"Calling It A Day":

the decision to end IVF treatment

Karen Throsby

Gender Institute, London School of Economics

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Abstract

This thesis focuses on the experiences of women and couples who have undergone *in vitro* fertilisation (IVF) unsuccessfully and who have subsequently stopped treatment. The thesis is feminist in that it aims to make visible the gendered power relations within which IVF failure is experienced and accounted for. IVF is viewed here not as a neutral artefact, or the violent imposition of male power, but as a form of disciplinary technology, the experience of which is always contradictory and ambivalent.

The thesis takes a discourse analytic approach to the interview data. This approach necessarily conceptualises the participants as active, but constrained, agents in the production of meaning in relation to IVF, and the analysis seeks to identify the discursive strategies which they employ in accounting for their experiences. It is argued that those who have stopped treatment occupy an ambiguous liminal space among the dominant discourses of gender, technology and body, and that this constitutes an unusually productive location from which to think about IVF, both in terms of challenging the apparent inevitability of those discourses and creating openings for the production of new knowledges.

The analysis is organised around four key themes which emerged from the interview data: the negotiation of discourses of nature and technology; the location of IVF within consumer culture; the distribution of responsibility when treatment fails; and the seeking of resolution around the end of treatment. This thematic structure forms a platform from which to consider not only the specificities of the experience of IVF failure, but which also generates broader insights at the theoretical and conceptual level, focusing particularly on the limitations of oppositional paradigms of transgression / conformity, material / discursive, agency / constraint and theory / practice in the feminist theorising of IVF.

Contents

Declaration

The thesis as a whole is an unpublished piece of work, but parts of this analysis have been published, or submitted for publication, elsewhere. An early draft of Chapter 7 was published as an LSE Gender Institute Working Paper in November, 2001, entitled *"No-one will ever call me mummy": making sense of the end of IVF treatment.* The work on masculinity, men and IVF which appears in Chapter 6 has been developed in collaboration with Ros Gill into an article for a special issue (in press) of <u>Men and Masculinities</u>, entitled *"It's different for men": masculinity and IVF.* An article entitled *"Vials, ampoules and a bucketful of syringes": the experience of the self-administration of hormonal drugs in IVF* is in press for a special issue of <u>Feminist Review</u> on women and drugs. The article focuses on the impact of the drug regimens on the privacy of the participants, and the use of metaphors of illicit and medical injected drug use to make sense of the experience and account for it to others. This issue is touched upon in Chapter 6, but is not explored in detail. A fourth article, entitled *Negotiating "normality" when IVF fails,* is in press for a special issue of <u>Narrative Inquiry</u> on counter-culture narratives. This explores strategies of "gentle resistance" in the accounts, and draws on analysis from Chapters 4 and 7.

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Part I: Foundations

Chapter 1: Introduction

Background

Research topics are not plucked out of darkness, and every project has its own story. Originally, this was going to be a study of men and women's experiences of voluntary childlessness, prompted by my own identity as a woman who has chosen to live without children. In my late twenties and living with my partner, I was starting to be questioned with increasing regularity about our reproductive plans, especially as friends started to have children of their own. My response that I did not want or plan to be a mother was met largely with disbelief – an experience common to many voluntarily childless women[1]. Even now, everything my partner and I do seems to signify preparation for pregnancy: the two new kittens were taken as a sign that we were honing our nurturing skills; the spare room in our new house was assumed to be for a baby. But in reality, the cats are just cats, and the spare room means that we have the luxury of a study each. However, I did begin to realise just how powerful the assumption is that women will be mothers, and how awful that questioning must be for those who want to have children but are not able to, for whatever reason.

As my attention turned to infertility, and in particular, to IVF, the project began to take shape based on two fundamental observations from the literature. Firstly, women's voices are curiously absent from the mainstream debates on IVF, which tend to focus instead on embryos. There is a dissonance between this invisibility of women on the one hand, and on the other, the overwhelming focus of the treatment process on interventions into the female body. Consequently, I was interested in the ways in which women are both supremely present and curiously absent in mainstream IVF discourse.

The second key observation was that in spite of IVF's failure rate of over 80%, that failure is largely absent from popular representations of the technology, in clinic promotional literature, and in research. Treatment failure is not the only under-explored aspect of IVF. In particular, there is even less research available into the experiences of those who want to engage with IVF but are prevented from doing so, or those who would qualify as candidates for IVF and could afford the treatment, but who choose not

to engage with it. In both of these cases, research into the impact of the non-engagement with IVF on their experiences of infertility would offer an interesting perspective from which to think about the technology and its effects. But these are projects for another time, and I selected IVF failure as my focus. This decision was made in part for pragmatic reasons, in that the process of recruiting participants, although not simple[2], was more manageable within the time and budget of a PhD project. However, my primary motivation was (and remains) the striking dissonance between the prevalence of IVF failure and the absence of that failure in popular and medical representations, and, more importantly, the implications of this absence.

Introduction

In vitro fertilisation (IVF) – literally, fertilisation in glass – hit the headlines in 1978 when Louise Brown, the first baby to be conceived using the procedure, was born. In the years preceding her birth, the nascent technology had been the subject of intense debate in terms of both the ethics of the endeavour, and its practicability. The safe arrival of Louise Brown confirmed that it was indeed possible to successfully remove an egg from a woman's body, fertilise it in a petri dish and transfer it to the uterus via the cervix, resulting in a pregnancy that was capable of continuing to term. The caesarean birth was filmed, and before stitching the wound, like a magician pulling back the curtain to reveal the splendour of his trick, Patrick Steptoe, who pioneered the procedure with Robert Edwards, showed Mrs Brown's uterus to the camera to confirm the absence of fallopian tubes (Challoner 1999: 46). The miracle baby was born.

Since 1978, IVF has mushroomed into a thriving industry, and in December 2000, the Human Fertilisation and Embryology Authority (HFEA)[3] issued a press release announcing that more than 50,000 babies have been born in the UK using IVF, with an astonishing 50% of those born in the last three years[4]. However, this large increase in the number of babies being born does not reflect a dramatic increase in the live birth rates, which only increased from 12.7% to 18.2% between 1991 (when HFEA records

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[1] See, for example, Morell 1994, Campbell 1999

[2] As described in Chapter 3.

[3] The HFEA was established in 1991 to regulate IVF, donor insemination (DI) and egg, sperm and embryo storage, as well as licensing and monitoring embryo research. For a detailed discussion of the parliamentary debates which led up to the establishing of the HFEA, see Franklin 1993, Pfeffer 1993, Challoner 1999.

[4] HFEA press release, 13 December, 2000 (www.hfea.gov.uk)

began) and 1999. Instead, the increase is explained by the rise in patients undergoing treatment from 15,087 to 27,151 in the same time period[5]. IVF can be described as having entered the mainstream as a treatment for infertility, although as will be discussed in the following chapter, there are many who would question the legitimacy of the status of IVF as no longer experimental. There are currently 75[6] clinics in the UK licensed by the HFEA to perform IVF, and since approximately 80% of all treatment cycles are performed in the private sector, often at the cost of several thousands of pounds per cycle, this constitutes big business. Furthermore, the introduction of new technologies such as pre-implantation genetic diagnosis (PGD), where fertilised embryos are screened for genetic disorders, as well as the development of micro-manipulation techniques which facilitate fertilisation even where the male partner has a low sperm count, suggests that this expansion will continue.

The prevailing cultural representation of IVF locates it centrally within modernity – a seductive image of benign, rational, efficient science giving imperfect nature a helping hand. The poster family for IVF is the grateful, infertile couple cradling their "miracle" baby – what one of the interviewees in this project described as "Good Morning TV [...] – the nice little fluffy story on a pink sofa" (Graham). The image is one of the natural order restored and rests heavily on the assumption of the naturalness of reproduction, particularly for women, and the understanding of science as progressive and capable of comprehending and controlling human reproduction. This discourse is perhaps best suggested by the marketing literature of clinics performing IVF, where images of white-coated doctors and gleaming cutting-edge equipment are interspersed with soft-focused pictures of smiling babies and happy nuclear families. Arthur Frank observes a similar marketing strategy in the brochure for a new cancer treatment centre, where smiling images of people who had recovered were interspersed with shots of the medical technology. There were, however, no shots of the machinery *in use*, obscuring the arduousness and uncertainty of the treatment process itself (Frank 1995: 79)[7].

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[5] All statistics are taken from the HFEA press release. These are the most recent statistics available at the time of submission.
[6] As of 31 August, 2000 (www.hfea.gov.uk)
[7] This pattern of the before and after shot is a characteristic of cosmetic surgery (Balsamo 1999: ch.3). The work of the performance artist, Orlan, aims at undermining this erasure of the *process* of the transformation by being filmed whilst undergoing surgeries (Davis 1997; Carson 2001)

Implicit in the construction of parenthood as the natural order is the obvious corollary that those who do not reproduce remain outside the natural order. This underlies the portrayal in the media of women living without children as selfish and child-hating – characteristics that are precisely opposite those of the idealised "mother" (Morell 1994: 55). Women who are involuntarily childless often find themselves tarred with the same brush, or alternatively portrayed as objects of pity, defined by their lack of a child (Sandelowski 1993: 3). These "hopeless stories" conventionally conclude with the collapse of the marital relationship as the price to be paid for the failure to "complete" the family (Franklin 1990: 213). The assumed inevitability and necessity of motherhood for women fails to acknowledge the way in which this privileging of motherhood is not extended to everyone (Shildrick 1997: 190), as can be seen in the collective political and media hand-wringing over teenage single motherhood, for example, or the coercive use of contraceptive implants in poor black women in the US (Raymond 1993). In the context of IVF, we only have to consider the incongruity of the iconic "miracle baby" image if we substitute the conventionally white, middle class parents with two young, black teenagers, or a couple with disabilities to see the ways in which the assumed privileging of motherhood is heavily contingent. Rosario Ceballo's account of the experiences of two black women struggling with infertility highlights the extent to which dominant discourses of infertility and IVF continue to presume a white, middle class subject (Ceballo 1999).

