertake IVF (to either have a child or feel they had done everything possible to try and have one) would have existed in the complete absence of any media coverage of this technique whatsoever. The parents of Louise Brown, for example, far from being motivated in any way by the novelty or celebrity of IVF were unaware it had never been successful (see Brown, Brown and Freeman, 1979; see also Edwards and Steptoe, 1980).

7. This also enabled me to discover the problem in how I had defined the 'problem', for example, in terms of 'actual experience' versus 'constructions' of it, or in terms of the 'gap' between women's choices to opt for IVF and feminist criticisms of the technique.

8. See Franklin, 1991a, in press a, and in press b.

9. Data for this Chapter were collected between 1986 and 1989. A further discussion of the data collection and methods of analysis is presented at the beginning of Chapter Four.

10. A description of the interview pool is provided below, and is discussed further in Part Three.

11. All of the names used to refer to interviewees in this thesis are pseudonyms.

12. See note 3, Chapter Two.

13. Of 85 requests to participate in the study, 25 positive responses were received, comprising less than a third of the potential interviewees. Of these, five proved impractical to pursue for logistical reasons, leaving 20 remaining participants, all of whom were interviewed. Hence, more than three-quarters of those who might have been interviewed were not included in this study, again indicating the importance of the self-selecting factor in the resulting portrait of the experience of IVF presented.

14. Part of the intensity of these interviews was also due to the subject matter. Infertility was described by most of the women interviewed as a major personal crisis or even disaster. Speaking to women in the midst of undergoing treatment was also infused by all of the intensity of the programme itself, and the extent to which it 'takes over' a woman's life. Hence, the interviews were often very fast-paced

and emotive, resulting in the discomfiting situation of discussing highly personal and upsetting issues with a complete stranger. This sort of ethnographic encounter, like the ethnography of elites, creates particular sorts of stress for the researcher.

15. For nearly all of the women interviewed, their paid work was also an important means of financing their treatment.

16. For live birth rates resulting from IVF programmes in the UK, see the published *Reports* of the Voluntary, and later 'Interim', Licensing Authority (see bibliography). This function was, as of 1991, assumed by the Human Fertilisation and Embryology Authority.

17. See Klein, 1989; and Klein and Rowland, 1989 for comprehensive accounts of both the known and the as-of-yet indeterminate hazards of the drugs and procedures used in IVF treatment.

18. This finding is of particular importance in relation to the claims by some feminists that women who choose IVF are ill-informed, or simply 'duped' by medical or media representations of the technique. Though there is an element of misinformation involved in many women's choices to opt for IVF, such as little or no warning of the risks involved in the procedure, the findings of this study confirm that a high degree of awareness of the costs of the technique, in physical, emotional and financial terms, is not incompatible with continuing to see it as a highly desireable option.

19. The homogeneity of this group in terms of class is more typical of Britain than it would be of private clinics in other countries where health insurance programmes cover part of the expense of IVF. At the time of the study, this was not a readily available option, and none of the interviewees received any support from private health insurance schemes.

20. A recent article in *Time* magazine (September 30, 1991), for example, refers to an 'infertility epidemic'.

21. Since the birth of Louise Brown, infertility treatment has become a major service industry in its own right both in Britain and in many other countries, including many countries in the Third World, such as India and Brazil. That infertility treatment should have become a major private healthcare enterprise in Britiain during the Thatcher period, in which the family was defined as the primary unit of consumption, was also significant. Reproductive choice was not unusually expressed in very explicit consumer terms during the interviews, as in hypothetical trade-offs between another 'go' at IVF versus a holiday, a new three piece suite or home redecorating. That such comparisons are made is hardly surprising, and is, indeed commonsensical. This is, however, one of the main points underscored by this Chapter, that the cultural meaning of reproduction and of reproductive choice is in the process of undergoing significant shifts in the context of new reproductive technologies. See further Strathern, 1989.

PART TWO

PUBLICISING IVF

Only a few years ago most couples with infertility problems had to turn to adoption or remain childless. But now, with advances in pharmaceuticals, micro-surgery, in vitro fertilisation and embryo transfer, many viable options have opened up to infertile couples -- with the result that 'miracle babies' are being born every day. *There is every reason for hope.*

Perloe, 1986, p. ix, original emphasis

Babies have price tags. The currency differs according to the circumstances. Sometimes the cost is measured in monetary terms, sometimes physical or emotional, sometimes spiritual. But every bundle of joy has its price. And while its unfashionable to state this in the midst of today's fervent baby worship, that price may be more than some of us can afford.

Hopkins, 1992, p. 84

CHAPTER FOUR

Deconstructing 'Desperateness':
Popular Representations of 'Women's Experience of IVF'

Introduction

The birth of Louise Brown was not only unique in terms of scientific importance: it was also a unique media event, arguably the most publicised birth ever to have occurred in the modern period. With the birth of Louise Brown was thus also born a new kind of media coverage of 'brave new babies' and 'miraculous conceptions'. Emblazoned headlines of procreative 'firsts' continue to appear regularly, and now comprise an established domain of news coverage in both the tabloid and the 'respectable' press.

In the wake of the birth of Louise Brown, Britain has remained at the forefront of reproductive medicine and science in terms of both research and clinical practice. Although not made available on the National Health Service, IVF and other procedures rapidly became available in private clinics, such as Bourne Hall, where Robert Edwards and the late Patrick Steptoe established their practice. Attracting an international clientele, and offering state-of-the-art reproductive services, the number of such centres, particularly in England, expanded rapidly.[1] In the city of Birmingham, for example,

the number of IVF clinics tripled, from two to six, during the three-year period of fieldwork (1986-9).

Among the first countries to initiate legislative procedures aimed at securing regulatory guidelines for assisted reproductive techniques, Britain also received much international attention in relation to the publication of the Warnock Report in 1984. With the appearance of the *Report*, parliamentary proceedings began in earnest, resulting in a string of parliamentary decisions concerning various aspects of assisted reproduction.[2] In sum, there emerged a significant public debate concerning the social, ethical and legal implications of new reproductive technologies.

The critical role of the media in this debate cannot be underestimated. As the media introduced Louise Brown to a worldwide audience, so too was it the means through which emergent understandings of new reproductive technologies were purveyed. As public interest in, indeed fascination with, the novel reproductive possibilities enabled by new forms of technological assistance increased, so too did media coverage of this new type of news. As regular features began to appear, so too did particular conventions of representation.

The following are typical of the headlines through which assisted reproduction in general, and IVF in particular, were introduced to the British public in the mid- to late-1980s: *NEW HOPE FOR THE CHILDLESS*, *COMFORT FOR THE CHILDLESS*, *JOY FOR BABY HOPE COUPLES*, *CHILDLESS COUPLES GIVEN HOPE*, *INFERTILE COUPLES GET HOPE FROM NEW METHOD*, *MOTHER'S JOY OVER 1,000th TEST-TUBE BABY*, *TEST-TUBE BOY FOR THRILLED PARENTS*, *TEST-TUBE TRIPLETS A CITY FIRST FOR 'ECSTATIC' PARENTS*.[3-11]

Through such representations, a now familiar story of infertility and its 'treatment' via new reproductive technologies was widely circulated. In these early accounts, the typical description of infertile women was one that emphasised their 'desperation,' 'anguish' and 'suffering' and refered to them as 'victims of childlessness,' 'unwillingly childless,' 'involuntarily childless' or as the 'sufferers of infertility'. Juxtaposed against these tales of 'desperateness' were stories of 'happy couples' who had won their battle against childlessness by producing a 'miracle baby' with the help of modern medical science. Together, these two sets of stories, of happiness and hopelessness, comprised a major frame of reference for discussions of infertility treatment.

The media representations discussed in this Chapter were a formative source of public opinion concerning new reproductive technologies at a critical period in the process of their public legitimation. They thus comprise an important source of cultural imagery in terms of the formation of public consensus during the period immediately preceeding, and concurrent with, parliamentary debate of the Human Fertilisation and Embryology Act, passed in 1990. Although media representations since this period have begun to become more diverse (eg Hopkins, 1992), those of the period described here have a unique importance as the means through which IVF was initially introduced to a wider general public. In their formulaic representation of both infertility and its 'treatment', particularly via IVF, these media accounts provide an illuminating case study in the production of particular meanings through which both commonsense

and more authoritative constructions of assisted reproduction were established.

Most importantly, these representations are notable for their foregrounding of women's experience of infertility, and their 'desperate' desires for reproductive assistance through technology. The centrality of women's needs and desires to the shaping of public opinion and consensus concerning new reproductive technologies is thus highly visible in these media accounts. It is to this feature of these accounts that this Chapter is particularly addressed, as it clearly indicates the ways in which women were simultaneously a defining presence and a structuring absence within the public debate. This feature of public debate is returned to in Part Four.

Methodology

Within cultural studies, the influence of popular culture in the formation of public debates about sexuality, reproduction and the family is a subject which has received considerable attention. Of the many recent approaches to this subject, those which analyse narrative and discourse are two of the most widely used. Both emphasise the 'constructedness' of popular culture, and the extent to which it is both determining of, and determined by, prevailing social practices and beliefs. Both also stress the importance of understanding popular culture in terms of the social forces which inform both its production and its consumption. In particular, these approaches have been helpful in demonstrating how social practices which are

represented as 'natural' or as 'biologically determined' are socially constructed according to specific conventions.'[2]

In the first section of this Chapter, extracts from a variety of sources are used to demonstrate the narrative construction of popular representations of infertility. Drawing upon a range of popular sources collected during the period of fieldwork (1986-9), including articles from the local and national press, infertility guidebooks and government documents, the social construction of infertility is analysed using approaches developed within cultural studies. Central to this approach are questions of how descriptions of infertility and reproductive technology are constructed as stories -- as linear progressions of events over time, structured by the emergence of a conflict or obstacle, and the subsequent need to provide a resolution. In the second section, the discursive construction of these accounts is the subject of discussion. Returning to the examples presented in the first section, suggestions are made about the ways in which these same accounts can be seen to operate discursively to produce a regime of medical and scientific 'truth' about the infertile body.

Whilst the emphasis in both sections is upon the production of ideas in accordance with dominant social practices and beliefs, there are also many *discordances* evident within the examples discussed. Indeed, I have argued that one of the most important features of the accounts, both discursively and as narratives, is the way in which they *attempt* to mediate the tensions and contradictions posed by 'artifical conception'. The question of how these representations mediate certain salient contradictions, and the question of what these accounts obscure are explored further in the conclusion.

Section One: The Desperate Infertile Couple Stories

The opening passage from a feature which appeared in the *Times* in 1986 is typical of the media representations of the new reproductive technologies as treatments for infertility during the mid- to late 1980s:

> The bright clusters of snapshots pinned to the memo board in a London clinic are a constant reminder that at least some dreams come true. Every picture of a new-born baby tells its own story of a successful fight against infertility.
>
> More than anything else in her life, Tessa Horton wants to add to that collection. But she is 38 now and after five years of disappointment, she knows the odds are against her.
>
> Neither she nor her husband Michael will surrender their dream while the doctors continue to offer them even a slender hope (....)
>
> For the Hortons, and an estimated one million other couples in Britain striving to overcome childlessness, doctors can resort to a remarkable and increasing number of treatments.
>
> Advances in the use of drugs, surgical techniques and *in vitro* fertilization mean that babies are now being born to couples who until quite recently would have been described as hopeless cases. (Prentice, 1986, p. 10)

This story contains all of the standard components of the desperate infertile couple stories. The plot is structured around the tension between the 'desperate' desire for a child and the biological inability to produce one. It is both an adventure story and a

romance, in which a successful fight 'against the odds' may end in 'a dream come true'. It is an epic story of medical heroism in the face of human suffering and the forward march of scientific progress. It is a story of winners and losers, of happy endings for some and hopelessness for others. It is, in fact, many stories condensed into one, an overdetermined story with several familiar themes. Most importantly, however, it is a story about 'desperateness'.

The representation of infertility in terms of 'desperateness' is a subject which has been commented upon by other researchers (Pfeffer & Woollett, 1983; Pfeffer, 1987). Naomi Pfeffer has written extensively on the subject of the stigma that is attached to infertility as a result of representations such as this. She writes:

> Besides their involuntary childlessness there is one characteristic which the infertile are said to share, that of desperation. The word desperation or some such synonym appears so frequently in conjunction with infertility that sometimes it appears that what troubles infertile men and women is not the absence of a child as such but some form of emotional disorder related to their failure. Desperation combined with infertility appears to produce a particularly potent mix; one that forces fecund women to lease their womb, sends infertile men and women scouring the world for orphans to adopt and incites some doctors into developing new techniques that subject people to many indignities. (Pfeffer, 1987, p. 82)

Pfeffer's argument is that the highlighting of 'desperateness' not only stigmatises the infertile but obscures the broader social context

in which it must be understood. Moreover, she maintains, not all infertile couples are necessarily 'desperate' for children. To the contrary, she points out, there are, for many people, clear advantages to remaining 'child-free'.

Despite the fact that 'desperateness' need not necessarily result from infertility, it is consistently the primary frame of reference within popular representations of infertility. Pfeffer is concerned with how this representation effects the infertile. However, the question in this Chapter is how the focus on desperation effects the formation of public opinion and debate over reproductive technologies. Almost invariably, these stories revolve around two central questions: 'why are they desperate?' and 'what are they desperate for?'. As a result, these representations proceed first in terms of *how the desperateness is accounted for*, and second, *how it can be resolved*. It is the need to account for the 'desperateness', and then to resolve it, which provides the central conflict structuring the narrative movement in these accounts.

Accounting for 'Desparateness': the Social Pressures to Conform

The accounting for, and the resolution of, 'desperateness' are commonly presented through two explanation systems: the social and the biological. These two explanation systems work together in ways that are both complementary and contradictory. In the first part of this Chapter, social and biological explanations drawn from popular texts are presented separately. Later in the Chapter, their relationship to one another is discussed.

Social pressures to conform to the conventional roles of adulthood are one of the most frequently encountered explanations for the emotional stress suffered by the infertile and their 'desperation' to produce a child. According to this explanation, the stress of infertility derives from the sense of social failure or emotional loss it may cause an individual or couple. The inability to produce a biologically-related child is represented in terms of a sense of exclusion, a lack of self-esteem or a loss of identity.

In the article from the *Times* cited above, expert testimony from a psychiatrist is provided to explain this loss:

> They face not only the loss of self as the kind of person they would have become, but the loss of the imaginary family, and with it the kind of life they would have led. (Prentice, 1986, p. 13)

The Warnock Report also refers to the loss of social identity and the sense of personal failure that may result from infertility:

> Childlessness can be a source of stress even to those who have deliberately chosen it....They may feel that they will be unable to fulfill their own or other people's expectations. They may feel excluded from a whole range of human activity and particularly the activities of their child-rearing contemporaries. (Warnock, 1985, p. 9)

These and many other examples demonstrate that the need for social approval is one of the major causes of the 'desperateness' said to characterise the infertile within popular representations of infertility. It is their 'desperateness' for social approval and

their biological inability to achieve it which provides the central conflict within these representations.

In *Getting Pregnant in the 1980s*, a popular guide to *New Advances in Infertility Treatment and Sex Pre-selection*, the authors, a doctor and a scientist, write:

> For most individuals, life moves in a progression that is highlighted by the events of marriage and childbirth. When this progression is interrupted by infertility, it produces an effect beyond just the physical absence of a child. A couple may, for the first time, feel they have lost control over a significant part of their lives. Their own anxieties about infertility may be magnified by well-meaning, but unthinking, relatives and friends who continually ask about the prospects for pregnancy. (Glass, 1984, p. 1)

It is because 'life moves in a progression' that infertility poses an obstacle to happiness. It is the disruption of the normal progression in the lives of 'most individuals' which causes them to 'feel they have lost control' and to suffer from 'anxieties' about their infertility. In *New Conceptions: A Consumer's Guide to the Newest Infertility Treatments*, author Lori Andrews makes the same point, quoting from a psychiatric expert who claims that 'No one enters a marriage expecting to hear that they are infertile' (Andrews, 1985, p. 86). Socially and emotionally, the stress of childlessness is attributed to failure in fulfilling conventional adult roles and failure to 'found a family'. The cause of 'desperateness', in other words, is an inability to conform to social norms.[13]

However, the suggestion in these accounts of an inevitable trajectory from marriage to childbirth, in which infertility can only be understood as an obstacle to happiness, is both simplistic and reductive. For whom is childlessness unacceptable? Under what conditions? For whom is adoption problematic? Must infertility continually be reduced to 'desperateness'? Because the narrative sequence of events begins with a 'desperate' infertile couple, who already desire to conform to the traditional biological family, the inevitability of life's 'progression' along only one trajectory which ends in childbirth is repeatedly reinforced. As a result, alternative childrearing practices are obscured. Couples or individuals not 'desperate' to conform, such as those who remain childless, those who adopt, lesbian and gay parents, or others who parent children non-traditionally do not fit into the desperate infertile couple story, and are therefore not represented.

In sum, the narrative representation of the social pressures upon the 'desperate' infertile couple offer only certain very specific positions to the reader. The reader is positioned to identify with the 'desperate desire' for conformity to the traditonal nuclear family, for conventional social approval, and for biologically-related children. The experience of infertility, however, does not reduce to this. And the desire for a family or for children may be quite a different thing from the experience of actually having them. Thus, the narrative representation of the 'desperate' infertile couple limits the kinds of questions which might be asked to only one: how can a pregnancy be achieved?

'Natural' Pressures: the Inbuilt Drive to Reproduce

In addition to social pressures, many popular representations of infertility also draw on the idea that there are natural, even biological, pressures to have children which cannot be suppressed. Thus, the desire to have a family is not only represented as a desire to conform to social expectations but as a natural or biological desire independent of a social context. The opening paragraph of *The Infertility Handbook*, a recently published, popular guide to infertility 'treatment' written by a doctor and a science journalist, reproduces this view precisely:

> Call it a cosmic spark or spiritual fulfilment, biological need or human destiny--the desire for a family rises unbidden from our genetic souls. In centuries past, to multiply was to prevail--the family was stronger, and better able to survive, than the individual. (Bellina and Wilson, 1986, p. xv)

The conflation of the language of evolutionary genetics with the language of spiritual desire and personal fulfillment in this passage (eg. 'genetic souls') is revealing. It suggests that the desire to have a family is not merely social but also biological, genetically determined by our evolutionary heritage and essential to our survival both as individuals and as a species. This view is reiterated in the introduction to *The New Fertility*, another popular guide to infertility treatment written by Dr Graham Barker. In the introduction, Barker describes the desire for parenthood as 'the natural product of pair bonding' and explains that 'the desire to

produce children is deeply rooted in biological instinct...and a natural expression of love' (Barker, 1986, p. 9).

Another example of this view is expressed by Lois Davitz, author of *Baby Hunger*:

> Baby hunger is powerful, defying all laws of logic. The drive to have a baby unleashes a whole range of obsessive emotions a woman may never have had to face. When a woman has baby hunger, nothing else is as important to her as this inner drive to bear a child. (Davitz, 1984, p. 1)

These views are also publicly expressed by test-tube baby doctors such as the late Patrick Steptoe (who wrote the forward to Barker's book). At a conference in Oxford, Steptoe publicly stated that 'It is a fact that there is a biological drive to reproduce'. He went on to claim that 'women who deny this drive, or in whom it is frustrated, show disturbances in other ways' (quoted in Stanworth, 1987, p. 15). In each of these accounts, the existence of an instinctive biological urge to reproduce, which is independent of the social context, is presented as an explanation for the 'desperate' desires of the infertile to procreate successfully.

This view is not limited to popular representations of infertility or individual members of the medical profession. The Warnock Committee expressed a similar view in their report, stating explicitly that:

> In addition to social pressures to have children there is, for many, a powerful urge to perpetuate their genes through a new generation. This desire cannot be assuaged by adoption. (Warnock, 1985, p. 9)

In this account, as in others, the argument that a sense of 'desperateness' results from biological urges which cannot be supressed is used to complement the argument that this 'desperateness' is the result of social pressures. Indeed these two arguments are used to reinforce one another and are obviously understood as complementary explanations for the 'desperate' desire to reproduce biologically that couples feel. Not only are they 'desperate' for social approval, these accounts suggest, but it is 'natural' they should feel a powerful urge to reproduce because it is a 'biological' drive.

However, if the drive to reproduce is biological, then everyone shares it, whereas if it is a product of social expectations, then only people who desire to conform to convention will be 'desperate' to reproduce. In other words, although the social and the biological explanations are used in these accounts as if they complement one another, their premises are contradictory. Patrick Steptoe, for example, simultaneously believed that all women have a biological drive to reproduce, and that it is immoral for lesbians or a single women to have children. Thus, for socially acceptable women, biology should be destiny, whereas for socially unacceptable women, the demands of biology should be restricted by social sanctions.

This shifting use of social and biological explanations of reproductive 'drives' reveals how contradictory explanations can be adapted to the dictates of particular moral and political beliefs. *Indeed, these contradictions are necessary for this sort of moral argument.* The same is true of many representations of sexuality, in which the relationship of heterosexuality to reproduction is depicted

as 'natural' or as socially and morally determined depending upon the circumstance. In the case of infertility, life is said to move in an inevitable progression, dictated by the forces of both social convention and biological urgency, for some but not for others.

Thus, in answering the question 'why are they desperate', the desperate infertile couple stories provide two explanations. They are 'desperate' because of social pressures to conform, and they are 'desperate' because of biological pressures to reproduce. However, these claims are used selectively, so as to produce explanations of the experience of infertility which reinforce social norms. Through familiar narrative mechanisms, the contradictions between the social and biological explanations are obscured, and they are held together as mutually reinforcing explanations of the 'desperateness' of infertility. Examples which might suggest alternatives to existing social norms are excluded from these stories, indeed are precluded by the structural requirements of the narrative.

Resolution 1: Medical Experts and Scientific Progress

In addition to providing explanations of the cause of 'desperateness', it is also necessary within popular representations of infertility to provide resolutions to this dilemma. This too is accomplished through familiar narrative mechanisms. Moreover, like the narrative construction of the causes of infertility, narrative resolutions of the dilemma of infertility contain it forcefully within existing social institutions and practices.

One of the most important features of the desperate infertile couple stories is the way in which they directly link the 'desperate' desire for a child with the hope for a medical 'cure'. Physically, there is only one possible resolution to the desperate infertile couple story, and that is a medical cure. The narrative movement from cause to effect here again obscures alternative options. Having constructed infertility as a biological problem, there is no alternative to a biological resolution. In these stories it is the recently acquired capability of medical science to provide a child for infertile couples which provides *the only hope of resolution.* As a result, the difference between happiness and hopelessness rests entirely in the hands of medical experts. In the *Times* article quoted above we read that:

> *Their only hope* lies with the gynaecologists, andrologists, urologists, endocrinologists and others who specialise in treating infertility, including the growing number of experts in *in vitro* fertilization -- the so-called "test-tube baby" doctors. (Prentice, 1986, p. 10, my emphasis)

Thus, within and framed by this tragic narrative of the 'desperate' infertile couple is a catalogue of the latest discoveries of medical scientists in the laboratory. In the language of advancements, achievements and progress, we read descriptions of medical scientists who are striving to alleviate the condition of infertility. In the *Times* article, we are informed that:

> [S]ome surgeons are now applying lasers to tubal surgery. Mr Simon Wood, a consultant gynaecologist at the Royal Devon

and Exeter Hospital, has achieved a 33 per cent live birth rate in a small number of patients using a laser. (...)

Last November, Australian scientists announced they were the first team to successfully freeze and thaw human ova (...)

Professor David Baird is trying to develop tests to identify which fertilized human eggs are healthy, and which are abnormal. They hope to exclude abnormal "pre-embryos" from IVF treatment. (Prentice, 1986, p. 10)

This glossy view of scientific progress is shared by many authors of infertility guidebooks. In *Miracle Babies and Other Happy Endings*, the author, a doctor, writes:

> Only a few years ago most couples with infertility problems had to turn to adoption or remain childless. But now, with advances in pharmaceuticals, micro-surgery, *in vitro* fertilization, and embryo transfer, many viable options have opened up to infertile couples -- with the result that 'miracle babies' are being born everyday. *There is every reason for hope.* (Perloe, 1986, p. ix, original emphasis)

A similar vision of scientific progress was also espoused by the Warnock Committee, who described the development of *in vitro* fertilization as 'a considerable achievement' which 'opened up new horizons in the alleviation of infertility'. In their report, the Committee claimed that advances in 'the science of embryology' have created 'hope of remedying defective embryos,' 'pride in technological achievement,' and 'pleasure at the new found means to relieve...the unhappiness of infertility' (Warnock, 1985, p. 4).

Enthusiastic representations such as these, uncritically depicting the 'achievements' of medical scientists in the 'battle' to overcome infertility, provide the adventure component to the desperate infertile couple story. It is important to emphasise the manner in which this component of the story is both introduced and framed by the hopes and desires of 'desperate' infertile women, such as Tessa Horton in the *Times* article above. Just as it is the woman's body which, quite literally, contains the 'reproductive frontier' which is the subject of manipulation by the 'pioneering' medical scientists described in this account, so it is her emotions and her desires which contain these descriptions within the text itself. It is the narrative movement from conflict to resolution which makes this shift in perspective, from infertile woman to medical expert, appear 'logical' despite the fact that it involves quite a dramatic transition in point of view.

A related consequence of this narrative structure is that the woman who is used to frame the story suddenly disappears with the introduction of reproductive technologies. From being the subject of the text, she is transformed into its object as soon as the medical descriptions begin. Whereas her point of view begins the story (eg. 'Tessa Horton wants...'), she is eclipsed by the more privileged point of view of the medical/scientific 'expert' shortly thereafter. The transition in the language is dramatic. In the space of one paragraph we move from the description of Mrs Horton, who 'lives from one appointment to the next', to a description of ovulation and 'the complex interplay of the pituitary hormone *FSH* (follicle stimulating hormone) and the hormone oestrogen in the ovary'. The language shifts

directly from the emotive description of 'slender hopes' and 'dreams come true' to the detached objective language of scientific description. 'Mrs Horton' is replaced by parts of her anatomy: 'eggs', 'tubes', 'ovaries' and 'embryos'.

The focus shifts as well from a human drama to a techno-scientific one in which detailed descriptions of technique figure centrally. Thus we are led directly from the 'desperate' infertile woman who 'will not surrender [her] dream' to the 'small pumps placed beneath the skin, which release regulated pulses of hormones', and the 'hundreds of embryos...now stored in liquid nitrogen tanks at 200 C below zero'. The woman described in the first four paragraphs is displaced by ten scientists, five scientific teams and over a dozen techniques in the next forty paragraphs, which constitute the bulk of the story (Prentice, 1986, p. 10)

Sometimes these accounts do not return to the woman at all. In these cases, the stories simply become adventure stories about techno-pioneers on the frontiers of reproductive biology. This absence results from certain tensions in the relationship between infertility and new reproductive technology. Firstly, there is a tension between the assertion that medical technology is the 'only hope' for the infertile and the fact that medical technologies such as IVF have such low success rates.[14] Secondly, there is a tension between the representation of procreation as a 'natural' process, and the 'artificiality' of the technological means of intervening to 'treat' infertility. One of the most important features of *narrative* representations of infertility is the attempt to resolve these tensions through narrative closure.

Resolution 2: The 'Happy' and the 'Hopeless': Stories of Heterosexual Romance

The provision of a medical 'cure' provides the physical resolution to the 'desperate' infertile couple, but there is often an emotional resolution provided to complete the 'happy ending'. For this purpose, the subjective point of view of the infertile is often reintroduced to provide narrative closure. To achieve this closure, the familiar conventions of heterosexual romance are frequently invoked.

In a conventional romantic fiction, a barrier to the shared happiness of the couple which must be overcome is the source of both character motivation and narrative progression.[15] We see this convention being drawn upon in the representation of both 'happy' and 'desperate' stories of infertility. 'Happy' stories are often accompanied by a photograph of the 'successful' couple, and/or their much sought after infant(s). The photograph serves as proof or evidence of their happiness, and thus provides a visual signifier to reinforce the narrative closure. The accompanying text includes descriptions of the couples' relationship, family ties, professional/work profile and other details in addition to the account of their infertility and its treatment. The baby is typically described as a 'miracle' baby, or a 'precious' baby.

Some 'local' examples, in this case from the Birmingham *Daily News*, can be used to demonstrate the characteristic resolution of the desperate infertile couple stories. In one example, the paper ran a front page story of a 'happy' couple, parents of triplets, beneath the banner headline: *OUR GORGEOUS TINY WONDERS.* Above the headline are

photographs of all three babies attached to infant life support systems.'[6] The couple are prominently pictured below, with the caption: 'Delighted parents Mandy and Clint Baker: overjoyed by their instant family'. At the end of the article we read that 'the couple met at a Birmingham Kissogram agency where Mandy worked when Clint joined as a "gorilla-gram". Now he runs his own garage and says they will have to move from their two-bedroomed semi into a bigger house' (Matthews and Jones, 1987, p. 1).

The second article, entitled *TEST TUBE BOY FOR THRILLED PARENTS*, also received front-page coverage in the *Daily News* (29 March, 1988). Described as 'A miracle of modern science' and as 'a triumph for the team who pioneered Birmingham's IVF programme', 'test tube baby Samuel' is featured in the requisite photograph of the happy couple with their longed-for progeny. In the accompanying text we read that:

> Proud parents Phil and Carol Goulding last night trembled with joy as they cradled their newborn son, Samuel....
>
> (...) for Carol and Phil, of Bewl Head, Bromsgrove, 9lb 5oz Samuel is nothing less than a miracle.
>
> 'We've been married 14 years, and trying for a baby for 12,' said 37-year old Carol. 'I still can't believe he's finally here.'
>
> Carol began treatment for infertility in 1977 in Bromsgrove and almost gave up hope of ever having a child when an operation to unblock her fallopian tubes failed....
>
> 'We were on holiday in Scotland when I realised I was pregnant, and we were just so happy.' (Cunningham, 1988, p. 1)

These personal details perform an important function in providing closure to the narrative. Their presence indicates the need for more than a medical resolution to the 'desperateness' caused by infertility. Whereas the medical 'cure' provides a physical resolution, the details of the couple's lives fulfils the need for an emotional resolution by providing a recognisable and familiar 'happy ending' in which all the threads are tied together. In these examples from the Birmingham *Daily News*, the resolution of infertility is linked to heterosexual romance, 'successful' marriage, upward mobility, parental approval and establishment. The themes of hope, happiness and dreams-come-true are thus linked to the 'miracle of modern science', a test-tube baby.

In the reverse case of the 'unhappy' stories, the failure of a couple to conceive may become a metaphor for the relationship itself. In the *Times* article mentioned above we read that:

> Sarah Browne and her husband are still solidly together, despite her ten miscarriages and seven operations. Others are less strong, *finding they cannot remain unified without a child.* (Prentice, 1986, p. 13, my emphasis)

Infertility guidebooks provide many similar examples of the effects of infertility on a couple's relationship. In her book *New Conceptions*, author Lori Andrews cites many experts on this subject: 'People have fantasies about having a child.... People become depressed, unhappy and wonder What happened to our dream?', says psychologist Aphrodite Clamar (Andrews, 1984, p. 86); 'The couple that can't have children faces a philosophical crisis. They ask themselves What am I on earth for? What will be left of me when I am gone?', declares psychiatrist

E. James Lieberman (p. 86). Thus, in both the 'happy' and 'unhappy' stories, the resolution of infertility is closely linked to individual self-esteem and conjugal harmony, demonstrating the profound symbolic importance of successful procreation for social approval, acceptance and establishment.

Summary: The Narrative Construction of Desperateness

In the first section of this Chapter, I have attempted to identify some of the key ingredients and structures of popular representations of infertility and its treatment. Whilst it is important to recognise the different conditions in which these accounts were produced, varying from government documents to infertility handbooks to stories in the local and national press, the emphasis in this argument has been on their underlying similarities. Indeed, these similarities are all the more significant *because of the diversity* of social sites in which they were produced. Because of the apparent consensus within these, and many other, accounts, about what the experience of infertility involves and what to do about it, even accounts which are partial or incomplete partake in what might be described as the emergent popular 'myth' of infertility. Through its myriad enunciations and retellings, this popular 'myth' is established as a commonsense understanding of the relationship between infertility and reproductive technology. In turn, this understanding informs the consumption of further information, according to the narrative construction of a myth which has become commonsensical.

In writing of contemporary cultural mythologies, Roland Barthes concludes that a myth is primarily defined by its form rather than its content. Myth, he argues, is essentially a form of communication: *a message* (Barthes, 1972). It is the form of the message, not its object, which makes of it a myth. To describe the formulaic, repeated, indeed ritualisitic, use of narrative structures in the desperate infertile couple story, this definition is highly accurate.

The cultural 'logic' of this mythic narrative is clear from the examples discussed. These stories revolve around the theme of 'desperateness': its 'causes' and 'effects'. Both the explanations and the resolutions of 'desperateness' involve a combination of social and natural determinants, often used interchangeably. The need both to explain and to resolve the 'desperateness' of the infertile provides the plot structure for narratives which draw on familiar conventions of romance and adventure in representing the anguish of the infertile and the activities of medical scientists. These representations, I have argued, use the emotions of the 'desperate' infertile woman, her 'longing' and 'hope' as a way into a discussion of medical achievements, thereby providing an apparently natural and obvious link between the 'hope for a medical cure' and the capability of medical science to provide one. Through the narrative mechanisms of selection, reduction, progression and closure, these stories mediate both the contradictions in the accounts of 'desperateness' and the transgressive potential of new reproductive technologies.

In addition to providing a 'logic' of cause and effect, through which events are ordered and their interrelations established, narratives also function through the forms of identification and

recognition they offer to the reader. Indeed, one might argue that the popularity of narrative as a form derives largely from this aspect of its construction. In this sense, narrative is similar to discourse as a form of representation which operates through the principle of inclusion and exclusion, constructing particular points of view that are accessible, often inviting, and excluding others. This feature of narrative allows us to see quite clearly how the desperate infertile couple stories 'work' as social constructions of infertility. The positions of identification and recognition established within these stories are very familiar. For example, the desire to create a family, the desire to restore conjugal harmony, the desire for social approval and acceptance, or the desire for a genetically-related child. All of these desires are on offer as points of identification for the reader in the narratives of 'desperate' infertile couples. They are not only recognisable desires, but, of course, socially constructed desires, which correspond to established social practices and institutions.

These narratives also offer a wide range of possibilities for identification and recognition in terms of the points of view established within the stories. The pioneering medical scientists offer identification with a recognisable adventure hero. The infertile woman offers a different form of identification with an equally recognisable 'heroine': the woman who is devoted to motherhood at whatever cost. The possibility of identifying with the desire to create a family is recognisable whether the reader is infertile, or not, indeed whether he/she desires to have children at all.

The popularity of narrative, and the predominance of narrative format within popular media, derive from this quality of narrative, that it is open to various forms of simultaneous identification from a wide range of readers. Yet, this openness goes only so far. Points of view which are not familiar or recognisable are less likely to be included in the range of identifications on offer. In this respect, *popular* narratives must, by definition, reinforce the status quo to a greater degree than other forms of representation. In the case of the narratives of infertility described above, this is clearly true, and has important implications for popular understandings of the experience of infertility.

It is through the establishment of a 'logic' of cause and effect, and of familiar points of identification and recognition that the narrative construction of representations of infertility structures commonsense understandings of the experience of infertility. The narrative mechanisms deployed in these accounts are a major means by which techniques such as IVF now appear the 'obvious' and even 'normal' means to 'cure' infertility, despite the fact that they are rarely successful, are costly and traumatic, contradict the supposed 'naturalness' of procreation, raise substantial moral and ethical questions, and do nothing to alleviate the condition of infertility itself. Such is the power of narrative that it can produce of these contradictions a coherent representation, in which the message that new reproductive technologies are the 'only hope' for 'desperate' infertile couples becomes popular knowledge and 'commonsense'.

Section Two: The Discursive Dimensions of Desperateness

In the first section of this Chapter, it has been argued that the representation of the 'desperateness' of infertility is framed in terms of loss and hope. The losses are described as both social and biological, the hope is described in terms of medical technology and scientific progress. It has been suggested that the framing of the representation of infertility in this way has a significant effect upon popular understandings of infertility and its treatment via new reproductive technologies. The emphasis upon the 'desperateness' of the infertile in these accounts provides the primary conflict or obstacle within the narrative, thus structuring the narrative trajectory along a particular sequence of causes and effects. The conventional points of identification and recognition on offer within these narratives contain them within the boundaries of the established status quo. It has also been argued that these representations achieve narrative closure by presenting techno-scientific means of reproductive intervention as the only solution to the problem posed, and by providing a 'happy family' as a 'happy ending'. Lastly, it has been argued that, in this respect, popular representations of infertility, drawn from a wide variety of sources, demonstrate a remarkable degree of consistency.

In the second section of this Chapter, these representations are analysed in terms of the concept of discourse, in order to draw attention to the construction of a regime of medical-scientific knowledge or 'truth' of infertility. In other words, it is argued that these representations can be understood in terms of a discursive

'logic' as well as a narrative one. It is also possible to suggest the ways in which discourse and narrative work together in the production of popular knowledge about infertility. For the purposes of this analysis, I have identified three discourses of infertility: the discourse of social loss, the discourse of biological destiny and the discourse of medical hope. Through the identification of these discourses, it is possible to map the production of the 'truth' of infertility across the many different sites in which it occurs. This is one of several reasons why the concept of discourse is especially useful for an analysis of this sort.

Both narrative and discourse can be understood as essential to the mythic status of the desperate infertile couple stories, for both are structural forms of speech characteristic of myth as a form of communication, or as a message. There are, however, important differences between narrative and discourse in terms of the subject positions they construct, particularly in terms of their power to inscribe subject positions beyond the text itself. Whereas the relation of the subject, or reader, to narrative is comparatively open, inviting multiple possibilities for identification, engagement or resistance, the subject position inscribed by discourse is non-negotiable.'[7] Discourse is the authoritarian language of the expert, whereas narrative is the more popular language of the storyteller. Whereas narrative invites the subject/reader to engage with it personally and emotionally, in exchange for the pleasures of identification and recognition, discourse is non-inviting and non-reciprocal, naming and positioning both the subject and desire with forceful authority. Although the two forms of speech may easily

coincide and overlap, the difference in their power to determine the position of the subject in social, as well as textual, locations is substantial.

The work of Michel Foucault, from which the concept of discourse is derived, has been particularly influential within studies linking the production of bodies of knowledge with the regulation of individual physical bodies (Foucault, 1973, 1977, 1978, 1980). Historical studies, particularly those concerning sexuality, have demonstrated how knowledges about the body are produced in accordance with specific social formations involving medicine, religion and the law (eg. Walkowitz, 1980; Weeks, 1981, 1985). The current production of particular forms of knowledge about infertility, and its subsequent management via new technologies provides a basis for a similar case study in discourse formation. The deployment of legislative measures to facilitate the control and 'treatment' of infertility based on this knowledge can thus be described as a discursive technology or practice. The Foucauldian concept of discourse, with its emphasis upon the power relations implicit within the production and deployment of knowledges about the body, is especially useful in identifying the relationship between discursive knowledge and discursive practice. It is also helpful in providing a framework for demonstrating the relationship between the transformation of knowledges, the transformation of social practices (such as the law) and the transformation of physical bodies. The aim of using discourse theory in the present analysis is thus to delineate the particular formations of knowledge associated with recent 'treatments' for infertility, and their linkages to other social practices.

The Discourse of Social Loss: 'The kind of life they would have led'

As we have seen, the social losses suffered by 'the involuntarily childless' are represented as a major source of 'desperateness' in popular representations of infertility. In the *Warnock Report*, for example, childlessness is said to result in a couple 'feeling excluded from a whole range of human activity' and to produce a sense of loss which 'cannot be assuaged by adoption'. Other accounts refer to 'the loss of self', and 'the loss of the imaginary family'. Couples are said to experience a loss of control over their lives, their individual identity, and their conjugal harmony. Couples are described in terms of existential loss, facing a 'philosophical crisis' as a result of their childlessness. They have lost the future they imagined and expected for themselves, their dreams and hopes for 'the kind of life they would have led'. It is said that 'life moves in a progession that is highlighted by the events of marriage and childbirth', and that the disruption of this progression causes anguish. It is said of infertile couples that 'They may feel unable to fulfill their own or other people's expectations' and that this causes despair. It is the tremendous scope of their personal and social loss which is said to account for the 'desperateness' of infertility.

The logic of discourse operates differently within these accounts from the logic of narrative. The logic of narrative concerns the causes of conflict, the relationship between events, and the mechanisms of resolution of the story. It is a teleological logic, ordering the movement of events from a beginning, or origin, to an end

point or closure. The logic of discourse is rather, as Foucault has described it, a logic of *enunciation*, defining the terms upon which knowledge is produced and deployed. It is a logic of inclusion and exclusion, of enhancement of some features and diminishment of others. It is a logic which defines the positions from which legitimate knowledge is produced, thus delimiting the field of knowledge by establishing the definitive concepts and categories.

The way in which discourse is implicated in the exercise of power also differentiates it from narrative. The power of discourse is that of articulating the production of knowledge with existing social practices of regulation and control. This exercise of power is not dependent upon the active participation of the subjects of discourse. Conversely, narrative requires a more active subject who is willing to position him/herself within it. The power of narrative also lies in its ability to order and to relate events into a logical sequence, whereas the power of discourse is to define their meaning in terms of truth.

In the discourse of social loss, the features of infertility which are repeatedly enunciated are those which contain it within the institutions of marriage and the family. It is a discourse which enunciates a specific definition of acceptable parenthood, and defines a specific context for 'acceptable' procreation. Through the discourse of social loss, which is enunciated across a wide range of representations, knowledge about the experience of infertility is contained within the parameters of the dominant legal and social institutions which structure kinship: heterosexuality, marriage and the patriarchal nuclear family. It is in this way that the discourse

articulates the production of knowledge about the body (infertility) with existing social institutions and practices which regulate and discipline bodily acts, such as procreation.

For example, the conflation of infertility with childlessness within the discourse of social loss is a means by which knowledge about infertility is restricted to a narrow frame of reference. Childlessness is only synonymous with infertility from the point of view of people medically diagnosed as infertile who want a biologically-related child. However, these people represent only a tiny fraction of the number of people who are actually 'childless' in this society. There are many people who are childlessness for reasons other than infertility. There are also people who are infertile who do not necessarily desire to have a biologically-related child. If it were truly childlessness which was the major source of distress, as the headlines quoted at the beginning of this article suggest, then infertility would be only one of many causes for concern.