The exclusivity of normative constructions of reproduction points to an alternative understanding of IVF not as a helping hand to the natural order, but as a fundamental threat to that order – a representation which emerges when what is achieved through technology, or is imagined to be achievable, falls outside of a particular construction of idealised motherhood. Popular perceptions of reproductive technology are more ambivalent than the iconic image would suggest (see, for example: Hirsch 1993), and these concerns find expression in the miracle baby's counterpart – the designer baby. The creation of a monster that grows beyond the control of its creators is a staple of science fiction. Mary Shelley's fictional "Creature", compiled from the body parts of stolen corpses and galvanised into life by Victor Frankenstein, is perhaps the most enduring archetype (Shelley 1818), forming a central metaphor for contemporary biotechnology debates (Turney 1998). The message taken from figures such as Frankenstein's Creature is that the further away from nature the procreative process

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moves, the greater the dangers to the individual and society[8]. A headline in the *Daily Express* puts this unambiguously: "Human Clones Will Mean the Birth of Evil"[9]. In fact, the pioneers of IVF were so afraid of the effects of public perceptions of the procedure if the first baby was "abnormal" that the couples undergoing the first experimental cycles had to agree to an abortion if the developing foetus was discovered to be malformed (Challoner 1999: 41). An example of this continuing suspicion that IVF children will be somehow marked by their unconventional beginnings can be seen in the experience of one of the participants in this study who discovered to her horror that behind her back her son was referred to as Damien (the Antichrist in *The Omen* series of horror films) among certain members of her family because he was conceived through IVF.

However, the products of reproductive technologies are not the only objects of vilification, and a key critical target in the designer baby discourse is the consumers, and specifically, the female consumers. While the desire for a child, especially for women, is judged to be natural, even morally necessary, it is also possible for that desire to be deemed dangerously out of control. The excoriation of lesbian or post-menopausal women engaging in the "unnatural" consumption of the reproductive technologies is a tabloid staple, and the nascent technologies that seem to hold the promise of even greater "deviations" such as genetic manipulation or cloning techniques receive equally short shrift. Whilst appearing at one level to shore up traditional "family values", IVF and its associated technologies is also capable of generating novel family structures, and fracturing the conventionally unitary categories of mother and father, creating new relationships which are legally and ethically without clear definition (see, for example: Andrews 1999). The unease is palpable when IVF is appropriated unconventionally, and a recent high profile case in France brought together many of these concerns, creating a story that the *Daily Mail* described as "sickeningly wrong", and which provoked many

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[8] This is, however, a contemporary distortion of the original Frankenstein story, where the Creature's "monstrous" behaviour results from social prejudice and exclusion rather than from being "primitive". In the year before writing *Frankenstein,* Mary Shelley was living in Clifton, which neighbours Bristol – a town which had thrived on the slave trade. Both Mary and Percy Shelley had participated in the fight for abolition, refusing, among other things, to eat sugar because it came from the plantations. Even though the Abolition Act was signed in 1807, ending the trafficking of slaves, domestic slavery continued well towards the end of the century, and Mary was strongly aware of a residual black population in Bristol (and elsewhere) who were subject to strong social prejudice. This was an important aspect in the construction of the social experience of Frankenstein's Creature (Seymour 2000: 137-138)
[9] *Daily Express*, 21 June, 2001

column inches of discussion in the media. The substantial media coverage offers an interesting insight into the attitudes and assumptions surrounding the use of technology for reproduction, the consumption of that technology, and some of the dilemmas it can create.

The story[10] runs that Jeanine Salomone, a 62 year old French woman, gave birth to a son, Benoit-David, who was conceived using a donor egg which was fertilised using the sperm of her 52 year old brother, Robert. Robert's sperm was also used to fertilise a second egg from the same donor, who then acted as surrogate[11] and gave birth to Marie-Cecile eight days before Jeanine gave birth to Benoit-David. The children are full brother and sister, since they have the same genetic parentage, and although they have different gestational mothers, they share the same social mother. The baby girl is also Benoit-David's half sister and his cousin; their father is also their uncle, and Jeanine is their aunt as well as being Marie-Cecile's adoptive mother, and Benoit-David's gestational mother. Because fertility treatment is illegal in France for post-menopausal women, the brother and sister went to California for treatment, passing as a married couple, paying the Californian doctor over £100,000 in total for the treatment which led to the births of the two children. The story is made even more salacious firstly by the revelation that Robert tried to shoot himself in 1996, leaving his face severely disfigured, and secondly, that the motivation they gave for wanting children was to secure an heir to their 82 year old mother's £2 million inheritance.

The newspapers almost universally observed that neither Jeanine nor Robert had ever married, or, as *The Independent* expressed it, they had "*failed* to marry" (my emphasis), marking their position as already outside of social norms. However, it was also clear who the villain of the piece was, and Jeanine was described as having "*engineered* the baby in a *scheme* with her brother"[12] (my emphasis). It was she, and not her brother, who was described in the *Daily Express* as having "sparked international outrage"[13]. *Le Monde* was cited in *The Independent* as noting her "cantankerous" nature, suggesting that "her bad temper probably brought about her brother Robert's depression which led

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[10] It is important to note that even the basic "facts" are difficult to establish from the newspaper coverage, and the basic details varied significantly in the telling.
[11] The term surrogate is highly controversial here, since the "surrogate" is actually both the biological and gestational mother of the baby.
[12] *The Times*, 21 June, 2001

him to try and kill himself in 1995"[14]. Robert's disability resulting from the suicide attempt is variously described as "partially paralysed"[15], "handicapped"[16], "disfigured"[17] and "mentally handicapped"[18]. Whatever the effects of his suicide attempt, in the newspaper articles he is constructed as a pawn in his scheming sister's machinations, and the blame is clearly laid at her door. This is a pattern of female blame that is repeated, although perhaps in less extreme circumstances, in cases taken up by the press where older women have given birth using IVF. While the female partners are criticised as selfish for risking the increased possibility of not living to see the child to adulthood, or of not having the energy to care for them, the male partners do not receive similar negative attention. In fact, older fathers find themselves congratulated for their virility, as was the case in February, 2000, when James Doohan (Scotty, from the Star Trek series) announced at the age of 80 that he was going to be a father again. The BBC could not resist trumpeting that he was preparing "to boldly go where few men of his age have gone before"[19].

It is important to remember that it is precisely the exceptional nature of such cases that catch the attention of the media, and therefore, in one sense, these extreme stories are sideshows which have little to say about the more mundane, everyday experience of IVF. However, the palpable unease and outrage when IVF is appropriated for non-conventional purposes is revealing of the power of the heteronormative reproductive standards which underpin the development and delivery of IVF. It is also significant to note that although the behaviour of Jeanine and Robert Salomone may be considered by many (including myself) to be morally questionable, they did not break any laws in creating their desired family[20], highlighting the uncontainability of IVF within conventional "family values". Furthermore, their pursuit of *genetic* parenthood is completely in line with the current emphasis on the importance of genetics. The designer baby exposes the fragility of the construction of those values as the "natural"

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[13] *Daily Express*, 21 June, 2001
[14] *Le Monde*, cited in *The Independent*, 23 June, 2001
[15] *The Times*, 21 June, 2001
[16] *Daily Express*, 21 June, 2001
[17] *The Independent*, 21 June, 2001
[18] *The Independent / Daily Express*, 21 June, 2001
[19] www.news.bbc.co.uk, 4 February, 2000
[20] They did not (technically, at least) commit fraud in allowing the assumption that they were married to continue, since they were never asked directly.

standard to which we should aspire, and puts into question the unified categories upon which those values are based.

However, what is most striking about miracle baby / designer baby representations of IVF is the fact that they are profoundly *unrepresentative* of the reproductive technologies in general, and IVF in particular, and of the experience of infertility. Firstly, IVF is an expensive procedure with limited health authority funded provision, and the poorer sections of society are therefore automatically excluded. In the US, it is estimated that two thirds of couples experiencing infertility do not seek treatment, and although black women are more likely than white women to have trouble conceiving, this is not reflected among those seeking treatment as a result of higher rates of poverty among those groups (Sandelowski 1993: 8). The dominant representations also fail to recognise the "Other Mothers" (Farquhar 1996: ch. 8), including post-menopausal women, and those who are not in a social position to conceive through heterosexual intercourse, such as lesbians or single women.

However, the problematic aspect of these representations of IVF that is of most concern in the context of this thesis is that both the miracle baby and the designer baby would not exist at all if they were truly representative of the dominant experience of IVF, which is of treatment failure. The reality of IVF is that less than 20% of all cycles started result in a live birth, and even those that are eventually successful will probably have been preceded by failure, which can occur at any stage in the process. This is particularly true for older women, whose chances of success fall away significantly as they enter into their forties. Ironically, it is the successes of IVF that have generated the ethical and moral debates in the media, the courts and the government, but little is known about the more prosaic issue of treatment failure. It is not difficult to see how IVF failure has been rendered so invisible. IVF success, unlike failure[21], is either seductively photogenic or salaciously newsworthy, and from the perspective of the clinics it is certainly not in their interests to over-emphasise treatment failure, although

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[21] An exception to this general rule was the media coverage of the Mastertons, whose failed treatment was widely reported. They had sought to use pre-implantation genetic diagnosis (PGD) to guarantee that they would have a girl, to replace the "female dimension" of their family after their only daughter had died in a fire. Refused sex selection in the UK, they sought treatment in Italy. However, the treatment produced a single embryo which turned out to be male and was given away (www.guardianunlimited.co.uk, 5 March, 2001). Unusually, failure was the focus of this story. However, it was the terms by which failure was judged that was of interest, rather than the fact that it had failed.

the law does require them to issue standardised live birth rate statistics for comparison between clinics. Furthermore, those for whom treatment fails literally drop out of the sight of the treatment providers, since they no longer attend the clinic unless they choose to seek further treatment. Consequently, as will be described in Chapter 3, this creates significant methodological and ethical dilemmas with regards to recruitment and confidentiality in conducting research, as well as, more generally, pulling the failure of treatment out of sight as a possible research topic.