Discussions of infertility would be very different if they were not discursively constructed in terms of only one way to have children, and therefore only one way to be childless. It is claimed by the Warnock Committee that: 'Childlessness may be a source of stress, even to those couples who have deliberately chosen it.... They may feel excluded from a whole range of human activity' (Warnock, 1985, p. 9). But if childlessness were itself the problem, if it were actually the difficulties of being excluded from parenting and the family that the Warnock Committee was concerned with, then the first question to ask would be who has access to children in this society and under what conditions? In fact, these conditions are quite

exclusive. Not everyone is equally positioned to 'choose' to have children or to participate in their upbringing. Rather than questioning these conditions, however, the Warnock Committee chose to reinforce their exclusivity by validating only the needs of the 'acceptable' childless -- those who are socially acceptable but physically incapable of producing a child. The Committee readily acknowledged that new reproductive technologies could increase the number of available options for parenting and procreative arrangements, and that they could increase the range of those who could potentially parent. This, they stated openly, would not be desireable. The Committee was explicit in its conclusion that new reproductive technologies should only be used to enhance the reproductive capacity of people who intend to conform to the traditional nuclear family. 'It is better,' they baldly dictate, 'for children to be born into a two-parent family, with both father and mother, although we recognise it is impossible to predict with any certainty how lasting such a relationship might be' (Warnock, 1985, pp. 11-12).

The unhappiness caused by childlessness is thus only recognised under certain conditions. As the *Report* clearly states, it is not of concern if you do not intend to conform to the traditional family. If you are a single parent, if you are not in a heterosexual relationship, or if you are intending to attempt any other 'pretended family relationship' (to borrow a phrase current in the period described here -- see note 22 below), it is better that you should remain childless. Nor is your childlessness of concern if it is the result of unemployment, lack of day-care facilities, disability,

sexual preference, denial of citizenship or if, for any other reason, you are prevented from having children by law, by prejudice or by social circumstance. The prescriptive heterosexuality of this view is also evident in the legislation derivative of the Warnock proposals, in which clinicians are required to consider 'the child's need for a father' as a condition of providing treatment to infertile women.

Discursively, therefore, the conflation of infertility with childlessness, as if they were one and the same thing, narrowly restricts the frame of reference within which infertility can be discussed. The problem is defined entirely within the parameters of the traditional nuclear family, with the result that the only knowledge available about the experience of infertility is that which reconciles it with the expectation of social conformity. This attempt to mediate the tension between the possiblities opened up by new reproductive technologies and the demands of the traditional nuclear femily is particularly ironic given that the traditional nuclear family is by no means the normative context for parenting and procreation in contemporary British society.[18] It is only through rigid narrative and discursive conventions that the representation of infertility and new reproductive technologies can be contained within the frame of reference of desperate couples longing for a conventional happy family.

The Discourse of Biological Destiny: the 'inner drive' to reproduce

Of particular importance is the relationship between the discourse of social loss and the discourse of biological destiny. As we have

already seen, the 'desparateness' of infertility is explained in biological as well as social terms. The desire to biologically procreate is described as essential and innate. It is described as 'the natural product of pair-bonding', as 'deeply rooted in biological instinct' and as a 'natural expression of love'. Experts call it an 'inner drive', a 'biological need' and refer to it as instinctual. 'The desire for a family' is said to '[rise] unbidden from our genetic souls' as a result of 'human destiny' and the 'powerful urge to perpetuate [our] genes through a new generation'.

The discourse of biological destiny, which is also enunciated across a wide range of representations, invokes the authority of the sciences, specifically of primatology, embryology and genetics. These powerful scientific knowledges already play important roles in the legitimation of existing kinship beliefs and practices. In particular, beliefs about the *naturalness* of heterosexuality and the nuclear family (also known as the 'biological family') derive their authority from the biological sciences. Defining infertility in accordance with the dictates of science further locates it within the domain of the natural family.

This has a particular significance when we consider the specific constellation of beliefs and practices which make up the prevailing kinship system. In this culture, as in most Western, post-industrial cultures, kinship ties are legitimated in two ways: through law (producing 'in-laws') and through genetics (producing 'blood' ties). Biological procreation through heterosexual intercourse in the context of marriage is the exclusive means of establishing 'legitimate' parenthood. Both the biological and the legal requirements of

parenthood must be established in order for parenthood to be legitimate and 'true'. Without marriage, parenthood is illegitimate. Without shared bio-genetic substance, kinship ties are incomplete, as evidenced by the statement by the Warnock Committee, for example, that the losses posed by infertility cannot be assuaged by adoption.

Thus, shared bio-genetic substance is the 'true' basis for kinship ties, but it must be legitimated by the institution of marriage. Therefore, according to the conventional trajectory of life's 'progression', marriage should be consummated by procreation which should result in progeny. Thus, the legal (social) and 'natural' requirements of 'true' and legitimate parenthood should be sequenced as one, unified trajectory. Like all kinship beliefs, this sequence and trajectory are considered normal, 'obvious' and even 'natural' despite the fact that exceptions abound. Both the unity and the sequence of this trajectory are protected. Violations are named and stigmatised, such as illegitimacy, adultery, single-parent families, 'pretended family relationships' and childlessness. In short, child-rearing arrangements which do not reflect the protected unity of the conjugal and procreative function are, in this society, regarded as lesser forms of parenthood, at best, and as immoral or even perverse in some cases.[19]

It is, of course, precisely the unity of the procreative and the conjugal function which is so profoundly disrupted by the new reproductive technologies. Not only do many techniques require third-party donations of what might be described as extra-conjugal gametes, but many are also non-coital, by any conventional sense of the term. In addition, the 'naturalness' of procreation and the 'biological'

family are thrown into question by new reproductive technologies through which an unprecedented degree of 'artifice' has been introduced into the procreative process. Thus, the belief that the unity of the conjugal and procreative function is protected by the dictates of our evolutionary heritage, our 'selfish genes' and the 'natural' relationship of heterosexuality to procreativity is also transgressed by these technologies. This poses a contradiction which must be resolved or, at least, contained. Indeed it is this difficulty, of mediating the contradiction between the existing kinship system and the unprecedented 'artificial' procreative arrangements made possible by new reproductive technologies which, in part, explain the persistence of certain rigidly specific narrative and discursive mechanisms in the representation of infertility.

Genetic science not only plays a role in providing the language of 'true' kinship ties ('blood' ties) but in defining many aspects of personhood and inter-generational continuity. It is, after all, the inability to produce a *genetically-related* child which is at issue in the discourse of biological destiny evident in representations of infertility. Genetic science provides the 'truth' of kinship in terms of inheritance and descent, shared substance, parenthood and procreation. The importance of this language is further demonstrated by its central place within dominant cultural understandings of human origins (genetic selection) and human conception (genetic recombination). The language of genetics is also important in the construction of personhood, as it is genetic inheritance which is said to make each individual both unique and like his/her parents.

All of this is 'denied' to couples who cannot biologically procreate, and it is to this loss that the discourse of biological destiny refers. The importance of this discourse thus lies in the specific definitions of 'true' parenthood, personhood and procreation it constructs, in which genetic continuity is privileged above all other forms of parent-child ties. Not surprisingly, therefore, since the desired kinship bond is defined in terms of biological science, the 'treatment' of infertility must be provided by biological science, and infertility is primarily defined as a biological condition.

The Discourse of Medical Hope: 'their only hope'

According to these accounts, there was a time when the victims of infertility had little choice but to suffer the stigma and unhappiness of barren wedlock. Now, thanks to scientific progress and the miracles of modern medicine, we need no longer endure the random injustices nature bestows upon us. Reproduction, it is said, is no longer the dark continent of medical knowledge, but a new frontier for the enterprising pioneers of modern medical science. We now have greater reproductive choice than ever before, and our choices are rapidly expanding. With greater reproductive choice we also gain greater reproductive control. Today we are increasingly capable of not only choosing when we reproduce, but how we reproduce, and even what we reproduce by testing and selecting and even genetically engineering the embryos we choose to nurture to viability. Or so would seem to be the story according to the popular press, television and radio news broadcasts and the reports of Government Committees.

The discourse of medical hope at work in this version of infertility and its treatment is defined by several features: a belief in scientific progress and the ability to control and manipulate 'nature' for the greater benefit of 'man'; an objective, clinical definition of human reproduction as a 'biological' process; and an emphasis upon the capability of medical scientists to increase reproductive choice through reproductive intervention. All of these features which characterise this discourse appear with regularity in media representations of infertility and its treatment.

These media stories about the miraculous achievements of doctors limit the kinds of questions that can be asked about infertility and its treatment through a characteristic fascination for details: why the embryo didn't implant, what the woman wore at the insemination, how the doctor couldn't find the egg, and so forth. It is as if given the biological urge to propagate and the capability of modern science to improve the process, no more need be said. This marriage of natural urges and scientific progress has been preeminently portrayed by the media as a one full of promise and hope.

As a result of the medicalisation of infertility, a privileged and disproportionate authority is conferred upon representatives of the medical and scientific profession in public debates about the control of reproduction. Framed by the subjective hopes and desires of the infertile, media representations of infertility uncritically present medical science as the obvious solution to the problem. This in turn reinforces the 'point-of-viewlessness' of medical science, as if it were a neutral position of objectivity and detached, clinical logic.

However, as many feminists have demonstrated, the 'objective' gaze of science is not neutral, especially when it is focussed upon women's reproductive organs. Historically, the perspectives of both medicine and science emerged as specific discursive formations in which the articulation of power and knowledge are clearly evident.[20] The language of clinical objectivity is not the language of neutrality, but of detached surveillance, through which the discipline of rationality is imposed upon the unruly body in the name of therapeutic obligation (see Foucault 1973). It is the discourse of medical hope which defines this position as the legitimate position from which to speak about infertility and its 'management' via new medical technologies.

We have already seen how, within descriptions of medical management of infertility, reproductive bodies, almost always women's bodies, are constructed as the site of physiological functions and dysfunctions requiring therapeutic technological intervention. In this process, the woman-subject of medical therapy becomes the woman-object of scientific scrutiny. This shift occurs both narratively and discursively. There is a convergence between the narrative movement from infertile woman as subject of the text to infertile woman as object of the text and the discursive mechanisms which legitimate this transition.

Although the narrative positioning of women may be seen as a textual process, the discursive positioning of woman-as-object of the scientific gaze is not confined to the text itself. The discursive positioning of women's reproductive capacity, of women's bodies, within representations of infertility, is a process that exists as

social, as well as textual, practices (see Smart, 1989; Eisenstein, 1990). The subject positions produced by the discourse in the text are also subject positions inhabited by women in actual medical practices. The medical definition of women's reproductive capacity, for example, has a privileged role in the formation of legal definitions of reproductive products and processes. It is the medical-scientific expert whose definition of reproduction wields greatest authority in both the public and parliamentary arena. Because it is seen as rational, detached and objective, the expertise of medical and scientific professionals is regarded as 'balanced' and 'factual' in legal and political debates, as if it did not represent a particular point of view.

Conclusion

In the conservative political climate of the mid- to late-1980s, reproduction, sexuality and the family were prime targets on the moral agenda of the New Right. In such a context, the implications of public debates about state regulation of new reproductive technologies must be seen as far-reaching indeed.[21] The establishment of legal protections for eggs, sperm and embryos cannot be separated from the continuing attempts by anti-abortionists to establish state protection for the fetus. Both the debate about abortion and about new reproductive technologies are shaped by the power of medical discourse to enunciate the 'truth' of reproductive processes. Likewise, the establishment of legal restrictions upon eligibility for infertility treatment, in the name of 'protecting the children', is an attempt to

regulate parenthood and procreation which cannot be separated from the discrimination aimed at the 'pretended family relationships' of lesbians and gay men.[22]

In sum, what is at stake in popular representations of infertility, and contemporary public and parliamentary debates, is not only the condition of 'involuntary' childlessness. Nor is it merely the 'treatment' of infertility. Nor is it simply the provision of 'medical miracles' for 'desperate' couples mired in the hopelessness, the helplessness and the unhappiness of having lost 'the kind of life they would have led'. Rather, these representations must be seen as constructions built on the occasion of these dilemmas which open up a space for the narrative and discursive negotiation af a much broader range of concerns. In these accounts, the 'desperate' infertile woman has become an overdetermined signifier of the need to reconstruct traditional kinship beliefs and practices in the face of disruption not only by new reproductive technologies, but the rise of single-parent families, illegitimacy and other 'pretended families' (Stanworth, 1987).

In sum, an analysis of the narrative and discursive construction of these accounts reveals that there is more than one reproductive dilemma at stake. At stake is not only the biological (in)capacity of couples to reproduce, but the necessity for the social and cultural reproduction of specific definitions of parenthood and procreation, of traditional family values and of conventional sexual arrangements. By limiting discussion of childlessness to that of heterosexual, married couples who cannot biologically procreate, representations of infertility narrowly restrict the kinds of questions that can be asked

within current public debates. Moreover, this discursive construction of reproduction in popular representations of infertility is also evident in the discursive practices of medicine and the law through which reproduction and parenting are regulated.

It is also important to note the extent to which a selective use of the needs and desires of infertile women are represented in these accounts. The way women's 'desperateness' is used as a framing device has two major uses. One is as an introduction to a quest narrative, in which the only route to a happy future is through medical science and conventional fertility treatments. The other framing device is as a transition from woman as active desiring subject, whose emotions provide an introduction to a discursive construction of her body as medical-technological object. In both instances, the fact that 'women want it', indeed are 'desperate' for new forms of infertility treatment, serves as a critical anchoring and framing device for the representation of reproductive technology as legitimate, necessary and benevolent.

Yet, in these representations women themselves disappear. The point is not that women do not 'really' want IVF, or desire happy families, or hope for a cure, or seek social approval, or any of the other features attributed to their desires. As is confirmed in Part Three, women do want these things, and to say their desires are socially constructed is merely to state the obvious. It does nothing to mitigate the force of these desires, which are no less genuine for being normative, constructed, or culturally and historically specific.[23] The point is rather that the ways in which these representations of women's experience are used is both selective and

partial, if not self-evidently disingenuous. Women's desires to have children do not reduce to 'desperateness' to pursue IVF, and the pursuit of IVF itself is a feature of women's experience which is rarely represented, and its aftermath even less so. Instead, 'women's experience of IVF' is used as a starting point for formulaic representations which subsequently give little recognition to women at all.

It remains, of course, an open question how successful either popular representations or political legislation will be in their attempt to contain the transgressive potential implicit in the very existence of reproductive technologies. The contradiction between the 'unnaturalness' of test-tube conception, and the supposed 'naturalness' of the institutions these techniques are meant to perpetuate can never be resolved, but only contained. This is especially likely to be true as new reproductive technologies, such as IVF, begin to be used more often for genetic manipulation than for infertility treatment.

Moreover, the representation of techniques such as IVF as 'the only hope' for the 'desperate infertile couples' will continue to be an unstable equation as long as IVF success rates remain in the unhappy vicinity of 5-10%. Already, as was noted at the outset of this Chapter, a far more critical set of media representations has begun to emerge, depicting the 'underside' of IVF. As the concluding paragraph to one such article, recently published in the prominent *New York Times* Sunday magazine, put it:

> Babies have price tags. The currency differs according to the circumstances. Sometimes the cost is measured in

> monetary terms, sometimes physical or emotional, sometimes spiritual. But every bundle of joy has its price. And while it's unfashionable to state this in the midst of today's fervid baby worship, that price might be more than some of us can afford. (Hopkins, 1992, p. 84)

In the meantime, however, it is clear that public debate about infertility and new reproductive technologies needs to be greatly widened, to encompass the long-term social implications of techno-scientific reproductive intervention. These implications are too important to be considered merely in terms of medical 'treatment' of infertility and the provision of 'happy families' for 'desperate infertile couples'. As we move into the era of bio-technology and genetic engineering, control over the means of reproduction is destined to be an increasingly important arena of political and legislative dispute. The investment women have in the outcome of this process of redefining reproductive control cannot be underestimated.

The question for feminists is not only that of inserting 'women's interests' into the existing debate, but of challenging the narrow terms upon which these debates are presently conducted, including the equation of 'women's interests' with high-tech reproductive intervention. As I have attempted to demonstrate in this Chapter, such a challenge requires careful analysis of existing representations in terms of both their structure and content. As other feminists have also argued (Duden, forthcoming; Ginsburg, 1989; Hartouni, 1991; Martin, 1987, 1991; Petchesky, 1987; Taylor, in press), popular representations are a powerful force in the social and cultural

construction of reproduction. The need to address this dimension of current public debate is therefore paramount in the struggle over reproductive control currently occurring in response to the development of new reproductive technologies.

In Part Three, 'women's experience of IVF' is examined not only in terms of the desires which lead women to choose IVF, but how these desires change through the experience of the procedure itself, and where these desires leave women at the other end of the process, which, for most of them, is the same as where they started in terms of childlessness. Yet, they have gained and lost significantly in the meantime. While infertility treatment such as IVF is often heralded, as the newspaper headlines at the outset of this Chapter indicate, in terms of the hope it provides to women who are infertile, this is often precisely what the process takes away in the majority of cases. The difference between women's desires at the outset of IVF, and women's desires on 'the other side' of IVF is that they are without even hope, not only hope for a child, but hope for a resolution. Features of women's experience and desires concerning infertility treatment such as this, the enhancement of loss, are what is missing from the partial representation of women's 'desperateness'. As is evident in the Chapters which follow, women's descriptions of the experience of IVF unfold along a very different narrative trajectory from that described in mainstream media representations. It is to these discrepencies, and their significance, that the following Chapters are addressed.

References to Chapter Four

1. According to the *Third Report* of the Voluntary Licensing Authority (1988:24-7), there were already 34 'approved' IVF centres in Britain at the time of this study. An additional 10 centres were in the process of being set up, and 41 'approved' research projects involving human embryos were in progress.

2. On December 7, 1988, Members of the British Parliament began debate of proposed legislation of 'Human Fertilisation and Embryology'. The aims and scope of this legislation, which closely followed the recommendations of the Warnock Report, are outlined in a series of government documents, beginning with the Warnock Report, published in 1984 ('Report of the Committee of Inquiry into Human Fertilisation and Embryology', London: HMSO, Cmnd. 9314). In December of 1986, the Department of Health and Social Security (DHSS) published a Consultation Paper entitled 'Legislation on Human Infertility Services and Embryo Research: A Consultation Paper' (London: HMSO, Cm. 46). This was followed in March of 1987 by a 'white' paper (proposed legislation) entitled 'Human Fertilisation and Embryology: A Framework for Legislation' (London: HMSO, Cm 259). Further information is also available in the published *Reports* of the Voluntary (later 'Interim') Licensing Authority (VLA, ILA) established by the Medical Research Council (MRC) and the Royal College of Obstaetricians and Gynaecologists (RCOG) in response to the suggestion within the Warnock Report that such a body be established to regulate

IVF and embryo research. See further Chapter One, and Morgan and Lee, 1991.

3. 'By a *Choice* Reporter', 1987

4. 'Comfort for the Childless', *Times* letters page headline.

5. Prentice, 1986.

6. Newbold, Anne, 1987.

7. 'By a Correspondent', 1986.

8. Morris, Michael, 1987.

9. 'Yorkshire Post Correspondent', 1987.

10. Cunningham, Anne, 1988.

11. Matthews, Louise and Geraint Jones, 1987.

12. For an introduction to approaches developed within cultural studies, see: Johnson, 1983.

13. Lorber, for example, queries whether 'infertility is in many ways a social rather than a physiological problem'. Her argument is that the conventions governing 'appropriate' means of reproduction may be

as much of an impediment to the realisation of fertility as physical factors. She refers, for example, to a couple in which one partner is fertile (see Lorber, 1989, pp. 117-8).

14. According to the *Third Report* of the VLA (1988), the overall success rate of IVF centres in Great Britain at the time of this study was 8.6%.

15. For further discussion of the conventions of romance, see Radway, 1984.

16. The incidence of higher order multiple births as a result of IVF is significantly higher than normal due to a variety of factors. For further details see Botting, et al, 1990; Price, 1989 an in press.

17. My acknowledgements are due to the contributions of Richard Johnson in the formulation of this distinction.

18. There is, for example, an increasing percentage of single-parent households in Britain. However, even in apparently traditional households, a 'normative' situation is not necessarily present. According to figures released by the Office of Population Census and Surveys, nearly one quarter of children born in England and Wales in 1988 were illegitimate. Whereas in 1950, the percentage of children born to unmarried mothers was down to 4%, it has since risen rapidly, now approaching 23%. These figures reflect a trend towards

cohabitation rather than marriage, as reported in *Social Trends* (HMSO: London, 1988).

19. For further discussion of the role of genetics in kinship beliefs, see Schneider, 1968.

20. This literature is outlined in Chapter Two and is not re-referenced here.

21. See the Science and Technology Subgroup, 1991, for a discussion of abortion legislation during the period described in this Chapter.

22. In the Spring of 1988, the British Parliament passed into law a section of the Local Government Bill which prohibited Local Authorities from 'promoting' either homosexuality or the 'pretended family relationships' of lesbian and gay people.

23. There is also no reason to impose standards of 'political correctness' upon infertile couples which would not be applied to any other couples. As Lasker and Borg argue with relation to the desire for genetically-related children:

> We belive it is unfair...to tell infertile people that they must raise their consciousness or overcome their racism in order to give up the goal of having their genetic child... There is no logical reason that the infertile...should have to bear these important burdens more than others. Were they somehow designated, beacause

of their biological handicap, to be more virtuous, more selfless, more liberated than the rest of us? (Lasker and Borg, 1987:201-2).

PART THREE

'LIVING IVF'

'It's your whole life
you're talking about...'

[Keating, p. 14]

CHAPTER FIVE

'The Obstacle Course': the Reproductive Work of IVF

'It just takes over, there's no doubt about it'. (Ives, p. 44)

Introduction

In Part One, IVF was discussed in terms of its representation within the feminist literature on new reproductive technologies, wherein the definitive importance of the idea of 'women's experience' was noted. It was argued these accounts are important not only in terms of the formulation of the present study, but as themselves a set of representations of IVF, infertility and women's experience of new reproductive technologies. In addition, these feminist accounts, though marginalised, comprise a significant field of current public debate, through which the meanings and implications attached to a range of new forms of reproductive intervention are contested and negotiated.

In Part Two, IVF was examined in terms of how it is constructed within mainstream media accounts of infertility. These accounts provided the opportunity to examine how IVF is portrayed at the level of dominant cultural representations. It has been argued that in such accounts, women's experiences, needs and desires in relation to new reproductive technologies such as IVF are central to the public legitimation of these techniques, and to the predominant image of benevolence which surrounds

them. The key signifier in this context is the newspaper photograph of a happy couple with their miracle baby, brought to them by the pioneering efforts of reproductive scientists on the frontiers of human reproductive failure. It has also been argued these representations are highly selective and partial, often focussing on the desires that lead women to choose IVF, and the eventual outcome for those who succeed, with little attention to what happens in between or to women who 'fail'.

In the subsequent three Chapters comprising Part Three, women's experience of IVF is investigated in terms of how women undergoing the procedure describe the experience of IVF. The title of Part Three, 'Living IVF', is one such description. Although the sample population presented here can in no way be considered representative, and within itself contains many differences, it is nonetheless a useful means by which to identify certain key disjunctures between the dominant cultural representation of women's relationship to IVF and their own descriptions of it.

The aim, however, is not merely to 'correct' the inaccuracies of the kinds of accounts discussed earlier. Indeed, it is hardly surprising such accounts are partial, as they are purposeful and thus selective. No account can ever be complete. The idea of 'realism' is not at issue here. Neither is there a singular or uniform 'reality' to the experiences described. Instead, the aim is to contrast one set of representations with another. I too have been selective, with the aim of providing a more detailed picture of women's experience of IVF, which draws largely on accounts provided by women themselves of their experience.

As with any ethnographic project, designed to elicit key terms or phrases through which people describe their own experience, certain condensed nodes of meaning emerge. These can be considered points where several layers of meaning converge to produce an overdetermined effect. They are often to be found in phrases that are heard again and again across a range of different contexts and from a number of different sources. In sifting through the interview material, and attempting to sort it into 'themes' or clusters of related statements, I discovered a number of phrases of this sort, which I then used to rework, organise and present the material.

Hence, this Chapter is entitled 'The Obstacle Course', which is a phrase often used to describe the experience of undergoing treatment. The headnote describes the way in which IVF 'takes over', which was another, related phrase that came up again and again. Both terms have the kind of 'overdetermined' status which makes them useful for explicating a wide range of features of the IVF experience. In this Chapter, then, the obstacle course metaphor is used to present the various stages of IVF and the difficulties they present, including physical, emotional and psychological difficulties. These in turn explain why IVF 'takes over', and can be used to illustrate concretely what this expression refers to. A sub-theme of the Chapter is indicated by its subtitle, 'the reproductive work of IVF'.[1] This too provides a connecting thread, albeit an analytic one, linking a range of different features of the IVF experience, which, it is suggested here, together comprise a form of reproductive labour. In the final section of this Chapter, the tensions between women's paid work as part of the waged labour force is compared with their reproductive labour. This in turn

provides the means for looking in another way at the most immediate demands of IVF, such as travelling, coordinating tasks, and general management of the 'regime' imposed by the treatment cycle.[2]

Chapter Six moves on to consider IVF as a 'way of life', a phrase quite similar to that for which Part Three as a whole is named, and in many ways the most important interpretive and analytic 'node'. This Chapter explores in more depth what is meant by this phrase, adressing the ways in which IVF is understood in relation to the wider social context. This Chapter, then, moves away from the immediate demands of treatment, to consider more broadly what is seen to be at stake in the experience of IVF, and how it 'makes sense', or is made sense of, in a wider frame. The idea of a 'way of life', again, is thus multi-layered, referring both to IVF as a 'way of life', the lifestyles of individuals and couples, and the wider 'way of life' of the society they inhabit.

The concluding Chapter to Part Three is entitled 'Having to Try and Having to Choose', which are again phrases encountered often in the course of the interviews. The former statement, encountered in every interview, proved integral to the overall analysis. This chapter is concerned with one of the original concerns of the study, namely *how* and *why* women choose to undergo IVF. As noted in Chapter Two, this is a question which has itself become overdetermined in the feminist literature, and is also one which bears directly on the issue of public representations, in which women's 'right to choose' IVF is often foregrounded in the legitimation of the technique. It is to this latter question that the concluding Chapter is addressed.

Putting Women Back Into the Picture

Throughout these Chapters, and informing the original decision to pursue this study, is a particular concern about women's agency in relation both to patriarchal culture and to technology. From a feminist perspective, reproductive technologies such as IVF, as has already been noted, comprise a very condensed encounter between clinical medicine, scientific discourse and women's bodies. In the spectre of the woman undergoing ultrasound-guided trans-vaginal egg 'recovery', or laparoscopic trans-abdominal egg 'harvesting' has emerged a kind of archetypal image of a woman (and thus 'Woman') being penetrated by the controlling, objectifying and technologically-enabled 'gaze' of patriarchal science (and thus 'Patriarchy'). Whether she is subject or object, willing or coerced, awake or asleep, engaged or enraged, the picture is the same: she is an object.

The obvious problem with this view is that it replicates many of the same features of the discourse it is attempting to dislodge. The woman is seen as passive, objectified, controlled and exploited. There is no room in this picture for a woman as she sees herself. Indeed, however she sees herself, the picture remains the same. In these ways, the 'feminist' view and the 'patriarchal' view merge. This is not only an ironic accord; it is a disturbing one, for in both accounts the image of women is not an empowering one. It is incompatible, for example, with this picture for a woman to be seen as having 'chosen' her place on the altar of the patriarchal conspiracy to control the womb. If she 'chose' this, it was a false choice, or her other choices were not good enough, or she was misled, or deluded, or duped or coerced. In any event, a

woman actively choosing to put herself into this picture is, from a feminist point of view, something of a problematic concept.

It is the view expressed in this thesis that such a picture is not only inadequate but divisive and counterproductive. It was in part the aim of this study to challenge this picture, to open it up and look more closely at what is going on in that condensed and overdetermined encounter. It is a continuing struggle to hold together what I believe to be accurate about this picture, in its depiction of a powerful and deeply patriarchal technology, with the attempt to challenge the construction of 'woman' it portrays. Yet, it remains my view that such a challenge is necessary, both in order not to replicate the very representations of women feminists are seeking to challenge, and to engage with the field of contemporary reproductive politics with better understandings of what is occurring in encounters such as this.

It is for this reason that a section addressing women's experience of IVF is positioned between sections addressing wider social processes and wider debates within feminism. The representation of women's experience in this section does not unproblematically present the 'truth' of 'living IVF'. As has already been noted, the feminist privileging of women's experience, of politics-by-testimony, can backfire in the context of new reproductive technologies, about which many women are unashamedly exuberent, not to mention articulate and filled with passionate conviction. Instead, this section presents extracts of interviews conducted with women in the hope of better appreciating the agency women do have in this process, and foregrounding their own descriptions of their encounter with new technologies of reproductive intervention. It is thus largely concerned with women's

decisionmaking processes and the terms in which they formulate their own experience. If women do not make choices on terms of their own choosing, to invert a phrase cited earlier, that is not to say they do not make choices. For this reason it is neither adequate to reduce the subject of reproductive politics to that of reproductive choice, nor to argue that 'choice' is a meaningless term given the restrictions within which women exercise it. The focus in the following Chapters is instead upon the difficult conditions under which women do make choices and decisions, and their reasons for doing so, as well as the consequences which ensue. Such an analysis offers a means of better appreciating, from a more textured and multi-layered perspective, what is occurring in the encounter between women and new reproductive technologies.

This Chapter, then, begins with a contrast between the representation of IVF in the standard clinical introductory pamphlet, and women's descriptions of the technique. It then moves on to consider the immediate physical, psychological and emotional demands of undergoing the IVF procedure. In particular, this chapter, like those that follow in Part Three, is concerned with how women make sense of the procedure. These ways of making sense are both determined by the experience of treatment, and determining of it, in a certain sense, as the attitudes women develop towards the procedure inform the ways in which they learn to 'manage' it, in both senses of the term. On the one hand, women undergoing IVF are presented with a set of non-negotiable demands by the procedure. On the other hand, they determine their own strategies to cope with these, and are thus active agents in relation to the technique, not merely passive subjects positioned by its dictates. Appreciating the ways in which women interpret and make sense

of their experiences, then, constitutes an important component in a feminist appreciation of what is at stake in women's decisions to opt for and undergo the technique.

Introducing IVF: the standard IVF description

Introductory descriptions of IVF are largely produced in the form of short pamphlets, compiled either by the clinics themselves or by the drug companies who produce the pharmaceuticals used in the procedure. Like the media representations of infertility, such descriptions could be described as formulaic in their adherence to specific representational conventions. Not surprisingly, for example, these decriptions emphasise the procedural and mechanical features of the technique, rather than the experiential dimensions of IVF. They are also structured as narratives which foreground the event of in vitro fertilisation. Again, this is not surprising, since they are best described as clinical descriptions expressed in more accessible, 'user-friendly' language. Like media representations in which the woman whose experience is used to introduce the story is then displaced by a mechanico-medical drama, these representations focus exclusively upon the clinical assistance being provided to the reproductive process.

The standard IVF description, as presented in the literature given to women to introduce them to the technique, is, as a result, often decptively straightforward. In part, this may be intended to provide reassurance. For what are likely to be similar reasons, there is frequently an emphasis upon the similarity between IVF and 'what would happen anyway'. Hence, IVF is represented as a bypass operation, or as

Figure 2 'If Nature Can't Deliver'

Reproduced here is the image from the cover of IVF publicity from a major pharmaceuticals manufacturer advertising one of the drugs used in ovulation induction. This and the following page reproduced in Figure 3 convey one of the central idioms of IVF, that of 'giving nature a helping hand'.

Figure 3 'With Metrodin's Help You Can'

From an empty cradle to a babe in arms, such imagery reinforces the construction of IVF as a 'hope technology'.

A bridge to new life

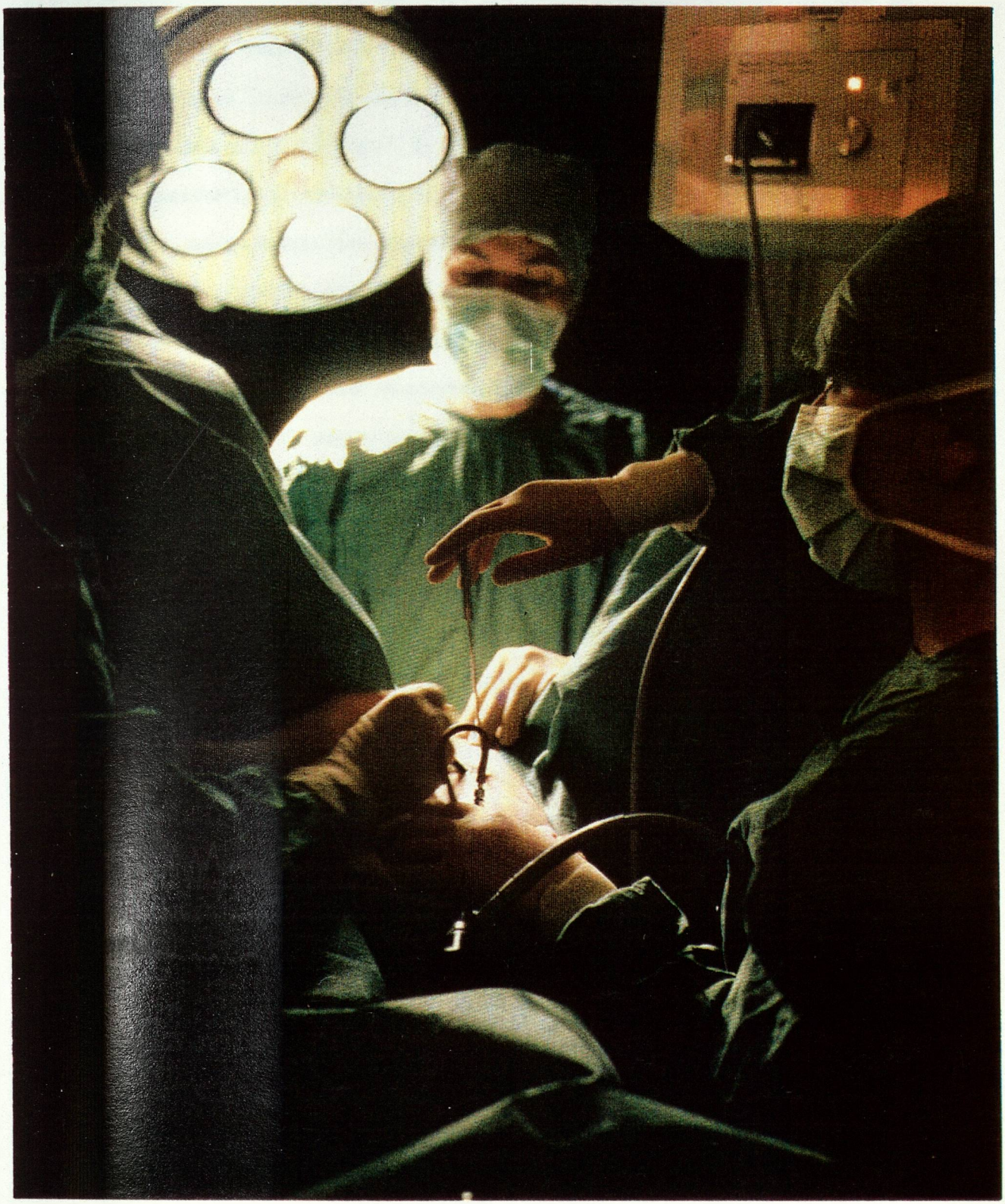

Figure 4 'A Bridge to a New Life' (Sartryck ur Medicinsk Teknik nr 3, 1986)

Shown here is an aspiration procedure featured in publicity by Bruel & Kjær, manufacturers of ultrasound technology. The phrase 'a bridge to a new life' emphasises the idea of natural science in the service of the natural family.

'giving nature a helping hand' (which is in fact the title of an Organon pamphlet and video introducing IVF).[3] Such representations of IVF as 'natural', or as assisting nature, are frequently encountered in IVF materials such as that reproduced in Figures 2 and 3. The technique is also represented as a 'bridge' (a 'Bridge to a New Life', see Figure 4). Such representations provide reassuring images, and are especially important in countering the spectre of 'unnaturalness' often associated with assisted reproduction. They also minimise the 'high-tech' associations which came to define the technique, especially in the immediate wake of the first 'test-tube baby', which term itself might be considered the kind of image these pamphlets are intended to displace.

The following are examples from introductory IVF leaflets, produced by drug companies and clinics, describing the technique:

> IVF involves collecting eggs from the ovary, putting them together with spermatozoa in a dish, and if those spermatozoa fertilize an egg, putting the embryo or embryos that result into the womb. (*In-Vitro Fertilization with Midland Fertility Services*, n.d., p. 2)

> In vitro fertilisation is a technique in which the sperm and egg, instead of meeting in the fallopian tube, are made to meet literally 'in glass' - i.e. the test tube (or a dish). (*Information Booklet: In Vitro Fertilization and GIFT*, Infertility Advisory Centre, n.d., p. 3)

> IVF or (IVF-ET) entails bringing the male sperm and the female egg together outside the body, so that fertilisation occurs.

> The tiny fertilised egg (now called an embryo) is then transferred back to the womb to develop normally. (*In-Vitro Fertilisation: Some Questions Answered*, Serono Laboratories (UK) Ltd., n.d., p. 1)

> Since 1978, in vitro fertilization has provided a positive solution to many couples' infertility. The principle is simple: the function of the defective fallopian tubes is assumed artificially under strict conditions in the laboratory. This takes scarcely 48 hours. (*When Nature Fails...A Modern View of In Vitro Fertilization*, Organon, n.d., p. 10)

> Commonly referred to as the test-tube baby technique, IVF is the technique of mixing the woman's eggs (ova) with sperm from her partner in a small dish or test tube in the laboratory, to allow fertilisation to occur. Once the ova are fertilised and have divided, one or more of the fertilised eggs (pre-embryos) are replaced into the woman's uterus through the cervix. (*Fertility Services*, AMI Healthcare, n.d., p. 2)

While technically accurate, descriptions such as these, which emphasise the simplicity of IVF treatment, fail to convey several important aspects of IVF. For one, they fail to convey the amount of procedure involved in removal of eggs. For another, they do not convey the number of ways in which the procedure can fail, or, in IVF parlance, lead to the cycle being 'abandoned'.

As representations of the technique, these descriptions are also notable in terms of how they are constructed. For example, they describe no agents. Or, it might be said the only agency in evidence is the 'invisible hand' of the clinician. It is as if the agency were naturalised, as a force in and of itself: 'the function...is assumed...by the laboratory'. Hence, missing from these accounts is any account of women's role in IVF; as is common in so many representations of IVF, the woman disappears. Conception here takes place through a union of medical science and natural processes, as if independent of the woman herself. What these descriptions address is the actual technique of in vitro fertilisation; that is, the bringing together of the egg and sperm in a dish. It is this particular technique for which 'IVF' is so named. In other words, 'IVF' as a procedure involves much more than 'IVF' itself: to achieve in vitro fertilisation, many other techniques and procedures are required.

The naming of the medical procedure 'IVF', whereby a specific technique stands in, metonymically, for a much longer sequence of events, constitutes a significant slippage. It not only accounts for the deceptive simplicity of descriptions of IVF, or their technicist quality, it also posits the one technique which occurs outside a woman's body as the signifier of a process which largely occurs inside her body. In other words, these descriptions effect a displacement inherent in the term 'IVF' itself: a displacement of the woman by a technique which occurs independently of her.[4] Ironically, but significantly, this renders the phrase 'women's experience of IVF' an impossibility, as women cannot experience IVF itself.

Women's Descriptions of IVF: the 'obstacle course'

A useful contrast can be made between the preceding accounts and a description of what is involved in IVF by one of the women interviewed:

> Um on the first day of the cycle, the first day of my period, we start with a, I have a nasal spray, which I use four times a day, one spray up each nostril, and then I had, then you have I think they are steroids, somebody said they were steroids, and then you take two in the morning and one at night, that's two, to help to grow healthy eggs. On the fourth day of your cycle you start with Perganol injections and my GP gave those to me, so I just had to go up to the surgery and he did those for me. And also on the fourth day you have to collect your urine and collect for 24 hours and then you have to send a sample off so that they can measure your oestrogen that's in your urine so they can see what response your body is making to all the drugs. And then on the sixth day you go for the first scan, that's when they can see if any eggs are growing and how many. You go for a scan every other day, and then on both occasions they said that on the 11th day, they said that the eggs, the follicles were sort of large enough for me to be given the hCG injection which they give about 35 hours before they aspirate the eggs, the hCG injection, it makes you ovulate, because without that you wouldn't ovulate. And then 35 hours later you have the eggs aspirated and if they fertilise and divide then two days later you put the embryos back. (Quigley, pp. 15-16)

Noticeably, this account puts most emphasis on the process of ovulation induction, and least on the actual process of IVF, which is in fact not even mentioned. From the point of view of a woman who has experienced IVF, in other words, the technique is defined *most* by what is missing from the introductory descriptions, and *least* by what is actually in them.

Far from being described as a simple technique, women repeatedly described the unanticipated complexity of the procedure. Even if they were well-acquainted with the entire range of techniques involved in the procedure, they were often unprepared for the extent to which the technique 'took over' their lives through its considerable demands upon them:

> It's a very intense procedure and if you're up at the hospital every day virtually and you are being monitored all the time so obviously it's a very intense time and you do get very involved in it all. Much more so than you imagine you will do, it's not like having one injection, you know, it's really involved...And it does sort of take over your life to quite a big extent. (Ives, p. 22)

In addition to finding the technique more complicated than expected, and suprisingly 'intense', the number of things that could go wrong during the cycle was not anticipated accurately. This too can be seen as a result of the difference between IVF as a clinical procedure and IVF from a woman's point of view. A frequent way in which this 'discovery' was represented was in terms of a series of hurdles or stages: an obstacle race. The analogy of the 'obstacle race' was for many women

the most effective way to describe their experience of the actual procedure of IVF.

Descriptions of IVF as an obstacle race or a set of hurdles to be overcome were very common:

> It's like, to me, when I think about it, it's like running the Grand National without a horse and with your legs tied together and with a blindfold on. I don't know how long the Grand National is..., it feels like that..., but with all the brooks and everything else, and you've got to get over every single hurdle and you can still fall at the finish line. (Flowers, p. 5)

> And you think the first time, oh yes, it's going to work, even though they say the first time doesn't usually work...and the reason the disappointment is stronger than you'd expect is because it's like a set of hurdles, and each one that you're successful you build your hope a bit more. (Clarke, p. 15)

> Well, just reading in an article and coming to the treatment I didn't realise that there were so many obstacles that you've got to get over, you've got to get over each obstacle one at a time before you can carry on to the next, you know there may be a problem where you just don't ovulate for one reason or another, so that cycle has to be abandoned, and then try again the next cycle and then the problem is whether they fertilise, and then the problem of whether they will divide.... (Doyle, pp. 9-10)

Far from a 'simple' technique, these descriptions address the difference between IVF 'in theory' and IVF in practice. 'In theory', each stage leads to the next stage, but in practice each stage becomes a potential source of failure, and thus an 'obstacle'. In descriptions such as these, the emphasis is not only on the unexpected difficulties encountered, but on the high risk of failure at each stage, a fact for which most women, despite being well-informed beforehand, were unprepared. As is also noted in the latter two extracts, one from a woman who was a trained nurse and very knowledgeable about IVF, appreciating beforehand the high likelihood of failure, or the number of ways in which the technique can fail, is difficult both because of the reluctance not to believe it will succeed, and simply because not enough information is conveyed. These are only some of the difficulties of conveying an accurate description of what the technique involves:

> There's a lot more to it than you're thinking [at the outset]. As I say, it all sounds wonderful but you don't realise the small percentage that works and the lot that doesn't work. When I first went up there I was thinking oh, if there's nothing wrong with it, it's going to work. And obviously it doesn't, you know. [But] you can't help but think you are going to be one of the successful ones, and that if nothing goes wrong you are going to get pregnant. (Ives, pp. 34-5)

There is both an initial reluctance not to believe 'you are going to be one of the successful ones'[5] and an underestimation of the number of things that can go wrong during the cycle.

Yet another consequence of the obstacle race element in the experience of IVF is its impact on definitions of success and failure. Initially, women define success and failure simply in terms of whether the technique results in a 'take home baby', the ultimate 'success' of IVF. This changes as the obstacle race element of the technique comes to be better appreciated. Coming to see IVF as a series of hurdles has the effect of a treatment being seen as 'successful' if it progresses beyond some of these obstacles, *even if it later fails*. But failure is also much harder to accept the further along the cycle it comes. Failure is absolute, and is described as 'the cycle being abandoned' or, simply, 'abandonment'. Success, on the other hand, is measured in terms of degrees of success, or relative success, more often than in terms of complete success, which is the exception.[5]

To appreciate more fully the series of stages or 'hurdles' involved in IVF, a schematic representation of the serial components of the procedure is provided below. This sequence also includes a brief indication of the demands of the technique in terms of the work that is required at each stage.

The Stages of IVF

1. Previous infertility investigations diagnosing, or not, source of obstacle to conception (if necessary).

2. Choosing an IVF programme (investigation, selection, referral, initial consultation, admission onto programme).

3. Initial work-up (updating of infertility tests, etc.).

4. Preparation for first cycle (getting drugs from GP, arranging time-off work, arranging transport, financial arrangements, etc.).

5. Ovulation induction (2-3 week period of daily injections, tablets, hormonal nasal spray, ultra-sound scans, urine collection and sampling, blood tests).

6. Egg aspiration (hCG injection 35 hours before removal of eggs, valium/pethadine 12 hours beforehand, aspiration -- surgical removal of up to 30 ova [general anaesthetic in some cases]).

7. Embryo transfer [ET] (if eggs have fertilised and divided successfully, up to three are selected and transferred into the cervix through a catheter after 24-48 hours).

8. Pregnancy testing (following a two-week waiting period, blood tests are performed to establish whether pregnancy has occurred).

9. Pre-natal monitoring (if pregnancy has commenced a programme of pre-natal monitoring is followed until completion of pregnancy by either miscarriage or birth). In some cases, 'selective termination' of one or more fetuses is indicated, due to a multiple pregnancy. This procedure is, however, controversial and is not widely used.

10. Birth (when they continue to term, IVF pregnancies are more likely to involve caesarian section, and are also more likely to result in premature birth and congenital abnormality, due to the higher incidence of multiple pregnancies).

Again, as is evident from this list, in vitro fertilisation itself is one of the few aspects of treatment in which neither the woman nor her partner are involved. It is also notable that this stage, for which the technique is named, occurs well along in the cycle and is not always achieved by couples undergoing treatment. During the first two weeks of treatment, the main aim is to induce successful ovulation. Successful egg maturation must then be followed by successful egg removal. The ova must then fertilise and divide. Finally, the fertilised ova must successfully implant themselves in the uterine lining in order for the pregnancy to 'take', and it must then continue to term in order for IVF to be a success and result in a 'take-home baby' -- the bottom line of IVF success or failure.

In addition to there being more potential sources of failure during an IVF programme than many women realised, it is often equally difficult to appreciate the extent to which IVF can be too 'successful'. In other words, if too many embryos implant, the woman may experience a multiple pregnancy. Such a prospect may not initially appear alarming, indeed it may even appear desireable. However, even with twins there is a greater risk of peri-natal complications or permanent congential disabilities. With higher-order births of three or more, the risk factors increase considerably. In addition, even if there are no congenital or peri-natal complications, simply caring for three newborns can produce

tremendous strain, effectively creating for a woman who keenly desired a baby a cruelly inverted scenario of 'overbirth', in which she finds herself in the previously unimaginable situation of having too many babies.[7]

In addition to being unaware of the number of stages at which the technique can fail, the 'obstacle race' analogy is also used to describe the nature of the demands of treatment, the work involved in meeting each new stage afresh, always with an awareness of the risk of failure, yet equally with a reservoir of hope for success. All of the interviews contain references to the unanticipated demands of 'the regime':

> I think it's always easier to read about something than to actually do it.... But until you've experienced [IVF], you know, you say oh we do this and we collect the eggs and we do this and it all sounds quite easy. (Newton, p. 16)

> [We just thought] that it would be an administration of a drug and a recovery of an egg and then fertilisation, test-tube fertilisation, and re-implant, and essentially that *is* the procedure, but that is very much an oversimplification of the procedure. (Flowers, p. 4)

> I think it's more complicated than I thought it would be.... They just went through the basics of what exactly they did, which basically meant taking the eggs out, fertilising them outside the body, and putting them back in and that sounded quite straightforward to me, I thought it was something you could do in an afternoon. (Norton, pp. 43-4)

In addition to being more complicated than many women initially thought, IVF is often more emotionally traumatic as well. In part, it is the unanticipated demands of treatment which make of IVF such an 'intense' experience. Likewise, it is often the first procedure which is the most overwhelming. Other factors also contribute to this sensation, however, in particular the anticipation inevitably generated at each stage of treatment, and the number of stages which must be successfully completed in order to succeed in realising 'the ultimate goal' of a take-home baby. Finally, and most obviously, there is the basic underlying stress of IVF being a woman's 'only hope' to have a child:

> I think unless you've actually been on an IVF programme you don't really know what's involved. Because it is, I mean I must admit I went there for the IVF programme thinking you go in, you have these injections, it is all, I mean I knew it took a few days, but I didn't think it would be as traumatic as it was. I think it was the way that emotionally, the way it upset me. I found one minute I was high and the next minute I was down. Going for the injections didn't bother me, taking the tablets and all the collections, that part of it never bothered me, but it was the fact that it was my last chance, I suppose, my only hope. (Keating, p. 2)

The potential for failure is always, and understandably, underestimated by most women -- the need to believe in the potential for success of treatment outweighing the need to recognise failure as the most likely outcome:

To say that's the procedure, which it is, sort of a, b, c, d, that's what happens, there don't seem to be that many, not as many people as I imagined actually got to the end result of even having the egg retrieved, the eggs or whatever. The insinuation seemed to be from the media I suppose that if you embark on IVF it's almost as if you are going to get there in the end, but it may take two or three times. Whereas it just seems to be incredibly more difficult than that, that almost as if the intimation is that there is definitiely going to be a positive end result in it so you get from the media[sic], to me, all of the positive sides of it, of the women who are having the babies, but you don't hear an awful lot about the women who start doing tests for IVF and don't get accepted onto it or get accepted onto it and fall at different hurdles. (Flowers, p. 5)

It is on their first cycle of IVF that women encounter most forcefully the unanticipated demands of treatment. Subsequent cycles are then undertaken with greater confidence and assurance, even satisfaction in having acquired sufficient experience to 'do the job well':

The first time 'round the IVF programme itself is hard, because you don't know what you're doing. You don't know, you don't know what they're doing. You don't know, you're thinking to yourself have I got my drug regime right, have I made a mess of it, when have I got to take my next tablet, when have I got to go for my next injection, or -- you're not sure what you have to do, but when you've done it once, you

know, you soon remember what you have to do, and then you're thinking 'oh, I know what I have to do' and then you have a programme of it. (Keating, p. 18)

The repetition of certain phrases in this extract, concerning the unknown dimensions of the programme, underscores the urgency often experienced on the first cycle about 'getting it right'. Familiarity with the treatment cycle gained on the 'first time 'round' enables a greater sense of control, and the confidence required to feel 'you have a programme of it'.

The initial sense of disorientation and uncertainty is not surprising given the number of procedures a woman has to coordinate. Again, it must be remembered both that medical matters can be more daunting than more ordinary tasks, and that there is a tremendous amount riding on a successful outcome. Both of these factors can make what would otherwise be comparatively simple tasks into an anxiety-producing test of a woman's organisational and coordinating skills.

Keeping track of the drug schedule requires integrating several courses of different hormonal preparations, including injections, tablets and nasal spray:

You can't neglect it, you can't say like all last week you'd taken your tablets and you'd taken your spray and you think, oh, I'll leave it off tomorrow and the next, you can't do that, you've got to work it for yourself the times that you are taking it. Like me, I work mine, I take it at nine, twelve, three, six, nine, twelve, between and you know where you are, you know, you've got to work yourself to a pattern as you know when you look at that clock, when you like three

o'clock time when you are sitting there about quarter to, you know you've got another fifteen minutes and you've got to take your spray like, you know. (Yates, p. 79)

Learning how 'to work yourself to a pattern' requires some adjustment and can initially feel like a constant preoccupation. On later cycles, it is easier for women to integrate their self-treatment programmes into their normal daily schedules.

Many women also expressed surprise at the extent to which the programme came to dominate their lives as soon as they commenced the cycle:

> The only trouble is that I find is that once I start going over to the clinic, on day 6 of the cycle, that tends to take over. Going there, it seems to be the only thing that I think about. [My husband] will come home with loads of typing for me and I'll say 'just leave it for the moment', you know what I mean, it just sort of takes over everything. And, um... I don't know if that should do or not [but] it takes an hour getting there, and an hour back, and you're there for an hour and a half, it seems to take up most of the day. You come back and you're absolutely shattered.... As soon as you start then it seems to take over everything. I keep on thinking about the scans, and working the dates out, roughly when there will be the aspiration, and hoping that [my husband] will be able to take me, and sort of thinking, well, if it's going to be late in the afternoon I'll have to arrange for someone to have [my child], sort of trying to work out everything, I have

to have everything settled in my own mind.... (Harding, pp. 7-8)

This is a typical description of 'women's work' in the way it describes the coordination of childcare, secretarial responsibilities and the demands of treatment having to be integrated not only on a daily basis but in the longer term. It thus presents a picture of household management which is characteristic of the ways in which several different kinds of work must be integrated, and the difficulties this can present.[3]

Both the intensity of the programme and the momentum which is generated by it were frequently commented upon aspects of the experience of IVF. In the extract above, the demands of the IVF programme are described as seeming 'to take over everything'. In several interviews, IVF was similarly described as becoming a 'way of life':

> I didn't know what hit me, I honestly didn't know what hit me, I couldn't believe the intensity of the programme.... All you do is eat, drink and talk IVF, your dinner conversation revolves around how big your follicles were that day, which side you had your injection in and that sort of thing, you just do, you just live and die IVF. (Chadwick, p. 3

> Because you go into it 100%, you see, it's not something you go into half sort of.... You throw everything in and everything else gets pushed by, I mean...you live, eat, drink -- everything is IVF. Nothing else exists...I wasn't interested in anything else. I felt guilty, because all I was thinking about was this like, but you can't, like it takes

over everything really, because it's your chance. (Keating, p. 13)

In both of these extracts, IVF is described as something you 'live, eat and drink'. It is a measure of the extent to which it is felt to 'take over' a woman's life, and the life of the entire household, that it is described in this language. That IVF becomes like the food you eat indicates the degree to which it becomes a 'way of life'.[10]

This feeling of 'living IVF' is similarly described in the following exchange between a woman and her husband concerning the logistics of urine collection:

husband: It's something you both live, I mean it's not something you just do once. It's things like...I've always got a jug in a plastic bag in the car....

wife: Yes, you have to take your jugs, just in case.... You've got to feel committed first, you've got to be prepared for that.

husband: You've got to be totally dedicated. You can't go nowhere without that bloody jug in the bag, you need two or three...

wife: That's it, it's become a way of life to us now, you know what I mean, I think we've got about six of these damn jugs, spread one here there and everywhere. (Yates, pp. 36-7)

There is the feeling that the programme becomes inescapable, pervading every aspect of a woman's life, and requiring that she show both dedication and commitment to succeed at meeting the demands of treatment.

Part of the intensity of the programme can be explained by the amount of attention it requires to coordinate urine collection, hormone injections, travel to the clinic for scans, and so forth. There is also a forcefulness to the build-up effect of the ovulation induction period, during which egg follicles are being monitored for their rate of growth: 'I felt as if I'd gone all the way up to 99% and then I've had to come all the way back down to zero again' (Keating, p. 18). Whilst there was quite a large degree of variation in the extent to which women became involved in the technical side of IVF, a sense of having ones life taken over by the waiting, the worry, the activity and the stress was consistent. Clearly, one of the most important sources of the intensity of the programme is the potential outcome of successful treatment -- a baby. This aspect of the experience of IVF, the balancing of hope for success against a realistic recognition of the likelihood of failure, was often described as a major pre-occupation, and is discussed in the next Chapter.

The Physical Demands of IVF

In addition to the work of managing the various tasks involved in an IVF programme, there are also physical demands. In addition to managing the demands of treatment in relation to the rest of her daily routine, women have to manage their own bodies and undergo physically quite demanding procedures as a result. This is another way in which the demands of IVF can be seen as having to be literally internalised by women undergoing the procedure. This is another way in which IVF can be seen as 'taking over' or becoming a 'way of life'.

Scanning Procedures

In terms of physical discomfort, many women described the scanning process as one of the most demanding aspects of the programme. The purpose of scanning with an ultrasound monitor is to evaluate the effects of the hormone injections upon the rate of follicular growth. In order for the scan to reveal a clear picture, the bladder must be full, indeed bursting. This has to be achieved in coordination with travel, and the following are typical descriptions of what many women found to be the most physically demanding component of the cycle:

> Mind you, the hardest part about all this treatment is just being able to gauge your bladder right. It really is, because, honestly, you can just be right one time and another time you go, you can feel right, and you ain't got enough liquid in you.... And yet you can be too full for it, you can never gauge it, that's the hardest part, and some people, well, I like, you can't just let a little drop out, you know what I mean, it's ever so hard to control down there, and then you have a little top up, like you know, them are the things in with treatment, I think they are more awkward, them little things like that.... (Yates, p. 89)

> When you are travelling every other day, then it's every day, and you have to have a full bladder, and that's discomforting in itself. You know what it is like if you are absolutely bursting, I mean I'm talking about bursting to go to the toilet, and then they are pressing something on you [the

scanner], all you can think of, you are not thinking about follicles, you are just thinking 'I'm dying to go to the toilet', you know, and that's all you can think of, you see. It sounds silly, doesn't it, I don't know.... (Lewis, p. 38)

A definitive feature of the ultrasound scanning procedure, then, is the requirement that women exercise physical control over a physiological process that is difficult to gauge accurately. Indeed, in conjunction with travel and the vagaries of appointment schedules characteristic of even the most well-organised clinics, 'gauging' the bladder correctly might be described as an impossible task. It is perhaps because of the standard amount of hilarity connected to anything 'down there' that such difficulties are dismissed as 'silly' in the second extract. This trivialisation of their own physical discomfort may also reflect the power-imbalances of the clinical setting, such as those mentioned in Chapter Three.

The Aspiration Procedure

While the scans are the most demanding physical aspect of the cycle from one day to the next, the operation to remove the eggs once they have matured is the most physically traumatic single event involved in IVF. At the clinic attended by women in this study, aspiration was performed as an out-patient procedure whenever possible. This meant the avoidance of the use of general anaesthetic, which is more complicated, and was often considered undesireable by women undergoing IVF because of its after-effects. However, it is not possible to use a local anaesthetic for the entire abdominal region, and therefore women were

only mildly sedated with drugs such as valium or pethadin beforehand. As a result, women were conscious during aspiration, during which a long needle is inserted into their lower abdominal cavity to puncture the egg follicles and remove as many ova as possible with the aid of an ultrasound scanner. Anticipation of this procedure was often anxiety-producing, and an understandable amount of trepidation was often expressed concerning this particular component of the programme. Again, while there was considerable variation, with some women not finding aspiration unduly traumatic, many women described egg removal as acutely painful:

> I wasn't prepared for how painful the aspiration was going to be. I mean they give you a pain barrier form, and I just went off the page.... I don't remember anything about the aspiration at all except the pain.... I was in agony. (Chadwick, p. 4)

> I mean the first time I went and had the eggs, what do they call it, the aspiration, it bloomin' hurt and in the leaflet it said there may be some slight discomfort, but this will be perfectly bearable, and it must have been a man that wrote that, because you have a needle straight through your bladder and it does hurt, apart from the fact as well that I was wide awake.... And I made sure that they knew that I, you know, I was aware of what was going on and it I know it hurt. I couldn't tell you how long I was in there, and I couldn't tell you how many eggs they'd taken out.... Put it [the pain] extreme, it was, and especially you bear in mind you are lying

there, and your bladder is full, and you can't move an inch, you know...you are just lying there, and I've got my nurse's hand in mine, and she must have nail ridges in her hand half an inch deep because it was, and I was crying, and all the other things I'd been through it never got to me like that! (Norton, pp. 35-6)

They say they just put the tube in and suck out the eggs and that, and that's it, you know.... It was quite painful, I nearly jumped off the table. (Ives, p. 26)

That aspiration is extremely painful is not surprising, given that tranquillizers have no anaesthetic properties. The piercing instrument used to extract the eggs must thus be inserted while the woman is fully conscious and awake. As mentioned above, anticipation of this procedure often causes considerable anxiety, as described below:

And if you can imagine that in your mind, you're sat there, all prepared, and you know within 35 hours you've got to go down there and all you know about is this needle going through your abdomen...and you're trying to imagine the pain before you get there, and I'm thinking 'Oh my God'...what's it going to be like to have that needle going through my abdomen, and I couldn't come to terms with that at all, all I could think of in my mind was this big needle going through my tummy, and it wasn't going to be numbed, I was only going to be sedated slightly, but they weren't numbing it like the dentist would do...and I thought, God, that needle's going to go through my tummy, and I'm looking at my tummy thinking 'where's that

needle going to go through', because I just could not imagine it. (Levy, pp. 13)

Exceptionally, women do not find the aspiration excrutiatingly painful. One woman, who was, perhaps significantly, successfully pregnant at the time of the interview as a result of IVF, even described it as enjoyable:

> I actually rather enjoyed the aspiration, I mean everybody was saying wasn't it awful and it was painful and this that and the other, and I actually was quite excited by it, really.... I was very aware of what was going on, and I found it quite exciting actually, they kept saying 'oh, got an egg' as they kept yanking these eggs out and I was really excited, I mean I was absolutely fascinated by how they were doing it, how they could retrieve these eggs. (Young, pp. 12-13)

As it is undoubtedly the case that a person's attitude can influence the experience of pain, and/or its interpretation, such comments are not surprising, though, I would imagine, are comparatively rare. Likewise, retrospective accounts of pain are not only altered through intervening circumstances, but also by the tranquillizers, which can have a mild amnesiac effect.

Far more common, in any event, was the description of the procedure as very painful and traumatic:

> Now the actual experience of having the eggs retrieved, they gave me the valium and the pethadin, and I thought oh this is lovely, this is a lovely feeling, I was sort of floating on air, you know, laying there, and all of a sudden it felt, well, I can imagine as though someone had stabbed me. The

pain, oh I just couldn't believe it, and I just lay very still because I remember him saying if you move Mrs Lewis we will lose the eggs, and they will go into your body and that will be it. So of course I had to suffer it and I just lay there and I was sort of moaning sort of thing. When it was done I said to my husband oh it was agony. (Lewis, pp. 33-4)

The operation itself was excruciatingly painful, I mean [the clinician] said he thought I was very unlucky because they actually got eighteen eggs out of me which was a lot more than they thought they would. He said the more eggs they get out of you he reckons the more painful the operation gets, because you know you are not under general anaesthetic, you are just, I was just doped up to the eyeballs with valium and everything and I remember bits of the operation, I remember crying during the operation, I could hear myself crying, and I could hear the nurse saying you are doing very well, it won't be long now, and I could hear [the clinician] saying there's one and there's another one.... (Caldwell, pp. 74-5)

These extracts not only describe the pain of aspiration, but reveal certain features of women's self-image during treatment which are perhaps significant. For example, there is in the latter extract the comment: 'I remember crying during the operation, *I could hear myself crying*', suggesting two different points of view on the self, one from within and one from without, as it were. The shift in point of view denotes the presence of a dual self-consciousness, of a direct self-consciousness ('I remember crying during the operation'), and of a

consciousness of self as seen by others ('I remember hearing myself crying'), which is spoken from a point of view analogous to those of the nurses and clinicians, as if she were outside herself. Lying on the table, looking at her inner abdomen on an ultrsound monitor, which is also being watched by the clinicians as they locate the follicles, it is clear the woman is instantiated in a complex web of mediated gazes, through which, including her own, her body is objectified at the same time that her insides are 'disembodied' via the monitor. This complex process is clearly overdetermined, both in relation to the broader procedure, and in relation to women's position as both subjects and objects of reproductive science.''

The Emotional Demands of IVF

Despite the number of women who remarked upon the considerable, and unanticipated, physical demands the programme made of them, nearly all agreed the physical demands were secondary to the emotional and psychological ones:

> I've never in my life experienced anything so much as that, as after I'd been through the programme [and failed]. I thought I'd get on, I'd cope, I'd pick myself up, but I didn't, I didn't, not for a long time.... You've gone so far, but you've still come back, and that's the hardest thing. I felt as if I'd gone all the way up to 99% and then I'd had to come all the way back to zero again. And I think that's what it is. You build yourself up, you get yourself so psyched up, I've done it, and then you think, like, I haven't, and I think

that's the hardest part. Because I don't think the IVF programme itself is hard. (Keating, p. 18)

Because it is, psychologically I think it's a lot worse than physically, and that's even with all the dashing around and the injections in your bottom every morning.... Paying for it and doing it is nothing compared with the psychological part of it.... It strikes you in your mind...because it's easy to get carried away with it. (Norton, pp. 37-8, 40)

Women can take the physical pain. We wouldn't have gone through four attempts of all that pain if we couldn't take the pain. It's the emotional side that's more traumatic than anything.... I just literally fell apart through all this treatment because of the emotional side of it.... It's difficult to overcome treatment, and I think when couples go in for IVF treatment they have absolutely no idea what they're going in for, or what it actually involves, because going in for IVF treatment you really are on your last resort...and also, it's very difficult to explain, but one of the reasons I did come to the end of it is, as I say, I was so emotionally drained, the physical side I could take, the pain, but the emotional strain that you go through.... (Chadwick, pp. 1-2, 10)

In such comments is again visible the importance of the basic, underlying purpose of IVF, which is to have a child. Underlying the demands of the daily IVF regime, the way it 'takes over' as a 'way of

life' and the physical demands of the procedure is the continual awareness that the procedure is a woman's 'only hope', her last resort in the attempt to have a child. The impact of this underlying awareness upon all of the other facets of treatment, and its significance in and of itself, cannot be overestimated.

Dealing With Failure

Dealing with failure is undoubtedly the most emotionally wrenching feature of IVF. The importance of failure as a component of IVF, again, derives in large part from the way IVF comes to feel like a series of hurdles. This has two consequences. One consequence is that each hurdle represents another point of potential failure, and there are many more hurdles to overcome than are initially appreciated, due to the apparent straightforwardness of treatment. Related to this is the consequence that the more hurdles overcome successfully, the harder failure is to accept, having 'come so far':

> I mean we were told, we were given details of the program at the London Hospital, we were told that on day one you take this tablet and day so and so you start taking the injections and then the eggs start developing and day so and so you have more scans, blah, blah, blah, but you may ovulate normally and then you may abandon the cycle. Well, what happened with me was that the drugs that I was taking and the injections and the tablets which was the drug regime at the time didn't or had very little effect so I didn't even produce one egg in the month so obviously they had to abandon it. Now that wasn't

> something [we'd been told], the assumption I believed was that I would at least produce one egg, although they would expect me to produce anything up to twenty-odd, so that was very disappointing. (Flowers, p. 11)

Hence, there is a considerable amount of emotional work involved in coping with the demands of the IVF procedure, particularly when it fails, which is almost always the case. Again, the intensity of the emotional and psychological demands of treatment are often unanticipated, even when a couple has undergone several cycles and know the routine.

Personal Boundaries

Emotional difficulties are also encountered in the context of information management, as it might be described, concerning both fertility problems and their treatment. In response to questions about who they told about IVF, women reported several difficulties related to personal boundaries concerning their treatment. This came up often in relation to paid employment, as discussed below. In addition, decisions had to be made about the pros and cons of telling family and friends, both about infertility and IVF. Some women felt that openness was the best policy, but others felt conscious of continually having to 'keep up a front'. Some women simply lied about their treatment, saying they had to visit the hospital for some other reason. Many found it hard to tell people even if they felt this was the preferred solution. Others found it hard to explain the nature of treatment itself, given the complexity of demands it presented. When telling people about their treatment,

some women also found the reactions of people they told difficult, thus leading them to feel that there were awkward responses to negotiate in addition to the difficulties of disclosure:

> My hardest part was keeping it from the girls at work. And every time I had to go down to [the clinic] during the day I used to tell them I was going to the hospital to be treated for a urine infection. The lies I told, honestly, it's a wonder I didn't have white spots all over my tongue! (Levy, p. 7)

> [Telling people] made it so much worse because there are all the more people to say well it hasn't worked, and there were too many people feeling sorry for me, and I couldn't cope with that either, oh, you know, we are all so sorry, we are so very sorry, and why didn't it happen, what went wrong, and you know, it just went wrong. (Norton, p. 23)

> It's just a difficult topic to sort of talk about, I mean once it's been broached it's not so difficult, because a lot of people have had problems, but just that initial deciding to tell is difficult. (Newton, p. 18)

> The one thing I got fed up of, I got fed up of talking to people I had to explain the treatment to...because it can get quite tedious to actually sit there explaining to someone.... They don't know the technical part, and you can be sure they don't know the emotional part. (Caldwell, pp. 12-13)

Most women found that going through the treatment with a group of other women provided the best forum in which to discuss issues related to the treatment. As they shared time together in the waiting room for scans, for example, the immediate circumstances of their treatment could be discussed with other women who were at the same 'stage' and therefore in a similar position. Although some felt that organised support groups, or counselling services, would have been helpful, many had reservations even about sharing their feelings amongst a group of other infertile couples. When asked about support groups, ten (50%) said they either had gone to a support group meeting, or would do. Seven (35%) said they would not go and in three cases (15%) the woman would have gone but her male partner would not.

For three of the women interviewed, organising support groups and acting as informal counsellors to many of the other women on the programme became a major component of their relationship to IVF. In one case, continuing in this capacity after having stopped treatment served as a means of coming to terms with ending treatment. This volunteer work provided by women was thus a contribution over and above the demands of treatment itself, constituting a traditional form of 'women's work', that of nurturing and caring in a volunteer capacity, and by so doing also servicing the clinic by providing a much needed, and freely provided, support service. At the same time, it is also understandable how work of this kind might function as a means of coping with the difficult emotional demands of IVF, including those of serial failure.[12]

Reproductive Work and Paid Work

As has been described so far, the IVF routine itself requires a considerable amount of work by the women who undergo it. This work takes a variety of forms, including the work of organising 'the routine', the work of travelling back and forth to the clinic, of monitoring and coordinating the various 'tasks' involved in the treatment cycle, and the physical, emotional and psychological work of coping with the technique's demands. In addition, a number of issues related to paid work were raised during the interviews. Although all of the women interviewed had been involved in paid employment at some point, 15 out of 20 (75%) had either already left or were planning to leave full-time paid employment for reasons directly related to their treatment. It was not only logistical difficulties, but other issues as well which account for the tensions between women's 'productive' (ie, paid) and reproductive work.

Arranging for cover and time off were the most significant logistical difficulties encountered by women in the attempt to adjust their paid work with the demands of IVF. Significantly, it was often easier for their male partners to arrange time off work to accompany them to the clinic than it was for the women themselves to do so. Whereas most of the men worked in white-collar, professional jobs, where they had comparatively greater control over their time and their work schedule, most of the women were in jobs which required being continually available in a supervisory or service capacity. A lack of a sense of

fulfillment or of future prospects in their paid employment also became apparent in several women's comments about their paid work. While many women expressed a reasonable degree of job satisfaction, many felt there was little or no opportunity for career advancement, and, by their mid-thirties, most were looking for a change. This ambivalence stemmed in part from the competing demands women felt between their lives as paid workers and the lives they hoped to lead as mothers. As women's lives were more likely to be transformed by the birth of a child than those of their partners, many had for long periods of time pursued part-time or temporary work in the expectation that they would soon become pregnant, and felt they had essentially put their work futures 'on hold' for a period which had extended much longer than they anticipated:

> IVF only makes life more difficult.... I would have had to accept it a long time ago if it weren't for IVF. At 28 I could have either gone for adoption or accepted my situation so I'd be 5 years down the line towards that and getting on with my life. Now, you're in a better position to do that when you're 28 than when you're 38. If you've missed all your career boats, burned all your career bridges because you've spent the last ten years chasing fruitless treatment, you've actually missed out a lot on life. (Carter, p. 1)

In such a statement there is not only an evident tension between the demands of productive and reproductive work or identity, but also an important feature of 'the IVF experience': how it changes women's views of their choices over time. This theme is developed further in

subsequent Chapters. For the purpose of this section, this extract demonstrates the familiar kinds of difficulties women face in having to 'choose' between motherhood and paid work outside the home, only in this instance it is the attempt to become a mother in the first place which is the source of tension.

Reconciling paid employment with the work of achieving a pregnancy demanded by IVF caused difficulties at both the practical and the emotional level. Logistically, women found it exhausting to maintain full- or even part-time employment during treatment:

> I mean it really does take it out of you. I mean I've been getting the earliest appointment possible at [the clinic], nine-o'clock, which means leaving here at half-seven and quarter-to-eight, you dash to [the clinic] because you are in all of that rush-hour, you sit and wait with your bladder bursting, and then you are straight out of there and you are tearing down the motorway again to get back to work.... You are breaking your neck, and you feel as if you've down half a day's work by the time you get there, and then before you've even got your coat off it's do this, do that, do that, and you are worn out. (Norton, pp. 18-19)

In the explicit reference to how the demands of IVF come to feel like 'half a day's work' is apparent the appropriateness of considering the demands of IVF in terms of labour. Often invisible as such, like the 'work' of femininity, which, similarly, involves consumption, bodywork, emotional and psychological work, IVF can be described as a form of

reproductive labour, or even the professionalisation of fertility management.[13]

For some women, however, paid employment was helpful as a means of coping with the emotional demands of treatment, despite the added burdens it imposed:

> Well the job I do, it is an office job but it is very very busy, very very hectic, so luckily most of the day I just don't have time to think about anything to do with me. (Flowers, p. 20)

Especially as a means of coping with failure after unsuccessful treatment, many women noted the usefulness of paid employment in taking them out of themselves. One woman, who had become a nurse after losing a pregnancy very late in term, expressed the following:

> Now they say it either kills you or cures you with nursing - to get yourself stuck into something - and it certainly did the trick. That cured me, and even then I'm feeling depressed but doing the nursing and seeing other people in desperate situations it made me feel well my worries are nothing, that's how I felt. (Lewis, p. 16)

It is a familiar enough sensation to feel ones own lot come to appear more bearable in the light of other people's suffering. It is as well, too, that work provides a means of distracting ones attention away from preoccupying sources of anxiety. In these ways, women's work experiences were no doubt an important source of solace and relief. On the other hand, however, comments such as 'I just don't have time to

think of anything to do with me' or 'it made me feel my worries were nothing' are also typical of the ways in which women often neglect their own needs and concerns, or see them as trivial or 'silly'.[14] In the context of IVF, for example, which may impose quite a severe physical and emotional burden, it is not entirely reassuring to think of women sublimating their own concerns through work, however functional this may be in the short term.

Paid work also provided a fall-back option for many women, who were self-conscious of the risk of 'putting all of their eggs into one basket' (or into a petri dish) and were careful to protect their work identities:

> I was very wary at the beginning, I mean I've come across women who seem to let it [infertility] control their every thought, gesture, life, their whole life is one of failure because they haven't had children and I was very anxious not to end up like that. So I have always, all the way down the line, put a lot of effort into having something else in my life. (Caldwell, p. 67)

Interestingly, this extract also indicates the thoughtfulness with which many women decided to undergo IVF. It is important to stress that, at least in this study, women were well aware of the risks they were running by opting for IVF. They were not blindly opting for a wonder-cure.[15] Yet also evident here is the kind of 'it'll work for me' attitude, in the form of not wanting to fail in the ways other women have.[16] The 'wariness' described here is a prudent one: it is evidence

of having not only seen, but having seriously considered, the dangers of over-estimating the likelihood of success.

Despite awareness of its advantages, both in terms of coping with the immediate stresses of IVF, and in terms of preserving future options in case it failed, women often found their paid jobs both exhausting and despiriting. This was particularly true for women in jobs such as teaching, nursing or social work, where providing cover for absences proved difficult, and was often impossible:

> When I left work, which was partly due to the treatment because I knew I was going to have to start going up to the clinic daily, there was no way in my sort of job I could get the cover I needed, because if you are not at work there's only two staff on duty, you can't just pop off to the clinic. (Caldwell, p. 67)

Remaining in full-time, or even part-time work, was also difficult because some women felt their absences were used against them in an exploitative manner. In addition to taking unpaid leave and often less pay, some women felt their employers took advantage of the difficulties their treatment presented:

> We are talking about a firm that is doing extremely well, knows I'm underpaid, uses this [IVF] as an excuse not to give me any more money because they are not sure how long I am going to be there, but I am loathe to leave because I don't know how I will stand benefit-wise if I am out of work for any

> length of time, and of course if it [IVF] doesn't work, where are you then? (Norton, p. 21

In this instance, the tension between paid productive labour and reproductive labour was exacerbated by the employer appearing to pit the one set of demands against the other. This is an important reminder of where women's tensions around combining paid work and parenting originate. It is not only women's ambivalence over which option they prefer, or whether they can 'have both' without sacrificing on both sides, but the conditions which create this 'choice' to begin with that need to be seen as the root cause of this 'either-or' dilemma.

Two Kinds of Work

Going through treatment had, for some women, the effect of concentrating their desire for a family and increasing their dissatisfaction with paid work:

> When I first decided to get pregnant...I think I was more philosophical about it, just, well, if I get pregnant I do and if I don't I don't. And then the longer it went on, the more I realised I really did want a family, and now I don't know what I am going to do if I can't become pregnant, if I can't have a family, I really don't know how I am going to cope with it. I decided that I'm not really interested in my career anymore. In fact, while I've been off this time we've discussed it and I am going to give up. [...] I think it

> changed my values and my attitudes, it put a different perspective on things, because I've always been conscientious at work and I've always felt it was extremely important, and I'm not saying it isn't important, and I've invested a lot in it, and then when I was pregnant [IVF pregnancy which failed] I realised it wasn't as important to me as I had always thought it was. (Quigley, p. 21)

In this extract, like the opening comment to this section, in which IVF was said to 'only make life more difficult', the experience of treatment has changed the perception of paid work. Here, the initial feeling is described as 'philosophical' towards pregnancy. But with the concentrated attention on getting pregnant involved in IVF, the perception of work changes, 'I realised it wasn't as important to me'.[17]

By other women, this dissatisfaction with paid work outside the home, and a sense of its shallowness, of not getting enough back, was framed in terms of the contrast between waged work in a professional and/or service capacity and the work of being a mother:

> My job was always second best to what I really wanted to do, and it got on my wick, and I think it showed in my working capabilities, definitely showed...Longing for a little-un really put the kybosh on that job...You think what am I doing? Why aren't I pregnant? Why am I still at work? Why aren't I at home looking after a little-un? You know you want to be a mummy and it really gets on your wick that you aren't pregnant. (Evans, p. 2)

The feeling of dissatisfaction with paid employment, and the desire to 'be home looking after a little-un', compounded by the fact that serial attempts at IVF can increase the desire for a child, may also be accompanied by an explicit desire to do the 'job' of being a mother particularly well. It is likely, for example, that women in infertile partnerships will have more fully investigated their desire for children, and given greater thought to what is involved in parenting than many women who have children without these obstacles. Part of the difference between achieved pregnancy and other pregnancies is the amount of careful thought focussed around the demands of parenting, and for women especially, the demands of mothering:

> I wish people could see that if every mother did a good job the world would be a 20-times better place than it is, because that mother is responsible for creating a worthwhile person who is going to live in this world.... To do that is such a vital role in life.... It's so important and that's why I think part of me drives me on. (Caldwell, p. 31)

Here again, the reference to mothers doing 'a good job' underscores the way in which women perceive the work of mothering both as analogous to paid work, and also as of equal, if not greater, importance. Also evident is that they are holding two systems of 'labour value', the one productive and the other reproductive.[18]

Finally, it is useful to note that in experiencing the conflict between the reproductive work involved in IVF, and their paid jobs, the women interviewed can be seen to be inhabiting merely a different

variation of a theme which runs through most women's lives: that of balancing the demands of reproductive work against the demands of their 'careers'. With IVF, the conflict differs in that it is the work of becoming pregnant, of achieving pregnancy, rather than the work resulting from pregnancy, of raising children, maintaining the household and belonging to a kinship network, which poses the conflict.

Conclusion

This Chapter began by contrasting the representation of IVF in introductory pamphlets with the demands of treatment as women experience them. The aim of this contrast has been to highlight what is described as the 'obstacle course' nature of the IVF procedure, and the corresponding ways in which it is felt to 'take over' a woman's life. In addition, the aim has been to introduce the IVF procedure in more detail, by exploring in greater depth the kinds of demands the technique imposes. It has thus attempted to provide an overview of what going through a cycle of IVF requires, including the kinds of emotional and physical demands or 'work' involved at various stages. In the latter part of this chapter, issues concerning the relationship between women's reproductive work, or kinship work, and their paid, productive work have been discussed. Here the focus also shifts, moving away from the immediate demands of treatment and towards the broader context in which women's experience is shaped. This perspective is extended in the next Chapter, in which the meaning of IVF as a 'way of life' is explored in

greater depth by attending to more of the external factors, such as paid employment, which contextualise the experience of the technique itself.

The demands of IVF are quite intense, and the nature of the work involved in pursuing treatment is one way in which the procedure comes to feel like a 'way of life', something you 'eat and drink', that you 'live' 24 hours a day. This intensity is also produced by the 'obstacle course' nature of the programme itself, involving a constant build-up at each stage, which either leads to another cycle of build-up at the next stage, or leads to the cycle being abandoned, which produces all of the demands of coping with failure. Understanding how IVF becomes a 'way of life' is also important in terms of the wider issues women have to make sense of while they are going through it, concerning their identities, their lives, their relationships and their futures. It is also particularly important in understanding the momentum IVF acquires as a process, and the difference between what it looks like going into it (pre-IVF) when IVF is an option about which a woman may have a lot of information, but by definition no experience, and what it looks like once it has begun, or 'taken over'. Repeatedly, women emphasise that they did not realise how demanding the technique would be, how intensely it would effect them, and how much their lives would feel as though they had been 'taken over' by the technique.

This feature of the IVF experience is also significant because it explains how and why some women change during treatment. As their assessments of the success or failure of the technique itself change, for example, so too do their assessments of other things, such as how

much they want a child, how much they like their job, what a future with or without a child would be like, and so forth. In this sense, IVF is like a rite of passage, through which an individual moves from one state to another. Not all women are changed significantly by experiencing IVF, but all are changed to some degree, and the potential for the technique to shift a woman's perceptions of herself, her needs or her goals is clearly evident in the descriptions provided here of how intense the procedure can be.

This again is important to understanding the differences between how women go into IVF, how they then experience IVF itself, and ultimately how they leave it. It is necessary to look at all three of these dimensions of IVF, before, during and after, in order to provide a thorough account of the experience of treatment. Representations of women's experience which focus solely on the way women feel going into treatment therefore exclude much of what is most significant about the experience as a whole. This experience is not static; it is a process, which may turn out to be a process of considerable and unexpected change. In the next Chapter, some of the ways in which the experience of IVF can change women's definitions of wider issues external to treatment are explored, as well as features of IVF as a process over time.

References to Chapter Five

1. Material for this part of Chapter Five was originally presented at a meeting of the Human Reproduction Study Group of the British Sociological Association in Cambridge in 1989. The contributions of members of that group to this and other sections of the thesis are gratefully acknowledged.

2. The term 'treatment' is used throughout the Chapters in Part Three because it is so much a feature of the language used by women themselves. This is a problematic term, however. It should be noted, for example, that IVF is not a 'treatment' for infertility, and is misleadingly described as such. Even if it is 'successful', it does nothing to alter the condition of infertility. This point has often been noted by feminist commentators on IVF and is repeated here as a qualifier to the use of this 'indigenous' term in Part Three.

3. See Burfoot, , 1990, pp. 70-71, for a discussion of the Organon video 'When Nature Fails'.

4. See Steinberg, 1990, for a further discussion of the language of IVF and the implications of it being so named.

5. This expression of belief is very similar to that discussed by Williams, 1988a, in which, as described earlier, she discusses why women continue to attempt IVF after serial failures.

6. Further sections on coping with failure are included in Chapters Six and Seven, where the psychological and emotional consequences of the relativity of success and failure are considered in more depth.

7. For a discussion of the consequences of higher order births, see Botting, et al, 1990; Price, 1989 and in press.

8. Although this is one of the few direct references to the kinds of media portrayal described in Chapter Four, it indicates an awareness of a certain image of IVF which can be assumed to have also influenced other participants in the study. More importantly, this particular reference underscores the arguments presented in Chapter Four in that it emphasises the partial nature of these accounts, their lack of attention to the actual experience of IVF, and their under-representation of the failure rates.