The current invisibility of IVF failure has a lengthy precedent, since Mr and Mrs Brown were not the first couple to have embryos fertilised *in vitro* and implanted (see, Crowe 1990: 35). The first ever transfer of a human embryo fertilised by IVF took place in December 1971, and the first IVF pregnancy was confirmed in 1975, although this turned out to be ectopic[22] and was terminated. A second IVF pregnancy was achieved (with a different patient) shortly afterwards, but was miscarried at a very early stage . Challoner describes these precedents as "false starts" (Challoner 1999: 37). In 1977, three further women were selected for treatment. For the first woman, her successfully fertilised embryo failed to implant, and Steptoe was unable to collect an egg from the third woman to receive treatment. The second woman was Lesley Brown, and the rest, as they say, is history (Challoner 1999: ch. 3-4).

Those for whom treatment has failed are confronted with the difficult choice of whether to pursue further treatment or whether to stop, either to live without children (or the desired number of children), or to pursue alternative routes to non-biological parenthood such as adoption or surrogacy. One of the commonly reported features of the experience of IVF is of being on a treadmill from which there is no easily apparent exit point and the cyclical nature of IVF presents a persistent maybe-next-time promise. Franklin describes this as a sense of a "tentative future, a future 'on hold' until a resolution is reached" (Franklin 1997: 135). In this context, the decision to continue or discontinue treatment can be seen as one of the only elements that the couple can have a sense of control over (Monach 1993: 181). However, particularly for women, the decision to end treatment involves confronting a future without much-desired biological

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[22] The early IVF female patients had ovaries that ovulated normally, but had no fallopian tubes. In the case of the 1975 pregnancy, the embryo had implanted at the point where the remains of one tube joined the uterus (Challoner 1999: 37)

children – a life course "for which there are few role models, maps or guidelines" (Daniluk 1996: 83). Furthermore, the end of treatment is often imposed rather than chosen, and even those who can choose have to negotiate the construction of IVF success as a matter of perseverance, which effectively renders stopping treatment as simply not trying hard enough.

The decision to end treatment is not necessarily any easier for those whose families already include children, either from the same relationship or from previous relationships. Indeed, those with primary responsibility for the day-to-day care of existing children may find it harder to withdraw from treatment since their daily lives continue to revolve around child-focused activity, making closure around the promise of IVF difficult. Ironically, even those for whom treatment is successful are confronted with the decision over whether to pursue further treatment to try for another child, with the added incentive of already having been successful once.

Aims and objectives

This study takes as its focus IVF failure, the decision to end treatment, and the implementation of that decision and its consequences, and the analysis is based on a series of in-depth interviews with women and couples whose most recent cycle of treatment had been unsuccessful and had taken place at least two years previously. The study aims to explore the ways in which those people made sense of their unsuccessful engagement with IVF, and begins from three central questions:

1. What are the factors informing the decision to stop treatment?

A common assumption is that couples seeking IVF either have a baby, or they pursue treatment until negative circumstances force them to stop. This perception lies behind the only consistent media portrayal of women, and to a lesser extent, couples, for whom IVF has not been successful – that of tragic figures overwhelmed by failed marriages, financial ruin and debilitating emotional devastation. These images are frequently marshalled in support of campaigns for the more equitable provision of health authority funded treatment, but provide a salutary vision of life after IVF. It is also significant that these portrayals suggest that couples are always *forced* to end treatment, rather than *choosing* to stop, which is related to the underlying assumption that women do (and should) pursue motherhood at all costs. In this study, stopping treatment is understood

as a process, rather than a single moment, and it is assumed that different factors influencing that process will take precedence at different times. By exploring the different elements of the process and the ways in which they are used and accounted for in the interviews, the analysis aims to identify some of the broader social and cultural issues which both implicitly and explicitly have a bearing on the ending of IVF treatment.

2. How does the experience of IVF failure impact upon perceptions of the technology?
IVF can be described as a technology of hope, and the end of treatment without a baby marks the end of that hope, since IVF constitutes the "end of the line" in terms of treatment options. This research aims to explore the impact of treatment failure on the ways in which the participants evaluated the technology, and the extent to which the technology and / or its practitioners were held responsible for that failure. The research also aims to explore the ways in which treatment failure intersects with negative representations of reproductive technology as "meddling" with nature.

3. How does the experience of IVF failure impact upon the ways in which involuntary childlessness is experienced?
IVF is not a discrete event, but instead is one element of a long process of coping with infertility. Consequently, the research aims to examine the ways in which the failed technological intervention in the reproductive endeavour marks the wider experience of involuntary (biological) childlessness, and how the unsuccessful engagement with IVF impacts upon future choices and life paths. In particular, in a society that stigmatises those who live without children, the study explores the degree to which the engagement with IVF is perceived to make a life without children (or the desired number of children) more or less socially and individually acceptable.

I have argued earlier in this chapter that IVF failure has been largely excluded from research into IVF, although this is not to say, of course, that the research is entirely without precedent. Indeed, this research is informed by a number of important studies of IVF which include the issue of treatment failure. These can be divided into three key bodies of work. Firstly, there have been a number of studies of treatment failure from a psychological or counselling perspective, focusing on data collected in the course of treatment, or at the point of stopping (see, for example: Callan, Kloske et al. 1988;

Braverman 1996; Braverman 1997; Epstein and Rosenberg 1997). These studies highlight the contradictory pressures which IVF places on women and couples and the emotional and psychological stress when treatment fails. However, they draw primarily on data from counselling sessions during, in between, or immediately after treatment, and therefore offer a commentary on the decision in the short term. This study, on the other hand, aims to establish a longer term perspective that will enable the participants to reflect on the ways in which the failure of IVF has marked the experience of infertility, and on the meanings given to IVF in the light of that failure. However, as the analysis will demonstrate, many of the conflicting pressures experienced by those confronting the decision to stop do not necessarily disappear over time, and these studies are therefore useful in understanding those pressures and the trauma that IVF can generate.

The second body of literature which addresses treatment failure, although to varying degrees, is feminist studies of IVF, and particularly those which are based on personal accounts of treatment. Margaret Sandelowski includes IVF failure and the decision to end treatment as one element of her study of infertility and the transition to either biological or adoptive parenthood, although the decision to live without children is not included (Sandelowski 1993). Others include treatment failure and the end of treatment as one of a number of possible outcomes (see, for example: Franklin 1997; Becker 2000). However, problems of accessing and recruiting research participants mean that the majority of studies recruit participants directly through clinics. While this provides important and valuable insight into the process of treatment and the dynamics of the clinics (Cussins 1998), the participants' continued contact with the clinic, or with patient support organisations, often marks the continued hope of future success. This study aims to explore the experience of IVF failure once that hope of future restitution has largely gone, although as the analysis will demonstrate, even after several years, this hope for restitution rarely recedes entirely. Radical feminists writing in opposition to IVF and other reproductive technologies[23] have touched upon the issue of treatment failure and stopping treatment. However, the primary focus of this literature is to argue against IVF (and other NRTs) as a valid response to infertility, and therefore, while recognising the crisis that infertility can provoke, these feminists' primary concern is

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[23] See Chapter 2 for a discussion of these perspectives.

the pressure towards biological motherhood which confronts women with "the choice that isn't" (Kozolanka 1989). This is seen as forcing women into the engagement with dangerous, abusive, experimental and ultimately unsuccessful medical interventions.

The third body of literature which addresses IVF failure and the decision to stop is the popular advice books on infertility and IVF (for example: Neuberg 1991; Brian 1998; McGrail 1999). The issue of treatment failure is raised towards the end of these texts, either embedded as one of a number of possible outcomes (Brian 1998), or as a final chapter (McGrail 1999). These concluding chapters characteristically end on an upbeat note, highlighting the ways in which IVF can reaffirm relationships and offer resolution through having tried everything: "normal people" posits Robert Winston on the final page of his "definitive guide", "though they feel desperate at the time, come out of this feeling much better and stronger" (Winston 1999: 222). While the inclusion of treatment failure in these texts is important, its appearance as an optimistic afterthought is problematic. Conversely, IVF failure marks the opening of books on coping with involuntary childlessness and learning to live childfree (for example: Carter & Carter 1998; Lisle 1999), but again, the specific relationship between the experience of infertility and the failed engagement with IVF is not explored in these texts.

Therefore, while this thesis can be located within a growing body of literature, it is unusual for its explicit focus on treatment failure, and as such, addresses very directly an aspect of IVF which has been easily and effectively rendered invisible in the dominant representations. However, while I would argue that the disjuncture between the prevalence of IVF failure and its lack of representation provide a strong imperative for research which focuses explicitly on that experience, the primary significance of this research does not lie in the plugging of a gap in the literature. Instead, the focus on IVF failure offers an opportunity to explore those aspects of the IVF process and the context in which it is experienced that are rendered invisible by treatment success. Those who have had IVF unsuccessfully and who have since stopped treatment find themselves occupying an ambiguous liminal space between social conformity and transgression: they have tried to conceive but have been unable to; they desire children, but are no longer actively pursuing that desire; they have brought technology into the "natural" process of reproduction, but without the counterbalancing "natural" outcome of a baby. This ambiguous location emerges as a particularly dense and productive arena from

which to explore the social and cultural context within which IVF operates. In particular, this offers a rich perspective from which to explore the complex and imbricated relations between gender, technology and the body; issues of agency, resistance and conformity; and the problematic nature of theoretical splits between the discursive and the material. The significance of this research, then, is not simply in the adding of another piece to an incomplete picture, but lies in the recognition of that missing piece as the product of a particular social and cultural context which can have material-discursive[24], and often deleterious, effects on women's lives. The seeking out of ways of making sense of this context and its interaction with the specificity of the experience of IVF failure constitutes the purpose of this thesis.

Clarifying the terms

Having set out the background to the research and its main objectives, at this early juncture it is necessary to consider some of the key concepts that emerge in the analysis of these issues in order to clarify the ways in which they are being used here. This section will focus on the following key terms: the new reproductive technologies (NRTs), IVF, infertility, stopping treatment, and living childfree.