9. See, for example, the classic studies of Ann Oakley on housework, 1974, 1975.

10. The references here to living, eating and drinking IVF not only indicate the extent to which IVF 'takes over', or the extent to which a

woman 'becomes her body' (nb Martin, 1987). They also indicate the extent to which IVF is a 'way of life' that is embodied in a particular way. The subject of IVF as 'the embodiment of progress' is returned to in Part Four.

11. This gives yet another meaning to the idea of 'personal boundaries' discussed later in this section. It also confirms Martin's (1987) argument concerning the disjuncture between medically-defined images of women's bodies and their own images of themselves. This argument is instrumental to the entire tradition of feminist revisions of medical models, particularly of reproduction, as in the volume *Our Bodies, Ourselves* discussed in Part One. It illustrates too the complexities of the 'mentality' required by IVF, and suggests a clinical parallel to John Berger's description of women's dual self-image, in seeing themselves as they are seen by others (Berger, 1972).

12. This component of the programme, the work of supporting the clinic, is discussed further in the next section of this Chapter.

13. The 'professionalisation of fertility management' is also to be found, for example, in the emergence of 'pre-conceptive care', such as vitamin regimes, which can now comprise part of the process of 'family planning'. Other evidence of this are the advertisements now regularly to be found in women's magazines for ovulation tests which are designed to aid conception (see Figure 1).

14. These more explicit references to self-denial suggest that part of the reason women downplay physical discomfort is part of a wider phenomenon fo feminine 'self-sacrifice', a trait, which is particularly associated with motherhood. See Jacobus, 1990 and Warner, 1976, pp. 34-49 for suggestive discussions of 'self-sacrificial' reproductive acts. See also further in Part Four.

15. Again, this point underscores the extent to which this study negates the possible explanation of women's 'choice' to opt for IVF as one of 'ignorance' or misinformation. To the contrary, the findings of the interviews, albeit in no way representative, do indicate a consistently higher-than-expected degree of awareness about the risks of IVF. A major exception to this, as already mentioned, is the lack of any apparent knowledge whatsoever about the physical risks of IVF.

16. See note 5 above.

17. The way in which IVF changes women's understandings, expectations and identities as a result of the way in which it 'takes over' is an important part of what is meant by the application of the description 'rite of passage' to this procedure. It is in part this change which occurs which it is argued is an undervalued feature of the experience. This is discussed in much greater depth in the next two Chapters.

18. For a suggestive discussion of 'reproductive labour' in the form of 'kinship work', see Leonardo, , 1987.

CHAPTER SIX

IVF as a 'Way of Life'

Introduction

In the last Chapter, women's experience of IVF was investigated in terms of the most immediate demands posed by an IVF programme, the impact of these on women's lives and the ways in which women 'manage' the procedure. In this Chapter, the focus moves to a wider frame, taking into account women's perceptions of their needs, desires and expectations of the technique. It is argued that these are important factors in understanding how women make sense of the experience of IVF not only as a procedure, but as a process over time which involves continual re-evaluation.

In order to understand women's expectations of IVF, then, it is first necessary to consider how these are framed in relation to the experience of infertility. In the first section, the experience of infertility is explored in terms of how it disrupts certain assumptions women held about how they would live their lives, and how they make sense of these disruptions. In other words, this section addresses the ways in which the discovery of infertility contradicts certain features of an assumed worldview, an assumed trajectory of the lifecycle, an assumed sequence of events. In turn, these disjunctures create the opportunity for women to reflect explicitly upon certain needs and

desires they feel in relation to parenthood and reproduction and to redefine their reproductive choices accordingly.

It is the way in which women evaluate the disruption posed by infertility, the losses they feel in relation to it, and the options they see before them which will determine their course in relation to expensive, high-tech infertility treatment such as IVF. Cost alone makes this an option available to some women more than others, and some women not at all.[1] But many other factors influence a woman's perception of the IVF option as a means of resolving her reproductive future. The 'logic' of the choice to opt for IVF is not self-evident, and not all women choose it. It is a particular way of evaluating a situation based on a specific set of assumptions and desires which, as is suggested below, lead to IVF coming to be seen as the appropriate and desirable course of action.

Hence, the way in which the disruptions posed by infertility influence the choice of IVF is the subject of section one. It is argued that the choice of IVF belongs to an assumed trajectory of the lifecycle not unlike that depicted in the media representations discussed in Part Two. The disruption of this trajectory, and the need for resolution through the attempt to have a child, produce the 'obviousness' of the choice to opt for IVF.

In the second section, a different trajectory is explored; that encountered in the context of 'achieved conception', that is, during the course of IVF treatment itself.[2] Here, a different sequence of events is anticipated, a different set of assumptions about what will occur is established and a different set of 'gaps' open up when, in the majority of cases, treatment does not proceed as hoped. Here, a very different

mentalite comes into being. In this section, the specific demands of IVF treatment itself are explored, with particular emphasis on the difficult decisions faced by women undergoing treatment and their strategies for negotiating them. This is 'new territory', and there are few precedents to guide women and their partners through the complex demands of treatment.[3] A tremendous amount of determination is required, and is evident, in their accounts of their experiences.

In the conclusion to this Chapter, these two trajectories are brought together, in terms of how the one leads on to the other, how they are inhabited and negotiated, and the difficult dilemmas they both produce.

The Disruptions Posed By Infertility

In this section, my aim is not to explore the experience of infertility itself in depth, as the interviews were not oriented to this task.[4] Rather, the experience of infertility is seen to be important here as the context out of which the decision to opt for IVF emerges. Hence, the account offered below of women's descriptions of how infertility affected them are presented with a view to more fully elucidating the ways in which IVF comes to be seen as a desirable 'solution', and the ways that particular hopes and expectations come to accompany the choice of the technique.

Encountering Uncertainty

Having taken for granted their abilities to bear children, and, in some cases having already given birth to a child or been pregnant, the discovery of infertility, either their own, their partner's or simply 'unexplained', was for many women difficult to accept, or even to comprehend. This discovery opened up a 'gap' separating them from the life they had expected to lead. It also opened up a number of 'gaps' in relation to their marriages, which they felt could not be 'completed' or 'fulfilled' without a child. Infertility presented an obstacle to the 'normal' and 'natural' progression they had anticipated from marriage to parenthood, and thus from marriage to family. For many women, this had not even been a fully conscious expectation, so self-evident was the assumption that they would have children of their own:

> We wanted children, and I suppose it's like everybody, you just think it's going to happen and you don't think there are going to be any problems and when it doesn't happen it's, you know, it's devastating. (Ingham, p. 3)

> And after about three years or so we decided that we would like a family so I stopped contraception and sort of waited to get pregnant, and I didn't. You know you sort of tend to automatically assume that you will, because after so many years of sort of trying to stop becoming pregnant, you sort of think the minute you stop contraception you will become pregnant. (Quigley, p. 1)

> Well we started trying for a family...and I think I was probably, well I can say it never really occurred to me that I might not be able to have children. I think that's common...it's something everyone presumes they can do...people do say *if* you get married, they don't always make the assumption that you will be able to get married if you want to...so you are always aware of that being an if, but people don't ever sort of talk about *if* you can have children, it's a sort of natural assumption that if you want them you will have them. Somebody sits there and says I'm going to have two children, I'm going to have one after being married three years and then I'm going to have another one...I mean I did that, I'm sure I did that. (Caldwell, pp. 39, 18)

> I think that not to be able to have a family is not something you consciously think about... because I think it's a natural assumption to be rather blase and to think that you assume you are fertile until you are infertile. (Flowers, p. 8)

> I always wanted to have children.... The thought of never having any more was blocked.... I couldn't believe I couldn't have children, I couldn't think about that. (Harding, p. 2)

Having children is assumed to be part of a natural and normal lifecycle and the thought that this might not happen had never occurred to many of the interviewees.[5] As the above extracts demonstrate, there are several reasons why the ability to have children is assumed unquestionably. It is described, for example, as an 'automatic' assumption, as 'not

something you consciously think about', and as a 'natural assumption'. The ability to bear children is also thought of as a natural capacity, unlike the ability to get married, which depends on social circumstances.[6] Another assumption, which has been noted earlier in the analysis of media accounts, is that of a 'natural' or 'normal' trajectory, in which getting married leads to 'founding a family'. The idea of 'life's progression' through these recognised stages of the life cycle was often cited. As the husband of one of the women interviewed put it succinctly, 'It's the central thing to do, to get married, have children, blah, blah, blah' (Mr Flowers, p. 9). This trajectory is seen to be both 'normal' and 'natural', and even 'blase'. It is understood as something 'everyone' presumes:

> Well it's something that everyone presumes they -- I think it's natural to want your own baby, I think in life you need to reproduce, it felt right, my husband and I get along so well, that was the natural progression, that was the next thing, it just felt right. I mean that's all I can say, it's just nature. I'm a firm believer in nature and what should happen. You should get pregnant and you should give birth and you should follow through with a child afterwards. (Evans, p. 4)

The desire to have children, or to have more than one child, is thus a desire which expresses in part the need to feel that one is progressing along a chosen, expected, or even biologically determined path. The inability to do so therefore creates a disrupted trajectory; expected events are not unfolding as hoped, and a set of expectations of which women were not even necessarily fully conscious become explicitly recognised in the wake of their failure to conceive as hoped.

Tentative Futures

Not being able to have children not only disrupted assumptions about what was normal, natural and right -- it also made planning for the future difficult. New plans had to be made, and visions of a future readjusted. The uncertainty surrounding the ability to have children thus creates a tentative future,[7] a future 'on hold' until some kind of resolution is reached:

h. So what we decided to do was we had to plan our lives out. If it wasn't going to happen, and it was just going to be the two of us, you know, what, what...

w. What are we going to get from life?

h. So we both had plans guided out for us so if it does happen great and if it doesn't...

w. If it doesn't, then, you know, what do we do then? What sort of road do we go down? to make our lives as full as possible? Until we knew, you go on for 6 years, and nothing's happening, you can't plan on anything because you're thinking well...

h. In case it happens.

w. What happens if I get pregnant next year? the year after?

h. So you really couldn't get on with the rest of your life because there was always this question...

w. There was always this back of your mind thinking well I may or I may not get pregnant. (Kaplan, pp. 1-2)

But I think it's that, the other reason that makes it so difficult in a way is that you are just left, you don't know

what is going to happen, you can't plan for the future, you don't know what you should do for the best....I think probably that's the most difficult part, you just don't know where you stand, you can't really have a positive outlook on life, because you are hoping for something that just doesn't happen and so it's a very negative situation to be in, isn't it? (Ingham, pp. 15-16)

Not being able to conceive as had been expected leads to a feeling of not knowing 'which road to go down', or not knowing 'where you stand'. It produces a 'negative' situation in the sense of both an absence and an unhappiness. 'You don't know what is going to happen', because there is always a 'question' in the way of 'getting on with the rest of your life'. From a 'normal' and 'natural' sequence of events, 'life's progression'[8] becomes indeterminate and unpredictable with the discovery of infertility.

For many women, the condition of infertility rendered their futures 'tentative' insofar as they felt unable to fully commit themselves to their jobs or careers as long as the possibility of having children remained unresolved. Many women spoke of 'living in two week spans' or 'living month to month' as they counted the days of their cycles. Of the women interviewed, 15 (75%) were explicit about the so-called 'treadmill effect' of infertility treatment, whereby a kind of tunnel vision forecloses other options.[9] This awareness was expressed in terms of strategies to ensure a cut-off point to treatment:

I want to get on with the rest of my life, really. I want either to have children or know that I'm not going to have children. I don't want to spend the rest of my life in this

> limbo.... I don't want to just stand in limbo thinking well maybe next year it would work...I want to get on with it.... Otherwise you are just in this limbo of time ticking on and not knowing, not having any plans for your life at all. (Caldwell, p. 79)

'Not having plans for your life' creates a sense of 'limbo' and the sense of not being able to 'get on with it' because of a loss of direction. The feeling expressed here is one of disorientation and frustration, of an aimlessness to the lifecourse. Not being able to have 'plans' creates a sense of being unable to have priorities. Again, the theme of not making progress forward is correlated to an uncertainty about being able to have children.

Feelings of Failure

In addition to their futures being rendered 'tentative' and indeterminate, and the lives they had imagined for themselves having been disrupted, many women felt their identities as women were threatened by the inability to have children. This was often expressed in terms of personal failure, inadequacy or guilt. As one woman put it, she felt she was 'not a woman' but more like a 'eunuch' as a result of her infertility (Carter, p. 1). Feelings of failure as a woman, of unnaturalness and of sexual, as well as reproductive, incompetence characterised many women's attitudes to infertility, even when it was not their own:[10]

> I went through stages of different feelings which still continue now but I've come to terms with them better, the

feelings of why me, being a failure, and looking at how easy it seems for everyone else to become pregnant is what hits you the most, that sort of feeling of it being so wrapped up in being a woman so you feel it's your failure, your body letting you down somehow. The one time you relied on it to actually do something and it doesn't do it. (Caldwell, p. 55)

As the female I think I was more upset by not having a baby than, I mean, I think really you've got back down to nature, that the whole object of why you're alive really is to reproduce. And if you don't get pregnant, I mean I'd been ready for at least 5 or 6 years, and if you're ready, you think 'what am I doing?', 'why aren't I pregnant'? (Evans, p. 2)

I think you feel inadequate, not quite a woman...I still don't feel quite natural. I mean it is difficult to know how it would be, you know, it would be an experience just to be sort of normal. (Brown, p. 24)

I felt a bit of a failure, I think we both, it hadn't occurred to us that we wouldn't have children...so it was very difficult to come to terms with...I felt very bitter, why me? (Young, p. 5)

Feelings of bitterness and disappointment accompany those of failure and inadequacy. Even when the infertility was shared, or likely to be the 'fault' of their partner, some women expressed a feeling that their bodies were 'useless' because they could not reproduce.''

> I felt my body was useless in that it couldn't even produce a follicle that was going to produce an egg, I did feel, you know, that my body was...resentment against my own body. Yes, I did think 'why can't I function normally'? (Doyle, p. 28)

The feeling that their bodies had 'let them down' made many women feel unnatural and excluded from normality as well as womanhood. Their bodies thus became an obstacle to fulfillment of their marriages, and thus to the attainment of 'normal' adult status. Pregnancy itself was an experience many women considered necessary to complete their identities as women:

> The whole feeling of actually wanting to be preganant is very, very strong. Not just because you are going to produce a baby at the end of it, it's just that inner feeling that you have that you need that fulfillment... (Chadwick, p. 12)

Pregnancy was described as 'wonderful and mystical' (Carter, p. 1) and sometimes desired as an experience in itself as much as a child was desired as an outcome. Hence, the inability to conceive left many feelings of inadequacy, both physical and social. The body's incapacity came to be seen as a blockage to a desired trajectory and left feelings of life's progress being on hold while women were left in an unpleasant condition of frustration and uncertainty. In the context of women's frequent sense of inadequacy about their bodies and their sexuality, it is easy to see how the situation of infertility could be interpreted in this way, notably, even when the woman had herself already had children or the problem lay with her partner's body, not her own.

Incomplete Marriages

Also important to the, often ambiguous, expression of desire for 'completion' or 'fulfillment' through having children was the idea of completing the marriage or the family unit:

> There's always that little gap that will never be filled. I'd love to be able to be pregnant, to produce a child, to know it's part of us. I'd love to be able to do that, to be able to go through childbirth.... It's the only thing I've ever felt I haven't achieved. We've got everything else. (Keating, pp. 6-7)

> There's something missing, there's something definitely missing in the marriage... (Lewis, p. 58)

The feeling that 'there is a little gap which will never be filled' summarises neatly an entire gamut of disruptions posed by the discovery of infertility. From the most literal level of there being a mechanical 'gap' in her reproductive physiology (which hence needs to be 'bridged'), to the 'gaps' in her identity because she is not a full woman or a mother, to the 'gaps' in her marriage and the 'gaps' in 'life's progression' generally, this is a most apposite phrase to describe a sense of loss on several fronts. Similarly, the idea of 'completing' a marriage by having children has many components: raising children together as an extension of the relationship between husband and wife; having worked hard to achieve a level of financial security by which to offer children 'a good home';[12] belonging to an extended family by participating in the activities of childrearing; the desire to share

an activity not defined by the demands of paid, professional work; and, simply, feeling that having children is part of the natural and normal progression of married life, some would say, even its purpose.

The idea of the 'little gap that will never be filled' expresses the sense in which the gaps opened up by the discovery of infertility are not only in terms of an expected trajectory, of 'life's progression', but in terms of relational expectations. The gap referred to here is in reference to an incomplete conjugality; children are seen to 'complete' a marriage by affirming the relationship between a woman and her husband, by literally producing a child which embodies a combination of its parents. This 'completion', like life's continuity, should flow through a woman's body: it is thus her body which comes to be seen as the 'blockage' to continuity and completion.

Such an idea is consistent not only with normative conventions, but with what has been argued to be the symbolic basis of Euro-American kinship systems, in which the conjugal relationship unites 'the order of nature' (blood ties) with 'the order of law' (marriage). Children who share an equal genetic ('blood') relation to both parents both symbolically affirm conjugality and create a dual system of 'relations': 'blood' relations and 'in-laws' (see Schneider, 1968). The 'gap' here is thus not only felt in the context of social expectations, but is arguably a disruption at the level of symbolic cultural meaning as well.[13]

Although the inability to conceive left many women feeling their marriages were incomplete, or that their marital relationships were 'missing' what a shared relationship to a child 'of their own' would bring, many also spoke of how the quest for parenthood itself, the

'crisis' of infertility, and the experience of IVF, brought them closer to their partners. It was precisely the *achieved* nature of parenthood, or the struggle to achieve hoped-for parenthood, which made it different from what it would have been like if it had happened 'naturally'. In this instance, the attempt to have a child through IVF itself provided the function desired by the birth of a child, that is, of bringing the couple together around a shared set of tasks related to parenthood, only, in this case, of would-be parenthood:

> You talk about things much more and talk about your inner feelings, probably more than normal, going through all these things together, it, yes, it has made us closer, hasn't it? It's the seeking after a common goal.... I think some people it could drive them apart but with us it has brought us together...because it's a shared unhappy time you go through together. (Newton, pp. 15-16)

Of the sample, 85% of the women who spoke about the effect of IVF treatment on their relationships to their husbands said it brought them closer together. Reasons for this included the effect of being brought closer together by enduring a kind of crisis, or, as described above, 'a shared unhappy time'. Women also felt it enabled men to become more emotionally involved with them, by having to discuss feelings more openly. Almost without exception, though often with a qualifier such as 'men feel things differently', women praised their husbands' supportiveness during treatment.[14] There was also a kind of protectiveness expressed towards men, who were seen as doing very well at something they did not necessarily find very easy:

He's been very supportive all the way through it. I mean obviously it hasn't been possible for him to come with me every day, you know, and I couldn't expect him to, but he's really been very good. (Doyle, pp. 16-17)

Feeling that the treatment brought them closer to their husbands, and affirming their partner's supportiveness, are among the few 'positive' interpretations of the experience of IVF that women expressed. At the same time, some women also expressed a sense of guilt about the burdens they felt their treatment imposed on their husbands:

And in some ways, I, um, (sigh) if I hadn't pursued it and sort of, I mean I wouldn't say I persuaded him because he's not the sort of person who would do anything that he didn't want to do, but I was the one that sort of instigated it and kept it going. And then sometimes I think, well I wish I hadn't done that because now I've brought a lot of hurt and pain to him that he wouldn't otherwise have had, but I mean at the time, I didn't know that would be the outcome. (Quigley, p. 32)

I think it's worse in a way for [my husband], because, especially in the first fortnight where there is so much going on, I mean you are thinking, have I done the nasal spray, yes, have I taken the tablets, yes, have I measured me wee, have I taken -- I'm busy for at least the first two weeks all the time, now he's got nothing to do. And then there's the waiting, I mean I know it affects him badly, last time when it started to go wrong [he] couldn't cope with it. (Norton, p. 32)

Although it was exceptional for women to be openly critical of their husbands, some did feel the treatment tested their marriages to the point of near dissolution.

> Let's just say I can't wait for [this year] to be over, to end, because we've been at it from December to December, and that's it now... I was just so tired, so uptight that I could feel that what it was doing to us was actually ruining our marriage.... I didn't want marriage problems, I could see what I was doing to my husband. My excuse was that I was so tired I wasn't interested in sex at all. Then I got to the point where I said I was going to sleep in the other bedroom, I was just turned off completely, I wasn't interested in him at all. I left him and I wasn't going to come back. We really got to that point. But I mean you just can't afford to waste a marriage, having gone through four and a half years of all the trauma that you do go through.... It's very hard, because you do put your marriage at risk, because of all the emotional strain you go through. (Chadwick, p. 7)

> Well basically we have been in infertility treatment for nearly ten years, which is virtually all our marriage and in some ways you, it sort of can spoil the relationship, because it is not quite the same, because it is dominated.... It becomes quite focussed on schedules, and that side of your life ceases to be private in a way, you feel that, you know, the doctors have sort of probed into it, I mean they have had to, but it does to some extent effect the relationship. (Brown, p. 15)

Like children, IVF can 'test' a marriage, bringing both positive and negative outcomes. A greater sense of shared closeness, and a sense of pursuing a shared goal can be accompanied by the stresses and strains of coping with the difficulties of infertility and IVF.

Genetic Continuity

Yet another important component of the disruption posed by infertility is the desire for genetic continuity through children. The feeling of there being 'no part of me to go on' (Carter, p. 1) was expressed by some of the participants in the study. This too was seen as an integral part of completing a marriage:

> SF: Is it important to you to have a genetic link to your child?
>
> Mrs. D.: I suppose it is, yes.
>
> SF: What's important about it?
>
> Mrs. D.: I think it's just something, who can say? It's so very difficult to say *why*, it's just this thing that seems to be in bred in us, isn't it? That you want to somehow carry on through your children and your children's children. (Doyle, p. 24)

Like the assumption that they would have children, which only became a conscious assumption at the point where its realisation was in question, so too are assumptions about the importance of genetic ties 'just something' so obvious as to not need any explanation.

On the whole, a genetic link was more important to the husband in this sample.[15] Of 16 interviews in which the importance of genetic ties was addressed, in three cases it was equally important to both partners,

in two cases more important to the woman partner than the male partner, in seven cases more important to the male partner than the female partner, and in four cases equally unimportant to both partners. It is perhaps significant that all but two of the respondents had considered adoption. Three couples had already adopted, of whom two sought infertility treatment to provide a sibling for their adopted child due to the unlikelihood of their being able to adopt a second child. In two cases the husband was not keen to adopt, but in the remaining 14 cases logistical difficulties, rather than strongly-felt preferences, were the main obstacle to adoption. Foremost among these logistical problems was age, while other reasons included one partner having children by a previous marriage, and the long lists and invasive vetting procedures involved in adoption procedures. Hence, for the majority of women interviewed, IVF was chosen over adoption because it was seen as the most expedient means of acquiring a child, not for reasons of preferring a genetically related child.

In sum, the gaps opened up by women's experience of infertility can be seen to be considerable, profoundly effecting several dimensions of their lives. These include the sense of their lives having deviated from an assumed trajectory in which having children played a key role; a sense of their futures being on hold or indeterminate because of this; a sense of failure or inadequacy as women, and in most cases of missing out on the physical experience of pregnancy, which was seen as central to the experience of womanhood; a sense of their lives and their marriages being incomplete without children; a sense that the treatment brought them closer to their partners, but also tested their relationships; and (in a minority of cases) a sense of loss of genetic

continuity. The need to resolve these gaps was strongly felt and it is not at all surprising that explanations and resolutions for/of infertility were strongly desired.

There are undoubtedly many women who resolve infertility by simply accepting that 'they were not meant to have children', or that it is 'nature's way' of redirecting their lives in directions they had not expected or wanted but with which they are content.[16] Some women explicitly stated as much, reflecting that they would have accepted their infertility, or indeed had done so, but for the existence of IVF which presented the necessity of re-evaluating their situation.[17]

Not all women evaluating the impact of the discovery of infertility would necessarily opt for IVF, and the reasons why the women interviewed did so are explored in the next Chapter. However, once they have chosen this route, they move onto a different trajectory, that of IVF itself. In doing so, they are opting for the enablement technological assistance offers as a means of attempting to resolve their situation. It is thus in the hope of finding a resolution that they turn to IVF. Yet, from one 'broken trajectory', in which hoped for events failed to materialise (ie having children, or having enough children, or having a child 'of their own'), they enter another trajectory which presents different hopes and expectations, and different kinds of potential disjunctures. Making sense of this new 'road forward' presents different demands.

The World of Achieved Conception

> I think it would be easier for people if they were told that there was just no way they could have children, then it would

be an easier decision to say, well, you know, just tell people that I can't have children and that's it. But most people who do have problems aren't ever told that. You know, they are always told that well this should work, or that treatment should work, you know, it should work this time or we can't find any reason why it isn't happening and or that you've got so much percentage chance of becoming pregnant and really most people aren't told that. I mean the amount of people that go through IVF and only to be told they've had all the tests, but they've been told there's nothing wrong with either of them, you know, so in that situation it's very difficult, it's just a very difficult situation to be in, you know. (Ingham, pp. 14-15)

In the effort to resolve the disruptions created by infertility by opting to pursue IVF, women encounter a whole new set of unresolved issues and 'gaps' which need to be 'bridged'. Having come to the technology to *resolve* their infertility, either by producing a child or by being able to say they 'at least tried everything', they in fact often find the procedure opens up whole new gaps and disruptions intrinsic to the trajectory of an IVF cycle. As noted in the previous chapter, IVF is compared to an obstacle course, presenting a sequence of 'hurdles' to overcome. Once immersed in the medical treatment of infertility, particularly IVF, women have entered a very different model of conception. From the 'standard', familiar model of conception in which events unfold along a taken-for-granted, 'natural' and 'normal' trajectory, they enter the model of assisted reproduction, in which conception is not a taken for granted event but has to be achieved.[18]

This shift can be seen to be paralleled in terms of ideas about the lifecourse. Instead of having a continuous flow across the 'natural' and 'normal' events of the lifecourse, 'life's progression' is disrupted by infertility, which becomes an obstacle to progress. Overcoming this 'hurdle' is what the choice to undergo IVF is all about. IVF itself is also described as 'like' an obstacle course by many of the women who experience it. Experientially, this obstacle course effect produces a specific set of demands for women undergoing treatment, and it is how the dilemmas produced by the trajectory of treatment itself are made sense of which are discussed below.

As noted earlier, the field of assisted reproduction is defined by specific discursive parameters which establish the 'legitimate perspective for the agent of knowledge' and the 'norms for the elaboration of concepts and theories' (Foucault, 1977, p. 199). In other words, what counts as meaningful information in the context of IVF is that which conforms to the established norms and perspectives of the medical experts supervising treatment. For both clinicians and the women they treat, the logic of this definition is obvious: women do not go to clinicians to explore their emotional relationship to their own or their partner's infertility, they go to clinics hoping for a diagnosis, assistance and the desired outcome of a 'take-home baby'.

However, the logic which enables women to accept the terms of infertility treatment does nothing to ameliorate the many dimensions of the experience of infertility and its treatment which are more or less excluded by its established clinical parameters. Having entered into the clinical context of achieved conception, and having accepted its terms, women are left to sort out for themselves the gaps between the

medically defined world of achieved conception and the meaning of their reproductive lives outside that frame of reference. The significance of this process becomes clearer in the examples below.

'There is Nothing Wrong'

A case which illustrates well the kind of paradox this situation can create is that of women who are repeatedly told 'there is nothing wrong':

> You know, the doctor is standing there telling me there is nothing wrong with a smile on his face, and I am thinking, well I actually wish you would find something wrong. (Lewis, p. 6)

> Each test we had they said 'well everything was fine in there Mrs. [Levy), everything was fine', and I kept saying I know you're smiling about this, but I wish you would turn around and say you *have* found something wrong.... (Levy, p. 14)

In such cases, clinical information ('there is nothing wrong') contradicts personal knowledge ('there is definitely something wrong'). To put this another way, IVF is considered to be a form of 'assistance' to conception. It is represented as 'giving nature a helping hand'. However, in order to proceed effectively, and in order to 'make sense', the nature of this assistance needs to be specified. Clinically, this problem is simply one of diagnosis. By diagnosing the nature of the infertility, the nature of appropriate assistance is determined. Without a diagnosis, the assistance is more haphazard. Often even with

a 'full' diagnosis of the problem, as in the case of blocked tubes, the technique is still unsuccessful. This in turn reveals the partial nature of a diagnosis of the inability to conceive, which is in turn symptomatic of the limitations of any clinical diagnosis, insofar as it depends on partial knowledge from the outset.

Technically, a diagnosis is defined as 'the identification of disease by means of a patient's symptoms' or 'the identification of the cause of a mechanical fault etc.' (*The Concise Oxford Dictionary*, 8th edition, 1990, p. 321). The problem of 'diagnosing' infertility thus already deviates from the standard definition of a diagnosis in that it is not necessarily a disease or caused by a disease, and it does not involve one patient, but often involves the interaction between two patients, or more precisely, the gametes of two patients. Perfectly healthy, fertile couples do not always conceive, even when all of the 'required' mechanisms are functional and complete. Similarly, IVF is not a 'treatment' or a cure, it is merely a bypass operation, 'bridging' a natural deficiency. Women who are infertile are not 'treated' for their physical condition, they are enabled to have a child, or not, despite it.'[19]

A problem for both clinicians and scientists in the field of reproductive medicine/biology, as well as for women and couples who undergo the various forms of assisted reproduction, is thus a gap between information and knowledge. No amount of factual information can compensate for inadequate knowledge, and clinical/scientific knowledge in the context of reproduction is manifestly 'incomplete'. In a sense, there is no such thing as a 'complete' diagnosis of infertility, or, for that matter, of any 'disease'. The point of a diagnosis is

instrumental: it is enabling of more effective intervention. One of the problems encountered in the context of achieved conception, both for professionals and for patients, is the problem of making sense of reproduction in a context of evidently 'incomplete' knowledge. This gap between information and knowledge, between the inability to establish a diagnosis and the desire to effect enabling assistance, is precisely the kind of 'new' disjuncture intrinsic to IVF itself.

As noted in the previous Chapter, one of the forms of reproductive work involved in IVF is the acquisition of considerable medical expertise about the biogenetic events involved in conception. This takes the form of accumulating a large amount of information which may or may not 'make sense' of the causes of reproductive failure. The following extract expresses well the dilemmas produced by inhabiting a model of conception based on medical information which does not always add up to knowledge, and which excludes the emotional dimensions of treatment:

> Well actually, I was abandoned the day before egg collection which was *really* distressing. I found that mortifying, because it was the same again, the follicles were good, there were lots of them, but my oestrogen level had levelled off, which normally happens at ovulation, so there they had left it a day too late, but I'd gone home, had hCG, which is the late night injection which causes you to ovulate, and all through the day they weren't sure, because I had been told yes, everything was fine and you're on line. Then the consultant had seen the oestrogens and said no, they're not good enough, rerun them, just check them again, if they come back the same

she's abandoned, if they come back any better she goes ahead. Now, quite honestly, to be abandoned at that stage is *hell*. Oh, it was just awful. And I had the whole day of waiting to see, and they reran the oestrogens, and at the end of the day they said no, they're no better, that's it. And there is a discrepency with these figures anyway, so I sort of really hate these oestrogen levels because they've actually been a problem for me all along, and in some ways I wish they would just look at the follicle levels. I don't know, I don't know, it's quite hard for me and what they don't do, sadly, is give you a chance to talk about it. (Carter, p. 6)

Here, dependence upon technologically generated information is resented, as its ambiguity causes stress, and its interpretation by the medical staff leads to abandoning the cycle. Inhabiting the medical model of reproduction is threatening in the sense of producing a feeling of being out of control and dependent upon signs and readings which may contain unwanted and distressing outcomes. Also evident is the large and detailed amount of information which does not add up to meaningful knowledge. This information, however accurate and sophisticated, is partial: the oestrogen level necessary for egg extraction to proceed was not attained. No explanation is available, either to the clinician or the patient, for why this is so, therefore throwing future treatment into question, as it is not clear what, if anything, might be done to improve the situation in subsequent cycles.

Decoding the Signifiers

Another example of the process of 'making sense' of technologically generated information is the process of interpreting scans. On the one hand, many women found the scanning process reassuring, as it enabled them to 'see' their bodies responding to treatment. On the other hand, because the scanning procedure is one of monitoring reproductive 'performance', and because the activity of her follicles is not under a woman's conscious control, scans could also be distressing, or yield ambiguous 'signs', even to the trained eye:

> Well I should say that your second week is - your treatment, things are starting to happen to yourself, in your body. You can't really see anything out of it, for them first few weeks. It's more interesting when you can see your eggs starting to, you little black patches where they are starting to come, do you know what I mean? It gives you encouragement then, it does me anyway, because I know I can see something coming there, for what I'm having my injections and my treatment and I know that I'm working, starting to work. I know that it doesn't work straight away, but you feel you know, like, even like me know. I know I'm at, I know I didn't take completely last time, but I know I have achieved something, I've tried, you know.... I write it down for myself, Sunday I was, I had one 13, and I had three size 10, that was on my left side, my right side of my ovary, what had never worked until this time, I've got one a size 12 and one a size 10, that was Sunday. So they both could do well in that time. And then yesterday, one

was 16, one was 13, one was 12, that was on my left side, so you see they grow a bit each day. They vary day to day, you see, and on my right side the one what was size 12 is 15, and that one...[end of tape]. (Yates, pp. 65-6)

I had that element of excitement about it because I was so interested in what was being done. I mean I'd never had a scan before and that was quite exciting, and as I say, I'm interested in the side of how it all works, not just from a will this make me pregnant [point of view], but oh look, that's how the scan works, and I can see the ovaries and so that interested me. So that kept me going really. (Caldwell, p. 72)

All I can see is the bladder! (Harding, p. 7)

He'll say 'well there's one' and I'll think well how the heck does he find that? I mean I'd see nothing to do with it, that blotch was nothing. I'd think oh dear, but in the end you got so you could see. But when he used to bring those little crosses down to measure it, I'd think what the hell is he measuring? I couldn't see anything you know...It's alright they're saying oh yea, I can see one or two or three, but I couldn't see it and no matter how my imagination worked I couldn't see them properly. (Keating, p. 8)

In these extracts, the process of making sense out of technologically generated information is represented as both enabling and

disorientating. From an initial incomprehension and anxiety ('oh dear'), women come to 'see' their bodies from the perspective of the clinician, a 'way of seeing' through which the follicles become visible and meaningful as signifiers in the context of IVF. As the last speaker describes her second cycle, this transformation becomes evident:

> And the second time 'round, you know, when they brought in the new probe,[20] I, with my left hand ovary, it wasn't always showing up as having anything there and they could never find it because it was always tucked under the uterus, with the normal scan, but using the probe they found it every time, and I could see then, and that made me feel better, I could see that there was plenty there and they were all growing, they were a lovely size. And I think that was smashing, it gave me such a boost.... I could see them and I knew then that everything was ok. As soon as they used that probe, yea, I could see them properly, wonderful, and I think that helped. (Keating, p. 9)

At one level, then, scanning can be reassuring, indicating that 'everything is ok'. It allows women who have felt their bodies had 'let them down' or 'failed' to see their follicles growing in a manner which has the potential to be interpreted as a sign of, at least, partial 'fertility'. This can give 'encouragement': 'I know I can see something coming there...and I know that I'm working'. They can create 'an element of excitement' and of achievement: 'I know I have achieved something'. Yet these signs are always contingent, and, in the case cited above, everything was not 'ok' and the cycle failed. The point is that technological assistance to reproduction creates the need to

develop complex relationships to technologically generated information, which do not always 'make sense'. This hermeneutics of assisted reproduction, both intimate and at the same time 'objective', creates particular demands which must be continually negotiated. These include developing a 'way of seeing' the scans. Their visual interpretation is a learned, acquired skill, transforming an experience of seeing 'nothing' to one where 'you got so you could see'.[21]

Clearly, the most difficult situation is where the 'signs' do not add up to any meaningful interpretation, in other words, where the cause of the infertility is 'unexplained'. It is generally assumed as a rule of thumb in approximating the causes of infertility that a third of all cases are caused by the female partner, a third by the male partner and a third by a combination of the two partners. Among the couples represented in the sample, the causes of infertility were largely unexplained. Only five cases, in which the women had blocked tubes, and two cases of diagnosed male infertility yielded 'identification of a mechanical fault' sufficient to account for infertility. In the remaining (majority) of cases, the infertility was either wholly unexplained or only partially so, where 'faults' were identifiable, but insufficient in themselves to explain the infertility.

The problem of making sense of conceptive failure was thus, for many women, a major source of frustration:

> When they said [IVF] was the only way I could have [children], I came to that decision because, like you do, we just assumed that you have the operation and things are going to be fine. And when they said everything was fine [eg. the tests]...same with the first IVF treatment, great, the eggs were lovely,

> everything is fine, you know, we can't find anything wrong, and then you'd ring up two days later and they'd say sorry, it didn't work, and we'd say, well why, you know, if everything is fine? I think I'd accept it more if there was, if they'd said the egg count is not high, or the sperm count is not high. Then you would know, and you would know what they are treating. It's this not knowing all the time. (Ives, pp. 9-10)

That 'not knowing all the time' causes such frustration is not only the result of lack of knowledge. It is also the result of the promise of knowledge which has gone unfulfilled. It is the promise of enabling knowledge and effective technological intervention represented by IVF which leads women to see it as a 'chance', a source of 'hope' and hence as an 'opportunity'. The entire field of reproductive medicine and biology is instrumental in this sense: the promise of knowledge is the control it offers over the reproductive process.

Unexplained Failure

That 'everything is fine' in the context of no apparent 'faults', whilst perhaps initially reassuring and intended to be so, has the potential only to add to the frustration of failure, when it becomes apparent that everything is not fine. It is for this reason many women wanted 'something to be wrong', despite this appearing paradoxical:

> You know, in some ways it would have been easier if they had said well you've got this problem and there is nothing we can do about it, you never will become pregnant, in a way it might

have been easier to accept. But it's quite frustrating for them to say well we can't find anything, you think there must be something, and you think well what is it? And I got pregnant before, so what's different now? And I just sort of keep thinking, you know, why could I then and why can't I now, and, you know, what's wrong? It's the same with IVF in some ways. It might have been easier if it had never worked. But because it started each time, and yet each time it doesn't carry on I might have accepted it and thought, well, I've had a couple of tries and it's obviously not going to work, and yet I think well there's a chance.... (Quigley, pp. 7-8)

In the case of the speaker quoted above, two 'successful' IVF pregnancies had ended in miscarriage. Such a situation is especially difficult for obvious and also significant reasons. For one, 'failure' is harder the more 'successful' the procedure has been. Also, a stark contrast emerges between evident 'fertility' and continuing childlessness. Hence the feeling that 'it might have been easier if it had never worked', which could be taken to refer both to the technique of IVF and the woman's own fertility.[22] Most frustrating of all is the knowledge that 'there must be something wrong' while it is impossible to 'find anything'. Not surprisingly, failure is easier to accept when there is at least 'a concrete reason':

> They kept saying there's no reason why you shouldn't become pregnant.... And I wished they could have given me a concrete reason. I think if they'd said there is no way you could have children, I could have accepted it, but it is all this well

you know we can try this and it might happen and there's no reason why it shouldn't. (Young, p. 4)

It seemed to be very much trial and error, because nobody ever found anything wrong with either of us, so we didn't feel as if, I've to think what I'm trying to say here, but I never felt as if anybody ever found out what was wrong. (Newton, p. 2)

The difficulties of coping with unexplained failure in the context of an individual cycle are closely related to the problems of coping with much larger questions such as how long to continue treatment. It must be remembered that even when a 'concrete' reason is found, it is not an explanation so much as a description. Hence, a woman may fail because her oestrogen levels were too low, which might be seen as related to the drug regime. But this is a very partial explanation; it is in fact only a mechanical description. In such circumstances, some women express the desire to be rescued from limbo, even if by the 'worst' news, which would at least provide an end to the stress of uncertainty:

There's just a part of me that thinks why hasn't it worked for me so many times? Shouldn't I have got pregnant after all those goes?... Nobody has ever said to me 'the reason you haven't got pregnant is...'. What they've *always* said to me, without fail, is 'I really don't know why you haven't gotten pregnant, but I thought you would do, and I'm sure you will'. Now that's terribly nice, but when a few times I've said I don't think I'll go through it any more, it's too much, 'Oh but you will be successful, you must go through it some more'.

> That's not a fair burden. In some ways, if they'd said to me, you're never going to get pregnant, I'm sorry, this is it, I could cope with that. I can't cope with the idea that, you know, there's just some minor adjustment to be made. (Carter, p. 7)

As these extracts indicate, the search for a resolution in the context of IVF is hampered by the lack of explanation for the high percentage of failures.[23] As several of the comments suggest, this feature of treatment can be so distressing as to lead women to wish they had never undertaken treatment to begin with. It is in such a context that appreciation of the reasons that lead women to choose IVF is useful to understanding the experience of the IVF procedure. Seen from this perspective, it is possible to appreciate the extent to which IVF is difficult *because it exacerbates the very situation it was undertaken to relieve.* In the same ways that women can feel their lives are 'in limbo' as a result of infertility, so they can feel their treatment is 'in limbo' because of the lack of a diagnosis. One set of distressing circumstances caused by an 'unexplained failure' (infertility -- 'why me?'), is simply replaced by another situation of 'unexplained failure'. One version of unresolved futures has led to a different version of the same problem.

The similarity of these situations is also evident in the responses to them. The response to infertility was to do something about it. Likewise, in the context of unexplained infertility, greater determination is required to maintain faith in the enabling potential of IVF despite not having an accurate understanding of exactly what kind of intervention will be successful.[24] *It is in this context that the quest*

for a child through IVF can become an end in itself. As each failure yields some diagnostic clarity on the situation, it increases the possibilities for the next treatment to be more successful. Or, having succeeded in reaching a certain stage of treatment in one cycle, the hope of proceeding further in the next cycle is increased. This matrix of determination, failure and hope for success is a definitive feature of the IVF experience, and is discussed in more detail below.