The new reproductive technologies (NRTs)

Broadly speaking, the NRTs are those technologies which either facilitate, manage or prevent reproduction. There is nothing novel about the intervention into the reproductive processes (Riddle 1997). In ancient Egypt, contraceptives made of pulverised crocodile dung and herbs mixed with honey were used to block the passage of semen (Porter 1999: 47). In the seventeenth century, herbal medicines to prevent or encourage pregnancy were well established. The juice of the herb savin (juniper) was said to work as a contraceptive or an abortificant (hence its nickname Covershame) and honeysuckle and rue were both credited with similar effects; more drastically, men were treated with emetic mixtures to "dampen their desire" and women were subjected to vaginal pessaries of ground bitter almonds and douches of camphor, castor oil and rue (Fraser 1999: 73-74). For the infertile, there was no shortage of advice[25]. In *The Ladies Companion, or The English Midwife*, written by William Sermon in 1671,

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[24] To use Jane Ussher's term (Ussher 1997: Introduction)
[25] As the analysis of the interview transcripts will show, this still remains the case, with couples frequently receiving unsolicited advice of a distinctly folklore-ish nature.

recommended treatments included powered white ginger, or, more bizarrely, "sitting over a bath in which skeins of yarn had been boiled in the water and then mixed with ashes" (Sermon, in Fraser 1999: 69).

In a contemporary context of the medical intervention in reproduction, the technologies include contraception, abortion, ante-natal testing such as amniocentesis and ultrasound scanning, the medical management of pregnancy and delivery, and the technologies of conception. These medicalised interventions into reproduction have been termed the *new* reproductive technologies, although their "newness" is questionable, since technologies such as the contraceptive pill, for example, date back to the 1960's (Oudshoorn 1994; Clarke 2000; Marks 2001) and IVF is in its third decade. In fact, Renate Klein questions whether they ever were new, claiming that they are simply part of a historical continuum of the medical interference in women's bodies (Klein 1987). In response to this, I would argue that the term NRTs remains useful because it recognises these technologies as productive of, and products of, an intersection of ideologies of science, technology, reproduction and the gendered body at a particular historical and cultural moment. Therefore, I have chosen to use the term NRTs to refer to this constellation of procedures, practices and technologies, although this is not to suggest that they constitute a completely new departure or to disconnect them from their own histories. For the purposes of this thesis, I am addressing specifically the issues raised by the conceptive technologies, and particularly IVF, but these technologies cannot be separated out easily from the others. Ultrasound, for example, plays a key role in monitoring the growth of egg follicles during the hormonal drug treatments, and is used to guide the egg collection procedure; contraception, particularly in the form of the intra-uterine device (IUD) is often implicated in the cause of fertility problems, and the use of the contraceptive pill can disguise the destructive progression of conditions such as endometriosis; where treatment succeeds, the pregnancy will continue to be monitored and intervened in if deemed necessary.

Not all of the conceptive technologies fall within the scope of this thesis, which focuses primarily on the constellation of technologies which rely upon the fertilisation of eggs outside of the body. In particular, the technology which does not fall under the IVF umbrella, and which is also potentially one of the least technological and therefore the most easily appropriated, is donor insemination (DI) – that is, where a semen specimen

is produced by masturbation, and then transferred while still fresh to a woman's vagina during ovulation (Farquhar 1996: 45)[26]. DI has a long history, dating back to 1790 (ibid.) and does not require medical intervention. A more medicalised version of DI is intra-uterine insemination (IUI), where the sperm is washed before being introduced directly via a catheter into the uterus. Neither of these procedures is considered in any depth in this thesis, although many of the women who participated in the project had undergone IUI as a preliminary stage in the technological escalation towards IVF. Although none of the participants in this study had undergone DI, having chosen, in the main, to pursue the possibility of shared genetic parenthood, donor sperm had been used in the IVF process in cases where both the male and female partners had fertility problems.

IVF

IVF is explained by Robert Winston as "the process by which egg and sperm are mixed in a small plastic or glass container outside the body and then placed in a woman's uterus after fertilisation. It usually involves the removal of eggs from the woman's ovary and the collection of sperm from her partner. The embryo, which results from fertilisation in the laboratory, is transferred to the woman's uterus about two to five days later" (Winston 1999: 1). This explanation is problematic, particularly in terms of the apparent equality of contribution by the male and female partners – an issue which will be considered in the following chapter. However, what is of interest here is that the term IVF, in centring on the moment of fertilisation, fails to even hint at the full *process* of engaging with the technology.

The fertilisation, if it occurs, is preceded by perhaps years of trying to conceive, invasive and stressful tests[27], and by several weeks of hormonal injections and scans. For some, the moment of attempted fertilisation may also have been preceded by having to take out financial loans, working extra hours to save enough money to pursue treatment or spending years on health authority waiting lists. After the embryo transfer, the process continues for the patient with a stressful two week wait, followed the task of coping with the outcome. When treatment is successful, there is the worry of pregnancy

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[26] For more discussion of DI, see, for example: Kimbrell 1993: ch.5; Saffron 1994; Farquhar 1996: ch.2; Daniels and Haimes 1998; Hogben and Coupland 2000.
[27] For a detailed description of the different testing procedures, see: McGrail 1999; Winston 1999.

loss, and the stress of ante-natal tests that could confront them with the cruel irony of having to decide whether or not to terminate a pregnancy. When treatment fails, couples have to grieve, communicate the news to others, and, in time, face the difficult decisions about what to do next. Therefore, in this thesis I make a distinction between the IVF *procedure* – the "fertilisation in glass" – and the wider IVF *process*, focusing primarily on the latter.

IVF refers specifically to the fertilisation of the egg outside of the body, and forms the basis of a proliferating number of other procedures. There are three key variations on the fertilisation process. For women with healthy fallopian tubes and where male factor fertility is not in question, GIFT (gamete intrafallopian transfer) involves the collection of eggs via laparoscopy. These are then mixed with the sperm and injected soon afterwards into the fallopian tubes before fertilisation has been confirmed. ZIFT (zygote intrafallopian transfer) is the same procedure, but the transfer to the fallopian tubes does not take place until fertilisation has been confirmed. And finally, TET (tubal embryo transfer) involves waiting until the embryo has begun to divide before transfer to the fallopian tube (Farquhar 1996: 53)[28]. All of these techniques carry an increased risk of ectopic pregnancy. Where male factor infertility is implicated, micro-manipulation techniques such as ICSI (intracytoplasmic sperm injection) can be used. In ICSI, the sperm is sucked up into a fine glass needle, then injected directly into the eggs[29]. In this study, IVF and ICSI were the two procedures most commonly used by the participants.

The final IVF-related procedure of interest here, although none of the participants in this study had undergone it, is pre-implantation genetic diagnosis (PGD). In PGD, the eggs are fertilised *in vitro*, and then the fertilised embryos are tested for particular genetic defects, such as inherited disorders. This creates the prospect of a new group of users of IVF, which until now has been targeted at those who cannot conceive and carry a child to term. PGD remains highly controversial because of the difficulties of legislating which particular disorders can be legitimately selected out, and the problems of defining what constitutes a disorder in the first place. The figure of the "designer baby" looms

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[28] Other variations on this theme include TUFT (transuterine fallopian transfer) and SHIFT (hysteroscopic intrafallopian transfer) both of which transfer the fertilised egg to the fallopian tubes via the uterus (Winston 1999: 52).

large over the debates. This is demonstrated by a recent headline in *The Guardian*[30] which trumpeted "Designer baby gets go-ahead" in response to the news that the HFEA had decided to allow a couple to use PGD to select out embryos on the basis of genetic compatibility with their seriously ill son. If treatment were successful and a baby was born as a result, blood cells from the umbilical cord would be used to treat the older sibling, who is suffering from thalassaemia (an inherited blood disorder). The high profile of this case in the media highlights the public interest and concern in these new developments and the unanticipated ethical dilemmas which they generate. Other cases have unsuccessfully fought for the right to use PGD to select a child of the desired sex. In the case of the Mastertons (see footnote 21), this caused the acronym to be misread by several newspapers, as well as Mr Masterton himself, as "pre-implantation *gender* diagnosis".

Infertility

Infertility is a concept which appears self-evident in meaning. Indeed, the HFEA does not even include "infertility" in its website glossary, and a number of self-help and advice books reviewed for this study fail to offer a clear definition (Neuberg 1991; Brian 1998; McGrail 1999; Winston 1999). Biomedical definitions are conventionally based upon a specified time period of regular unprotected intercourse without success. In the case of the HFEA, a two year time period is used[31], but self-help and advice books often advocate a year, placing greater emphasis on setting the often slow process of testing in motion sooner rather than later (Brian 1998; McGrail 1999)[32]. Elizabeth Britt notes that these arbitrary temporal boundaries defining infertility are contested by women, many of whom identify themselves as having trouble conceiving after a few months of "trying" (Britt 2001: 81). Many of her interviewees responded to this self-identified problem by keeping temperature charts in order to predict ovulation, and by beginning to make inquiries about further fertility testing and treatment. This is a pattern that was repeated by many of the participants in this study. This points to the nature of infertility not as "a static *condition* with psychosocial consequences, but as a

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[29] Winston observes that the injection is performed with a "sudden but controlled thrusting movement"!! (Winston 1999: 68). See Francoise Laborie for an exploration of the ways in which the construction of ICSI is gendered (Laborie 2000).
[30] 23 May, 2002
[31] www.hfea.gov.uk

dynamic, socially conditioned *process* whereby couples come to define their inability to bear their desired number of children as problematic and attempt to interpret and correct this situation" (original emphasis) (Greil 1991: 7). Arthur Greil's understanding of infertility is articulated specifically in relation to heterosexual couples. However, this understanding can also extend the concept of infertility as a process of self-identification to include those for whom "trying for a baby", in the sense of regular, unprotected heterosexual intercourse, is not an option. Lesbian women, gay men, and both women and men living without a partner may all be in the position of deeply desiring parenthood whilst being socially positioned to make that impossible without technological intervention. Britt describes these as the "socially infertile" (Britt 2001).