Coping With Failure

Meanwhile, coping with failure is undeniably the most emotionally demanding aspect of IVF. While the physical demands may be taxing, many women felt the emotional demands were far worse. While infertility is often described as akin to the grief and sense of loss accompanying bereavement, the problem of infertility in the context of IVF is that it becomes a *tentative condition.* There is a seriality to the experience of grief and loss which would not characterise a bereavement, which is final. In describing the emotional work involved in undergoing IVF, many women emphasised the importance of balancing hope for success against awareness of the likelihood of failure. Hope for success and preparedness for failure are the opposing extremes of the IVF *mentalite* which must be held together, and somehow balanced. This 'balance' between opposing potentialities was always difficult, and often unsuccessful. Too much hope led to devastating disappointment. Toomuch preparedness for failure was seen as potentially damaging to the outcome, as in a self-fulfilling prophecy, or by creating a level of discouragement incompatible with continued treatment:

Mrs F: There is very much a feeling that you get from the medical staff that you've got to be realistic about the programme, which I think means that you are not to, I don't know what it means actually, it appears to mean...

Mr F: On the one hand they want you to be positive about it and on the other hand they want you to be prepared to fail. But they don't really understand the emotions that are involved.

Mrs F: It's very difficult to..., that sounds very black and white, and it's something that can easily be said by someone who is not participating, but there are so many shades of grey in between. It's like saying be realistic, so expect the possibility of not succeeding, either in this attempt or ever, but you've got to be positive enough to be going through - you've got to want to succeed, but if you don't succeed you've got to accept it. Now to me, that's well, not just thinking about it, but in actuality, that is a very difficult psychological thing to come to terms with.... It's a really difficult thing to try and find an equilibrium. (Flowers, pp. 32-3)

And then each time, you know, they give you some treatment, then you start sort of hoping again, you know, and then it doesn't work, so um, you know, you begin to think it will never work and then you try something else, and it just goes

on like that in a cycle until you just accept it in the end that that's it, you know. (Ingham, p. 3)

[You can't] raise your hopes at all...you've got to be sort of half and half. Raise your hopes a little but don't get too disappointed and it's a good thing. It's a good thing to just go in for it, not too pessimistically, but not too oh well what's the point, you know, but not too euphoric and too oh it's definitely going to work.... (Lewis, p. 88)

And all this time you've got so many emotions going on in your head, that you daren't get happy anyway. I suppose I'm a bit resigned to the fact that I probably won't ever have any. That's the only way to be. (Norton, p. 11)

I mean I know they say to you they don't guarantee success. They tell you that. But you still say I might be one of them one percent. And I think every woman that sits in that chair will think the same thing. You think well I'm going to be one of those one percent.... Well they say you've got to go there thinking, well ,alright, alright, I might not be successful. But in your heart of hearts you *don't* go in with that attitude. I mean you sit down and talk to them and they say 'you do realise there are no guarantees' and, oh yeah, we know all that, but you don't, not really, inwardly you're saying 'I'm going to do it', you think so positive, and I think that's what it is.... (Keating, p. 20)

Failure in the context of IVF is never absolute. Both failure and success are continually subject to redefinition, both during and after treatment. Some cycles are considered not to have 'failed' because they did not proceed far enough, and are thus not even considered 'real' attempts:

> On the first cycle they did a retrieval but they only got one good egg, as they thought, but then it fertilised, but it wasn't good enough to put back, so I didn't even get as far as the embryo transfer the first time, which was soul-destroying, because you go through all those up to your seventeenth day for the egg removal to get there and to actually be lying on the table and you know before you've even come off that it's a failure. And I think that was the worst, you haven't even got off the starting blocks, that's how I felt. (Keating, p. 2)

In other cases, failure is defined as a 'success' relative to previous failed cycles which fell at earlier 'hurdles'. Hence, even if a treatment fails it is sometimes considered a success in relative terms. Another means by which a failed cycle can be redefined as a successful one is if it yields any diagnostic evidence of potential benefit to future treatment cycles. In both of these cases, 'failure' becomes an impetus to proceed, subsequent cycles being undertaken with a greater degree of hope for success. It is by this means that a failed cycle can be resolved or coped with by undertaking subsequent cycles. This is part of the so-called 'treadmill effect' of infertility treatment, a cycle of dependency on subsequent treatments to resolve failed ones and an increasing determination to succeed in the face of serial failures:

> And then when it didn't work, as I say, I felt pretty awful, but only for a few days, then I started to pick up and think, well next month another attempt, you know. (Caldwell, p. 74)

> I don't know whether we would have tried again had they not pointed out that progesterone problem and said that we could do something about it. [...] If they had said, well we honestly don't know why it didn't work, it should have done, then, you know, what's to say that exactly the same thing is not going to happen again next time? (Norton, p. 33)

While failure at one of the later stages of treatment can be redefined as a relative 'success' in retrospect, such failures may also be the most difficult to cope with, 'having come so far' only to have their hopes dashed:

> And then even months afterwards I'd be sitting here doing something, I'd be having a cup of coffee, while I was doing something I was fine, but the minute I'd sit down I'd start crying, you know, [my husband] would phone because he does many times during the day, and he would say what the earth's the matter, and I would say I don't know, I just don't know. My character had completely altered, really, I was always a confident person, I knew what I wanted, and I got on and did it, nothing used to bring me to tears like that. Not just to sit down and cry. I mean if somebody walked through the door, especially my Mum, if my Mum walked through the door, oh, out it would come, I'd just start crying. I found that very hard. It's only in the last month that I've gotten

> myself together. [...] I've never in my life experienced anything so much as that, as after I'd been through the programme. I thought I'd get on, I thought I'd cope, I'd pick myself up, but I didn't, I didn't, not for a long time. [...] You sort of have to come back. You've gone forward so far, but you've still come back, and that's the hardest thing. I felt as if I'd gone all the way up to 99% and then I'd had to come all the way back to zero again. You build yourself up, you get yourself so psyched up, and I think that's the hardest part. (Keating, pp. 14-15, 18)

It is because of the difficulties of coping with failure, and the necessity of 'hope management', that is, of balancing a sufficient measure of hope against a realistic appraisal of the likelihood of failure, that a certain kind of psychological determination is required to continue with IVF. In meeting the psychological demands of IVF, women and their partners were frequently explicit about conscious strategies they had developed in order to cope effectively:

> husband: One of the things which we did...was to concentrate our minds on eating healthily, to take an interest in what we were eating...
>
> wife: Well I'd seen my friend going through treatment and getting stressed, so when we started...we started eating better, etc., and I thought well I'm not going to get like that, I'm going to sort of take it easy and take what comes, hopefully, you know, I will get pregnant without all these problems, but it just didn't work like that. No, I mean I felt stressed a lot of the time which made me very irritable

at work, the pressures of going through this and going to work, and we did read up about it, but to actually try to sort of eliminate stress is very difficult. I mean we go to yoga and things like that. We also joined a badminton class as well because I wanted to feel I was doing things other than work. I am a teacher which involves a lot of work at home and I wanted to get out for two evenings a week and do something more relaxing. And people have said to us, oh, well it worked for you because you felt so much more positive about it, and weren't under all the stress that you were before, so I mean it could be true, I don't know. (Newton, pp. 27-8)

I went through hypnotherapy before [the cycle I'm on now] and it's extraordinary how much it has helped. I've actually gone through this whole procedure believing it will work, and enjoying it, enjoying it far, far more and finding it less stressful...I feel as though I'm pregnant now, I imagine that I am, there's no way I could feel it if I really was, but I've gone through it thinking this is going to work and this is positive, and it's been a lot better..... Always before I've never thought it was going to work, and I've never allowed that to even enter my thinking, and if I did, just imagine, what it was like, I would be in tears very quickly and it would be very difficult to cope with.... I remember on a few occasions thinking how I will feel if they tell me I'm pregnant, and it was so overwhelmingly wonderful, oh it was

> just lovely, and very moving, and then I'd find myself just in tears thinking of how it would feel, I still could if I, no, I wouldn't, I feel differently now, and I, then I'd push it down again and I actually feel that I never thought it would work, and I wonder, you know, if you don't believe something's going to work if it ever will? (Carter, p. 8)

The work of 'hope management' is complemented by strategies such as 'thinking positively' and trying to implement measures to improve the quality of life. In these extracts are apparent the explicit, conscious strategies, often the acquisition of a particular mental attitude, which are seen as necessary to continue the pursuit of an elusive goal. This is a major component of 'living IVF' psychologically; it requires deliberate internalisation of a particular *mentalite*:

> [After failing the first time] I knew I'd got to be a lot more prepared for it, so as for preparing myself psychologically [I did] lots of positive things. After the operations, I'd had the doctor who did them, each time I see him he sort of says, you are a terrible mess you know inside. Well that might well be a fact, but I don't want to know that, that's a negative thing. I know that there are things wrong with me, but I've got to concentrate on the positive things, because, for example, I know I've got nothing wrong with my womb, and to me that is one of the most important things, I know I can carry a baby if I'm pregnant, so that's a very, very important thing, so now I also think instead of worrying about this endometriosis, because it isn't something that just goes away, if you are not doing anything to stop

ovulation then it can come every month and you can get worse every month, it's like a Catch-22, the only way to stop it is to stop the ovulatory cycle, which is, yeah, to me Catch-22 if you want to have a family. So I've now decided I don't want endometriosis, not that I've got it or I might get it, but that I don't want it, and I'm not going to have it, so, it probably sounds a bit daft really I suppose, but if ever I think I might have it, or I have a painful period and I think of I might have it again, I imagine it in my mind and I imagine these little spots of endometriosis exploding, disappearing, so you know I'm not having it because it's interfering with what I want so I'm not having it, and [the doctor] telling me things about oh there's scar tissue here and there and everywhere, so I consciously imagine my ovaries. I've got bits and pieces sewed together, so I imagine them as being perfect, and I imagine the fallopian tubes as being wide open and perfect, so in my mind's eye, although this doctor keeps telling me it's a dreadful mess, I'm not believing that, I don't want to listen to that...I like to think that what I'm feeling is having a positive effect on my body because I wanted it to work, and I know I can do it in the end, it's just sort of having these stumbling blocks in the way, so those are a few, ah, daft things that might help [laughs], well, they help me, I feel a lot better thinking so much more positively about them.... (Flowers, p. 18)

In the above extract, quoted at length because of its detailed rendering of a particular mental coping strategy, there is an interesting resistance to the medical model of 'mechanical faults' in favour of a more 'positive image'.[25] Such a strategy not only indicates the kind of mental strategising considered necessary to 'self-management'[26] in the context of IVF, but also suggests a dual self-consciousness whereby a woman both inhabits and 're-visions' a medical definition of her reproductive capacity. Hence, whilst the medical definition of her ovaries and fallopian tubes is accepted at one level (in that she is undergoing IVF), it is also rejected at another (as causing her to feel too 'negative'). Most importantly, this extract demonstrates precisely how IVF is 'lived' in terms of personal identity, by adopting complex strategies of psychological preparedness.

The IVF Commitment

This extract is also suggestive of the tremendous amount of determination required to undergo IVF, since the odds are against women succeeding at the outset, and the technique itself is very demanding. Again the obstacle course analogy is appropriate to describe the situation, suggesting as it does the need to acquire the corresponding mindset required of a competitor. These extracts also demonstrate the very particular kinds of psychological demands intrinsic to the experience of IVF, and the ways in which 'making sense' of the experience can be quite demanding, requiring determined strategies of mental self-preparedness to negotiate a 'path forward'.

This determination can bring its own rewards. As already noted, some women felt the experience of treatment brought them closer to their husbands through the shared 'ordeal' of struggling to succeed against the odds. Some women also felt a sense of teamwork, of being at the centre of a medical quest for success, where their hopes were shared by dedicated professionals.[27] This feeling was reinforced by comparisons to bad experiences of NHS treatment where they had felt, at best, neglected, if not grossly mishandled:[28]

> Yes [the clinic staff] are wonderful.... And it's marvellous, it is just a nice and relaxed atmosphere, you talk to them on first name terms, and there is no shouting like they do at the women's hospital. [Quinn, p. 31]

> At least you can look back when you are in your early forties or whatever and say well I did try, I had three good tries, four good tries, ok, it didn't work, but I did try, and at least you know you've had a go. And there's all those people working really hard at the clinic, they all want to make you pregnant, they are all battling, the embryologist, the doctor, all of them, as a team. You know, they are battling to help you. You owe it to them as well, because without them, what would we do? (Cooper, p. 9)

In the language of a 'battle' for pregnancy, this last extract clearly indicates the kind of epic determination which often characterises IVF. The achieved nature of pregnancy in the context of IVF is also apparent, in the emphasis on a team of committed professionals who 'all want to make you pregnant'.[29] Only two of all the interviewees failed to praise

the clinic staff, often in glowing terms. The opportunity to feel they were being taken seriously and kept well informed, as well as feeling reassured that everything possible would be done for them was frequently noted.

> They couldn't have been better. They explained everything...[they said] come and talk to us if you want to change the drugs or the treatment or whatever. They were very nice. As I say, they explained all of the possibilities that they know of. Very helpful. (Ives, p. 28)

> They were brilliant, really, you can't fault it, I mean they were so caring with you.... I mean on most of the NHS it seems to be like a cattle market. (Keating, p. 5)

> They've been fantastic, absolutely fantastic...I'm not just saying this because I'm pregnant...I mean really, what they do there is absolutely fantastic. They're just miracle creators, absolutely fantastic! [pause] And they're so patient and so gentle, the staff, the crew they've got there...they're only eager to help you. (Levy, p. 11)

Being at the centre of a team effort, aided by a 'fantastic crew' of 'miracle creators', who are 'brilliant', 'caring' and 'helpful', as well as professionally dedicated, could not be further from most women's previous experiences of reproductive healthcare, many of which had been appalling, and even life-threatening, due to negligence. Yet, such comments have also to be seen in the context of an emergent 'two-tier' health system in Britain, whereby those who can afford to pay for

private health services are thus afforded access to superior care. Compared to 'the cattle-market' of 'the women's hospital' and 'the NHS', a strong contrast is apparent in the 'patient' and 'gentle' staff who are 'eager to help'.[30]

Not surprisingly, this combination of a sense of teamwork, achievement and determination to succeed often made women comment that IVF had 'made something of them'.[31] Not unlike an outward bound course, of sorts, it had given them a sense of hard won accomplishment:

> As I said, I've always been a very determined person, if I want something I go out and get it.... I'm stronger willed I suppose than I thought I was. Everybody says I'm easy, and too soft, and I suppose people didn't think I would be able to go through all this [but] I was quite certain in my mind that this was it, I was going to try everything, no matter how much it cost or how much it pained.... It brought out a strength of character I didn't think I'd got, you know, because you've got to be strong enough to cope with it. (Ives, pp. 31-2)

> It's a funny thing really, it's a hard programme but it really makes something of you. (Keating, p. 13)

> I think the whole traumatic experience, although it's awful, I think it does make you accept that you can't have everything in life and things aren't just given to you on a plate. You know, some things you've got to work for, and I

mean it sounds ridiculous, but we've had to work for it, you know, eventually, and it's taken us six years. (Doyle, p. 18)

Having to *achieve* pregnancy, even though it is 'traumatic', is appreciated for being a greater accomplishment than having children would have been 'normally'.[32] Whereas most couples 'take for granted' their ability to reproduce, women who undergo IVF can feel, as the last speaker states, that achieved parenthood is special because it is different: a unique accomplishment. In this too lies an important component of the meaning of 'achieved' conception. It is different, it 'makes something of you', and it is all the more valued as a result.

It was this determination which led women to choose IVF, *even when they thought it was likely to fail.* The determination to do everything possible, and even to test themselves in the process, was very strong. This determination can become an end in itself, ironically coming to serve many of the functions that having a child was expected to provide, such as proving oneself, providing a focus for the marriage, dedicating shared resources to the quest for parenthood, and so forth.[33] It is in the conjuncture of women's determination to do everything possible to attempt to achieve a pregnancy, and the clinician's offer of enabling technologies of reproductive assistance, that an 'obvious' trajectory out of the 'hopelessness' of infertility comes into being. Once on this trajectory, determination to succeed against the odds, while facing the challenges of IVF, becomes a potentially rewarding activity in itself, despite the high costs.[34]

At the time of their interview, all of the women said they would recommend IVF. Without exception, they praised the technique, and many considered themselves fortunate or 'lucky' to have been able to undergo

treatment. By so doing, they were also affirming their own decision to have opted for IVF as a means to resolve the disruptions posed by infertility. Of course, such affirmations of the technique and of their own decisions are hardly surprising, especially in a context where hope for success was considered critical to its realisation. Doubtless, some women might later have regrets, or indeed at the time had reservations they did not express, possibly even to themselves.[35]

Conclusion

What this determination and positive assessment of the technique demonstrates cannot in any way be considered representative. What it does show is the way in which the technique comes to be positively evaluated by women who do so. Despite its costs and pains, it is not only possible for women to endorse the technique, but even to feel it has 'made something of them' as women. In order to appreciate the reasons why women opt for IVF, a technique with an overwhelming rate of failure, acute demands, high costs and taxing emotional and pyschological, as well as physical, requirements, these ways of 'making sense' of treatment must be appreciated. They demonstrate how IVF as 'a whole way of life' rests on the promise of enablement through technological assistance, and the maintenance of hope against the odds that it will succeed. It is defined by a sequence of obstacles that pose a constant challenge to women who undergo it which they meet to the best of their ability, using a range of strategies to cope, and demonstrating a sophisticated self-awareness in the process. Their observations of how the technique effects them, in terms of their sense

of self, their relationships, their work and their futures were often remarkably frank, honest and perceptive. As a 'way of life', IVF was something they coped with ably and knowledgeably, an accomplishment incompatible with a sense of self largely defined as that of an exploited object, a ready dupe or a willing victim.

This is not to argue that IVF is without its faults, and these shortcomings are entirely apparent in the comments women make about their experiences. No matter how positive their final assessment of the technique, their experiences demonstrate the inadequacies of IVF as a means of dealing with the distress causes by infertility. The question is why women opt for IVF despite its inadequacy, and what alternatives exist to this 'choice'? It is to these questions that the next Chapter is addressed.

References to Chapter Six

1. The cost of undergoing IVF must be calculated as additional to the cost of the procedure itself, which can range from £850 at the 'budget' end, such as the clinic involved in this study, to £2,500 for in-patient and more up-market services, such as Bourne Hall in Cambridge (set up by Edwards and Steptoe after the birth of Louise Brown). Travel, accomodation and time-off work are the other major costs incurred. The cost of IVF is higher if the NHS does not supply the necessary drugs for superovulation. At the time of the study, a certain degree of anxiety surrounded this aspect of the programme. Although most GPs were willing to prescribe these drugs on one or two occasions, many were reluctant to absorb the huge costs of these drugs (often around £500 per cycle) indefinitely, and some were outspokenly critical of the technique as a waste of public resources in the context of tightening health budgets.

2. By 'the context of achieved conception', later referred to as the 'world' of achieved conception, is meant the clinical model of conception derivative of the context of assisted reproduction. In other words, and as is described in more detail below and elsewhere (Franklin, 1991b and c, in press a), it describes the model of conception as mediated by the discursive and technological apparatus of clinical assistance to procreation.

3. In her study of amniocentesis (1989), Rayna Rapp uses the term 'moral pioneers' to describe women as they confront the uncertain moral territory presented to them in the context of assisted reproduction.

Indeed, there are many senses in which women might be described as 'pioneers' in this context, and might well describe themselves as such.

4. For literature on the experience of infertility, see in particular Pfeffer and Woollett, 1983.

5. In relation to the subject of 'life's progression', the interviews replicated very closely the terms of the media accounts. This overlap underscores the central importance of normative family values to the successful marketing and social acceptance of new forms of reproductive assistance.

6. The use of the language of 'naturalness' to describe fertility is, of course, particularly ironic in the context of achieved conception, where the definitive condition is, rather, artifice. See further at note 13 below.

7. I am here deliberately making reference to the title of Rothman's book, *The Tentative Pregnancy*, and to her argument that technology renders pregnancy tentative. This idea of technological dependence creating the condition of 'tentativeness' is widely applicable in relation to new reproductive technologies in general, and IVF in particular.

8. This is not to deny that life is fundamentally unpredictable. It is the particular expectation of control expressed here which must be put into perspective. The idea is that some forms of lack of control are

more acceptable than others: there are some things 'you just can't help'. There are others where it is seen as necessary to 'try harder' to gain a semblance of control. There are countless moments when people must live with insecurity. What matters here is how reproductive insecurity comes to be considered unacceptable and intolerable in relation to normative expectations about children and families.

9. Such comments again indicate the degree of awareness of the risks involved in IVF, as against the notion that women who choose it are 'blind' or uninformed.

10. Such comments also demonstrate the extent to which women's sexuality remains defined by their reproductive function. The reference here is not only to impotence (also often linked to sexual identity in men) but to castration (which, in contrast, is not so often associated with infertility in men, as is made evident in expressions such as 'shooting blanks').

11. The emphasis in this extract upon 'failed production' directly supports Martin's (1987) argument concerning women's internalisation of dominant medical models of female reproductive capacity as profligate and badly designed. Martin also argues that middle-class women are more likely to internalise such models, due to their greater comparative 'investment' in dominant, normative values. This would, of course, apply precisely to the situation of IVF, which almost exclusively involves a comparatively privileged group.

12. The desire to have children because of the material wealth one has to offer to them instantiates both the enterprise-culture definition of parenthood and the Thatcherite impetus to construct the family as the definitive unit of consumption (see Franklin, Lury & Stacey, 1991b, McNeil, 1991).

13. Other commentators (Haraway, 1992; Strathern, 1992) have noted that the 'order of nature' is displaced by technology in the context of achieved conception. For a more detailed discussion of this issue, see Strathern, 1991, 1992 and in press.

14. Judith Lorber's (1988) concept of 'the patriarchal bargain', discussed in Part One, is also relevant here.

15. This finding confirms that of Crowe's (1985) Australian study.

16. Several researchers have commented upon the desireability of a study specifically concerned with couples who refuse the option of IVF. There are certain logistical difficulties locating a population of 'refusers'. One can speculate that such a group would either have strong values preventing them from pursuing IVF, or would not be as concerned to define their lives according to dominant, normative conventions as the sample population described here. In any event, such a study would be of particular interest in relation to Martin's empirical finding and consequent hypothesis that degrees of material privilege are correlated to degrees of acceptance of medicalised reproduction.

17. The feeling that 'IVF only makes life more difficult' again expresses the underside of pain and disappointment to the promise of technological enablement and is discussed in much greater depth in the next Chapter.

18. Certain arguments presented in this section were first presented at the President's Day of the British Association for the Advancement of Science meetings in Swansea in August 1990, organised by Professor Margaret Stacey, and forthcoming in an anthology edited by her (Stacey, forthcoming).

19. See note 2 in the references to Chapter Five above.

20. The 'new probe' referred to is a scanner which is inserted vaginally in order to give a 'better view' of the ovaries. Mixed feelings were expressed about 'the new scanner' by the interviewees. Some, such as the speaker in this extract, preferred the increased accuracy of the vaginal 'probe'. Others were less enthusiastic. The necessary manipulation of the probe by the clinician to achieve visual control was a source of both joking and some discomfort.

21. 'Learning to see' is perhaps an understatement in the context of interpreting a two-dimensional 'slice' of the lower abdominal interior as shown on a nine-inch black-and-white monitor via soundwaves emitted from a probe inserted into ones vaginal tract.

22. This conflation is notable, and runs through the entire experience of IVF. The point is that the technology, though described as 'assisting' the reproductive process, actually comes to define it by displacing it. Indeed, technology *becomes* the reproductive process, as is here succinctly evidenced in the dual referents of 'cycles'.

23. Here again, the tantalising promise of technology is so far from its 'deliverables', it becomes apparent that investment in it is not entirely *about* the deliverables. Again, the investment is about hope: IVF must be understood in part as a 'hope-technology'. Even when women *know it is most likely to fail*, even when they do not even *expect* it to work, the investment is seen to be 'worth it'. One answer to this apparent connundrum is that it is not the expectation it will work which appeals, but the occasion for hope, fantasy, romance, heroism or other, non-'rational', desires to be satisfied which it offers. This phenomenon is much more well-established in the context of surrogacy, and should act as a reminder that reproduction is 'wonderful and mystical' as well as biologically functional.

24. The ways in which IVF can become an end in itself are explained in part by the 'hope' it offers. Hence, the relationship to the technology becomes a relationship of hope, and about preserving hope. In turn, the technology can 'succeed' in providing this hope, even if it fails to deliver other goods. It is the balance between IVF 'being worth it for the hope it gives you' and 'just too much' when it fails that must continually be renegotiated.

25. This example of 'resistance' presents an interesting contrast to Martin's (1987) study. In her account, 'resistance' took a variety of forms, from direct avoidance to 'oppositional consciousness'. The example here is of resistance from within the clinical setting and adds suggestively to the range of resistances available to, and undoubtedly widely practiced by, women in the context of medical management of their bodies.

26. The idea of self-management here, as well as the techniques of visualisation and 'positive-thinking' employed, also evoke the context of 'alternative medicine'. Whilst in one sense a form of 'resistance', this can also be seen as a capitulation to an individualistic model of health, whereby people are made responsible for their own diseases via their lifestyles. See further in Coward, 1988.

27. There is, however, a double-edged nature to this valorisation, as it is arguably not just the woman's welfare which is the reason for her 'special' provision, but much less personal concerns, such as providing a competitive service; advancing research goals; procuring 'spare' embryos; increasing the clinic's success rates; and so forth.

28. Many women recounted very disturbing episodes of reproductive illness or malfunction, or both. Two women had nearly died from undiagnosed conditions, and many women's lack of adequate reproductive healthcare (or for that matter, any reproductive healthcare) was the suspected, or known, cause of their infertility.

29. Also evident in this statement is the expansion of parenthood effected by the provision of reproductive assistance. Not only penetration, but fertilisation and impregnation are performed by the clinician, who thus acquires what was conventionally understood as the role definitive of fatherhood.

30. IVF is part of an emergent reproductive service industry which is almost entirely private, and as such arguably plays a 'leading' role in the normalisation of a two-tier health system in Britain.

31. This again can be understood in terms of all of the things IVF can 'deliver' in addition to a baby. It was sometimes my feeling that women's pursuit of IVF motherhood was like a woman's equivalent to war. Her body *was* 'the front line', and she had the scars to prove her bravery in the pursuit of motherhood. If motherhood is to the establishment of womanhood what warfare is to the establishment of manhood, then this analogy provides a very different picture of the woman lying on the table during aspiration.

32. In addition to being described as 'miracle babies', IVF offspring are also referred to as 'precious babies'. This has a double-referent, both to the cost of IVF and to the fact that these children are seen as especially wanted because of what their parents went through to get them.

33. In the classic romance narrative, an obstacle to fulfillment is required to produce the requisite tension and anticipation from which

much of the pleasure associated with this genre is derived. Though it may well be that an obstacle to parenthood is not experienced in this way, it may well serve a function of this sort, binding the couple together in adversity. See Radway, 1984.

34. Here again it is 'the hope that it offers' which can make IVF 'worthwhile', insofar as the preservation of hope, 'keeping hope alive', can become a goal in itself. In this sense, IVF can be seen as a devotional activity built around faith, faith in a technological 'miracle'. These issues are discussed at greater length in Chapter 8.

35. That women have later regrets is demonstrated by the extract from a radio broadcast discussed in the next Chapter, in which one of the women interviewed for this study voices her regrets about the procedure.

CHAPTER SEVEN

'Having to Try' and 'Having to Choose': How IVF 'Makes Sense'

Introduction

In the previous Chapter, two 'trajectories' were described in order to illustrate how the choice to opt for IVF is framed in relation to the disruptions posed by infertility, and subsequently how an IVF cycle poses its own disruptions. It was argued that descriptions of IVF itself as an 'obstacle course', a set of 'hurdles' to be negotiated, a 'way of life' and an experience that 'takes over' and that 'makes something of you' all are indications of the way IVF functions as a *rite de passage* of sorts. IVF is described as an experience structured by a model of achieved conception, in which determination to succeed, and faith in the enabling potential of technological assistance are definitive features of the trajectory established by the procedure. It has been argued that the importance of recognising these features of the experience of IVF must be contextualised within an understanding of IVF as a process: a process which is entered into with expectations that change as the procedure 'takes over' and becomes a 'way of life'. Definitions of success and failure, for example, are changed in the process of undergoing IVF.

In this Chapter, these features are explored in more depth, particularly in terms of their consequences for women's attempts to find

a resolution to their infertility through IVF. Having established the ways in which the intensity of the technique imposes its own particular demands, and elicits particular strategies of coping and 'making sense', this chapter attempts to examine in greater depth the way the technique changes women's expectations and the consequences of these for the longer term. The Chapter concludes with an evaluation of the technique seen in this light: in terms of the way IVF can be understood not only as a *process*, but as a rite of passage.

It is argued in the introduction that IVF is exemplary of the kind of emergent reproductive choice which has a very double-edged character. It typifies the kind of choice which is entered into with an expectation of enablement, and hope for an improved reproductive future through technological assistance, but which may well acquire a very different character once the process has begun. Presented as a simple technique, IVF turns out to be 'an obstacle course'. Chosen as a means of resolution, either by succeeding or being able to feel every effort was made, IVF generates its own momentum as a 'way of life', replete with new dilemmas and disappointments. Once IVF is chosen, new kinds of choices have to be negotiated, such as those presented by an ambivalent diagnosis or a 'partial success'.

That women can feel a sense of accomplishment and an empowering degree of determination in the face of the demands posed by an IVF programme is one side of the story. The other side is the cost IVF imposes physically and psychologically. It may bring women closer to their partners, but it can also dominate their relationship and test their marriages to the point of near dissolution. Women may feel it 'made something of them' in a positive sense, but they may also feel

disembodied, objectified, endlessly poked and proded or 'like a specimen on a table' (Flowers, p. 12). Coping with the failure of serial IVF attempts not only imposes severe emotional demands, it may ultimately lead to a profound experience of hopelessness. The hopelessness of never having children, the 'condition' IVF 'responds to', may be compounded by a hopelessness about ever coming to terms with this condition. If IVF offers resolutions to some women, it can also take away any hope of resolution for others. What IVF is seen to offer, in other words, may be precisely what it takes away. Nearly succeeding can be even worse than never coming close to success, as the hope has come even closer to becoming a reality, and the resulting loss is that much more devastating. Lost is not only all the effort of treatment, but everything about a woman's future a hoped for success had promised, which can be a great deal indeed. As one woman put it, 'It's your whole life you're talking about' (Keating, p. 14).

Understanding the reasons why women choose IVF is thus essential to understanding their experience of the procedure. The reasons informing this choice, and the emotions which give rise to it, are the 'bottom line' informing the experience of undergoing IVF. It is all about hope: hope for success at each stage, hope for a resolution, hope for the future, and mostly hope for a child. Yet it is also all about failure. Even women who succeed have done so under the constant threat, if not several direct experiences, of failure. Even if they are 'successful', their IVF pregnancies literally embody this constant risk of failure, as they await each test with the same 'balance' of hope and preparedness for failure that shaped their experience of assisted pregnancy. Hence the language of miracles -- miracle makers and miracle babies. After

the experience of IVF, in which conception and pregnancy seem like an obstacle course, it is hardly suprising some women end up considering it a miracle that anyone ever gets pregnant at all.

'Having to Try'

One of the most striking features of the interview set is that in every instance women said they felt they *had* to try the procedure. Often this was stated in the same breath as the acknowledgement that they knew they would most likely be unsuccessful. In stark contrast with what women are left with in the majority of cases where they are unsuccessful, the ways that women enter into IVF were uniformly described in terms of 'having to try':

> I think when you have been trying for so long and you really want it you are going to try everything you can think of, that you've heard of that will do it, you know. [...] So we think it's only fair if you've tried everything and I've tried everything.... [We] both think that we should both do all we can, to see if it works [...] and I think well if I don't try am I forever going to be thinking if I had done? So I'll just keep trying. I mean at least I'll know in myself that we have tried everything and if it doesn't work then eventually we might accept it, but I feel I've got to try every possibility. As I say, if you really want it, you've got to try everything you can. You daren't give up on the first attempt. If you really want something, you have to go for it. I think you are willing to spend as much time as there is if you really want a

> baby.... I suppose there will still be loads of people that have had [IVF] suggested but who have said no, can't be bothered with that. But I'm not like that. You either go out and get it or you sit on your backside and leave it. (Ives, pp. 9, 11, 21)

In this statement, the feeling of 'having to try' is repeatedly stated. It is composed of several elements. At one level, it expresses sheer determination: if you really want something, you will do whatever you can to get it. In addition, there is the feeling that you might look back at a future date and feel regret for not having tried everything. Noticeably in this extract, a clear distinction is made between people who do not opt for IVF and people who do. The speaker strongly categorises herself as a doer, a seeker -- as opposed to someone who 'can't be bothered' or who sits on their backside.' She sees herself temperamentally as someone who does not give up easily, although she agrees that even she might give up eventually. Such a statement shows a clear awareness of the difficulty of IVF, the fact that not all women would chose it, and the determination to succeed that so thoroughly characterises the experience of IVF. The feeling of 'having to try' is both powerful and unhesitating. It is the feeling of 'having to try' which creates the feeling of 'having to choose' IVF.

The essence of this statement is articulated by another woman, who already had one child, and wanted another child both for herself and her partner, and for her son to have a sibling. When asked about her first response to IVF, she answered: 'It was just another way to have a child, so I said yes', adding 'At least I've tried, that's how I feel, at least I've done my best' (Harding, p. 2). In a sense, the 'decision' to opt

for IVF is precluded by the pre-existing desire to have a child. If the procedure is seen as the only way to realise this desire, then there is no decision, no 'choice'; the answer is a foregone conclusion.

For many of the women interviewed, the 'choice' of IVF presented itself in the form of the clinic's opening in October, 1988. As many of them lived nearby, and the local papers ran announcements about the clinic, a 'choice' which may have been lurking in the backs of their minds, or 'on hold' for whatever reason, suddenly surfaced and became immediate. As one woman described her 'decision' in this manner:

> When the clinic opened in October, there was a big splash in our local paper, [and I thought] haah, let's have a go! As soon as [my husband] came home I showed him that and we made our decision, well it's either your decorating or it's - because we'd just moved in, you see. I mean [my husband] says, well the choice is yours, *well there wasn't a choice*, I mean I just had, I had to have a go, for my own peace of mind, because you never, if you don't you're always saying well if only I'd had a go perhaps it would have worked.... (Keating, p. 4)

The statement here that 'there wasn't a choice' indicates well the paradoxical nature of 'choice' in the context of IVF. On the one hand, a choice was made. On the other hand, it is described as an inevitability: a foregone choice, as it were.

The speaker is one of six of the women interviewed who already had children (30%), and among the three of those (15%) whose children were adopted. Having adopted two children had partially enabled her to come

to terms with her infertility, but this situation changed with the opening of the clinic. She continues:

> Mind you, we'd forgotten, we'd said alright, once we'd got the girls, let's just get on with it, accept that we're not going to have any and we can't get IVF on the NHS, let's just be done with it, and we'd accepted it pretty well until the clinic opened and then you go, ah! I've got another chance. I mean you've got to take it really, you've got to have a go, which is what we decided. (Keating, pp. 4-5)

As the speaker makes clear, she had more or less come to terms with her inability to give birth to children, had adopted children and had decided to 'get on with it', until the clinic opened nearby and thereby presented a new option for treatment. Yet, after two unsuccessful cycles, in which 'everything was fine', but a pregnancy did not result, coming to terms with the situation and attempting to just 'get on with it' became much more difficult:

> If it's not working for you you've got to come to a stop, you can't keep doing it, you can't drain yourself to rock bottom physically and emotionally as well as financially. There's got to be a time when you think, right, let's do something for us now, we've tried it. That's what I'm going through at the moment, I'm saying to myself, alright, we've tried it, I've done this, the dream that I'd always wanted to do is try. Alright, it hasn't worked, I've got to get on with my life now.... But it's ever so hard...you still never give up the wanting to have a baby...I don't know if I'll ever give that up...the actual wanting, the need, the desire to have a

> baby.... I mean we've resigned ourselves to the fact that we were always, we were never going to have children, never be able to have a natural born child.... But I don't think, even now I always think to myself, if I've come a day late kind of, wonder if I've done it? So you never forget it, I mean you have your monthly periods so you cannot forget it, I don't think you can ever give up while you're still having your periods properly and everything, you never give up. 'Cause I even thought up to a month ago, why don't I have an operation and get rid of the lot, be sterilised, and that'll *stop* the wanting.... I thought if it's *gone*, it's *finished* that's the answer to *stop* it. But then I think to meself, well if I do that I know what's going to happen. Next week somebody's gonna bring something out and I could have done it! Can you understand that? You're pulled by your emotions both ways.... How do you find a happy medium to cope with it all? You never win. You can never have peace of mind. I mean that's just the way I feel about it, I know I will never settle. (Keating, p. 16)

As this extract demonstrates, and as was noted above, what women look to IVF to provide may be exactly what it takes away from them. In other words, attempting IVF may be seen to be essential in order to feel that 'everything possible was done', all routes were tried, and no options were neglected. Even when they know they are likely to fail, many women who choose IVF do so in the hope that at least they will not look back later in life and wonder what would have happened if they had tried it. If they cannot be certain of the outcome of IVF, in terms of whether

they are successful in giving birth to a child, at least they can hope for the certainty of knowing they did everything possible to succeed.

Yet, as the above extract demonstrates, this is precisely the certainty that IVF takes away. From an uneasy but functional ability to 'get on with life' pre-IVF, the speaker describes a shift into a 'no-win' position of indefinite irresolution: 'I know I will never settle'. She is without even hope of a resolution, feeling caught in a kind of Catch-22. Like the field of achieved conception itself, her future has become technologically dependent. She has considered extreme measures, a hysterectomy, to put an end to her distress. But even this will not provide a sense of 'resolution', because she fears the kind of newspaper headline that brought her into contact with IVF to begin with: a description of a technique she would 'have to try'. What if she comes home and finds the local paper running a feature article on a brand new technique which could enable someone like her to have children? Which would be the worse regret, to regret having a hysterectomy or to regret spending years of her life torn in two? She is faced with imponderables. Her 'choices', as she sees them, are both unsatisfactory, and she feels she 'can never have peace of mind' and that she knows she 'will never settle'.[2]

An attempt at IVF was described by the speaker as a kind of dream come true: 'the dream that I'd always wanted to do is try'. By trying she could have her 'chance', her bid for 'a natural born child' of her own. In addition, even if she failed, she would at least know she tried everything, and would be relieved of the fear of looking back and wondering what might have happened if she had tried IVF. But this

longed-for peace of mind eludes her, in the aftermath of IVF, which has left her bereft of consolation.

This theme of having to try IVF in order to feel they had at least reached 'the end of the road' was repeated again and again in the interviews:

> Well I think you feel you've got to try it. It may not work, but if that's the only thing that's left for you, you've got to try it.... I didn't want to feel in a few year's time, oh I wish I had tried that, you know, I had the opportunity and I didn't take it, I wish I had. I felt as if I might regret it, later on. (Norton, p. 11)

> I don't want to get to menopause and feel I haven't tried everything. (Carter, p. 1)

> Yes [it is definitely worth trying IVF] because then you can live with yourself knowing that you did everything you possibly could, there was no other option open to you.... I think to know we've done everything in the end would have helped, would have helped to come to terms with it, because otherwise you would always have wondered had you gone through with it would it have worked. (Doyle, pp. 32-3)

> I think that the decision that I felt was that if IVF was the only possible means then that was the avenue I wanted to go through to have our own child. (Flowers, p. 4)

> It's nice that there is somewhere you can go...that you could go down and have a couple of tries so you know like later on in your life you could think, you know, yourself, well, I've tried, I have really tried, I wanted a baby, I wanted a family, we have tried, we've given it all we can and they at the hospital, they've done all they can for us, like it's better than thinking well we might have been able to have a family if we had went and had treatment, if we had went such and such, do you know what I mean? You don't want to have that doubt there, at least you give a shot, you know. (Yates, p. 73)

As these extracts demonstrate, IVF is sought not only to provide a child, but to provide a resolution to the uncertainty created by infertility. To 'know we've done everything' is sought as a means to 'come to terms with it'. The knowledge that 'you've got to try it', even though it 'may not work' is seen as a protective measure against 'doubt' or 'regret' in the future. Such fears are often correlated to the onset of the menopause, at which point a woman's fertility is seen to have ended.[3] The feeling that 'you don't want to have that doubt there' is thus an important motivating factor in the choice to undergo IVF, because then *even if it fails*, at least the knowledge that 'everything' has been tried will be some comfort.

Even women who expected the technique to fail often felt that at least trying would give them peace of mind:

> I don't think I expected it to work, actually, I went in with a very negative attitude...but I felt we owed it to ourselves to give it a try. (Young, p. 3)

These and the many other similar statements throughout all of the interviews emphasise the necessity of attempting IVF in order to come to 'the end of the road', and to ensure no avenues of possibility are foreclosed. The forcefulness of this logic is clearly apparent in the imperative to choose IVF expressed by many speakers in response to questions about their decision to undergo treatment. Invariably, this was not a complex decision; it was simple and obvious, so much so as to not even be a 'decision' or a 'choice' at all, but more of an inevitability. If there was a chance, it had to be taken. If there was hope, it had to be pursued:

> I think it sort of keeps you going to know that there is a chance. And if there is a chance you take it. The options are there, if you don't take them it is your own fault really, you can't look back and say if this had happened, we have tried, we have done everything possible to make it work. (Quinn, p. 34)

> It's not all a bed of roses, but if it works it's a bonus and it's better than nothing. It's better than no choice, it's better than being told last January that that's it and that would have been it totally, at least I have got a chance, albeit slim. There's a chance, and I think of it that way. (Lewis, p. 88)

IVF 'keeps you going' because it offers a chance, the only chance of success. Likewise, as another woman put it, 'it is worth every minute because of the hope that it gives you' (Doyle, p. 32). In stating that IVF is 'your only chance' or 'your only hope', however, is a suggestion

that keeping this hope 'alive' by opting for the only chance available is an important end in itself.[4] Again, the importance of 'making progress forward' in life is emphasised, as in the case of the descriptions presented earlier of how infertility renders women's futures tentative. Knowing that everything possible has been done, knowing that there is still hope, there is still a chance is initially seen as far preferable to the finality of being told there is nothing to be done. Later, some finality, or boundary is desired as a means to reach 'an endpoint' to the cycles of disappointment and failure. Again, it is the contradictoriness of the emotions and desires involved in IVF which are apparent here.