In this thesis, therefore, infertility is understood as *the active but frustrated desire for a biological child*. This definition offers two key advantages over biomedical definitions. Firstly, it opens a range of possibilities for resolution. Within the biomedical discourse, a baby is the only satisfactory resolution to infertility. Robert Winston demonstrates this clearly in his introduction, arguing uncompromisingly that "having a child brings parents a kind of immortality which childless couples may only watch with envy" (Winston 1999: viii). Denied the opportunity of "contributing to the continuity of human existence" (ibid.: xi), those experiencing involuntary childlessness are consigned within this discourse to unhappy, envious genetic death. However, if infertility is understood as the socially constructed, but unfulfilled, desire to be a parent (Shildrick 1997: 185), then resolution of that situation can take the form of not only becoming a parent, biologically or by other means, but also by living without children (Carter & Carter 1998). From this perspective, it is possible to stop identifying as infertile without having a baby. The second advantage of this perspective is that it allows for the separation of identifiable (or unidentifiable) physiological impediments to reproduction from the experience of infertility. This is important in the context of heterosexual couples, for example, where the desire for a child may not be equally shared, or where the physiological impediment in one partner may result in infertility being experienced by the other. This is particularly pertinent where male factors are implicated, since it is the female partner who then becomes the object of fertility treatment. This also

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[32] A DIY fertility testing kit for both male and female fertility is soon to become available, which could be expected to bring down the lengths of time a couple is prepared to wait, particularly if the tests indicate a problem (www.netdoctor.co.uk, 2 July , 2001)

facilitates the inclusion of the "socially infertile" for whom physiological problems may not be an issue at all, or who may be unaware of a physiological problem until long after the self-identification as infertile.

Stopping treatment

I have selected the term "stopping treatment" in a not entirely successful attempt to avoid the pejorative implications of "giving up", which renders stopping an act of weakness indicative of a pending downward spiral. Yakov Epstein and Helane Rosenberg, describing differing reactions to infertility, offer the scenario of people who "consult a gynaecologist, follow her advice about monitoring temperature and timing intercourse, and then if they don't get pregnant, *give up and become depressed*" (my emphasis) (Epstein & Rosenberg 1997: 131-2). This scenario is contrasted with the other "extreme" of "couples who constantly undertake new medical procedures, repeat cycles of the most advanced treatments, and persist until they become pregnant" (ibid.). They end with the question of what might account for the differences between "those people who *give up easily* and those who never give up" (my emphasis) (ibid.). Within this discourse, "giving up" is a personal, moral failure to fight the good fight – in this case, to continue to work towards pregnancy. Ann Woollett identified this as a feature of infertility clinic and self-help literature, where those women who made the decision to stop treatment were seen as "giving up" or "failures" who lacked commitment, rather than as people capable of making positive choices (Woollet 1996: 75). However, this also has to be balanced against the popular construction of never giving up as equally pathological.

Conventional medical discourse constitutes what Frank describes as a "restitution narrative" (Frank 1995: ch.4). The plot of the restitution narrative is of health, followed by sickness, then the restoration of health (ibid.: 77), and these stories have obvious appeal for those encountering illness, either in themselves or in others. However, implicit in this narrative is the assumption of the capacity of medical science to eventually provide a cure. The patient, then, is required to retain their faith in that capacity, and not to "give up". This can be seen in the exhortations to patients to "fight" their cancer, for example, and not to give up, as if "winning" were simply a question of trying harder (Frank 1995; Stacey 1997). The metaphors within this narrative are

distinctly militaristic[33] and extend into reproductive discourse, where the sperm that reach the egg are described as the "crack troops" (Lee 1996: 20), or in the recent delivery of septuplets at a Washington hospital, where each baby had its own "medical SWAT team"[34]. What is clear from the restitution narrative is that the hope of restitution promised by medicine crowds out other options (Frank 1995: 83). In the case of cancer, these other options might include, at a certain stage, preparing for death (and preparing others) (Kleinman 1988: ch.9). In the case of infertility (although this is not to make a direct comparison between the two), this might be contemplating living without children, or acquiring children through another route, such as adoption. For as long as the only acknowledged form of restitution for infertility is the birth of a baby, there is no positive and empowering exit route out of treatment for those for whom it does not succeed.

Consequently, "giving up" was clearly not an appropriate term to use in the context of this study, and I also rejected "abandoning" (Braverman 1997) and "withdrawing" (the term used in the working title) because of the inherent connotations of defeat. I finally settled on "stopping" or "ending" treatment, used interchangeably, simply because this suggests a degree of control over the end of treatment, although the decisiveness of the terms belies the lengthy process involved in making that transition. Therefore, "stopping treatment" should be understood as a long and complex process, rather than a single definable moment, and nor should it be understood as necessarily denoting the voluntary determination of the end of treatment, since many patients are forced to stop as a result of financial limitations, health problems, age or their partner's refusal to participate.

Living Childfree

The difficulty in locating a suitable and positive term for those living without children is a testimony to the extent to which parenthood continues to be the normative standard, particularly for women (Campbell 1999: 117). The lack implied by terms such as child*less*, living *without* children, or *non*-mothering suggests the normality of parenting from which those who are not parents must distinguish themselves. Mardy Ireland

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[33] See Martin (1998) on the use of metaphors of war and violence to describe the workings of the immune system.
[34] *The Guardian,* 26 July, 2001

argues that for as long as motherhood is perceived as the only satisfactory identity for women, then for those who do not have children "the idea of absence is always present in their lives as emptiness, rather than as generative space" (Ireland 1993: 125). The term *childfree* is an attempt to replace the negative connotations of childlessness with the recognition of the positive opportunities that living without children can bring (Carter & Carter 1998: 10).

The concept has its roots in the childfree movement of the 1970's, in a post-baby boom revolt against the "powerful postwar ideology of domesticity" (Tyler May 1995: 184), although childfree networks began emerging in the US as early as the 1960's (ibid.: 182). However, the problem with the term childfree for both voluntarily and involuntarily childless people is that it implies the absence of something that is undesirable, as in "a smoke-free environment" or "fat-free food" (Morell 1994: 21). Childfree, then, can imply that those living without children are hostile towards them, making it a highly contentious label, particularly for those whose life without children was not what they would have freely chosen. Consequently, despite its radical roots, "childfree" can be seen to "[reinforce] the dominant ideology which views mother as superior" (ibid.: 21). Furthermore, it leaves no space to accommodate the grief and sadness of those who have been unable to have their own biological children, which should not be seen as incompatible with living childfree. Similarly, just as mothers are conventionally not permitted to express ambivalence about motherhood, "childfree" is too absolute a term to allow for an expression of ambivalence in those who have chosen not to have children.

Morell's ideal solution would be to create a new word, but she also accepts that this can cause confusion among readers, and finally settles on "childless" and "not-mother" whilst recognising the political risks of those choices. I use childfree in this thesis to refer to those participants whose lives are not defined by the absence of a child, in that they are no longer pursuing IVF or any other means of becoming parents and that their lives are now moving along a trajectory that is not dependent on the anticipation of parenthood. However, it is important to note that this childfree status is subjectively determined by me, and none of the participants described themselves explicitly as childfree in the course of the interviews. Elsewhere, I use "childless" and "living

without children", although with a constant caveat regarding the political implications of those terms.

Structure

Having clarified some of the key terms that will be used throughout the thesis, before moving on, I now set out the structure of the thesis, including a brief summary of each chapter's content.

Chapter 2: A Feminist Approach to IVF

This chapter aims to locate the thesis in relation to the core bodies of literature which have informed the research and to which it aims to make a contribution. There is an extensive body of feminist literature on the NRTs – a body of work which is marked by strong ideological divides, and yet which shares a concern to centralise women in those debates. It is this placing of concerns about women at the centre that marks out feminist research into the NRTs, and as such, this thesis is identified as feminist. The chapter aims to locate the thesis within the feminist literature by exploring the range of feminist positions on the NRTs against a backdrop of writings on gender, science / technology and the body. These narratives highlight the impossibility of conceptualising IVF as a distinct entity which can be understood in isolation from the broader social and cultural context within which it operates. This points not only to the importance of contextualising IVF in order to understand its specificities, but also to the ways in which a specific focus on one aspect of IVF can illuminate that wider context. In particular, it will be argued that this focus opens up important issues around the (in)separability of the material and the discursive, the possibility of agency and resistance in the engagement with medical technology, and the multiple intersections and overlaps between conceptualisations of gender, technology and bodies, which are shown to be both produced by, and productive of, each other. The chapter concludes by outlining a feminist approach to IVF which resists a definitive acceptance or rejection of IVF in favour of an approach which can accommodate the ambivalent and contradictory nature of that engagement, and which aims to be able to speak both from and to the broader theoretical and social context.

Chapter 3: Methodology

This chapter is divided into two main sections. Leading on from the exposition in the previous chapter of the feminist approach on which the research is based, the first section sets out the epistemological basis for the research and explores the reasons why a discourse analytical approach was used in the analysis of the interview data. It is argued that discourse analysis is particularly well-suited to the task of rendering visible that which has been obscured in dominant representations because it begins from the premise that talk is always *doing* something, rather than transparently reflecting reality. By extension, this reveals the extent to which agency, however constrained, is always present in the construction of talk or texts. This is important in the context of this study, which rejects at the outset an interpretation of IVF as the exercise of patriarchal power over female powerlessness. However, the analytical focus on discourse is identified as raising several methodological problems in the context of this study, particularly in terms of the contradictions which emerge from the integration of a discourse analytic approach with empirical research. The second section of this chapter will set out how these debates played out in the research itself. In particular, this section explores how a commitment to explicitly feminist research impacted upon the interview process and the subsequent process of analysing and writing up the research, and how I attempted to resolve some of the dilemmas that arose from this commitment. Feminist theory and practice emerge from this not as opposites, but as mutually constituted facets of a reflexive and iterative process.

Chapter 4: Negotiating Nature and Technology

This chapter is the first of the four analysis chapters which form the main body of the thesis, and focuses on a tension central to the concept of reproductive technology – that of the embodiment in the term itself of that which is constructed as supremely natural (reproduction) and that which is rational and progressive (technology). This tension is resolved in the dominant discourse through the concept of "giving nature a helping hand", but this resolution collapses when treatment fails and nature cannot be helped. Furthermore, when treatment fails, in the absence of an apparently "natural" baby to counterbalance fears about technological interventions into reproduction, this technological intervention remains exposed and suspect. This chapter explores the ways in which the participants managed the contradictory discourses of nature and technology in their accounts, and highlights the primary orientation of this discursive work towards constructing the self as within the natural (and therefore, normal) domain. The

implications of these discursive strategies are considered, both in terms of the material-discursive impacts on the participants themselves, but also in terms of feminist theorising, particularly in relation to Donna Haraway's cyborg.

Chapter 5: Coping with Consumption

This chapter explores the ways in which those undergoing IVF are defined not only as medical patients, but also as consumers, regardless of whether that treatment takes place in the public or the private sectors. Consumption is an important focus for this analysis because it raises important questions about what is being consumed, and by whom, and what the implications of that consumption are when treatment fails. Furthermore, consumption is not only profoundly gendered, but it is also productive of new identities. In the case of IVF, treatment can be seen as strongly implicated in the creation of the identity "infertile", and this chapter aims to explore the identities that are produced by treatment failure. Consumption is also strongly associated in popular discourse with an individualism which does not sit easily with the normative selflessness of motherhood. However, it also offers an intelligible set of discursive resources by means of which the engagement with treatment can be normalised and the anxieties of others can be assuaged. This chapter aims to explore the ways in which the participants managed and negotiated competing discourses of consumption in relation to the engagement with IVF. It is argued that the identity of both patient and consumer in the engagement with IVF centralise the female partner as an object of public surveillance whilst locating the male partner beyond the scrutiny of others.

Chapter 6: Taking Responsibility

Following on from the conclusions of the previous chapter, this chapter focuses on the distribution of responsibility when treatment fails. It explores the ways in which it is the female partner who not only carries the burden of medical intervention throughout the treatment process, but she also performs the majority of the "work" of IVF, such as shopping for treatment, as the previous chapter discusses, organising appointments and arranging the injections. One of the consequences of this is that when treatment fails, it is the female partner who emerges as responsible, even where male factor infertility is implicated. It is argued that this is consistent with the wider social and cultural context within which IVF takes place, where reproduction is conventionally woman's work, and the female body has been constructed as inherently liable to failure. The chapter

explores the ways in which hegemonic masculinity is implicated in the construction of female insufficiency, and explores ways of making sense of the woman-blaming that emerges with shocking consistency in the interviews without recourse to a framework of female victims and male oppressors.

Chapter 7: Seeking Resolution

This chapter focuses specifically on the participants' experiences after stopping treatment, and how they are negotiating the transition out of infertility, where infertility is defined as the active desire for a child. This transition should not be seen as inevitable, and should be conceptualised as a long, non-linear process rather than an identifiable moment. In their accounts, the participants drew repeatedly on the desire to be perceived by others as fundamentally "normal", in spite of their inability to reproduce. This was achieved both by demonstrating that they had "tried everything" to become pregnant, but also that they possessed the attributes and characteristics of the "good parent", even in the absence of a child. The chapter concludes by looking at the ways in which the participants claimed and resisted the childfree life, and some of the risks that are incurred in "moving on" from identifying as infertile. The chapter concludes by considering the implications of these claims to normality for those normative categories themselves.

Chapter 8: Conclusion

This final chapter sets out the key findings of the research, the implications of the analysis for IVF policy and the delivery of treatment, and the areas of future research that this analysis opens up.

Chapter 2: A Feminist Approach to IVF

This chapter aims to locate this thesis within the bodies of literature upon which it draws and to which it hopes to contribute. While it can be argued that feminist approaches to the NRTs share a concern with centralising the experiences of women in relation to those technologies, this extensive and constantly evolving body of writing is marked by its heterogeneity. Therefore, to claim a feminist orientation for this thesis is only the first step in setting out the approach which has informed this research and analysis. In order to articulate the specificities of this approach further, in this chapter, I have set the heterogeneous feminist debates against a backdrop of three areas of research where feminist critiques and writing have proliferated: gender, science / technology and the body. In exploring the complex ways in which these fields of research intersect, it becomes possible to understand IVF not as an isolated, immutable artefact which is inherently bad (or good) for women, but as a "cultural formation" (Balsamo 1999: 96) which has been developed along a particular, but not inevitable, trajectory. Both the technologies and their effects, then, are understood here as a product of "the articulation between technologies, cultural narratives, social, economic and institutional forces" (ibid.: 162). However, while there is nothing inevitable or immutable about the reproductive technologies, the discursive practices and networks of power relations through which the technologies are constructed are persistent and powerful, constituting significant limitations to the transgressive potential of the technologies. In particular, discourses of gender, the natural inevitability of reproduction as the only fulfilling life course for women, and of scientific knowledge as benign, progressive and capable of understanding and controlling reproduction are implicated in the construction and maintenance of the current technological formations and practices.

This is not to suggest that the meaning of IVF is produced entirely in the realm of discourse to the exclusion of the material body; the body is not treated here as a natural "thing" in opposition to cultural signification, or as the blank material upon which culture is inscribed. Indeed, the exclusion of the material female body in the dominant discourses of IVF can be seen as one of its most pernicious effects. Instead, I wish to follow Balsamo in treating the body "as a site of mutually constitutive interaction between discourses *about* the body and the materiality *of* specific bodies" (emphasis in

the original) (Balsamo 1999: 163).That is to say that there is no universal female body, only bodies, whose material specificities directly impact upon the body that is produced in the interaction with culture (Grosz 1994: 191). It is argued here that the engagement with IVF is never without consequence, and that the material-discursive body will always be marked by it, even when it fails. The analysis, then, seeks out the processes by which those marks are created, sustained and resisted, and the ways they can be seen to change (and be changed) over time.

This chapter will begin by exploring what is meant by a specifically feminist approach to the reproductive technologies. The second section will consider the knowledge claims of the scientific paradigm, focusing on the scientific construction of the female body as inherently unruly, inferior to the male body, and naturally and inevitably reproductive. The section will conclude by exploring some of the feminist critiques of these dominant discourses and consider some of the ways in which feminists have approached issues of reproduction. The third section focuses on the dominant discourses of technology and explores some of the feminist responses. The fourth section concentrates specifically on feminist approaches to the NRTs, which are discussed against the backdrop of the preceding sections. The chapter concludes by outlining the key features of the approach taken in this thesis.

A Feminist Approach

The reproductive technologies are a site of profound ethical, legal and political debate, generating "ubiquitous public fascination and horror" (Farquhar 1996: 14). However, one of the most striking features of these debates is the absence of women. In the parliamentary debates which established the legislative framework for fertility treatment in the UK, it was embryos, eggs and sperm, and not women, that remained the central focus[35]. In the course of these debates, an alliance of scientists and other interested parties, pointedly titled PROGRESS, argued for the long-term benefits that would accrue from embryo research in the relief of suffering, both in terms of infertility and in the detection and possible future treatment of genetic disorders. This remains the strongest argument for the pro-embryo research lobby, and in the recent debates in the US over whether or not to permit controversial stem cell research, a parade of public

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[35] See, for example, Pfeffer 1993; Franklin 1993; Challoner 1999 for more details of these debates.

figures with direct or indirect experience of diseases such as Parkinson's, Alzheimer's and spinal injury spoke out in favour of research on this basis. Robert Winston, a leading practitioner and spokesman for the reproductive technologies, is not modest in his assessment of what this research can offer, suggesting that nothing less than the "salvation of the planet" is at stake (Winston 1999: viii). Women, however, are nowhere to be seen as actors in these scientific and policy debates.

With the embryo firmly positioned at centre stage in the debates against a backdrop of promised medical-scientific advances in the fight against disease, women are easily instrumentalised as foetal containers for the precocious embryo protagonist, or as the suppliers of eggs. Indeed, as Sarah Franklin notes, the IVF procedure itself is named after the one element of the treatment process that takes place outside of the woman's body (Franklin 1997: 105). From this perspective, women emerge as both supremely present as the objects of treatment, yet absent as active agents in that process. Sandelowski argues that infertile women are absent from conventional accounts of IVF to the point where their views seem irrelevant to health policy and are therefore "either storyless, or more typically, trapped in the wrong story – typified, for example, as selfish, desperate, damaged or easily duped" (Sandelowski 1993: 2-3). Writing of the use of military language in relation to nuclear weapons, Carol Cohn (1996) describes how the reduction of the technology to a series of acronyms that sound cute and harmless, and which trip easily off the tongue, make it difficult to keep in mind what the actual effects of the bomb potentially are, and Nora Jacobson (2000: 248) observes a similar strategy in the marketing of a new cosmetic surgery technique entitled Breast Augmentation Mammoplasty By Injection, or BAMBI, where the striking image of the harmless baby deer obscures the dangers of the surgery. In the context of IVF, this same strategy can be seen in the use of diminutive-sounding acronyms such as ICSI, or the altruism implied by GIFT. However, more generally, the delivery of IVF, as described in the previous chapter, is awash with acronyms, all of which refer to *procedures*, with no overt recognition of those whose bodies are the objects of these interventions.

Robert Winston's description of IVF, as referred to in the previous chapter, offers a striking example of the ease with which the particular experience of women in the IVF process can be disregarded:

IVF is the process by which egg and sperm are mixed in a small plastic or glass

container outside the body and then placed in a woman's uterus after fertilisation.

It usually involves the removal of eggs and the collection of sperm from her

partner (Winston 1999: 1)

Most egg collection, and particularly in an NHS context, is performed under sedation rather than a general anaesthetic. The eggs are extracted from the follicles (following intensive hormonal stimulation by daily injections) by an aspiration needle which, guided by vaginal ultrasound, is passed through the top of the vagina – a procedure during which Winston confidently asserts that "[there] is seldom any *real* pain" (my emphasis) (Winston 1999: 9). This differs sharply from the descriptions of the procedure by women who have experienced treatment, where significant levels of pain are reported to have been endured (Franklin 1997: 117)[36]. The casual alignment by Winston of the experiences of egg and sperm collection not only belies the asymmetry of those experiences, but also actively invalidates the painful experience of the female partner.