Hope and Determination

That keeping hope alive is important in itself again must be seen as a cornerstone of the entire IVF experience. It is what keeps women going through the arduous treatment cycles and is the source of their determination to continue. For this alone, for the hope that it gives, and the feeling that there is still something that can be done, which is being done, which they have chosen to do, rather than doing nothing, women unanimously recommended IVF when asked what they would recommend to other women in their position:

> I would never ever put somebody off IVF. I would never say - oh, don't bother, it's pointless, it's useless, it doesn't work, because you see the results - it does work, and you've just got to be one of the real lucky ones for it to work...literally it's the luck of the draw when it comes to

> IVF.... As I say, I would never put anybody off going for IVF, because you've just got to use every option that's open to you. (Chadwick, p. 18)

In this statement, a belief in the technique in general, 'it does work', overrides the fact that the technique fails for the majority. This is explained as 'the luck of the draw'. In such a statement is evident the forfeiture of a certain kind of control of ones future; it is felt 'you have to try' IVF, but 'you've just got to be one of the real lucky ones for it to work'. No amount of trying harder will ensure success, however important trying as hard as you can may be. It is like a kind of gamble or roulette. Hence, on the one hand, IVF is sought out as an enabling technology, yet on the other hand it is perceived as subject to a kind of random element no amount of assistance can mitigate. This is very similar to the situation of the ambiguous diagnosis, where the ability to produce quantities of sophisticated medical information does not add up to meaningful knowledge. The promise of technological enablement is not always realised. It is the *hope* it promises, as much as what it can actually provide in the way of a child, which is the reason it is chosen. In fact, dependence upon technological solutions is often *dis*abling, rather than the reverse. As the speaker above later comments, in a statement which runs directly counter to that offered earlier:

> Years and years ago, if couples couldn't have children, they just couldn't have children, because there is so much known about it now that I often wonder, if we hadn't started going to fertility clinics right from the beginning, would we have not been so uptight, pressurised, um, be more relaxed in

> trying to have a baby, whereas you're looking at temperature charts, the time of the month...and that's a pressure in itself. I mean we made light of it, but there's still that pressure...you're thinking in two week spans. (Chadwick, pp. 20-1)

On the one hand, the 'hope it gives you' makes IVF a desireable opportunity. Yet this hope is also acknowledged to be disabling in its substitution of one 'tentative future' (infertility) for another (IVF).

It is this feature of the IVF experience which leads some women who fully endorse the technique also to state that it 'Only makes life more difficult' (see below). Given the disruptions produced by IVF, it is not surprising many women end up wondering whether they might not have been better off never having attempted it to begin with. In a set of statements which ran counter to their endorsements of the technique, many women were outspoken about its drawbacks. Having felt they 'had to try', many women nonetheless wondered whether having done so only left them worse off.[5] As one woman put it, 'it is a lot down the drain' (Brown, p. 33). Other women felt similarly:

> IVF only makes life more difficult.... I would have had to accept it a long time ago if it weren't for IVF. At 28 I could have either gone for adoption or accepted my situation so I'd be five years down the line towards that and getting on with my life. Now you're in a better position to do that when you're 28 than when you're 38. If you've missed all your career boats and burned all your career bridges because you've spent the last ten years chasing fruitless treatment you've actually missed out a lot on life. (Carter, p. 1)

Going forward, determination is the most important component in the experience of IVF. Maintaining determination can be an end in itself, an accomplishment, an achievement against the odds in its own right. Struggling to maintain hope for success, faith in the technique and belief in the purpose of continuing on creates its own momentum. This goal-orientated mentality can be extreme:

> If, I mean they've got a lady at the clinic and it's her twelfth attempt, and she's become pregnant on her twelfth attempt. If I were younger and if I had lots of money I would leave work and I think I would just have attempt after attempt...and if I had the time I think I would have the treatment sort of every three months until it worked..... I mean, you've got to put it in perspective, I mean up to a point you're prepared to go through anything to achieve a pregnancy, you are prepared to put up with the lot.... I think there's noth-, I would go through more or less anything that they suggested physically, you know, if they well if you had surgery or anything like that. (Quigley, pp. 19-20)

Stopping just short of saying there is 'nothing she wouldn't do' to have a child, the speaker emphasises an intense determination to 'go through more or less anything' to succeed. But looking backward, this determination may not seem to be such an accomplishment in itself. Often, it is a woman's age which ultimately prevents her from continuing IVF treatment. In other cases, lack of sufficient funds brought an end to treatment. The important point is that the determination to persevere along the 'road forward', the 'only avenue of possibility', can become such a 'way of life' that the likelihood of its being a dead

end disappears from view. Indeed the possibility of this road leading to a dead end is precisely the possible eventuality which has to be so carefully managed, by balancing hope for success against the likelihood of failure, that *creates* the determination to continue.

Given that the women interviewed for this study were in the midst of treatment, it is not possible to provide data on their retrospective assessments of IVF. A follow-up study would be required to establish the nature of these assesments and the extent to which women's evaluations of their investment in IVF changed over time. Such a study, though beyond the resources of this project, would provide a valuable set of data regarding the 'other side' of the rite of passage involved in IVF. For example, one woman from the study who was interviewed on national radio approximately a year after the interview for this study, stated:

> The first thing that any woman and her partner should think about when they feel that [IVF] is what they need is that *there are a lot of us who come away with nothing*. And although we may have our hopes fulfilled we may also have our hopes left unfulfilled and they should consider that one of their options is not to pursue treatment and there are many brave women who say I'm not going to take this any further, I'm going to stop now.
>
> interviewer: You say that but you yourself have been through several courses of IVF treatment.

> Yes, I've started ten [IVF cycles] and I had my first one six years ago. I'm very grateful that I had the opportunity to do it and maybe, you know, the doctors will be able to improve the success rate of IVF because they were able to use women like me to learn, fine, but I'm not going to invest any more of my life in IVF because it hurts too much, it's too much of a payment to make and I'm not just talking about money. I'm talking about expectations, not pursuing your career, not having a holiday, all of those things that if you come to the end of the time and you haven't had your baby, you have to balance up what you've paid with what you've ended up with and I feel that I've paid my debt and I've ended up with nothing but I have accepted my infertility now. (File on Four, BBC Radio Four transmission 05.12.89, transcript p. 14)

In this statement, expressed in the language of investment, payments, and balances, IVF is seen to impose a high price. Although it is not claimed that the procedure is worthless, the speaker feels she has 'ended up with nothing' and her advice to other women is to take greater cognizance of this possible outcome. Likewise, although she does not say she felt exploited, she does refer to having been 'used' by doctors to improve their success rates, a comment which comes close to a feminist assessment of IVF as a research technique as much as, if not more than, a form of therapy.

The paradox of IVF is summed up in the statement that 'although we may have our hopes fulfilled we may also have our hopes left unfulfilled'. Similarly, although she states she is 'grateful' for having had the opportunity to try IVF, and has come to accept her infertility, the overall feeling conveyed is one of ambivalence. On the one hand she is glad she tried IVF, but on the other hand it was a costly investment which left her with 'nothing'. There is indeed the sense of a double loss. Although she states she has come to terms with her infertility, the impression is not given that IVF made this any easier, which is what many women hope it will do, even if it fails. Instead, there is the sense that in addition to accepting her infertility, she has had to accept the losses she incurred through IVF, and that in this sense her losses were compounded, rather than eased, by pursuit of treatment. In addition to having lost 'the kind of life she would have led' as a mother, she has also lost the kind of life she would have led if she had accepted her childlessness earlier, and in this sense her losses have been doubled..

Tentative Resolutions

The reasons for the apparent contradiction between her advice to other women and her own decision to undergo 10 cycles of IVF can be seen to derive from many of the features of the experience of IVF presented in these chapters. Infertility is a condition which will lead some women to pursue every possible avenue of potential assistance, no

matter how remote the chances of success may be. Once in the field of achieved conception, the procedure creates its own demands and thus a considerable amount of work, determination and endurance is required to continue treatment.[6] These strategies can involve complex mental 'self-management': an important component of 'living IVF' or of inhabiting the world of achieved conception.

It has been argued that this determination can become an end unto itself, as can any quest for an elusive goal. Moreover, it has been suggested that many of the features of the experience of IVF are only visible in retrospect. Going forward, women such as those interviewed are motivated by a strong desire either to succeed with IVF or to feel they have tried everything. IVF is seen as a road with two possible endings: success or failure. But neither is the 'end of the road' it is anticipated to be. Coming close to pregnancy, or achieving a 'chemical pregnancy', or even simply viewing her own 'fertility' through scans, can make it harder for a woman to accept her infertility than it might have been beforehand. Opting for technological assistance, seen to be enabling, can be disabling when technological assistance becomes technological dependency, and technological potential threatens a woman's own sense of agency.

One of the major ways in which this feature of the experience of IVF becomes apparent is in the way it brings a woman much closer to pregnancy, to her goal, and thus increases both the determination to continue and the desire for a child:

One of the reasons I was talking to [a friend also undergoing IVF] on the Monday is...because I had gotten myself upset.... I looked through a photograph album and the last photograph...[was one that my husband] took of me in bed the day after [ET], and when I asked him why he'd taken that photograph he said it was because the grin on my face was so large, you know, it went from here to here, because the day before I'd gotten a positive result. Nobody can explain what a person feels when they say it's a positive result, and I just didn't stop grinning, but unfortunately I lost it. Getting over that was something else.... And when I saw that photograph, it brought it all back to me, that, you know, I *was* pregnant, even it being just a chemical pregnancy and that, you were told it was positive. (Chadwick, pp. 1-2)

Even before a positive test result, two weeks after embryo transfer, many women 'felt pregnant' immediately after the fertilised embryo was 'transferred' into their bodies:

SF: So did you actually see the embryos?

Yes, oh, that was so emotional, that was, I didn't believe it would, but when I went in there for the embryo transfer, you're lying there on the bed, and they've got this screen, you know, this big television, and then quickly under the microscope and she says 'right, I'm going to bring them out now, now look quickly' because she wants to put them back

because obviously she doesn't want to leave them there too long...and then all of a sudden there they are and you *see* these little eggs that are dividing and well they are my babies 'cos they are my embryos, they're divided, they've just got to grow. And they are the actual start, it's the closest you've got to actually being pregnant, and oh I just burst out crying. Oh I just couldn't believe it. And when [the doctor] said there were three put back, you know, to me then I was pregnant, you know, I was actually pregnant, albeit it only lasted a week but I was actually pregnant, and you know that was just marvellous. (Keating, p. 9)

Actually feeling pregnant under these circumstances is hardly suprising given that the technique would appear to be one of literal impregnation.[7] The tentativeness of this 'pregnancy', the fact that it is 'only' a chemical pregnancy -- at once 'close' to pregnancy and pregnancy itself, again underscores the technologically-dependent nature of events in the context of IVF generally.[8] Neither is it suprising that such an experience would have the effect of increasing a woman's determination to succeed:

When I first attempted to get pregnant...I think I was more philosophical about it, just, well, if I do get pregnant I do and if I don't I don't, and then sort of the longer it went on the more I realised that you know I really did want a family, and now I don't know what I'm going to do if I can't become pregnant. If I can't have a family, I really don't

know how I'm going to cope with it. I decided that I'm not at all interested in my career anymore, in fact while I've been off this time, we've discussed it and I'm actually going to give up.... (Quigley, p. 20)

Yes, I mean I'd always, that's what I wanted, I always wanted children. I didn't want them desperately at the beginning, you know, like some people are absolutely, that's what they see as their role in life, and I mean I didn't feel that strongly about it, until we started going through all this, and I think when you are, when suddenly something is taken away from you, obviously you get very strong feelings about it. (Ingham, pp. 17-18)

In both these extracts, a process of transition is noted, from a feeling of having to try IVF in order to feel that every option had been pursued, but not a feeling of 'desperateness',[9] to a feeling that the longer treatment continues unsuccessfully, the more focussed the desire for a child becomes, to the point that, as the first speaker was previously quoted as saying, she 'would do more or less anything'. Notably, these women describe themselves as *not* 'desperate' initially, and as becoming *more* 'desperate' *as a result of treatment.* This is the exact opposite of the media accounts, in which the woman's 'desperateness' is what drives her to seek IVF, which is in turn seen as giving her hope. In fact, it is the hope IVF gives which can *cause* the desperation it is said to alleviate. The search for a resolution

through IVF, then, can be seen to create precisely the irresolution it was meant to eliminate.

It is this transition, from one side of IVF to the other, which is part of the 'passage' women may encounter undergoing IVF. It is a passage from one set of expectations, desires and experiences to another. But there is also an important difference. Classically, in ritual terms, a rite of passage involves the transition from one recognised social status to another (see Van Gennep, 1909). This passage has been seen to involve a 'liminal' period of undefined ritual space between the one status and the other, which is seen as necessary for the shedding of one identity to make way for the acquisition of another in the ritually constructed space of ambiguity or social void of liminality (see Turner, 1969).

In IVF, the transition is analogous, but different. The transition is internal, rather than public or collectively affirmed. It does not enter, but *begins* in a 'liminal space' of infertility, which is seen to *block* the transition from one social status to another. IVF is undertaken as a means to exit from this liminal condition (the 'limbo' created by infertility). Yet, IVF creates yet another liminality -- a different kind of 'limbo'. The transition *out* of liminality is, thus, not provided by the 'rite' of IVF (unless, in the exceptional case, it succeeds). In other words, the 'rite' does not provide the 'passage'. Rather, the woman herself has to extricate herself from this rite of passage stuck in its liminal phase by an inward transition of some kind, such as coming to terms with her infertility and ending treatment. On

the other side of such a decision, she indeed inhabits a different 'status', in the sense of having accepted an identity as either childless or more childless than she would like to be. A passage has thus been effected. If IVF has helped her to make this transition, however, it is not because of the technique itself, but because the procedure is something she felt she 'had to try' in order to reach a resolution. The point, of course, is that the IVF procedure has not necessarily made this resolution any easier.

Double-Edged Determination

IVF is paradoxical in many respects. £2000 is not a lot to pay for a child, if you have one. Even £20,000 may not be too high a price when it is something as intensely desired as a child of ones own. But either £2000 or £20,000 are a great deal to pay for nothing. They are even more to pay for nothing minus the remainder of the investment, which includes not only the work, stress, disruption, physical pain and emotional heartache but everything a hoped for child had come to represent. In addition to 'nothing' there is the aftermath of failure, a 'debt' composed of a part of ones life that will never be 'repaid'.

The cyclical nature of women's fertility, their menstrual cycles, that is, which is paralleled in the IVF cycle, also shapes the experience of treatment. Women describe the 'cycle' of hopes building up, the 'cycles' of coping with failure and the generally cyclical nature of their relationship to their infertility as well as the

technology. Indeed, these are entirely conflated. This is emphasised by the measurement of time in terms of 'day one of the cycle' through to the last day, 'day X' of the cycle', when a woman begins to menstruate. The descriptions of life's progression in terms of 'living in two week spans' or 'living month to month' constitute another way in which the 'way of life' of assisted reproduction becomes internalised, part of an identity, part of a world view. As time went on, over serial failed attempts, many women described their experience of IVF in terms of trying harder and harder whilst believing in it less and less:

> Because I think so much of it, it's a bit like a wounded animal. I mean if it's got somebody that loves it and is coaxing it and is saying get better and we love you and all of this and giving it a will, it will live. If it's deprived of that it will die. And I think the further you go on, the more resigned you are to the fact that it probably isn't going to work. Because I was a lot more enthusiastic about it the first time than I am now. (Norton, p. 50)

In this extract, the reference to 'dying' not only indicates the extremity of the emotional experience of IVF, it also describes the central importance of hope remaining 'alive' in order for the will to continue to be sustained. The analogy to a 'wounded animal' describes the hope for success which initially spurred her own. After failing, the hope had to be nurtured back to strength in order for the 'will' to continue to survive. Yet, it has survived only to be tested again. As time goes on it is getting weaker: the desire to continue survives, but

the will to do so fades. Resignation to the likelihood of failure replaces the initial enthusiasm about success. Yet, even this resignation does not protect against the continuing distress of failure:

> I mean I have gotten past the stage of thinking it will work, and you know I am pretty sure it won't, but I mean you still get the disappointment, but I don't feel optimistic about it at all anymore. (Brown, p. 15)

When the hope, optimism and enthusiasm which carried women forward is lost, the will to continue diminishes too, creating doubts about the decision to pursue further treatment, and a greater readiness to accept that there is nothing to be done but accept their infertility, and get on with other things. Yet, even women whom the technique has failed and who feel they personally cannot continue, may express a continued faith in the technique itself. The belief in the enabling potential of technological assistance, often framed in terms of a more general belief in scientific progress,[10] may well survive despite a woman's decision to terminate treatment:

> I mean when I listen to [my daughter] talk, she's on about, because of our going through the IVF, it would, I mean she was so upset when we failed with it, really was, and um, we've spoken, and she's said if I ever can't have children will I have to do this Mum? And I think to myself, well, maybe it'll be better for you, we're only in the first stages of it, I tell her, it's something new that's been brought in now, I said, but perhaps by the time you're old enough to

have your own children, I says, and if you're unfortunate enough that you can't have your own children, perhaps there will be something for you.... I said there might be more perfection then, but I mean she's only nine, I says it might be better than it is now, because it's only just something that's been tried as a new thing. I said they're really, you know, they're not, it's not an everyday thing at the moment, is it? I mean it's better than it was ten years ago, I mean there were hints of it then, wasn't there, the first things that were being done, but now it's even better, and by the time she's older, it will probably be better still. There might be something else. (Keating, p. 17)

I mean research is a funny thing, researchers can plod along for five years, ten years making only minute gains and then somebody has a flash of inspiration or something goes right and they take a great leap forward. It could be that in ten years' time we are not much further down the road of knowing about infertility, on the other hand in three weeks' time someone might discover a real breakthrough. (Newton, p. 25)

I [have] a feeling of being really fortunate in being able to try this treatment, you know, to be able to have the treatment, you know, because it is very recent. I mean ten years ago, and really even five years ago, you couldn't, it

> just wasn't available. And in a lot of ways I feel really fortunate that I'm here at the right time in a way and that you know things have progressed amazingly. (Ingham, p. 26)

> They're learning all the time, and they're getting more and more successful. (Levy, p. 13)

Although occasional suspicion was expressed concerning the manipulation of embryos, IVF was uniformly endorsed as a worthwhile technique, despite having failed in the majority of instances, in which case the technique itself was praised, and seen to be improving, despite its unsuccessfulness for particular individuals. That IVF was 'recent' was even seen to enhance its desireability, adding a novelty value that created a 'feeling of being really fortunate'. This endorsement of IVF is thus part of an endorsement of science more generally, and is an affirmation of a belief in scientific progress as enabling, and in enabling technology as an outcome. Assistance in the realm of reproduction was endorsed in both these statements and in the frequently-expressed praise for the clinic and its staff.[11]

Such endorsements comprise an important component of the hope and determination which figure so largely in the experience of IVF. To attempt IVF, which is arguably a 'failed' technology as a result of its very low success rate, a certain degree of 'faith' is indeed required. This 'leap of faith' may be facilitated by a strong belief in scientific progress. This is evident in many of the extracts presented above, in which faith in scientific progress is shown not only to have influenced

the choice of IVF, but to help in the acceptance of its failure, by creating a sense of having contributed to something larger than themselves.

Miracles of Nature

Somewhat more suprisingly, the naturalness of IVF was also affirmed by several of the women interviewed:

> You hear all these things about test-tube babies and I think a lot of people think that it's quite an abnormal process, and I don't think we really appreciated what's involved. And I think we thought it was all a bit, um, clinical and -- I mean I don't think we realised what a natural process it was, I mean it's only sort of emulating a natural process, it's just that it's sort of got outside interference and sort of done outside your body rather than inside it.... [W]e didn't realise it's as natural as it is. (Quigley, p. 12)

> I mean the end result will be the same as if it was all happening inside the body, it just happens outside the body, there's nothing peculiar about that. I mean it's like saying people shouldn't have kidney transplants and things like that, you know, because that's not natural...I mean I don't see it as any different from any sort of medical intervention at all for anything. I mean obviously if you get into the

> realms of trying to create a superbaby by two parents that are geniuses or something, then obviously that's an entirely different thing, but I don't consider them in the same breath anyway, I don't see it, I mean I think it's going to become much more common anyway. (Ingham, p. 36)[12]

This affirmation of the 'naturalness' of IVF may seem at first surprising. It is a testament to the plasticity of ideas about 'the natural' and their ability to be readjusted even to circumstances which patently contradict this claim. On the other hand, if these ideas are considered to be symbolic, rather than literal, then the message is coherent. This message, after all, is that IVF is only 'giving nature a helping hand'.[13]

At the same time, IVF is still considered a 'special' way to conceive. Although not seen as 'unnatural' in the sense of being immoral or abnormal, IVF is seen as 'miraculous' by many. Indeed conception itself comes to be seen as 'miraculous' under any circumstances, given how many obstacles there are 'naturally' to its occurring. In this way, the model of achieved conception produced in the context of assisted reproduction, such as IVF, comes to define conception more generally. The 'miracle' of assisted conception is conflated with the 'miracle' of natural conception in a manner which suggests the ways in which modes of 'making sense' particular to the field of assisted reproduction have the potential to become definitive of reproduction more generally. That 'nature' ever succeeds *without* a helping hand is as miraculous as when it succeeds in the context of

assisted conception. According to this definition, every baby is a 'miracle baby':

> I mean that's how I see it, it's a total miracle anyone ever has children once they're pregnant. You read the books, so much can go wrong, pages of all the different things that can go wrong at different stages. (Ingham, p. 20)

> I mean it's a miracle anyway when anybody has a child, but it just seems to be an even bigger miracle I'm trying to achieve, and as the old saying goes, impossible things take time and miracles take even longer. (Flowers, p. 37)

> Do you remember that programme on tv[14] where they showed you right from the beginning what was involved in conception? Fantastic it was, they actually showed you everything, it was as though they'd just dropped a camera inside a woman's body to see what caused them to conceive. And at the end of the programme they said it's a wonder anybody does get pregnant, so many obstacles to it.... (Mr Levy, p. 15)

> When you sit down after five years of effort and the specialist says to you well you fall into the unexplained category, that's I think the key to it. We do not know. It's like saying every generation thinks it knows everything and that there's not much more to find out, but we really

> don't know what happens when a sperm meets an egg, or why sometimes it fertilises and sometimes it doesn't. (Mr Newton, p. 26)

In these extracts, the way in which the experience of IVF changes understandings of conception are apparent. From a normal, natural sequence which is clearly understood and scientifically legitimated, conception becomes a 'fuzzy area' [Levy, p. 16]. From a simple causal chain of events, conception becomes a badly designed process that hardly ever works. This is the point of view of reproduction which is defined within the field of assisted conception: nature needs a helping hand. According to this view, it is a miracle indeed that nature even gets off the starting blocks without technological assistance.[15] If natural conception and pregnancy are 'miraculous' considering the apparent odds against their occurring unaided, then IVF is an even bigger miracle in its confirmation of the potential for technology to subsume this function successfully. 'Miracle babies' are the result of IVF, not of 'nature'. They are the definitive offspring of assisted conception, their very existence making manifest the enabling potency of technology.

The contradiction between IVF being seen as 'natural', in the sense of 'just doing what nature would do anyway', and IVF being seen as a 'miracle' is functional. It allows IVF to be perceived at once as 'miraculous' and as 'normal'. It allows for 'nature' and the artifice of technological assistance to reproduction to be reconciled. Indeed, they become one, analogous to one another. Nature is like a badly designed machine, and technology is just doing what nature does anyway.

Natural processes, technological intervention and the 'invisible hand' of human scientific agency are thus unified.[16]

This view of assisted reproduction also enables women and couples who participate in IVF programs to feel part of a much bigger process, that of scientific progress. As noted earlier, opting for the enabling potential of IVF is also an endorsement of the enabling potential of scientific progress more generally. Hence, individual failure can be understood as a 'success' insofar as it makes a contribution to 'greater understanding' or improving the technique. There is the possibility of a vicarious participation in something greater than the individual, the couple, the IVF team or the clinic.[17] Failed IVF can potentially be viewed in almost sacrificial terms, whereby, for example, a mother expresses a hope that her own failure will at least lead to a potentially improved situation, should her daughter need reproductive assistance.

Conclusion

So far in Part Three, various features of IVF as a 'way of life' have been explored with a view to emphasising how the experience of IVF is 'made sense of' and inhabited. This experience is discursively constructed at the level of popular culture within media representations such as those discussed in Section Two. It is also structured internally by the parameters of the clinical discourse of assisted reproduction. Finally, it is defined by the individuals who participate

in IVF programmes and formulate their own 'lived understandings' of what is occurring, and their own ways of making sense of the procedure.

Within this constellation, there are both overlaps and disjunctures. As the clinical construction of reproduction is one in which it appears as an obstacle course, beset by potential sources of failure, and in need of assistance, so too do women describe the technique of IVF as an obstacle course, and conception as so beset by risk of failure it is a 'miracle' anyone ever conceives at all. Similarly, as the media construction of IVF emphasises the disappointment suffered by couples whose lives have not progressed along conventionally established routes, so too do women and their partners describe this as a major source of distress. As the clinical discourse constructs reproduction mechanistically, so too is this how many women come to think of it themselves, becoming experts in the 'nuts and bolts' of conception. As the media portrays IVF as scientific progress in the service of happy families, so too do women describe their perceptions of the technique.

Yet, to note these concordances between the discursive construction of IVF, its popular portrayal in media accounts and women's own descriptions of the experience of IVF is not to assume there is a seamless continuity between them. Most important among the disjunctures between popular representations of IVF and the experience of it is the overemphasis upon the reasons women choose it, and their expectations going into it, to the exclusion of the ways in which these can change and come to look very different further on. As has been noted, IVF can take away precisely what it is anticipated to provide: a means of

resolution, a feeling that everything has been tried, and hope for a means of completion. The willingness to undergo IVF is structured by expectations which are themselves transformed by the intensity of the procedure, leaving women with only their own ingenuity and determination to make sense of the altered situation in which they find themselves. Though this can be satisfactorily accomplished, the costs may well be unexpectedly high and the options are limited as to how one comes to terms with being on 'the other side' of IVF. Looking forward, and going forward, can be motivated by a very different picture from that encountered with hindsight, when making the best of failure may prove far more difficult than initially envisaged.

It is for this reason that the experience of IVF has been examined here in terms of both the particular *mentalite* it requires, and the way in which it can be seen as a rite of passage. Both these terms refer to the unexpected way in which IVF 'takes over' and becomes 'a way of life'. The *mentalite* of IVF is comprised of a number of factors. It involves a careful balancing of hope for success against preparedness for failure. It involves tremendous determination to succeed. It is because IVF requires a particular *attitude*, as well as particular kinds of *labour*, that a term such as *mentalite* is appropriate. It describes the internal requirements of IVF: the adaptation of a functional mindset to the demands of the procedure. This in turn sheds light on how the difficulties presented by IVF are negotiated, how and why the technique is described as 'taking over', and, especially, how this mental adaptation comprises part of 'living IVF'.

The idea of a *mentalite* or mindset to IVF is also useful to emphasise the very paradoxical components of what is required by it, and the *habituation* to these conditions the procedure often entails. IVF presents contradictory demands: to hope enough but not too much; to try your best but realise it is a gamble; to make sense of the unexplained; to believe in miracles. It is a technique that is both simple and complex, 'natural' and 'achieved'. Through IVF a woman can come closer to preganacy, 'see' her 'fertility', be 'impregnated' and become a 'mother' or 'pregnant', by which means she can both feel 'more fertile' and more acutely the pain of infertility. IVF can 'reassure' that 'there is nothing wrong' despite there clearly being 'something not quite right'. Failure and success in IVF terms are both relative and absolute, dependent on the outcome 'in the end'. But one of the most difficult questions involved in IVF is when the 'end' will be. IVF is a choice, but not a choice. It is a resolution but not a resolution. It 'makes something of you' but 'leaves you with nothing'. It is something women recommend but wish they had not done. IVF is described as a wonderful opportunity, and as only making life 'more difficult'.

That IVF 'takes over' is thus not merely logistical. To negotiate a successful passage through IVF requires physical, emotional and psychological 'self-management'. This in turn explains how IVF functions as a rite of passage, involving the search for a resolution as well as the attempt to achieve reproduction with the aid of technological assistance. The important feature of a rite of passage is that it involves transition. One possible transition is from the

inability to reproduce successfully to the production of a 'miracle baby'. But this is the exception.

The other desired transition going into IVF is a reproductive resolution: an end to reproductive 'limbo'. It is an important argument of the analysis of IVF presented here that the technique itself can make the attainment of a resolution more difficult. Although this is not necessarily the case, the interviews suggest the ways in which women's needs and expectations of the technique *change* over the course of treatment. Going into IVF, either a resolution or a baby is described as the expected outcome, leading to a security of mind that one or the other will result. On 'the other side' of IVF, it is evidently possible that neither outcome will have manifested itself, thus leaving a woman without an apparent means of satisfactory conclusion.

It is also argued that this feature of IVF is, like the world of achieved conception more generally, a product of technological dependency. IVF is described as a 'hope technology' because it is the hope it promises, as much if not even more than a 'successful' outcome, which leads it to be seen as a desireable option, even when it is expected to fail. The problem is that although 'the hope it gives you' makes IVF seem 'worth it' at the outset, the hope is not enough indefinitely. This hope, like so many aspects of the IVF experience, is double-edged, both enabling women to continue and dis-abling them from reaching an endpoint of treatment.

Ultimately, women are left with what they invested in the technique to begin with. They are left with the courage to put themselves to the

test, the determination to carry on against the odds and the resourcefulness to find resolutions and make meaningful sense out of whatever situation they eventually find themselves in. Women who successfully give birth to IVF babies will feel in their relationship to those children the sense of achievement that child literally embodies. Women who are unsuccessful can feel a different sense of achievement, of having tried everything possible and having determinedly persevered to the extent of their endurance or their emotional, physical or financial limits.

Justifying IVF as a procedure in terms of women's 'desperate' desires to have it, or representing IVF as technology's answer to the plight of the 'desperate infertile woman', are not only partial and inadequate, they are exploitative of women's desires for children. Women who choose IVF because they needed to try everything, as the women interviewed unanimously claimed, are not only expressing a desire for children, but a desire for a resolution. Insofar as IVF rarely provides a child, and not only fails in the majority of cases to provide a resolution, but can take away the means of doing so in the process, it can only be seen, at best, as a partial response to women's needs. That *it is not possible* 'try everything' is the realisation with which many women terminate their relationship to IVF.

It is important to repeat that the interviews were exclusively conducted with women who had a very high estimation of the technique. The evidence for this was substantial. The amount of praise for the technique and for the clinicians was striking. Women frequently

expressed their gratitude, good fortune and 'luck' in being able to undergo IVF, *even when they failed.* Even after devastating experiences of failure and loss, none were critical of the technique. All gave it a ringing endorsement and stated they would recommend it to other women. Not all women would respond in this way (see Klein, 1989), nor would all groups be so homogeneous in their collective endorsement of the technique, however ambivalently this was at times expressed.

Both the uniformity of this response, and its generally affirmative tone may be due in part to the fact that the women interviewed were either in the midst of IVF treatment or had been until very recently. In this context, such endorsements can be appreciated as instrumental, enabling and functional. To think otherwise under these circumstances would indeed be almost perverse. Moreover, *even amongst this group of women*, who on the whole expressed an extremely positive assessment of the technique, a noticeable degree of equivocality and doubt is apparent.

Despite giving the technique an endorsement, some women also stated it would have been easier for them if it did not exist, or if they had never tried it. Despite coming to terms with their situation ably and determinedly, many women were also frankly outspoken about its costs. Although able to feel a sense of accomplishment and achievement, many women also felt enormously drained both physically and emotionally. Although highly appreciative of the support they received from others, they also expressed concern about the ways in which the technique created tension and stress in their relationships, including those with

family, friends and colleagues as well as their husbands and children, if they had them. Although none of the women interviewed articulated statements of regret on the whole, many expressed reservations, even in the midst of treatment, and all were candid in their admission of how much more the procedure affected them than had been anticipated at the outset.

The argument here is not that 'the real truth' of IVF lies beneath a superficial veneer of naive or self-affirming endorsements of the procedure. It is rather an argument that the 'truth' of IVF is multiple and contradictory. The argument is that women's experiences of IVF, in their own terms, are far from simple. They are composed of feelings and perceptions that are equivocal and ambivalent, positive and negative, empowering and disempowering. The point is that the claim that women's experience of IVF can be neatly packaged, either to endorse or to negate the validity of treatment, is misleading. The paradoxical dimensions of the experience of the IVF procedure are fundamental to many of the ways of making sense of it described in these Chapters. Balancing hope for success against awareness of the likelihood of failure, believing in the technique against the odds, creating a sense of achievement out of serial losses, and the many similar challenges posed by the demands of the procedure are all characterised by at least dual, and often conflicting, impulses and desires.

Such a claim is, nonetheless, sufficient to argue that media representations of IVF are incomplete, and that medical justifications of the technique as responding to women's needs are, at best, partial,

if not deceptive. However, such an argument is limited for several reasons. To begin with, it assumes that preferable representations or justifications would be 'more accurate'. Since representations are not neutral or objective to begin with, this is an argument with a limited purchase, though not one that is without its importance. Moreover, the argument here is precisely that there are substantial obstacles to providing an 'accurate' representation of IVF, given that women are likely to change as a result of going through it, and that what may seem 'worth it' at the beginning may not appear so at the 'end'. In addition, experience is not the only measure of a technique such as IVF. Though a crucial component in any assessment, it is not sufficient in itself. 'Experience' as such is not accessible, rather a set of representations of it are. These are mediated by several factors, and constitute here a set of transcribed statements collected from interviews conducted with a particular group of women in the midst of treatment. At the very least, experiences are continually re-evaluated, and a follow-up study to this one, with the same group of women, concerning the same set of experiences, would undoubtedly contain different versions from those recorded here. Since experience is inevitably contradictory, it is never 'complete', and it is always subject to multiple readings both by those to whom it is communicated and those to whom it belongs.

These Chapters too are representations of the experience of IVF. Like other representations, they are purposeful, selective and constructed in accordance with particular aims. The findings presented

here confirm those of other feminist researchers who have investigated women's experience of IVF. Like Crowe's (1985) study, the material presented here confirms the socially constructed nature of the choice to opt for IVF. This is not only indicated by the importance of normative social conventions in the articulation of the choice to opt for IVF, but also by the 'investment' in dominant cultural belief systems such as scientific progress. Like Williams's (1988a & b) Canadian studies, the attitude of determination, 'It's Gonna Work For Me', has been found to be a major factor accounting for why women continue treatment in the wake of serial failure. In addition, the interview material for this study indicates the importance of a search for resolutions, accounting for why the technique is pursued *even when it is expected to fail.*

This finding is also relevant to Koch's (1990) Danish study in which the information about failure rates 'did not matter' (p. 225, emphasis removed). Indicated by the present study would be that a successful outcome, in terms of a 'take-home baby', is not the only goal motivating the choice of IVF to begin with. This, then, extends Koch's argument as to why IVF does not constitute an 'irrational choice', given its high failure rate, but instead must be understood as part of a specific 'rationality'. Koch argues this rationality is based on the desire for a child, and the fact that IVF may be the only potential means of achieving this, *regardless* of the likelihood of failure. A desire for a reproductive resolution, *regardless of the outcome of IVF*, could be seen as complementing this argument.

In all of these studies, an attempt has been made to reconcile women's experience of IVF with what would appear to be, from either a feminist or a non-feminist perspective, the inexplicability of women's desires to undergo a largely unsuccessful, costly and demanding form of reproductive assistance. To those features of the experience of IVF described by other researchers could be added here the difference between what IVF looks like going into it and the meaning it takes on later during treatment. In this sense, it might be suggested that a focus on the 'choice' alone is too static an account, to which a more processual or diachronic perspective is usefully added.

It is not a finding of the present study that one reason women opt for IVF is out of ignorance or misinformation, as is suggested by Klein's (1989) study. However, several features of Klein's study are confirmed. To the claim that 'IVF fails women', for example, can be added its failure to provide a reproductive resolution as expected. It would also be accurate to conclude, as does Klein concerning women who opt for IVF, that the women interviewed for this study do not see themselves as 'colluding' in a wider patriarchal process of reproductive control. To the contrary, as has been indicated, the women interviewed for this study were, on the whole, full of praise for the clinic staff and the 'opportunities' afforded them by IVF. If, as Klein claims, women who have experienced IVF are the best spokepersons about its costs, then those costs would have to be seen as other to the ones identified by Klein. As has been argued, the costs of the IVF 'investment' are often unexpected, and described as such.

As noted at the outset of this section, a concern motivating the study presented here was to 'put women back into the picture'. This alters the view of the 'agents' of reproductive intervention as much as the view of women in the spectre of woman-as-object-of-patriarchal-science commonly associated with feminist accounts of women's encounters with reproductive technology. If women do at times feel they are 'poked and prodded', 'used' to increase success rates, or 'like specimens on the table', that is nonetheless not the whole picture. For all of the admittedly 'overdetermined' features of women's relationship to reproductive technology, it is also important to appreciate the agency women *do* have, and to thus present a more multi-layered account of this often oversimplified encounter.

An important point here is that it should not be assumed, as feminists such as Klein appear to do, that if IVF is understood as violent, painful and dangerous that they will decide to reject it. In descriptions of aspiration, women were explicit about acute levels of pain for which they often felt unprepared. In describing IVF as 'like running the Grand National with your legs tied together and wearing a blindfold' it is apparent women perceive it as physically dangerous and unlikely to succeed. In the description of aspiration as 'being stabbed in the belly' is evident an explicit image of violence. Such descriptions are not incompatible with continued treatment. They may even be evaluated positively, in the sense of 'having tried everything', perhaps even to the point of heroism. Similarly, an awareness by women that they are being 'used' by doctors to 'increase their success rates',

or to learn how to 'improve their technique' is not necessarily considered a disincentive.

The evidence presented in these Chapters suggests that women's experiences of IVF do not conform to any simple conclusions in terms of critically assessing IVF. They do not present a simple picture, and neither feminist nor non-feminist evaluations of IVF can be neatly correlated to 'women's experience of IVF'. Like the way the experience of IVF itself is described by women who have undergone it, so too must the assessment of women's experiences acknowledge the often paradoxical and contradictory dimensions of what is occurring in that encounter.

More importantly, experience cannot be the only basis for evaluating IVF. Opposing positions are readily substantiated by 'women's experiences of IVF'. Both the most exploitative and the most benevolent dimensions of IVF can be portrayed through women's 'testimony'. For every 'IVF survivor' called to the witness box is an 'IVF enthusiast' who can endorse the technique.

The concern here is thus also with the way 'women's experience of IVF' has been used in public debate. It has been used not only to support certain positions within both feminist and non-feminist debates, but has also been a key factor in the relationship between them. In other words, insofar as 'feminists' are understood to be representing 'women's interests', one of the most effective ways of precluding feminist perspectives is to put forward a 'pro-woman' argument. It is to these questions that Part Four is addressed. Having investigated the feminist account of 'women's experiences of IVF', the media uses of

these, and women's own account of their experience of IVF, the concluding section addresses the wider public debate in which yet another set of representations are at work.

References to Chapter Seven

1. Such a description also contrasts rather starkly with the image of women as 'passive' in relation to the technology.

2. This situation of unsatisfactory 'choices' corresponds to Rothman's similar descriptions of 'choices' in the context of amniocentesis.

3. Although menopause is often seen as a 'natural boundary' to a woman's fertility, there are already cases of post-menopausal women giving birth via IVF. Hence, even this potential point of 'finality' to a woman's fertility is now provisional in the context of assisted reproduction. Indeed, the period of ovulation induction is also referred to as 'artificial menopause' in that the pituitary gland is blocked and an artificial 'cycle' produced by hormonal injections.

4. Here again, IVF can be seen as a 'hope technology'.

5. In such contradictory statements is evident the difficulty of assuming that even women's own descriptions of their experience represent a complete account. As experience is itself composed of contradictory components, there are clearly multiple and simultaneously conflicting 'truths' to the 'reality' of experience.

6. In this description there is also evident a determination that suggests the epithet 'desperate' is misplaced. Instead one should perhaps refer to 'determined' infertile couples.

7. See note 29 in the references to Chapter Six.

8. The definition of 'mother' in the Human Fertilisation and Embryology Act of 1990 is similarly defined in technological terms. Clause 27 states that a mother is to be defined as 'the woman who is carrying or has carried a child as a result of *the placing in her* of an embryo or of sperm and eggs...' (italics added).

9. Again, it is determination rather than 'desperateness' which could be said to characterise women undergoing IVF. This is not only a more flattering description, but one that correctly identifies her active desires in relation to treatment as opposed to an image of near pathological need.

10. Here again there is shared ground between popular cultural representations of IVF and women's descriptions of their experience. Both draw on well-established cultural belief systems indicating once again the definitive importance of normative conventions in the framing of the IVF experience.

11. Martin's (1987) argument concerning the greater likelihood of privileged middle class women accepting the dictates of scientific dicourse is again suggestive here.

12. Recent ethnographic work on surrogacy in the US by anthropologist Helena Ragone suggests an 'ends over means' rationale by which the unconventional nature of procreation in the context of emergent reproductive options is mitigated by a strong emphasis on the outcome, the end result. The point is to end up with a proper nuclear family, in which case it does not really matter how you 'achieved' it, would be the argument. (Ragone, personal communication).

13. The idea of 'giving nature a helping hand', for example, is described earlier in the analysis of IVF pamphlets.

14. The reference is to two films shown on British television in March of 1988 entitled 'The Agony and the Ecstasy' and 'The World of the Unborn'. This was one of the few references to media sources mentioned in the interviews. For an analysis of these films, see Franklin, 1991b)

15. Martin's analysis of scientific constructions of female reproductive capacity as 'badly designed' is clearly relevant in this context.

16. Nature, defined mechanistically, thus becomes a metaphor for scientific intervention, which is defined naturalistically. In such

cross-borrowing is rendered somewhat dubious the distinction between these otherwise seemingly opposing categories.

17. This possibility for vicarious participation in 'something greater than the individual' has many dimensions, including the celebrity attached to IVF, the potential to 'embody progress' as well as a 'miracle baby', the heroism of IVF and also a certain altruism which can be seen on numerous occasions. Undertaking IVF can thus be seen as a choice formulated in relation not only to an individual's, or a couple's, reproductive future, but for 'the future' in several other senses, most notably in terms of scientific progress. IVF, even when it fails, can be seen in this way as contributing to the welfare of the next generation, both in literally bearing it and in contributing to its welfare more indirectly.

PART FOUR

WOMAN AS SIGN

The joy of those who achieve fertility or are able to achieve a baby through IVF has been described from all sides of the House. It is developing a special place in this argument.