Feminist research into the reproductive technologies, then, is characterised by taking women as the focus of interest, although this takes many forms, as is described in the final section of this chapter. Choosing to focus on women does not imply that male experience is of no relevance, and nor does it imply that gendered power relations can be read simply as male power over women, since this fails to account for the ways in which men are more or less able to benefit from the advantages conferred by hegemonic masculinity (Connell 1995). Indeed, while male infertility has received some attention (Mason 1993; Imeson & McMurray 1996; Lee 1996; Webb & Daniluk 1999), the male experience of fertility treatment, particularly where male factor infertility is not implicated, has received very little research attention (although see, for example: Meerabeau 1991; Throsby & Gill, in press). Interestingly, then, men too are easily rendered invisible in accounts of IVF, although as will be described in Chapter 6, the implications of this invisibility are very different for the male partners. Therefore, while I would not support an approach which focuses exclusively on women's experiences outside of the broader context of gender relations, this research begins from the

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[36] See also Chapter 4.

understanding that the extensive and intimate intervention into, and surveillance of, the female body which IVF involves demands the centralising of women's experiences in any analysis of the technology and its effects.

Gender, Science and the Female Body

The scientific paradigm has its roots in the Enlightenment – the European intellectual movement which reached its zenith in the eighteenth century, and which claimed to mark the transition out of the dark age of superstition and ignorance into a new era of scientific rationality, reason and social justice (Gamble 2001: 223). Steve Woolgar describes the paradigmatic view of science as based on four main assumptions: firstly, that human agency is incidental to the world out there and objects in the natural world are objective and real; secondly, that scientific knowledge is determined by the actual character of the physical world; thirdly, that science is a unitary set of methods and procedures about which there is consensus; and fourthly, that science is an activity which is individualistic and cognitive (Woolgar 1996: 13). Implicit in this paradigm of knowledge as discoverable rather than produced is an understanding of science as civilising, progressive and increasingly enlightening. The march of science is represented as unstoppable, and those who try and stop it are therefore uncivilised and ignorant.

Feminist approaches towards science began to gather pace with the feminist concern in the 1970's with the lack of access for women into the conventionally male professions, including science (Wajcman 1991: 1) Efforts initially focused on recovering forgotten female scientists through the publication of biographies of women such as Rosalind Franklin and Barbara McClintock – whom Harding describes as the "women worthies" who have "made important contributions but who are ignored or devalued in the androcentric mainstream" (Harding 1991: 22). Harding also highlights the less visible contributions of women to science, in the form of the female-run salons where scientists would meet patrons, as providers of the material conditions for scientific achievement in the form of domestic labour, and as illustrators, teachers, lab technicians, data analysts and computer programmers (Harding 1991: 25-27). This recovery of forgotten women has also led to a more general focus on the participation of women, and the structural obstacles they face in entering traditionally male professions. The issue here remains one of access, and has been seen as remediable through educational opportunities,

supported by equal opportunities legislation. Within this discourse, however, science itself remains beyond criticism, and the problems are located in women, who essentially have to become more like men in order to be accommodated and to be allowed to share in the bounties of professional status (Wajcman 1991: 2).

When science itself became the focus of attention for feminists, it was "bad science" that became the critical target (Wajcman 1991: 3) – that is, that androcentricity emerges in the research process when scientists have failed to follow the well-established methodological and theoretical principles of their fields (Harding 1992: 59). At one level, this "bad science" perspective leaves intact the possibility of better science", or "science-as-usual". However, Anne Fausto-Sterling's (1992) description of the rod and frame test – a test devised to assess the visual-spatial skills that are conventionally associated with men - demonstrates the extent to which the methodological critique extends outwards to a more penetrating challenge to science. In the test, subjects have to instruct an experimenter to adjust a lighted rod against an illuminated frame until it is vertical. However, the experiment fails to take into account the power dynamics of a male investigator alone in a dark room with a female subject, or a potential lack of assertiveness in female subjects which might make them reluctant to insist on minute adjustments. Furthermore, when the test is repeated with a human figure instead of a rod and redefined as an empathetic task, gender differences in the results are erased (ibid.: 32).

This is not simply a question of methodology. Fausto-Sterling notes that the actual differences in skills have proved to be very small, with gender accounting for only 5% of the variance (ibid.: 32-33). In addition, the role of learned skill through gendered toys and play are ignored in the interpretation of difference data (ibid.: 34), and there is also a cultural variation in skill levels that correlates with the degree of freedom allowed to girls (ibid.: 35). In spite of these observations, the possibility of social factors influencing sex difference is largely ignored. Scientists, argues Tanesini, have "latched on to the hypothesis that makes difference 'natural', a fact of life that one must simply accept" (Tanesini 1999: 71), and it is from this perspective that the research agenda is determined. Therefore, it can be seen that gender bias cannot be confined to method, but extends to the interpretative framework within which the results are understood, and also in the selection of the research topic itself – in this case, the pursuit of research

which will confirm biological sex difference and a concomitant difference in particular skills which have been taken *a priori* as indicative of superiority.

In the context of this study, the ways in which science has produced sex difference is crucial to understanding the development and practice of the NRTs and their effects. The shift towards the scientific paradigm that took place as a result of the Enlightenment is marked by the Cartesian dualism of mind and body, where the body is something to be rejected as an obstacle to rationality (Shildrick 1997: 16), constructing a separation between the rational knower and the unruly, natural known. The binary pairs form a predictable pattern of greater and lesser, with each defining the other by what it is not: culture / nature; order / disorder; strong / weak; subject / object; man / woman. "Woman" is situated in the realm of the natural, or of the body, as an object , and in the case of malfunction, to be fixed (ibid.: 15).

With man positioned within the dualistic oppositions of Enlightenment thought as the rational knower, and woman as the known, the establishment of fundamental, biological differences in male and female bodies and physical capacities became a central feature of the scientific endeavour[37]. Pre-Enlightenment, male and female bodies were assumed to be essentially the same, with the female body forming an inferior, and in the case of the reproductive organs, inverted, version of the male body (Martin 1989; Lacqueur 1990; Shildrick 1997; Birke 1999). From this perspective, the ovaries are a form of testicles, and the vagina was imagined in the shape of a penis, turned inside the body. The two sets of organs are conventionally distinguished in illustrations by the presence of a fully formed child drawn in a uterus at the top of the penis-like structure (Lacqueur 1990: 88).

However, the one-sex model is not one of egalitarian interchangeability, as suggested by the description of the female body as the *inverse* of the male. Galen proposed that the male body was marked by an excess of heat, and that the female body was cool and moist. This was cited as an explanation for various aspects of (assumed) female

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[37] Schiebinger (2000: 26) credits this determined seeking out of difference to the increased need for population growth in response to rising mercantile interests, leading to a rise in the ideal of motherhood, and a re-evaluation of the female body in an attempt to buttress arguments against female participation in public life and to prove women's natural destiny for the private sphere of motherhood.

difference: their inability to produce fertile seed of their own; their underdeveloped and inverted genitals; and their inferior brains (Shildrick 1997: ch.1). The "hot-blooded male" of contemporary culture demonstrates the lingering endurance of this construction of sexual difference. It was also widely assumed that women could become men, and cases were reported of women coughing and forcing the inverted penis (the uterus) out of the body to form a penis (Birke 1999: 36), although men could not become women since "nature always tended towards the more perfect" and the male excess of heat would not allow the contraction of the organs (Lacqueur 1990: 141-2).

What the one-sex model shows us, both in illustration and in explanation, is that what is represented is independent of the actual structure of organs and what was known about how they work: "Ideology, not accuracy of observation, determined how they were seen and which differences would matter" (Lacqueur 1990: 88). In her highly entertaining collection of tales of the lives of seventeenth century women, Antonia Fraser suggests that "the biological role of the female in procreation was only *properly understood* after the invention of the microscope revealed the existence of the female 'egg' as opposed to 'seed'" (my emphasis) (Fraser 1999: 74). However, this is to accept the scientific paradigm of knowledge as objective and discoverable (or in this case, already discovered). Past knowledges within this discourse are constructed as ignorant myths, whereas scientific knowledge has the status of truth. However, contemporary scientific "truths" about the body are equally ideological in construction.

Londa Schiebinger's study of illustrations of the female and male skeletons is particularly revealing of the extent to which language and ideology both constrain and produce the seeing of differences (Schiebinger 2000). In the sixteenth and seventeenth centuries, the one-sex model of the body meant that observation of anatomical sexual differences was largely confined to external appearance and the reproductive organs, with the skeleton assumed to be interchangeable (ibid.: 28). However, when specifically female skeletons began to be drawn as representations of biological difference, illustrations showed a small skull, a narrow chest and a large pelvis, based upon culturally determined ideal-types. In 1829, the anatomist John Barclay displayed male and female skeleton illustrations alongside animal skeletons which were deemed to reflect the most distinctive features of the human skeletons (ibid.: 38). The male

skeleton was shown alongside that of a stallion[38]; the female next to an ostrich skeleton, with its wide hips and tiny skull. Strikingly, the realisation that the female head was actually proportionately bigger than the male head relative to body size did not lead to a revision of the assessment of the capacities of women. Instead, the female body was re-interpreted as child-like and primitive, since babies also have disproportionately large heads: it was incomplete growth that was now seen as responsible for relative skull size, rather than the size and potential power of the brain (ibid.: 42). This "natural" inequality and its reconfiguration formed a justificatory basis for the social inequality, and the exclusion of women from public life.

Emily Martin's work on the role of metaphor in the construction of stories of conception demonstrates that ideology remains alive and well in scientific explanations (Martin 1989; 1990; 1996; 1998). Martin describes the ways in which stereotypically gendered characteristics of passivity and activity are ascribed to eggs and sperm in accounting for the process of conception (Martin 1996). Sammy Lee provides a perfect example of this in his book about male infertility and counselling, where he describes the sperm as undergoing an "epic journey" through the female body, with only the "crack troops" – "the roughest, toughest sperm" – making it all the way to the waiting egg (Lee 1996: 20). Furthermore, in semen analysis, as well as being counted, it is subjectively analysed for quality of movement based on "how strongly and purposefully the sperm move" (ibid.: 16).

This discursive construction of ideology as scientific fact is not innocent, and the ascription of activity and task-orientation to the sperm has significant consequences in the practice of fertility medicine since it defines male fertility entirely by the capacity of the sperm to fertilise an egg. Consequently, once an egg is fertilised *in vitro*, male fertility is confirmed and the focus shifts onto the female partner. The "child" has been fathered, and it is time for the mothering to begin. This means that it is female, and not male, behaviour that is considered responsible for foetal development, ignoring the potential negative developmental impacts of male alcohol and drug abuse, or workplace exposure to pollutants (Balsamo 1999: 101-2; Daniels 2001).