Lord Kennet, House of Lords, 7.12.89, c. 1028

CHAPTER EIGHT

The Embodiment of Progress:
'Women's Experience of IVF' in Public Debate

Introduction

So far in this thesis, 'women's experience' of new reproductive technology has been approached from three distinct perspectives. In Part One, it is viewed in terms of the feminist analysis of the forms of patriarchal control over women's reproductive capacity effected through new forms of 'assisted conception'. In these accounts, 'women's experience', of IVF in particular, has become a source of tension, in the form of the need to balance a respect for women's individual choices against a critical assessment of new reproductive technologies as mechanisms of increased medical management of women's bodies.

In Part Two, 'women's experience of IVF' is analysed in terms of how it is constructed in popular media accounts of infertility. The argument here has been that a selective prioritisation of women's needs and desires at the outset of treatment, and a valorisation of 'successful' IVF cases, have been key elements in the media legitimisation of new reproductive technologies. Hence, a kind of reversal can be discerned, whereby a longstanding principle of feminist activism in relation to reproduction -- 'a woman's right to choose' -- is used to displace critical feminist voices which invoke a wider context, and a more insidious history, to these forms of reproductive intervention.

In Part Three, 'women's experience of IVF' is presented in the form of extracts from interviews with women in the process of undergoing the procedure. The aim here has been to demonstrate what is left out of media accounts, indeed how the 'hope' so poignantly foregrounded in the 'desperate infertile woman' stories has a double-edge. The same 'hope' which is experienced as motivating, gratifying and enabling at the outset may become the most difficult and 'soul-destroying' obstacle to a successful resolution on the 'other side' of 'living IVF'.

However, as noted in the conclusion to the previous Chapter, it is not sufficient merely to demonstrate the double-edged nature of 'the hope that IVF gives you'. Neither is it sufficient to argue that there are features of the IVF experience which are selectively excluded or neglected within mainstream media accounts, or popular images, of IVF. A more 'complete' account of the experience would not eliminate the problems with IVF. Nor is 'women's experience' a sufficient basis upon which to ground assessments of the procedure, as there will always be such a great variety amongst women who experience the technique. For that matter, even the same woman might begin with one understanding of the IVF experience, and emerge with quite another.

It is for this reason that it is necessary also to consider the wider context in which women's experiences are socially shaped. Hence the emphasis in many feminist accounts of women's choices to opt for IVF on the fact that not only is infertility a condition not of a woman's own making, but neither are the social conditions informing her decisions about how to deal with it, such as the social pressures on women to realise their adult identities primarily as wives and mothers.

In this final Part, then, the emphasis is somewhat different. For the reasons outlined in Chapter Three, it has been argued that a feminist strategy of attempting to bring women's understandings of the conditions that shape their choices 'into line' with feminist expectations and understandings, though an implicit and important aim of feminism, is limited. Indeed, it has been suggested such a strategy can be counterproductive. Hence, the emphasis here, and in this thesis as a whole, upon the need to take equally into account women's choices and understandings, and the conditions which influence these more widely.

Challenging Public Debate

An important intermediary strategy in this respect is challenging the terms of public debate through which public understandings of the 'choices' offered by new reproductive technologies are constructed. These terms are the means by which certain 'choices' come to 'make sense' in particular ways, to the exclusion of others. These understandings are part of the social conditions which affect women's reproductive choice. As has already been noted here, indeed as has been consistently argued by feminists, the predominant image of reproductive technologies as merely extending women's reproductive choices is deeply problematic. This thesis is a contribution to this argument insofar as it examines how a choice made in one context may have unexpected consequences in another.

It is also a contribution to the analysis of the terms of debate through which such choices come to be seen as legitimate and desireable to begin with. A major obstacle for feminists in this regard, arguably

in Britain in particular, has been the difficulty of gaining recognition within mainstream public debate about the new reproductive technologies. Indeed, this absence is quite remarkable, given that this debate began in the late-seventies, arguably at the peak of current feminism's public profile as a political movement. Since then, though feminist initiatives and understandings have in many ways become more well-established, and even commonsensical, even to the point of feminism having come to be seen as 'no longer necessary' (eg 'post-feminism'), the public debate over new reproductive technologies in Britain has shown few signs of engagement with feminist perspectives.

The argument here engages with this difficulty. It presents a discussion of yet another version of 'women's experience of IVF', which is that portrayed within public debate. Specifically, it is concerned with the way in which the voices of women who see new reproductive technologies as desireable are used to represent 'women's needs' more generally. This metonymic substitution of certain women's testimony in place of a more encompassing view of the issues at stake for women is argued to be a major obstacle to more effective challenges to the relentless pace with which not only new reproductive, but increasingly new genetic technologies, are being publicly legitimated *in the name of 'women's interests'*. Specifically, it is argued that women who are represented as 'desperate' for a technological 'miracle' of impregnation have become a particular kind of condensed signifier, or sign, in public debate: a sign of embodied progress.

We have already seen that even women who themselves opted for IVF may come to see these technologies as much more problematic than they initially thought. Their later misgivings are effectively screened out

of view by a foregrounding of the 'Our Only Hope' headlines. We have also seen how the woman used to frame these formulaic media accounts disappears from view, her subjective desires and needs being replaced by a clinical objectification of her body parts, which become the backdrop to a medical-scientific drama. In this final Chapter, yet another displacement is examined: that effected by the use of 'women's experience' as a condensed signifier within public debate.

Why 'Public Debate'?

A focus on the terms of public debate is thus important for several reasons. To begin with, public debate is an important site in which the terms are set through which new reproductive technologies come to be understood in particular ways. Secondly, and as is discussed at length below, 'women's experience' came to play an important role in the public debate of new reproductive technologies. A different kind of valorisation of 'women's experience' from that encountered in the media accounts can be discerned, and with it a particular set of consequences for the representation of 'women's interests'. In other words, feminism's significant absence from public debate, it is suggested, derives in part from the privileging of other 'women's voices' in debate. In all of these respects, public debate can be seen as an important part of the wider social context shaping both individual women's reproductive decisions, and the terms upon which these came to be, and not be, formulated.

All of the above reasons were particularly salient during the time period involved in this study, the mid- to late 1980s and the early

1990s, during which there was not only considerable media attention to the new reproductive technologies, as novel forms of reproductive intervention, but considerable public debate of their meanings, implications, legitimacy, regulation, and so forth. Beginning with the birth of Louise Brown, in 1978, public concern in Britain about new forms of reproductive intervention closely paralleled a series of government initiatives aimed at filling the 'legislative vacuum' brought into being by the birth of the world's first test-tube baby. In 1982, the British Government commissioned a Committee of Inquiry, chaired by philosopher Mary Warnock, to investigate 'recent and potential develpments in medicine and science related to human fertilisation and embryology' (Warnock, 1985, p. 4). In 1984, the Warnock *Report* was published and debated in Parliament. A series of preparatory and consultative legislative exercises, described above in Chapter One, were then undertaken, culminating in the introduction of the Human Fertilisation and Embryology Bill into Parliament in November of 1989, its debate over the subsequent 12 months, and its enactment in November of 1990.

Accompanying this lengthy process of legislation was the emergence of what is described here as a wider public debate of the new technologies. The media portrayals discussed in Part Two comprised one particular dimension of this debate, but there were many others. On television talk shows, on radio call-ins, in newspapers and magazines, at conferences and symposiums, and in a range of other locations, new reproductive technologies became the subject of extensive public commentary and dispute. In the context of a lack of formal public regulation, and given the proximity of these issues to emotive matters

such as abortion, marriage, the family, and parenthood, public debate often involved moral panic (see Riviere, 1985; Cannell, 1990). It was, therefore, a distinguishing feature of the period of time during which this study was conducted that new reproductive technologies were put squarely on the public agenda.

The interview data for this thesis were collected at the height of this public controversy, in the two years preceeding the introduction of the Human Fertilisation and Embryology Bill into Parliament in November, 1989. This was a period of intense lobbying by various interest groups who sought to influence the views both of legislators and the general public.[1] It is for this reason a comparison between the version of 'women's experience' collected during the interviews, and that circulating in public debate at more or less the same time, is noteworthy.

Given its dispersed, or capillary, character and effects, it is not possible here to convey the full scope of public debate. A more focussed discussion is therefore presented. As it might be considered the acme of formal public negotiation of 'human fertilisation and embryology', the parliamentary debates comprise the focus of discussion below.[2] These debates, contained in the *Official Record* of parliamentary proceedings, were both determined by, and uniquely influential within, the wider public debates of this period. They thus comprise one of the key sites in which a particular construction of 'women's experience' can be examined. It is to the significance of this particular construction of 'women's experience', and its relation to the other representations of this discussed in the three preceeding Parts of this thesis, that the analysis presented here is directed.

Public Debate Revisited

The use of 'women's experience' to legitimate the procedure of IVF is not restricted to media portrayals of 'desperate infertile couples', and stories of happiness and hopelessness. 'Women's experience' is also a key feature in much public debate concerning the new reproductive technologies. It serves not only as an important, but in a certain sense privileged, form of evidence. In parliamentary debate of the Human Fertilisation and Embryology Bill, and accompanying media coverage, for example, accounts of 'women's experience' were frequently used as a form of evidence, or testimony, in support of various positions. In particular, accounts of 'women's experience of IVF' were, and continue to be, used in the representation of IVF as an expansion of women's reproductive choice and a beneficial form of infertility treatment.

The following, for example, is a typical extract from the parliamentary debates of 1989-1990 as a result of which IVF gained official state sanction as a form of reproductive intervention, and became subject to governmental regulation via the Human Fertilisation and Embryology Authority. The extract is taken from the opening debate (the Second Reading) in the House of Lords, in December 1989, which occasion was of major importance in establishing the foundational arguments informing subsequent proceedings. The speaker is a parliamentarian who has been to visit an IVF clinic in Cambridge, where she met and spoke with a woman undergoing IVF. In the following passage, she describes this occasion in language that is immediately reminiscent of the generic conventions structuring the popular media accounts discussed in Chapter Four:

> IVF has seemed almost like a miracle for desperately unhappy couples who are able to undertake the new process.... I am speaking today because I have been able to visit the IVF clinic at Addenbrookes Hospital in Cambridge.... I saw one woman who is a senior midwife. She loves her work and is obviously dedicated to her patients, but until now she has had the experience of delivering babies day by day while unable to have one of her own. She has had two failed IVF pregnancies but is now in the 25th week of her third pregnancy and is expecting twins, if all goes well. She has to stay in bed in the clinic for a highly critical period of time just now, and probably for most of the rest of her pregnancy, but she said: "It's all worth it -- without IVF I would never have had the chance of having a child". (Baroness Llewelyn-Davies, House of Lords, *Official Record*, 7.12.89 cols. 1023-4)

This passage is noticeably similar to the accounts of 'women's experience' encountered in the media representations in several respects. The language of 'desperateness' and 'miracles' is used in the description of the relation between the individual woman and the promise of new reproductive technology. The extract typically describes the woman's needs and desires in the midst of treatment, indeed we encounter her at a 'highly critical period of time'. It thus describes the 'going forward' mentality described in the last section. Despite two failures, IVF is still described as 'worth it' because it is the only 'chance of having a child'. The extract thus describes the *potential* of technology. Whether or not it will succeed is still open to question. In both its description of context, and of consequences,

the extract is thus characteristically partial. Excluded here is the likely aftermath of failure yet again, and the corresponding magnitude of a disappointment proportionate to the amount of investment so far.

Such descriptions are, however, not only partial and characteristically formulaic. The repeated use of such descriptions, not only in the media, but in public debate of new reproductive technologies, confers upon them a status which could be described as *iconographic*. The image of the 'desperate infertile woman' and the hope she has invested in technology is so frequently encountered, so consistently repeated and so strikingly similar in its ubiquitous enunciations that it can be seen as not only a powerful iconographic image in itself, but a condensation of the debate as a whole. It is in this sense that description here can be seen to function as a kind of condensed signifier to affirm the value of IVF. It is not only narratively and discursively significant, it is *symbolically* significant as well. Encapsulated in this image of human suffering are a wide array of condensed meanings, through which abstract values, such as beliefs in scientific progress and technological enablement, are given a human face.

Woman as Sign in Public Debate

Such descriptions invoke a familiar kind of essentialism. The image here, of a 'desperate infertile woman' hoping for a technological 'miracle' is not simply a literal description. Rather, it is a particularly powerful form of symbolic imagery. The use of such imagery as a form of condensed signification is familiar from other struggles

over reproductive issues in the past. The feminist campaigns against legal restrictions on abortions in the past have used similar images, such as that of the woman victim of a backstreet abortion. Such images are successful precisely because they simplify the issues: 'it boils down to this', they suggest. Condensed in the image of a woman's death or injury in a backstreet abortion is the simple message that control over her reproductive capacity is for many women an issue of life or death. Condensed into such an image, the basic, though abstract, issues of human rights and individual freedom are concretised. So synonymous did the image of backstreet abortion trauma become with abortion that even a badge bearing a coat hanger was able to denote the pro-choice position.

A more recent example is the use of fetal picture postcards and fetal replicas to denote opposition to abortion during both the Alton debate [3] and the debate of abortion which took place during the pasage of the Human Fertilisation and Embryology Bill. Like the image of the 'desperate infertile woman', the image of the fetus is iconographic; an important icon within, as well as an icon of, the abortion debate as a whole. Here again, a literal message also functioned as a symbolic one. The literal message referred to a purported 'victim' in order to concretise and popularise more abstract arguments about human rights and human personhood. Concern for the individual fetus, though important, was not all that fetal imagery conveyed. As a symbolic object, the fetus could stand for an array of more abstract cultural values, from nationalism to nurturance. As a point of public identification, the image of the fetus became a powerful instrument through which to command and to direct public opinion concerning the abortion debate.[4]

It is suggested here that the image of the 'desperate infertile woman' performs a similar function in recent public and parliamentary debate concerning new reproductive technology. Like the condensed signifiers of previous struggles over reproductive politics, the image of the 'desperate infertile woman' is of a 'victim': a 'victim' of reproductive failure. It is an emotive and evocative image, which condenses a range of more abstract concerns into an immediate and recognisable scenario. Like the other images, it suggests that this is the 'bottom line' of argument. Descriptions such as that presented above are convincing and compelling precisely because they reduce the issue to a simple narrative of desperateness and hope.

These descriptions are also effective because they rely on eye-witness testimony. In this extract, a parliamentarian describes how she has seen for herself the hope that IVF can provide. Her formal public testimony describes the impact of having personally witnessed what IVF can offer. She has herself been convinced by what she has seen, and is seeking to convince others on the basis of her own experience. It is this experiential dimension to such images, in this case the experience of the woman described being amplified by the parliamentarian's experience of meeting her, which makes them so effective. The issues at stake are rendered more human, more meaningful and more poignant for their being depicted in this way, through the hopes and sufferings of another person rather than in the rarified and abstract language of ethical principles or moral duties.

That such descriptions played a key role in parliamentary, as in wider public, debate was explicitly noted by more critical commentators. It was precisely the effectiveness of such imagery that was of concern

to those who sought to challenge it. That such images, and their 'special place' in the argument was both noted and challenged in Parliament provides a measure of their disproportionate influence and persuasive capacity:

> The joy of those who achieve fertility or are able to achieve a baby through IVF has been described from all sides of the House. It is developing a special place in this argument. (Lord Kennet, House of Lords, *Official Record*, 7.12.89, c. 1028)

This comment, also taken from the critical Second Reading in the House of Lords at the outset of parliamentary consideration of the Human Fertilisation and Embryology Bill, attests to both the 'special' character of the 'desperate infertile woman' image and the frequency with which it was employed in public debate. It is also indicative of the difficulties presented by such imagistic rhetoric, in that it is difficult to challenge directly. In the face of such an evocative and emotive image, it is difficult to voice opposition. In the face of palpable suffering, it is harder to assert a critical viewpoint than in relation to more abstract, 'reasoned' discourse. Recognised in this extract, therefore, are the very qualities that make such imagery effective: the reduction of the issue to a concrete instance with a human face; the condensing of complex arguments into an essentialist image; and the consequent production of a kind of screening effect, by blocking out the wider context or the wider issues in their depiction of an immediate and emotive human tragedy.

Many parliamentarians, like Baroness Llewelyn-Davies, became similarly convinced of the value of IVF through visits to IVF clinics.

These were arranged by Lord Jellicoe, a member of the House of Lords and the Medical Research Council, to enable parliamentarians to 'see for themselves' what new assisted reproduction techniques can offer. Similar eye-witness testimony was often referred to in debate, as in the extract above, as a conversion experience. Doubts were dispelled in the face of the immediate evidence of medical science in the service of would-be parents.[5] But what have they seen?

Viewed from the clinical context, however, is only one portion of the experience of IVF. By definition, women who are attending the clinic are still 'living in hope' for a successful pregnancy. The clinic is the site of this technological promise and potential, *and it is this 'hope' which is the most important value signified by the image of the desperate infertile woman.* In this sense, the image is metaphoric: it stands for a belief in scientific progress and faith in technological enablement. It is a symbolic image of hope for an improved future, and of faith in the ability of medicine to alleviate human suffering. It is an image that powerfully unites traditional family values with faith in the power of science, technology and medicine to improve the human condition. In this sense, the image stands for much more than the woman herself. It is not only an image of individual needs, or even the collective needs of a group of similarly deprived individuals. Like the displacement of women's subjective needs and desires in media accounts of infertility treatment, a symbolic displacement also operates in such imagery to displace women's *actual* experience in favour of the *potential* of science and technology.

It is very noticeable in the extract from Baroness Llewelyn-Davies that she has *not* seen the outcome of the scenario she describes. She

has not witnessed a miracle, and her testimony is not based on having done so. What she has witnessed is *hope* for a miracle and *faith* in the capacity of medical technology to provide one. *All* she has witnessed is conviction, dedication and belief. That in her view this is sufficient grounds to be convinced of the value of a technology which she has not even seen be successful precisely demonstrates that success is not only, or even mainly, what it offers.[6]

The Embodiment of Progress

The most important feature of the image of 'desperate' infertile woman is the hope it signifies. Here again, we encounter IVF as a 'hope technology', but this time in the context of the hope it *symbolises*. The hope of the individual woman described can function as a symbolic hope because it is so widely shared. It is not only *her* hope this image conveys, but the shared collective hope invested in the promise of science and technology out of which the manifest destiny of the Enlightenment has been realised. The effectiveness of the essential message in this image is that it stands for instrumentality as an end in itself. *It is for this reason it does not even need to be stated whether or not this woman succeeds.* Her success is not what is at stake. It is her hope which is the important component. In the same way that the hopes and desires of 'desperate' infertile women are used in media portrayals of new reproductive technology as vehicles to provide a way in to accounts that then displace them, so too can there be seen a kind of displacement in these accounts.

Indeed, in the explicit way in which this woman's body is the hoped-for conduit for a technological miracle, it might even be suggested a religious comparison is not inappropriate. Again, the image is not only symbolic: it is *iconographic*. It is a *devotional* image. This woman (a dedicated nurse) has devoted herself to hope in a technological miracle. We bear witness to her devotion through her suffering, and also through her dedication. But importantly, we also bear witness to her *faith*. As she says herself, this faith alone makes her ordeal 'worth it'. It is this same faith with which scientists and clinicians 'devote' themselves to devising more effective means of reproductive management.[7]

At one end of parliamentary debate, then, is the concrete image of the 'desperate' infertile woman who has invested her hopes in technology. At the other end of the spectrum is what the technology itself represents:

> The discovery of DNA, the very blueprint of life, is certainly awe-inspiring, and when the full map of the human genome is known, probably within a decade, we shall have passed through a phase of human civilisation as significant as, if not more significant than, that which distinguished the age of Galileo from that of Copernicus, or that of Einstein from that of Newton. Its political significance is almost beyond our comprehension. We have crossed a boundary of unprecedented importance.... There is no going back.... We are walking hopefully into the scientific fotthills of a gigantic mountain range. Hitherto, man has had no option but to come to terms with a serious burden of genetic impairment, but now he can look ahead, perhaps a long way, to its eventual

> elimination.... For us to forswear the assistance which science can provide in modifying that code to the advantage of the human race would be an indefensible abdication of responsibility. It would cross the portcullis of this place with a most sinister and destructive bar. (Sir Ian Lloyd, House of Commons, *Official Record*, 23.4.90, cols. 96-8)

Although this extract concerns the use of new genetic technologies, the reference is also to IVF, insofar as an important justification for the use of IVF was the proposed implementation of gene therapy via this technique.[8] Two primary groups of 'afflicted persons' were foregrounded in arguments based on experience. One was of the infertile, and the other was of carriers of genetic disease who could be helped to have healthy children via IVF, such as those referred to here.

However, the most important component of this extract is again the reference to hope: of 'walking hopefully into the scientific foothills of a gigantic mountain range'. The hopefulness expressed towards technology is in this extract given much fuller explication. It is, for example, given a moral imperative. Not to pursue scientific inquiry is described as 'indefensible', 'sinister' and 'destructive'. It is also described as inevitable: 'there is no going back'. There is no stopping this advance, we cannot 'close the doors' on the 'frontiers of human knowledge', to do so would not only be 'unenforceable', but would 'merely inflame curiosity', claimed the speaker. The will to know is in this extract described as an essential human need and an essential moral good.

The hope and faith invested in technological progress is here proclaimed in its most expansive and exalted form. The entire future of

the human race is seen to be at stake. The imagery of scientific pioneers entering new terrain, the foothills of 'the gene age', whose significance is 'almost beyond our comprehension', is again almost mystical. The image is of scientific knowledge lying in wait to be discovered. There is no sense of choice or options about this image of scientific progress: it is as eventually inevitable as it is morally imperative to proceed forward.

Interestingly, this counter-image to that of the 'desperate' infertile woman-martyr also introduces her counterpart in the form of the heroic scientific pioneer. On the one hand is the devotional woman figure beckoning technological impregnation, whilst on the other is the forward-marching scientific pioneer devoted to the cause of fathering invention. Both images have powerful symbolic resonance within Judaeo-Christian doctrines of divine creation. It is man's fate to have eaten from the tree of knowledge and been burdened with mortality. It is woman's fate to suffer in childbirth and to be subservient to patriarchal authority. As the potency of the Father and the Holy Ghost were realised through the vessel of Mary's in the miraculous conception of Christ, so are women's bodies in the context of IVF the symbolic repositories of a profound faith in the moral and historical imperatives of scientific progress.[9]

Similar religious symbolism attends the use of fetal imagery which, it has been suggested, make of the foetus a Christ-like figure. As Faye Ginsburg has noted in her analysis of fetal symbolism in the context of the American abortion debate, 'the aborted foetus becomes a sacrifice offered for the redemption of America' (Ginsburg, 1989, p. 107). Similarly, as Barbara Duden has argued in the context of the abortion

debate in Germany, the fetus becomes a 'public sacrum', a sacrifical object of worship symbolising a wide array of social ills (see Duden, forthcoming). A kind of religious mystery surrounds the tiny, perfectly formed foetus in its private inner sanctum which has been converted into a powerful source of overdetermined symbolic rhetoric by right-to-life campaigners (Petchesky, 1987).

That such religious parallels appear in the context of evocative imagery concerning reproduction is hardly surprising given the importance of beliefs about conception to cultural accounts of human origins or genesis.[10] Beliefs about conception are inseparable from questions about what it is to be human, how a human comes into being and the 'miracle' of this creation. In the long history of western scientific accounts of generation, from Aristotle's writings on the subject in the 4th century BC through the contributions of William Harvey in the 17th century and up until the present, the question of conception has been inseparable from metaphysics and cosmology (see Dunstan and Sellers, 1988).

In the iconographic image of the 'desperate' infertile woman, and the equally important symbolic figure of the 'miracle baby', are evident not only a devotion to the ideals of scientific and technological progress, *but their capacity to be embodied.* Through IVF, science and nature are unified in an act of procreation. This is a critical interface. Symbolically, this union and its 'fruit' not only signify, but actualise, the potency of natural science in the service of the natural family. Where there was no family, technology has enabled one, through an act of miraculous creation, at once the product of nature and of science. The 'miracle baby' is both the 'fruit' of knowledge, and of

the maternal body: it embodies their unity, it confirms their potency, and ensures their continuity.

It is in this way that 'women's experience of IVF' functions as a sign in public debate. Far from a literal description, it is the repository of condensed signification with the capacity to reference a wide-ranging index of collective cultural hopes and faith. It is a sign: a sign of embodied progress. It is a sign of hope, just as the miracle baby is a sign of joy. For not the first time, the body of a woman, and its 'desperate' maternal desires, are the vehicle for a hoped-for miracle, in this case of scientific and technological progress. With the same double-message of other forms of patriarchal chivalry, which inscribe women's subordination in the act of their elevation and idealisation, the privileging of women's desire to embody a technological miracle is not what it appears. Without having to impute disingenuousness, as such habits of cultural practice are not necessarily intentional, and hardly novel, there are considerable reasons to be suspect in the face of the hope, joy and beneficence such images suggest.

Feminist Challenges

An appreciation of the symbolic, iconographic or metaphoric dimensions of the representation of 'women's experience of IVF' in parliamentary debate and in the public debate in its wake bears a particular importance for feminist interventions in this field. For one, it is the paramount form of representation of 'women's interests' in this debate. The image is one of women's potential gain through new

reproductive technologies. It is an image of women themselves investing their hopes in this potential. These are images which *directly contradict* feminist criticisms of the technique as controlling, manipulating or damaging both to individual women and to women's interests as a group. They can thus be seen to have a particularly powerful displacing effect on feminist arguments, *indeed a capacity to make these non-sensical.* In the face of the gratitude and conviction expressed by the 'desperate infertile woman' undergoing IVF, feminist arguments that this procedure is a 'con', a 'dupe' or a mechanism of enhanced patriarchal control not only appear unconvincing, they appear heartless and prescriptive. It is feminists who appear to be the ones attempting to control women's choices when arguments, for example, that IVF should be banned are held up against the impassioned convictions of women who see it as 'their only hope'.

It was in part this difficulty to which this thesis as a whole is addressed, and it can be seen in one of its most polarised extremities in the context of public debate. The image of the fetus in the abortion debate is effective precisely because it has a similar capacity to turn feminist arguments inside out in a set of particularly powerful reversals: it is not the woman who is the 'victim', it is the woman who is the assailant. It is not the woman whose rights are at stake, it is her selfishness which endangers the rights of innocent victims. It is not women's lives which are at stake in the abortion controversy (as in the image of the backstreet abortion), it is the lives of the unborn, who are described as suffering the equivalent of a holocaust in their callous, immoral and daily elimination, such images are deployed to suggest.

It is for this reason the image of the 'desperate infertile woman' needs to be challenged, not only on a literal basis, but in terms of the privileged symbolic status it has achieved in public debate of new reproductive technologies. This image can be literally challenged by pointing out all of the risks IVF poses to women, in terms of their health, their quality of life, their working lives, and so forth. It can be challenged on literal terms by documenting the many unpleasant aftermaths of IVF, including multiple births, insoluble grief, or even fatalities. The costs of IVF, financially, emotionally, physically and psychologically can be invoked. Such challenges have in fact become a major component of the feminist literature on this subject. They comprise a reverse-discourse to the mainstream image of IVF as primarily beneficial to women. A similar reverse discourse can be found in the feminist attempt to document and publicise an alternative set of 'women's voices', those of the 'I was an IVF patient but now I am a feminist' variety (eg Klein, 1989). This counter-image, of women who have attempted IVF and discovered its costs, has provided an important set of challenges to the image of the happy couple with their miracle baby. Increasingly, there are indications, particularly outside Britain, that such a view is becoming more widely recognised, and beginning to undermine the monolithic picture of the 'desperate infertile woman' filled with hope for a technological miracle (eg Hopkins, 1992).

However, there are problems and limitations in these approaches, and it is for this reason an additional strategy is suggested here, in terms of challenging this representation of the 'desperate infertile woman' on its own terms, as in the challenge by parliamentarians to the 'special

place' such images have come to hold in public debate. The main problem with the literal challenge to this image is that it constructs women who seek IVF as complicit with patriarchal oppression, as victims of false consciousness, or, at best, as uninformed consumers. These are not untenable arguments, for the costs of IVF are by no means well publicised, and it is as true for feminists as for anyone else that we are always paradoxically implicated in the very culture we seek to change. However, this can be very awkward ground for feminism, particularly in its capacity to be seen as 'blaming' women for their own oppression. The main problem with the reverse discourse of women who have attempted IVF and undergo a feminist conversion experience is similar. It too has its value as a feminist strategy, but has resonances that are troubling in its potential to alienate the very women it seeks to address in its capacity to appear as a feminist orthodoxy to which all women should subscribe. For all of their justifiable merits, both of these arguments have the potential to be divisive and to pit 'feminists' against 'women'. Most importantly, these arguments are for these reasons particularly vulnerable. Especially in the context of public debate, in which one of the most important persuasive goals of feminism must be to make visible 'women's interests', and to effectively challenge sources of 'women's oppression', the question of 'women's experience of IVF' can be a minefield.

Hence, one of the most important arguments for attending to the representational level of this debate, and examining how the terms are set, in addition to challenging the terms themselves, is because it shifts the focus away from women who opt for these technologies. To

what extent, for example, is feminist concern about 'women's experience of IVF' itself a product of the debate having privileged particular representations of it? Have feminists seen an imperative to re-convince infertile women seeking IVF of the 'error of their ways' in part because their 'voices' have been so convincing within public debate? By so doing, are feminists responding too uncritically to the terms that have been set in mainstream public debate? Is there a danger feminists are reinforcing the centrality of such representations in debate of the new reproductive technologies through the production of reverse discourses which also privilege this particular fulcrum of controversy? Is the extent to which 'women's experience of IVF' has become a 'condensed signifier' within feminist debate also contributing to this problem? Does it impede more effective means of shifting the debate in the direction of other interests at stake in the field of reproductive technology, such as those of ambitious research scientists, professionally competitive clinicians, drug company representatives, and so forth?

These are questions which are suggested by an approach which challenges, at a cultural level, what is being affirmed through the image of the 'desperate infertile woman' and her quest for a technological miracle. Instead of responding to this image by turning to infertile women and trying to convince them they should not be so 'desperate' for technological solutions, is it not possible for feminists to challenge this image directly, by critically addressing the way it is used? Were the privileging of this image to be more critically interrogated, feminists might move onto more familiar territory. For example, to the extent that the women whose experiences

are being foregrounded are being used as a symbolic vehicle to express much more abstract values, can it not be said this is itself a form of exploitation? These women are paraded through Parliament, but do the parliamentarians even know what happened to them? These women's hopes and desires are foregrounded in the media, but what about the aftermath? It is, after all, something of an exceptional occasion to witness Parliament so concerned about women's needs. It may not be deliberately exploitative of women that they are foregrounded in this way, but exploitation need not be premeditated to occur.

By challenging the 'special place' of the image of the 'desperate infertile woman', the focus can be shifted towards those who can covertly further their own interests disguised as selfless altruism. No shortage of such dissembling claims to be 'helping women' through improved medical-scientific 'management' of reproduction are at hand to substantiate claims of this sort. It is admitted by leading IVF professionals that infertility 'treatment' is a fortuitous side-effect of a research-led initiative (see Edwards and Steptoe, 1980). Clinicians are often the best spokespersons on this subject themselves, candidly admitting it is easier to do research on women than on animals, or that they are furthering their view that it is woman's role to reproduce by providing IVF services. From such a vantage point, the idea that IVF is purely in women's interests, and that noone has any right to question the 'desperate' desires of infertile women for 'treatment' is much more readily challenged. Moreover, challenges from this angle are less likely to have the potential to backfire and be used against feminists by casting them in the very role of trying to 'control' women as the interest groups they challenge.

In sum, then, it has been suggested that, like the popular media accounts discussed in Chapter Four, the representation of 'women's experience' in public debate can be seen as functioning according to particular conventions. These are argued to have a similar displacing effect on women, whose experience comes to serve a symbolic function in debate. The focus on the use of 'women's experience' in parliamentary debate has been used to suggest it is a condensed signifier of much else besides the woman's own experience or interests. It has been suggested her 'voice' is privileged because it conveys much more than her own experience, and has the capacity to stand for and symbolise dominant cultural beliefs such as a faith in scientific progress.

The overdetermined nature of the capacity for women's experience to become a 'sign' of much else in public debate has been briefly discussed in terms of other forms of similarly essentialist imagery in debates over reproduction, and their resonance in the context of Enlightment and Judaeo-Christian values. In particular, it has been argued her capacity to signify so much derives from her capacity, and her desire, to embody scientific progress and to give birth to a technological 'miracle'.

Finally, it has been argued there are several reasons why it is important for feminists to attend to this representational level of contemporary reproductive politics. This argument has been made by other feminists addressing other public debates, such as that concerning abortion, and it is argued this approach has numerous important advantages. In particular, it has been suggested this approach avoids the pitfalls of a reverse discourse which similarly privileges the 'experience' of infertile women. In contrast, the turn towards the way in which the terms of public debate are set enables a shift in focus

onto the other parties to recent technological developments in the 'management' of reproduction. Hence, a parallel can be drawn between the feminist emphasis on women's exploitation by new technology, and the exploitative valorisation of selected components of their experience in public and parliamentary debate. By demonstrating the instrumentalism of the use of the image of the 'desperate infertile woman' and her 'experience', the power of this image to silence and displace alternative feminist approaches can be directly challenged.

Reproduction as Public Domain

An important reason to be somewhat sceptical about the amount of attention paid to women's reproductive needs and desires in both mainstream media accounts, and arguments in the context of parliamentarydebate, is that this prioritisation is rather dramatically at odds with the actual state of reproductive healthcare facilities for women in Britain. That certain reproductive needs are selectively exalted suggests a parallel with the idealisation of motherhood in theory and its relative neglect in practice. Such comparisons are an important measure of the basis for such images in ideology and belief rather than more practical or material considerations.

This is not to suggest that those who expound on the subject of women's desires for IVF do so disingenuously. It is rather a question of proportion: such appeals rest on a certain degree of concern for individual women, or others like her. But they are to at least an equivalent, if not far greater degree, concerned with issues that have nothing to do with the woman described, and for which her experience

therefore becomes merely an enabling vehicle or effective symbolic repository.

It is this slippage which is somewhat worrying in itself. The problem is the degree to which this suggests a woman's reproductive capacity is not entirely 'her own'. Indeed, the contents of women's bodies have become increasingly 'public' in the context of new reproductive technologies. They have become visually more accessible by means of of new technologies, such as ultrasonography, which have made more publicly accessible the contents of the womb. The use of ultrasonography, for example, in advertising is indicative of the pronounced degree to which the insides of women's wombs have acquired a 'public profile'. The contents of the womb are now also subject to increasing state legislation, such as the Human Fertilisation and Embryology Authority, which governs the parts and processes of reproduction when it is assisted. Such legislation thus extends the jurisdiction of the unborn established by previous abortion legislation. Reproduction has also become more 'public' in the form of the commoditisation of reproductive services and reproductive tissues, which are now part of a global market. Finally, reproduction has become more 'public' in having become the object of a rapidly expanding international scientific community dedicated to the study of 'human fertilisation and embryology'.

All of these developments have provided the occasion for the emergence of widespread public debate of reproduction, such as that described in this Chapter. In all of these senses, reproduction is increasingly defined as part of the public domain, rather than as a largely private matter. The lengths to which public morality or the

'public good' is seen to be in need of being upheld on the terrain of women's bodies is most dramatically illustrated in cases of forced caesarian section and the incarceration of pregnant women drug abusers in the United States. Such measures, upheld by criminal sanction, bear witness to the unique dilemma of 'a conflict of interest' between two 'individuals' who inhabit the same body. The appointment of lawyers to represent the unborn, and the establishment of government regulatory bodies devoted, in part, to the protection of the rights and status of the unborn herald an unprecedented degree of public concern over unborn human life.'[11]

The most significant immediate implications of these changes in the politics of reproduction concern abortion. There is an obvious legal contradiction in affording legal protections to embryos up to fourteen days, as established by the Human Fertilisation and Embryology Act, and then again at 20 weeks gestation, at which point abortion laws resume protection of the fetus. The intervening 18 weeks of pregnancy thus acquire a kind of liminal semi-regulated status that is bound to be subject to increased scrutiny. That abortion is increasingly under attack both in Europe and America is particularly worrying given the rapid pace of scientific innovation in the field of human gene 'therapy'. Deemed an experimental research procedure by a recent Committee of Inquiry in Britain'[12], the prospect of genetically modified embryos being reimplanted in a woman's body for gestation raises unprecedented dilemmas in terms of the ethics of research involving human subjects. Quite simply, who is the human subject of this research? Is it the modified embryo? Or is it the woman in which it has been

implanted? When there are two human subjects inhabiting the same body, how are their respective interests to be equally protected?

The prospect of increasingly radical experimental techniques being conducted *in vivo*, at a time when women's access to legal abortion is diminishing might seem an inescapably obvious concern. To the contrary, however, such concerns have received negligible recognition within public debate. While feminists are busy producing increasingly sophisticated arguments concerning the new politics of reproduction, public debate, at least in Britain, appears to remain untouched and untroubled by such concerns. In the teeth of what might appear incontrovertible evidence to the contrary, eminent public figures with leading roles in current debate of these matters insist there is no connection between the technologies aimed at the generation of life and those involved in its termination.

As Carol Smart has pointed out, the development of new technologies extends not only the scope of legal jurisdiction, but the means through which legal regulation and surveillance can be realised (Smart, 1989). This is particularly true in the context of new reproductive technologies, in which medical and legal definitions of reproduction converge in ways that are mutually reinforcing. As in a kind of patriarchal exchange of powers over women's bodies reminiscent of Levi-Strauss, the law confers legitimacy upon medical scientific intervention into human fertilisation and embryology, while medical scientific technology in turn delivers new forms of surveillence and regulation, such as genetic forensic technologies, to the law. At the same time that women *become* their bodies before both medicine and the law, so

their bodies are simultaneously being rendered less 'their own' and instead part of the public domain.

Conclusion

In the context of what Ann Oakley has described as the 'over-medicalisation' (1987) of women's bodies, new legal restrictions and new medical forms of intervention can hardly be seen as an unproblematic good for women. In the context of decreasing access to safe and legal abortion in Britain and other parts of Europe, the idea that new reproductive technologies are an extension of women's reproductive choice and control is clearly false. It is for this reason particularly insidious that the experiences and choices of infertile women who opt for IVF have been championed so consistently by participants in public and parliamentary debate. That this is identified as the progressive position in the debate, as opposed to the opponents of new forms of assisted reproduction is also regrettable.

Instead of promoting 'women's interests', such representations have often been used to silence and exclude other versions, particularly feminist versions, of what is at stake for women in the domain of assisted conception. This selective valorisation of women who have chosen IVF, and who will speak with conviction on its behalf, often testifying on the basis of their own experience, can be seen to have a deeply divisive potential. It has the potential to pit women against one another, and to obscure the many common interests that are shared. It is particularly for this reason that feminists must be wary of the

evident tendency to demonise those women who both choose techniques such as IVF, and are willing to defend them.

There is a particular importance for feminism of realising the symbolic dimensions to the iconographic use of 'women's experience' of new reproductive technologies. That such imagery is not only literal but also mythic both enables a distinction between the use of 'women's experience' in public debate and women's *actual* experience of IVF, but also reveals another set of displacing effects, whereby arguments in the name of 'women's interests' can be revealed as the reverse. In turn, such recognitions can facilitate intermediary strategies, aimed at challenging the terms of public debate, and the selective use of certain women's 'voices' not only to exclude but to silence others.

References to Chapter Eight

1. One of the main lobbying organisations in Britain on behalf of both new reproductive technologies and embryo research is aptly named 'PROGRESS'.

2. Portions of this analysis were developed in the context of the ESRC funded study 'The Representation of Kinship in the Context of the New Reproductive Technologies' (see Franklin, in press b).

3. For a detailed analysis of recent public debate concerning abortion, see Science and Technology Subgroup, 1991.

4. See Ginsburg, 1989, for an ethnographic analysis of the abortion debate in the United States, and the power of fetal imagery as a symbolic resource in these.

5. The capacity of fetal imagery to bring about a 'conversion experience' both in pregnant women intending to abort, and among the wider population, is one of the main reasons it is used by right-to-life groups (see Ginsburg, op cit., and Petchesky, 1987).

6. This point is also important in relation to the discussion of contrasts and connections presented in Part One. The same hope as that described in the interviews is here located in a very diffferent context, giving it a different meaning.

7. For this reason, many feminists are sceptical of the claims of scientists and clinicians to be merely 'helping women'. Many feminists argue that IVF was itself first designed as a research technique (see Edwards and Steptoe, 1980) and only fortuitously had the potential to 'help' women.

8. 'Gene therapy', for example, may in the future be a more common use of IVF than infertility treatment. This will be accomplished by modifying the genes of the embryo between fertilisation and transfer while it is out of the body.

9. See Jacobus, 1990 and Warner, 1976 for discussions of religious imagery which are highly relevant to the context of IVF.

10. The emphasis upon the importance of beliefs about conception to cultural constructions of cosmology is a subject of longstanding anthropological concern. See, for example, Malinowski, 1929.

11. Barbara Duden argues it is life itself which has become fetishised and by which the woman is displaced. 'Women are eclipsed by something entirely new, LIFE', she writes (Duden, forthcoming, p. 1).

12. The *Report of the Committee on the Ethics of Gene Therapy* was published in January of 1992 (Cm 1788). It states there are no new ethical issues arising out of gene therapy, which it compares to organ transplants. Such a position has particularly worrying implications for

reproductive rights, especially in the context of Duden's observation cited above.

CHAPTER NINE

Conclusion:

The Representational Politics of Reproduction

As noted in Chapter One, the overall structure of this thesis derives from the connecting argument which emerged over the course of this study. Although this thesis combines an ethnographic approach to the experience of IVF with the representation of IVF as part of public culture, it does not seek to contrast the 'reality' of the experience of IVF against its representation in various other domains. Such a view is reductive of both experience and representations. It effects a dichotomisation of phenomena into those which are seen to be 'true' and those which are regarded as mere apprearences or distortions. It is thus based on an assumption which can be highly problematic in terms of political strategies, authorising as it does those who 'speak the truth' above others, who are seen as misled, deluded, or unfaithful.

For these reasons, the thesis is structured in such a way as to enable each domain to be analysed not only on its own terms, but also as a context for others. The 'truth' of IVF is represented here as both multiple and contradictory: one that is not easily reduced to slogans or established political certainties. 'IVF' is presented as a contested domain, a technology which has become a site of uncertainty. This is evident in a variety of contexts, through which many different struggles -- over meanings, values and, above all, futures and hopes -- are being

waged. From its most literal, decontextualised meaning (fertilisation in glass) to its most abstract cultural connotations (scientific progress), 'IVF' makes different kinds of sense in different contexts. In the different locations in which its meaning is culturally produced and defined -- in which IVF is negotiated, lived, embodied, celebrated and decried -- there exists a contested diversity of understandings of this technique and its implications.

The aim in this thesis has been to chart some of these processes of making sense of IVF, both in terms of the specific representational practices through which they are each constituted, and in terms of how they serve as meaningful contexts for eachother. Hence, an analysis of how the technique is lived and embodied (Part Three) is set in the midst of Chapters addressing the ways in which it is represented in public culture (Parts Two and Four). Similarly, the focus in Part Three on women who have chosen to undertake IVF stands in contrast to the discussion in Part One of feminist critiques of the technique. Although all these dimensions variously overlap, coincide and intertwine, they do not do so systematically, for example, hierarchically. Indeed, there is a sense in which 'IVF' means quite different things in each of these contexts, as is perhaps most notably evident in the contrasts between popular and parliamentary representations of 'women's experience of IVF' and those of women undergoing the technique.

In analysing each of these contexts, an attempt has been made to foreground the representational practices through which IVF is constructed differently in different contexts. There are several reasons for this, which have been outlined earlier. An important aim has been to shift the grounds of political intervention to the terms of

through which both 'IVF', and by extension 'the new reproductive technologies', and 'women's experience' of these have been constructed. The shift, in other words, has been away from the 'truth of IVF', the 'reality of women's experience', or the problematic construct of 'women's interests' and towards a politics of representation through which different kinds of interventions can be realised.

By 'the politics of representation' should not be understood an exercise in relativity. It is essential to appreciate, for example, the extent to which some representational domains are more authoritative than others. The representation of 'women's experience of IVF' in Parliament, through which the legitimacy of the technique was established by the State, cannot be considered as simply one domain amongst others. The voices within each of these contexts are not equal. Some are more powerful than others; some cannot be 'heard' at all without the amplification, and thus mediation, necessary to represent them in a public context, such as those of women undergoing IVF. Some can represent themselves within public contexts but are unequally positioned within them, such as feminists. In contrast, both the media and Parliament are institutionally established within the public sphere, by definition instantiated in and through a representational apparatus altogether different from that avaiable to feminists or women seeking infertility services.

However, this is precisely the point of an exercise aimed at elucidating the means through which the terms of public understanding and public debate are set. *It is from this point of view that the politics of representation becomes most forcefully apparent.* If the politics of reproduction at stake in the development of new procedures

such as IVF is reduced to the question of whether they are 'truly' in 'women's interests', or not, there are only limited strategies available. If, however, this question is expanded to encompass the way in which the terms of the debate are set, the technique is made meaningful, and publicly 'legitimate', then a much wider range of contestations, not all of which are tied to a unified concept of 'women's interests', becomes possible. To do this, however, it is necessary to clarify in more detail what is meant by a representational politics of reproduction.

This phrase does not denote an evaporation of 'reality' into 'representativeness'. Such a dichotomy, like that between objectivity and relativity, is itself a product of the former term, by which the second is defined as an absence. Both dichotomies are thus themselves representations which effect a particular view, which can suffice to demonstrate the important difference between a representation in the sense of a reflection, and in the more active sense of production. Likewise, representations of 'IVF' or of 'women's experience' do not merely reflect with greater or lesser accuracy the 'reality' of the technique, but are themselves the mechanisms through which their meanings are produced, constituted and reconstituted. *Re*-presentation should be seen as such: as the opposite of duplication.

To achieve what Haraway has described as a 'political semiology of representation' (1992, p. 313), this thesis has examined four main representational fields. In each of these, representations of 'IVF', and in particular of 'women's experience' of it, have been analysed as productive and instrumental. In each field, both the technology and women's relationship to it are seen to be differently constituted in

relation to particular aims and goals. Representations have thus been seen not only as practices, but as practical -- as means or instruments in relation to interests and values. Representations have themselves been seen as enabling technologies in this respect, aimed at effecting particular ends.

Part One introduced feminist representations of IVF, and women's relationship to it, which are seen as extensions of a particular history of patriarchal control over reproduction. In this view, women's encounter with IVF is seen as a particularly overdetermined instance of reproductive politics, raising questions about the extent to which women can enable themselves by means of a technology that is so demonstrably enmeshed in a long history of male-medical management of women's reproductive capacity. Part Two introduced a very different set of representations drawn from popular media sources which could be seen to conform to formulaic conventions through which the technique of IVF was both normalised and legitimated. Also evident in these accounts was a particular construction of women's encounter with IVF, largely framed in terms of women's hopes and desires in relation to the technique. Part Three explored these hopes and desires in more depth using the representations provided by women undergoing IVF of their experience and of the technique. Again strong themes emerged, particularly concerning the investment of hope in IVF as a technology, and the feeling of 'having to try' the technique. Finally, a very different representation of IVF as a 'hope technology' was described in Chapter Eight, in which both IVF and women undertaking it could be seen as condensed signifiers of more general cultural investments in scientific and technological progress.

Different methods have been used throughout these Chapters to chart the representational practices at work. In Part One, a literature survey is used both to introduce feminist perspectives on new reproductive technologies such as IVF and to identify points of tension and uncertainty within feminist debates concerning them. In Part Two, methods from cultural studies, particularly those of narrative and discursive analysis, are used to analyse the representational conventions specific to the popular media accounts described. Part Three relies on a different form of cultural analysis, loosely described as ethnographic, in which the condensed nodes of meaning encountered in women's representations of their experience are explored. Approaches developed within cultural studies are returned to in Part Four to develop an argument concerning the ways in which 'women's experience of IVF' has been used in parliamentary and related public debate as a 'sign' of much else.

It is the argument about signifying practices developed in the latter Chapter which best articulates the concerns of the thesis as a whole, and it is in this Chapter that a particularly potent instance of the politics of representation can be seen to be at work. As noted in the conclusion to Chapter Eight, the privileging, yet simultaneous decontextualising, of 'women's experience of IVF' in parliamentary debate has a resonance which feeds back through all of the preceeding Chapters. Through an appreciation of the distinction emphasised in Chapter Eight between 'women's experience of IVF' *and how it is represented* can be discerned a potentially useful means of shifting the feminist debate out of some of the cul-de-sacs described in Chapter Two. This same distinction underscores one of the central arguments of Part

Two concerning the framing of popular media accounts of IVF with women's needs and desires, only to leave them behind in favour of a medical-technological drama. Part Three is particularly important in establishing the basis for the distinction made in Chapter Eight concerning experience and its representation. These Chapters thus work together precisely by demonstrating how differently IVF and its experience are constituted within different representational contexts. Again, it is the contrast between these Chapters which enables each domain to be seen both on its own terms and as a context for the others.

In surveying these different domains, a range of representational practices have been examined. An appreciation of this range of practices is integral to the development of a representational politics. To begin with, it is in this way that representations can be best appreciated *as practices*. Popular representations can be contrasted against politicised representations, which in turn differ from self-representations. Discursive constructions have different effects from popular narratives, just as lived understandings are represented differently from political critiques. Hence, the different domains analysed here not only comprise different representational fields or contexts, but different representational operations or mechanisms. That representational constructions are enabling, productive and constitutive, rather than mere reflections or free-floating constructions to be measured in terms of whether they are more or less accurate, is most clearly underscored by an appreciation of their instrumentality.

The necessity to contrast divergent representational fields in the aim of elucidating these points, however, is not without its shortcomings, which deserve brief mention here. A more 'thickly'

ethnographic account, for example, would have involved a follow-up study to that described in Part Three. This in turn would have provided the opportunity to more thoroughly interweave the different cultural domains presented here into a more multi-layered cultural account. Similarly, a longer history to the discussions presented in Parts Two and Four would have provided the opportunity to consider changes in the representation of IVF and women's encounters with it. Contrasting, for example, the scepticism towards, indeed outright condemnation of, 'test-tube babies' in the media of the late 70s against the benevolent representations of the late 80s would undoubtedly have contributed even more to the comparison of representational practices. Similarly, broader, or comparative, scope to the consideration of recent parliamentary and related public debate would be of considerable value in appreciating the cultural dimensions of changing public opinion towards new reproductive technologies.

All of the above dimensions would contribute to an understanding of what has been described here as a representational politics of reproduction. Already there is evidence of an increasing concern amongst feminists with this level of political contestation. Following in the wake of Ros Petchesky's (1987) compelling analysis of the use of fetal imagery in struggles over abortion in the United States, the power of visual and other imagery in the formation of public opinion has become increasingly apparent (Burfoot, 1990; Duden, forthcoming; Franklin, 1991a; Haraway, 1989, 1991, 1992; Hartouni, 1991; Jordanova, 1989; Taylor, in press). Reproduction is a particularly important domain in which to consider the politics of representation, because it is increasingly present on the public political agenda as a site of

acute and far-reaching contestation. In the context of debates about human gene therapy, for example, which can only be fully realised through the reproductive process, women are less and less in evidence as the embodied citizens through which the putative benefits of scientific progress will be realised. As reproductive conduits to a technologically enhanced future, women have simultaneously become most-valued vessels and invisible handmaids to scientific progress. As noted in the previous Chapter, it appears of little public concern that the proposal to genetically modify embryos before transferring them back to the uterus, which procedure is of unknown consequence, is contextualised by increasing restrictions to abortion rights in the United States and Britain (the two leading countries in this experimental field). The absence of concern for women's reproductive rights from discussions such as these is not merely due to their lack of representation (in both senses), but to the presence of particular constructions which displace them. Challenging the terms of this displacement, and developing the theoretical and political means to do so more effectively, will undoubtedly be increasingly important feminist strategies for change in the reproductive politics of the premillenium.

Bibliography

Andrews, Lori

1984 *New Conceptions: A Consumer's Guide to the Newest Infertility Treatments* New York: Ballantine Books

Arditti, Rita; Renate Duelli Klein and Shelley Minden

1984 *Test-Tube Women: What Future For Motherhood?* London: Pandora Press

Arms, Suzanne

1975 *Immaculate Deception*, New York: Bantam Books

Barker, Graham

1986 *The New Fertility: A Guide to Modern Medical Treatment for Childless Couples* London: Adamson Books

Bart, Pauline

1977 'Biological Determinism and Sexism: Is it All in the Ovaries?', in *Biology as a Social Weapon*, Ann Arbor Science Collective, ed., Minneapolis, MN: Burgess

Bartels, Dianne, et al, eds.

1990 *Beyond Baby M: Ethical Issues in New Reproductive Techniques*, Clifton, NJ: Humana Press

Barthes, Roland

1972 *Mythologies* (trans. Annette Lavers) New York: Hill & Wang

Baruch, Elaine, Amadeo D'Adamo and Joni Seager, eds.

1988 *Embryos, Ethics and Women's Rights: Exploring the New Reproductive Technologies*, New York: Harrington Park Press

Bellina, Joseph and Josleen Wilson

1986 *The Fertility Handbook: a Positive and Practical Guide* Harmondsworth: Penguin

Berer, Marge

1986 'Breeding Conspiracies: Feminism and the New Reproductive Technologies', *Trouble and Strife* 9:(summer):29-35

Berger, John

1972 *Ways of Seeing*, Harmondsworth: Penguin

Birke, Linda

1986 *Women, Feminism and Biology: The Feminist Challenge*, Brighton, Sussex: Wheatsheaf Books

Birke, Lynda, Susan Himmelweit and Gail Vines

1990 *Tomorrow's Child: Reproductive Technologies in the 1990s*, London: Virago Press

Bleier, Ruth

1984 *Science and Gender: A Critique of Biology and Its Theories on Women*, New York: Pergamon

Bleier, Ruth, ed.

1986 *Feminist Approaches to Science*, New York: Pergamon Press

Boston Women's Health Collective

1971 *Our Bodies, Ourselves*, New York: Simon and Schuster

Botting, Beverley, Alison Macfarlane and Frances Price

1990 *Three, Four and More: A Study of Triplet and Higher Order Births*, London: HMSO

Braidotti, Rosi

1989 'The Politics of Ontological Difference', in T. Brennan, ed. *Between Feminism and Psychoanalysis*, London: Routledge

Breeze, Nancy

1984 'Who is Going to Rock the Petri Dish? For Feminists Who Have Considered Parthenogenesis When the Movement is Not Enough', in Arditti, et al, eds., *Test-Tube Women: What Future for Motherhood?*, London: Pandora

Brighton Women and Science Group

1980 *Alice Through the Microscope: the Power of Science Over Women's Lives*, London: Virago

Brown, Lesley and John, with Sue Freeman

1979 *Our Miracle Called Louise*, London: Paddington Press

Burfoot, Annette

1990 'The Normalisation of a New Reproductive Technology', in M. McNeil, et al, eds., *The New Reproductive Technologies*, London: Macmillan, pp. 58-74

Butler, Judith

1990 *Gender Trouble: Feminism and the Subversion of Identity*, New York: Routledge

'By a Correspondent'

1986 'Childless Couples Given Hope By Sperm Process', *The Guardian*, May 12

Cannell, Fenella

1990 'Concepts of Parenthood: the Warnock Report, the Gillick Debate, and Modern Myths', *American Ethnologist* 17:4:667-686

Carter, E. O., ed.

1983 *Developments in Human Reproduction and their Eugenic and Ethical Implications*, London: Academic Press

Chadwick, Ruth, ed.

1987 *Ethics, Reproduction and Genetic Control*, London: Routledge

'*Choice* Reporter'

1987 'New Hope for the Childless' *Birmingham Choice*, March 20

CIBA Foundation

1986 *Human Embryo Research: Yes or No?*, London: Tavistock

Cohen, Sherrill and Nadine Taub, eds

1989 *Reproductive Laws for the 1990s*, Clifton, NJ: Humana Press

Collier, Jane; Michelle Rosaldo & Sylvia Yanagisako

1982 'Is There a Family: New Anthropological Views' in Thorne, ed. *Rethinking the Family: Some Feminist Questions* New York: Longman, pp. 25-39.

Corea, Gena

1977 *The Hidden Malpractice*, New York: Harper & Row

1985 *The Mother-Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs* New York: Harper & Row

Corea, Gena, et al (eds)

1985 *Man-Made Women: How the New Reproductive Technologies Affect Women*, London: Hutchinson

Coward, Rosalind

1988 *The Whole Truth*, London: Pluto

Crowe, Christine

1985 '"Women Want It"; In Vitro Fertilisation and Women's Motivations for Participation', *Women's Studies International Forum* 8:547-552

Cunningham, Anne

1988 'Test-tube Boy for Thrilled Parents' *Birmingham Daily News*, March 29, page 1

Daly, Mary

1978 'American Gynecology: Gynocide by the Holy Ghosts', in *Gyn/ecology: the Metaethics of Radical Feminism*, Boston: Beacon Press, pp. 223-293

Davis, Elizabeth Gould

1971 *The First Sex*, New York: Putnam

Davitz, Lois

1984 *Baby Hunger: Every Woman's Longing For A Baby* Minneapolis, MN: Winston Press

De Beauvoir, Simone

1974 *The Second Sex* (trans. H M Parshley), New York: Knopf (1949, Librarie Gallimard)

Department of Health and Social Security

1986 *Legislation on Human Infertility Services and Embryo Research: A Consultation Paper*, London: HMSO (Cm 46)

1987 *Human Fertilisation and Embryology: A Framework for Legislation*, London: HMSO (Cm 259)

Diner, Helen

1973 *Mothers and Amazons: The First Feminine History of Culture*, New York: Doubleday

Donchin, Anne

1989 'The Growing Feminist Debate over the New Reproductive Technologies', *Hypatia* 4(3):136-149

Donnison, Jean

1977 *Midwives and Medical Men: a History of Interprofessional Rivalries and Women's Rights*, New York: Schocken Books

Downie, Susan

1988 *Baby Making: The Technology and Ethics*, Oxford: Alden Press

Dreifus, Claudia, ed.

1977 *Seizing Our Bodies: the Politics of Women's Health*, New York: Vintage

Duden, Barbara

forthcoming *The Public Fetus* (extracted in *Science as Culture*, no. 15, 1992)

Dunstan, Gordon, ed.

1990 *The Human Embryo: Aristotle and the Arabic and European Traditions*, Exeter: University of Exeter Press

Dunstan, Gordon and Mary Sellers, eds.

1988 *The Status of the Human Embryo: Perspectives from Moral Tradition*, London: King Edward's Hospital Fund for London

Easlea, Brian

1980 *Witch-Hunting, Magic and the New Philosophy; An Introduction to the Debates of the Scientific Revolution 1450-1750*, Brighton, Sussex: Harvester Press

1981 *Science and Sexual Oppression: Patriarchy's Confrontation with Women and Nature*, London: Weidenfeld and Nicholson

Edwards, Robert

1989 *Life Before Birth: Reflections on the Embryo Debate*, London: Hutchinson

Edwards, Robert and Patrick Steptoe

1980 *A Matter of Life*, London: Hutchinson

Ehrenreich, Barbara & Deirdre English

1973a *Witches, Midwives and Nurses: A History of Women Healers* Old Westbury, New York: The Feminist Press

1973b *Complaints and Disorders: The Sexual Politics of Sickness* Old Westbury, New York: The Feminist Press

1978 *For Her Own Good: 150 Years of the Expert's Advice to Women*, New York: Doubleday

Engels, Frederick

1972 (1942) *On the Origins of the Family, Private Property and the State*, New York: International Publishers

Faludi, Susan

1991 *Backlash: The Undeclared War Against American Women*, New York: Crown Publishers

Fausto-Sterling, Anne

1985 *Myths of Gender: Biological Theories About Women and Men*, New York: Basic Books

Fee, Elizabeth

1981 'Is There a Feminist Science?', *Science and Nature*, 4:46-57

Fishel, S and E M Symonds, eds.

1986 *In Vitro Fertilisation: Past, Present, Future*, Oxford: IRL Press

Ford, Norman

1988 *When Did I Begin?: Conception of the Human Individual in History, Philosophy and Science*, Cambridge: Cambridge University Press

Foucault, Michel

1973 *The Birth of the Clinic* (trans. A. M. Sheridan) London: Tavistock

1976 *The History of Sexuality: Volume One* (trans. Robert Hurley), Harmondsworth: Penguin

1977 *Discipline and Punish* (trans. Alan Sheridan) London: Allen Lane

1980 *Herculine Barbin* (trans. Richard McDougall) Brighton: The Harvester Press

Franklin, Sarah

1987 'Select Bibliography', in Spallone and Steinberg, eds., *Made to Order: the Myth of Reproductive and Genetic Progress*, London: Pergamon

1990a 'Deconstructing "Desperateness": The Social Construction of Infertility in Popular Representations of New Reproductive Technologies', in M. McNeil, et al, eds. *The New Reproductive Technologies*, London: Macmillan

1990b 'Redefining Reproductive Choice: The Changing Landscape of Reproductive Politics in the Context of the New Reproductive Technologies', paper presented at the London School of Economics

1991a 'Fetal Fascinations: New Dimensions to the Medical-Scientific Construction of Fetal Personhood', in Franklin, Lury and Stacey, eds., *Off- Centre: Feminism and Cultural Studies*, London: Harper Collins, pp. 190-206

1991b 'Postmodern Procreation', paper presented at Symposium 113 of the Wenner-Gren Foundation for Anthropological Research, Terrosopolis, Brazil (forthcoming in Ginsburg and Rapp, eds, *The Politics of Reproduction* and *Science as Culture*, no. 15)

1991c 'A Miracle Called Louise: Visual and Narrative Dimensions of Assisted Conception', paper presented in the Department of Social Anthroplogy, University of Manchester

in press a 'Making Sense of Misconceptions: Anthropological Perspectives on Unexplained Infertility', in M. Stacey, ed., *Changing Human Reproduction: Social Science Perspectives*, London: Sage

in press b 'Making Representations: Parliamentary Debate of the Human Fertilisation and Embryology Bill', in J. Edwards, et al, *Procreation: Kinship in the Context of Assisted Conception*, Manchester: Manchester University Press

Franklin, Sarah, Celia Lury and Jackie Stacey

1991a 'Feminism and Cultural Studies: Pasts, Presents and Futures', *Media, Culture and Society*, 13:2:171-93

1991b 'Feminism, Marxism, Thatcherism', in Franklin, Lury and Stacey, eds., *Off-Centre: Feminism and Cultural Studies*, London: Harper Collins, pp. 21-49

Franklin, Sarah and Maureen McNeil

1988 'Reproductive Futures: Recent Feminist Debate of New Reproductive Technologies', *Feminist Studies* 14:3:545-574

Fraser, Nancy and Linda Nicholson

1988 'Social Criticism Without Philosophy', *Theory, Culture and Society*, 5:2-3:373-94

Fried, Marlene

1990 *From Abortion to Reproductive Freedom: Transforming a Movement*, Boston: South End Press

Gallagher, Janet

1985 'Fetal Personhood and Women's Policy', in Sapiro, ed., *Women, Biology and Public Policy*, Beverley Hills, CA: Sage Publications

1987 'Eggs, Embryos and Foetuses: Anxiety and the Law', in Stanworth, ed., *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge: Polity Press

Garcia, Jo, Robert Kilpatrick and Martin Richards, eds.

1990 *The Politics of Maternity Care*, Oxford: Clarendon Press

Glass, Robert & Ericsson, Ronald

1982 *Getting Pregnant in the 1980s; New Advances in Infertility Treatment and Sex Pre-Selection*, Harmondsworth: Penguin

Glazer, Ellen and Susan Cooper

1988 *Without Child: Experiencing and Resolving Infertility*, Lexington, MA: Lexington Books

Glover, Jonathan, et al

1989 *Fertility and the Family: the Glover Report on the New Reproductive Technologies* (Report commissioned by the European Commission), London: Fourth Estate

Gordon, Linda

1974 *Woman's Body, Woman's Right: A Social History of Birth Control in America* Harmondsworth: Penguin Books

Griffin, Susan

1978 *Woman and Nature: the Roaring Inside Her*, New York: Harper and Row

Grobstein, Clifford

1981 *From Chance to Purpose: An Appraisal of External Human Fertilisation*, Reading, MA: Addison-Wesley

Gunning, Jennifer

1990 *Human IVF, Embryo Research, Fetal Tissue for Research and Treatment, and Abortion: International Information*, London: HMSO

Haraway, Donna

1978a and b 'Animal Sociology and a Natural Economy of the Body Politic', Parts I and II, *Signs* 4:1:21-60

1981 'In the Beginning was the Word: the Genesis of Biological Theory', *Signs* 6:3:469-81.

1983b 'Signs of Dominance: From a Physiology to a Cybernetics of Primate Society', *Studies in the History of Biology* 6:129-219

1983b 'The Contest for Primate Nature: Daughters of Man the Hunter in the Field', in M. Kann, ed., *The Future of American Democracy*, Philadelphia, PN: Temple University Press, pp. 175-207

1985 'A Manifesto for Cyborgs: Science, Technology and Socialist Feminism in the 1980s', *Socialist Review* 15:2:65-108

1989 *Primate Visions: Gender, Race and Nature in the World of Modern Science*, New York: Routledge

1991 *Simians, Cyborgs and Women: the Reinvention of Nature*, London: Free Association Books

1992 'The Promises of Monsters: A Regenerative Politics for Inappropriate/d Others', in Grossberg, Nelson and Treichler, eds., *Cultural Studies*, New York: Routledge, pp. 295-357

Harding, Sandra

1986 *The Science Question in Feminism*, Ithaca, New York: Cornell University Press

Hartmann, Betsy

1987 *Reproductive Rights and Wrongs*, New York: Harper and Row

Hartouni, Valerie

1991 'Containing Women: Reproductive Discourse in the 1980s', in Penley and Ross, eds., *TechnoCulture*, Minneapolis, MN: University of Minnesota Press

Henifin, Mary Sue and Joan Cindy Amatniek

1982 'Bibliography: Women, Science and Health' in Hubbard, Henifin and Fried, eds., *Biological Woman: the Convenient Myth*, Cambridge, MA: Schenckman Publishing Co.

Herschberger, Ruth

1970 *Adam's Rib*, New York: Harper and Row (originally 1948)

Hirsch, Marianne and Evelyn Fox Keller, eds.

1990 *Conflicts in Feminism*, New York: Routledge

Holmes, Helen, Betty Hoskins and Michael Gross, eds.

1980 *Birth Control and Controlling Birth: Woman-Centered Perspectives*, Clifton, NJ: Humana Press

1981 *The Custom-Made Child?: Woman-Centered Perspectives*, Clifton, NJ: Humana Press

Holmes, Helen and Tjeerd Tymstra

1987 'In Vitro Fertilisation in the Netherlands: Experiences and Opinions of Dutch Women', *Journal of In Vitro Fertilisation and Embryo Transfer* 4:2:116-123

Homans, Hilary, ed.

1986 *The Sexual Politics of Reproduction*, Aldershot: Gower

Hopkins, Ellen

1992 'Tales from the Baby Factory', *New York Times Sunday Magazine*, 15 March, pp. 40-41; 79-84; 90

Hubbard, Ruth, Mary Sue Henifin and Barbara Freid

1982 *Biological Woman: The Convenient Myth*, Cambridge, MA: Schenckman Publishing Co.

Hubbard, Ruth and Marian Lowe, eds.

1979 *Genes and Gender II*, New York: Gordian Press

Interim Licensing Authority

1989 *IVF Research in the UK: A Report on Research Licensed by the Interim Licensing Authority (ILA) for Human In Vitro Fertilisation and Embryology 1985-9*, London: Interim Licensing Authority

1990 *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology*, London: Interim Licensing Authority

1991 *The Sixth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology*, London: Interim Licensing Authority

Jacobus, Mary

1990 'In Parenthesis: Immaculate Conceptions and Feminine Desire', in Jacobus, Keller & Shuttleworth, eds., *Body/Politics: Women and the Discourses of Science*, New York: Routledge, pp. 11-28

Jacobus, Mary, Evelyn Fox Keller and Sally Shuttleworth, eds.

1990 *Body/Politics: Women and the Discourses of Science*, New York: Routledge

Johnson, Richard

1983 'What is Cultural Studies Anyway?', Stencilled Paper no. 74, Centre for Contemporary Cultural Studies, University of Birmingham

Jordanova, Ludmilla

1980 'Natural Facts: a Historical Perspective on Science and Sexuality', in MacCormack and Strathern, eds., *Nature, Culture and Gender*, Cambridge: Cambridge University Press, pp. 42-70

1989 *Sexual Visions*, London: Routledge

Keller, Evelyn Fox

1983 *A Feeling for the Organism: the Life and Work of Barbara McClintock*, W H Freeman: San Francisco

1985 *Reflections on Science and Gender*, New Haven, CT: Yale University Press

Klein, Renate, ed.

1989 *Infertility: Women Speak Out About Their Experiences of Reproductive Medicine*, London: Pandora Press

Klein, Renate and Robin Rowland

1989 'Women as Test-Sites for Fertility Drugs: Clomiphene Citrate and Hormonal Cocktails', *Reproductive and Genetic Engineering* 1:3:219-237

Koch, Lene

1990 'IVF: an Irrational Choice?', *Reproductive and Genetic Engineering*, 3:225-232

Laqueur, Thomas

1986 'Female Orgasm, Generation, and the Politics of Reproductive Biology', *Representations* 14:1:1-82

1990 *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge, MA: Harvard University Press

Lasker, Judith and Susan Borg

1989 *In Search of Parenthood: Coping With Infertility and High Tech Conception*, London: Pandora (US edition, 1987)

Leonardo, Micaela di

1987 'The Female World of Cards and Holidays: Women, Families and the Work of Kinship', *Signs* 12:3:440-453

Liebowitz, Lila

1978 *Females, Males, Families: a Biosocial Approach*, North Scituate, MA: Duxbury Press

Lorber, Judith

1987 'In Vitro Fertilisation and Gender Politics', *Women and Health* 13:117-33

1988 revised version of above in Baruch, D'Adamo and Seager, eds., *Embryos, Ethics and Women's Rights: Exploring the New Reproductive Technologies*, New York: Harrington Park Press, pp. 117-126

1989 'Choice, Gift or Patriarchal Bargain?: Women's Consent to In Vitro Fertilisation in Male Infertility', *Hypatia*, 4:3:23-34

Lovenduski, J and J Outshoorn, eds.

1986 *The New Politics of Abortion*, London: Sage

Lowe, Marion and Ruth Hubbard, eds.

1983 *Woman's Nature: Rationalisation of Inequality*, New York: Pergamon Press

Mackinnon, Catharine

1982 'Feminism, Marxism, Method and the State: An Agenda for Theory', *Signs* 7:3:515-44

Malinowski, Bronislaw

1929 *The Sexual Life of Savages*, New York: Littlefield and Adams

Martin, Emily

1987 *The Woman in the Body: A Cultural Analysis of Reproduction*, Boston: Beacon Press

1991 'The Egg and Sperm', *Signs*, 16:3:485-501

Matthews, L. and G. Jones

1987 'Our Gorgeous Tiny Wonders', *Birmingham Daily News*, 3 December

McLean, Sheila, et al

1990 *Legal Issues in Human Reproduction*, Aldershot: Dartmouth

McNeil, Maureen

1991'Making and Not Making the Difference: The Gender Politics of Thatcherism', in Franklin, Lury and Stacey, eds., *Off-Centre: Feminism and Cultural Studies*, London: Harper Collins, pp. 221-241

McNeil, Maureen and Sarah Franklin

1991 'Science and Technology: Questions for Feminism and Cultural Studies, in Franklin, Lury and Stacey, eds., op. cit., pp. 129-147

McNeil, Maureen, Ian Varcoe and Steven Yearley, eds.

1990 *The New Reproductive Technologies*, London: Macmillan

McNeil, Maureen and Jackie Litt

1991 'More Medicalising of Mothers: Foetal-Alcohol Syndrome in the USA and Related Developments', paper presented at the British Sociological Association Annual Conference, Manchester

Merchant, Carolyn

1980 *The Death of Nature: Women, Ecology and the Scientific Revolution*, London: Harper & Row

Mies, Maria

1986 *Patriarchy and Accumulation on a World Scale: Women in the New International Division of Labour*, London: Zed Press

Miller, Nancy

1986 *The Poetics of Gender*, New York: Columbia University Press

Modell, Judith

1986 'In Search: the Purported Biological Basis of Parenthood', *American Ethnologist* 13:646-61

1989 'Last Chance Babies: Interpretations of Parenthood in an IVF Program', *Medical Anthropology Quarterly* 3:124-38

Morgan, Derek and Robert Lee, eds.

1989 *Birthrights: Law and Ethics at the Beginnings of Life*, London: Routledge

Morgan, Derek and Robert Lee

1991 *Human Fertilisation and Embryology Act 1990: Abortion and Embryo Research, the New Law*, London: Blackstone Press

Morgan, Elaine

1972 *The Descent of Woman*, New York: Stein and Day

Moscucci, Ornella

1990 *The Science of Women: Gynecology and Gender in England 1800-1929*, Cambridge, England: Cambridge University Press

Newbold, Anne

1987 'Joy For Baby Hope Couples', *Birmingham Daily News*, March 19, p. 1

Oakley, Ann

1974 *Housewife*, Harmondsworth: Penguin

1975 *The Sociology of Housework*, London: Martin Robertson

1980 *Women Confined: Towards a Sociology of Childbirth*, Oxford: Martin Robertson

1984 *The Captured Womb: a History of the Medical Care of Pregnant Women* Oxford: Basil Blackwell

1987 'From Walking Wombs to Test Tube Babies', in M. Stanworth, ed., *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge: Polity, pp. 36-56

O'Brien, Mary

1981 *The Politics of Reproduction*, Boston: Routledge & Kegan Paul

Ortner, Sherry

1974 'Is Female to Nature as Male is to Culture', in Rosaldo and Lamphere, eds., *Woman, Culture and Society*, Stanford, CA: Stanford University Press, pp. 67-96

Overall, Christine

1987 *Ethics and Human Reproduction: A Feminist Analysis*, Boston, MA: Unwin Hyman

Overall, Christine, ed.

1989 *The Future of Human Reproduction*, Toronto: The Women's Press

Perloe, Mark and Linda Gail Christie

1986 *Miracle Babies and Other Happy Endings: How Modern Medical Advances Can Help Couples Conceive*, New York: Rawson Associates

Petchesky, Rosalind Pollack

1984 *Abortion and Woman's Choice: The State, Sexuality and Reproductive Freedom*, Boston: Northeastern University Press

1987 'Foetal Images: the Power of Visual Culture in the Politics of Reproduction', in *Reproductive Technologies: Gender, Motherhood and Medicine*, ed. M. Stanworth, Cambridge: Polity Press, pp. 81-97

Pfeffer, Naomi

1987 'Artificial Insemination, *In Vitro* Fertilisation and the Stigma of Infertility', in M. Stanworth, ed., op. cit., pp. 81-97

Pfeffer, Naomi and Allison Quick

1988 *Infertility Services: A Desperate Case*, London: Greater London Association of Community Health Care

Pfeffer, Naomi and Anne Woollett

1983 *The Experience of Infertility*, London: Virago

Prentice, Thomson

1986 'Living in Limbo, Longing for Life', (part one) *The Times* April 8, p. 13 and (part two) 'The Test-Tube Maybe....', *The Times*, April 9, p. 10.

Price, Frances

1989 'Establishing Guidelines: Regulation and the Clinical Management of Infertility', in Morgan and Lee, eds., op. cit., pp. 37-54

in press 'Having Triplets, Quads or Quins: Who Bears the Responsibility?' in M. Stacey, ed., *Changing Human Reproduction: Social Science Perspectives*, London: Sage

Purdy, Laura, ed.

1989 *Hypatia* (Special Issue on Ethics and Reproduction), 4:3:(Fall)

Radway, Janice A.

1984 *Reading the Romance: Women, Patriarchy and Popular Literature* Chapel Hill & London: University of North Carolina Press

Rapp, Rayna

1988 'A Womb of Ones Own' (book review), *The Women's Review of Books*, 5:7:(April):9-10 (see reply by P. Spallone, *TWRB* letters page, 5:10-11:(July):4

1989 'Moral Pioneers: Women, Men and Fetuses on a Frontier of Reproductive Technology', in Baruch, et al, eds. *Embryos, Ethics and Women's Rights*, New York: Harringdon Park Press, pp. 101-116

Raymond, Janice

1984 'Feminist Ethics, Ecology and Vision', in Arditti, et al, eds., *Test-Tube Women: What Future for Motherhood?*, London: Pandora Press, pp. 427-437

1987 'Fetalists and Feminists: They are Not the Same', in Spallone and Steinberg, eds., *Made to Order: the Myth of Reproductive and Genetic Progress*, London: Pergamon, pp. 58-66

Rich, Adrienne

1976 *Of Woman Born: Motherhood as Experience and Institution*, New York: Bantam

1979 'Women and Honor: Some Notes on Lying', in *On Lies, Secrets and Silences: Selected Prose 1966-78*, New York: WW Norton, pp. 185-195

Riley, Denise

1988 *Am I That Name?: Feminism and the Category of 'Women' in History*, New York: Macmillan

Riviere, Peter

1985 'Unscrambling Parenthood: The Warnock Report', *Anthropology Today* 1:4:2-6

Roberts, Helen, ed.

1981 Women, Health and Reproduction, London: Routledge & Kegan Paul

Rosaldo, Michelle and Louise Lamphere, eds.

1974 *Woman, Culture and Society*, Stanford, CA: Stanford University Press

Rose, Jacqueline

1986 *Sexuality in the Field of Vision*, London: Verso

Rothman, Barbara Katz

1984 'The Meanings of Choice in Reproductive Technology', in Arditti, et al, eds., op. cit., pp. 23-34

1986 *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*, New York: Viking

1989 *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*, New York: WW Norton

Rubin, Gayle

1975 'The Traffic in Women: Notes on the "Political Economy" of Sex', in R. Reiter, ed., *Toward an Anthropology of Women*, New York: Monthly Review Press

Russell, Diane and N. Van de Ven

1976 *The Proceedings of the International Tribunal on Crimes Against Women*, Millbrae, CA: Les Femmes

Sapiro, Virginia, ed.

1985 *Women, Biology and Public Policy*, Beverley Hills, CA: Sage

Savage, Wendy

1986 *A Savage Inquiry*, London: Virago

Schiebinger, Londa

1987 'The History and Philosophy of Women in Science: A Review Essay, *Signs*, 12:305-332

1989 *The Mind Has No Sex?: Women in the Origins of Modern Science*, Cambridge, MA: Harvard University Press

Schneider, David

1968 *American Kinship: a Cultural Account* Englewood Cliffs, NJ: Prentice-Hall.

Science and Technology Subgroup

1991 'In the Wake of the Alton Bill: Science, Technology and Reproductive Politics, in Franklin, Lury and Stacey, eds., op. cit., pp. 147-214

Scutt, Jocelynne, ed.

1990 *The Baby Machine: Reproductive Technology and the Commercialisation of Motherhood*, London: Green Print

Seal, Vivien

1990 *Whose Choice: Working Class Women and Control of Fertility*, Manchester, England: Fortress

Sherwin, Susan

1989 'Feminist and Medical Ethics: Two Different Approaches to Contextual Ethics', *Hypatia* (special issue on Feminist Ethics and Medicine, ed. H. Holmes), 4:2:(summer):57-72

Shiva, Vandana

1988 *Staying Alive: Women, Ecology and Development*, London: Zed Press

Singer, Peter and Deanne Wells

1984 *The Reproductive Revolution: New Ways of Making Babies*, Oxford: Oxford University Press

Smart, Carol

1989 *Feminism and the Power of the Law*, London: Routledge

Snitow, Ann

1990 'A Gender Diary', in Hirsch and Keller, eds., op. cit., pp. 9-43

Snowden, Robert and Duncan Mitchell

1983 *The Artificial Family: a Consideration of Artificial Insemination by Donor*, London: Allen and Unwin

Spallone, Patricia & Steinberg, Deborah (eds)

1987 *Made to Order: The Myth of Reproductive and Genetic Progress* London: Pergamon Press

Spallone, Patricia

1989 *Beyond Conception* London: Macmillan

1992 *Generation Games: Genetic Engineering and the Future for Our Lives*, London: The Women's Press

Spelman, Elizabeth

1988 *Inessential Woman: Problems of Exclusion in Feminist Thought*, Boston, MA: Beacon Press

Stacey, Meg, ed.

forthcoming *Changing Human Reproduction: Social Science Perspectives*, London: Sage

Stanworth, Michelle, ed.

1987 *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge: Polity Press

Steinberg, Deborah

1990 'The Depersonalisation of Women through the Administration of "In Vitro Fertilisation"', in M. McNeil, et al, eds., op. cit., pp. 74-123

Strathern, Marilyn

1989 'Enterprising Kinship: Consumer Choice and the New Reproductive Technologies', paper presented at the Centre for the Study of Cultural Values, University of Lancaster

1990 'The Meaning of Assisted Kinship', paper presented at the annual Meetings of the British Association for the Advancement of Science, Swansea (forthcoming in M. Stacey, ed., op. cit.)

1992 *After Nature: English Kinship in the Late Twentieth Century*, Cambridge: Cambridge University Press

in press *Reproducing the Future*, Manchester, England: Manchester University Press

Tanner, Nancy and Adrienne Zihlman

1976 'Women in Evolution: Part 1: Innovation and Selection in Human Origins', *Signs* 1:3:585-608

Taylor, Janelle

in press 'The Public Fetus and the Family Car: From Abortion Politics to a Volvo Advertisement', *Science as Culture*, Number 15

Tilton, Nan & Todd, and Gaylen Moore

1985 *Making Miracles: In Vitro Fertilisation: A Couple's Triumph Over Infertility*, New York: Doubleday

Tobach, Ethel and Betty Rosoff, eds.

1978 *Genes and Gender I*, New York: Gordian Press

1980 *Genes and Gender III*, New York: Gordian Press

Turner, Victor

1969 *The Ritual Process: Structure and Anti-Structure*, Ithaca, NY: Cornell University Press

Van Gennep, Arnold

1909 *The Rites of Passage* (trans. Monika Vizedom and Gabrielle Caffee), London: Routledge & Kegan Paul

Voluntary Licensing Authority

1986 *The First Report of the Voluntary Licensing Authority For Human In Vitro Fertilisation and Embryology*, London: Voluntary Licensing Authority

1987 *The Second Report of the Voluntary Licensing Authority For Human* In Vitro *Fertilisation and Embryology*, London: Voluntary Licensing Authority

1988 *The Third Report of the Voluntary Licensing Authority For Human* In Vitro *Fertilisation and Embryology*, London: Voluntary Licensing Authority

1989 *The Fourth Report of the Voluntary Licensing Authority for Human In Vitro Fertilisation and Embryology*, London: Voluntary Licensing Authority

Walkowitz, Judith R.

1980 *Prostitution and Victorian Society: Women, Class and the State* Cambridge: Cambridge University Press.

Warner, Marina

1976 *Alone of All Her Sex: The Myth and the Cult of the Virgin Mary*, New York: Knopf

Warnock, Mary

1985 *A Question of Life*. Oxford: Basil Blackwell

Weeks, Jeffrey

1981 *Sexuality and its Discontents*, London: Routledge, Kegan Paul.

Walters, Williams and Peter Singer, eds.

1982 *Test-Tube Babies*, Melbourne: Oxford University Press

Williams, Linda

1988a '"It's Going to Work for Me": Responses to Failures of IVF', *Birth* 15:3:153-156

1988b *Wanting Children Badly: An Exploratory Study of The Parenthood Motivation of Couples Seeking In Vitro Fertilisation*, doctoral dissertation, University of Toronto

Winkler, Ute

1989 'He Called Me Number 27', in Klein, ed., op. cit., pp. 90-100

Winston, Robert

1989 *Getting Pregnant: The Woman's Answer Book*, London: Anaya Publishers

Wittig, Monique

1980 'The Straight Mind', *Feminist Issues*, 1:1:104-113

1981 'One Is Not Born a Woman', *Feminist Issues* 1:2:44-57

'Yorkshire Post Correspondent'

1987 'Mother's Joy Over 1000th Test-Tube Baby' *The Yorkshire Post* December 30th

Zihlman, Adrienne and Nancy Tanner

1978 'Women and Evolution: Part Two: Subsistence and Social Organisation Among Early Hominids', *Signs* 4:1:4-20

Appendix A: Interview Schedule

pseudonym	date of interview
Brown	16.12.88
Caldwell	28.2.89
Carter	3.11.88
Chadwick	12.14.88
Clarke	27.2. 89
Doyle	16.12.88
Evans	13.12.88
Flowers	3.1.89
Harding	12.12.88
Ingham	9.3.89
Ives	20.2.89
Keating	12.12.88
Levy	13.12.88
Lewis	20.2.89
Norton	21.2.89
Newton	2.3.89
Quinn	6.3.89
Quigley	21.2.89
Young	23.2.89
Yates	22.2.89

Total = 20