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[38] Ironically, it was the presence of "female" hormones in the urine of a stallion – that most masculine of creatures – that led to the revision of the construction of sex hormones as dualistic, with male hormones generating male characteristics, and female hormones generating female ones (Oudshoorn 2000: 98).

The blaming of women and therefore the need to subject them to surveillance and discipline is well established. Grosz observes that in the context of contemporary AIDS discourse, it is women and not men who are "urged to function as the guardians of the purity of sexual exchange" by insisting on using condoms, not to protect themselves, but to stem the spread of the disease (Grosz 1994: 197). Men, here, as in the case of foetal protection, are absolved of responsibility which is designated as female. This responsibility also extends to reproduction more generally, as is evidenced by the absence of men from contraceptive discourse (Oudshoorn 2000b: 123). This contemporary construction of women as contaminants has its echoes in the Contagious Diseases Act of 1864, where women living in or around specific ports or garrisons who were *suspected* of prostitution could be arrested and forcibly examined for signs of sexually transmitted disease. If infected, they could be detained for up to three weeks and compulsorily treated. The Act was the result of fears that rising rates of infection would affect combat efficiency during the Crimean War. Similarly, more than 20,000 US women were quarantined during the first world war in order to prevent soldiers from becoming infected and therefore being "lost to the war effort" (Porter 1999: 421). The status of women here as the spreaders of disease and a threat to the national order justifies their surveillance and discipline. In the UK, a recent study showed that in London in the previous year, there had been 33,000 new cases of chlamydia in women, and 24,000 in men, prompting a call for six-monthly screening *of all women under the age of 25* for the disease[39]. The screening for chlamydia will be offered to women alongside smear testing[40], suggesting that the close surveillance of women's bodies continues.

In seeking out difference, it is the reproductive capacity of women that remains the primary site of difference. Linda Birke notes that in medical illustrations of the body, the images offer a universalised male body, contrasted against a gravid female body (Birke 1999: 67), and diagrams of the female reproductive system routinely exclude the clitoris as irrelevant (ibid.: 71). Jack Challoner is particularly reductive, identifying the ovaries as "the female sexual organs" (Challoner 1999: 2). Fausto-Sterling (2000)

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[39] www.netdoctor.co.uk, 27 July, 2001
[40] www.guardian.co.uk, 27 July, 2001

describes the way in which the two sex model is only able to cope with intersexed children by defining them as one sex or the other at birth, and then surgically altering the body to conform to that assignment. Babies are determined to be male based on whether they will be able to urinate standing up, and whether the penis will be big enough for heterosexual penetrative sex; however, a baby is designated female based on reproductive capacity (ibid.: 57). Furthermore, where babies designated female have a large clitoris, this is surgically reduced to meet medically determined cosmetic standards, regardless of the resulting loss of sensation. If the baby does not have fully functioning organs of either sex, it is more likely to be made into a girl, because of the technical difficulties of creating a penis. Fausto-Sterling cites one surgeon who jokes: "you can make a hole, but you can't make a pole", confirming the definition of the female body as empty and insubstantial (ibid.: 59). This highlights the extent to which ideology determines which treatments and technologies are developed, which in turn determines which treatments become available to patients. This is important in the context of reproductive technology, for example, where technological developments have focused on the female body, with scarcely any interventions into the male body for either contraceptive (Oudshoorn 2000b) or conceptive purposes (Laborie 2000).

The definition of women according to their reproductive capacity assumes that women want to have children, and that that desire is biological in origin, and therefore, natural and inevitable:

> *Many people experience an emotional desire to have children, which is deeper and more complex than a mere drive for sexual intercourse. This desire is so common – across all cultures – that it **must be innate** (my emphasis) (Challoner 1999: 8)*

Challoner universalises the desire to reproduce across *all* cultures with disregard for the multiplicity of meanings that reproduction has for different cultures, and for individuals within those cultures. Furthermore, by attributing the desire to reproduce to "people", he fails to make a distinction between the construction of male and female reproductive motivations and the differential attribution of reproductive desire. In the context of contemporary western culture, it is women who are attributed with the innate, hormonally fuelled drive to reproduce, regulated by the biological clock.

The biological clock is constructed as a strictly female phenomenon, since it is women's and not men's reproductive capacity that is perceived to be imperilled by the march of time. However, the audible ticking which is presumed to correlate with the winding down of female fertility is constructed as beginning well over a decade, or even two decades, before the menopause. In medical terms, a woman is a "geriatric mother" even in her 30's. Furthermore, similar "drives" to reproduce at either end of the "natural" reproductive period are discredited as selfish, irresponsible and misguided, with both teenage motherhood (Aarvold 1998) and older maternity (Henriksen and Heyman 1998) perceived as beset with physical and social risks. Reproductive normality is also situated firmly in a heteronormative context and within conventional reproductive discourse, the lesbian mother is "a monstrous hybrid creature which threatens the ideological basis upon which society is structured" (Sourbut 1996: 228; Allison 1998). This is reinforced by the legislative framework for the reproductive technologies, and the Warnock Report (Warnock 1984), upon which the UK legislation is based, clearly affirms a belief "that it is better for children to be born into a two-parent family with both father and mother" (ibid.: 11). When in August 2001, Dr Antinori, an Italian fertility specialist announced that he was ready to clone humans by the end of the year, he justified his plans on the grounds that it will "give infertile men the chance to be a father"[41] in order to give legitimacy to the procedure, even though this is precisely the procedure that would enable the realisation of gynogenesis, as imagined by Sourbut (1996).

Ironically, the constructed "sacred calling" (Rich 1977: 43) of motherhood is something of a poisoned chalice, even for those who fall within the normative standards. The pregnant body, whilst represented as the natural state for women, is also an object of fear and disgust, as the response to the now infamous picture of a heavily pregnant Demi Moore on the cover of Vanity Fair in 1991 demonstrates. Showing her posing naked but for some diamond jewellery, the cover provoked raging controversy, and generated 95 television items, 64 radio shows, 1,500 newspaper articles and a dozen cartoons. Some news stands refused to carry the issue; others wrapped it in brown paper, signalling its pornographic status (Stabile 1994: 84).

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[41] www.netdoctor.co.uk, 8 August, 2001

The pregnant body represents the leakiness and uncontrollability of the female body, and confusion of bodily boundaries implicit in pregnancy (Shildrick 1997). This highlights the fundamental contradiction in the location of the woman primarily in the biological, reproductive body which is the object of medical observation and intervention and the construction of the female body as uncontainable, leaky and beyond control (ibid.: 27). Ann Dally, a doctor herself, reinforces this message in her history of surgery on women when she describes gynaecology as "messy and smelly" (Dally 1991: 27). Reproduction, then, is both an act of natural order, but also of disorder. This fear of the messiness of the female body is clearly demonstrated in attitudes to pregnant women in public spaces (Longhurst 2001), menstruation, where feminine *hygiene* products are advertised according to their capacity to be hidden (Laws 1990: ch.3), or in the discomfort around breast-feeding in public (Carter 1995: ch.4).

The reproductive body also marks the curious positioning of the corporeality of the female body as existing alongside the absence of any real personal presence (Shildrick 1997: 25). The materiality of the female body is diagrammatically represented in the form of disembodied body parts – "organs without bodies", in Rosi Braidotti's terms (Braidotti 1994: ch.1) - surrounded by empty spaces, or even constituted of empty space, as in the case of diagrammatic representations of the uterus – an empty space, waiting for a baby (Birke 1999: 69). Shildrick notes that this lack of bodily substance is apparent even in the pre-Enlightenment, one-sex illustrations, where it is the male model that is given structure and solidity with musculature and a skeleton, while the female body is represented in terms of surface and internal spaces. The body becomes a foetal container of highly developed foetuses, distinct from the mother – an image that has its echoes in contemporary ultrasound images of the foetus, surrounded by "space and silence" (Shildrick 1997: 38-41). These technological images posit an independent foetus whose interests are at odds with those of the mother, and who is perpetually threatened by her – the assumptions underlying the surveillance and disciplining of pregnant women, culminating in the US in foetal protection legislation (Bertin 1995; Gallagher 1995) or in legal actions by offspring against their mothers. Lupton reports a case in Australia where a woman with severe cerebral palsy successfully sued her mother for negligence, claiming that her mother's reckless driving had caused the

accident which had led to the injuries that were responsible for the cerebral palsy (Lupton 1994: 154).

This assumed incompatibility between mother and foetus was explicitly referred to by Siemens when they launched a new, 3-dimensional ultrasound scanner. Although the advanced capability of the scanner to detect abnormalities was claimed as its greatest benefit, the developers also expressed hope that the machine would help to promote closer bonds between parents and their children[42] - suggesting an assumption that their interests are already opposed and that they therefore need persuading to respond positively towards the foetus. Ann Saetnan highlights the ways in which this "family-building" function is built into the delivery of the technology, noting that the male partners of the women she interviewed were invited to attend the routine scans, but were actively excluded from scans instigated by symptoms suggesting pathology (Saetnan 2000: 349) . Similarly, Lisa Mitchell observed sonographers in her Canadian study animate the foetus for the watching couples by "tickling" its feet on the screen, creating a voice for it to address its parents, or waving to it (Mitchell & Georges 2000: 388).

Reproduction has been an obvious focus of interest for feminists. The feminist approach to reproduction which has been most easily absorbed into mainstream discourses to reproduction is that of the "right to choose". This liberal approach asserts that the right *not* to be pregnant, or to be able to control when to become pregnant, is essential to the achievement of equality in the public sphere. Campaigns focused primarily on access to abortion and contraception, with the goal of freeing women from the physical risks of closely spaced pregnancies, or of illegal abortions (de Beauvoir 1949: 504-508) and enabling women to achieve fulfilment through education and paid employment (Friedan 1963). Legal access to contraception and abortion enabled women to limit their family size, or to create spaces between pregnancies. It also enabled women to live childfree, either to pursue a career, or to maximise leisure time as an individual or a couple (Tyler May 1995: ch. 6). From this perspective, reproduction constitutes an obstacle to equality of opportunity for women – an obstacle which could be transcended through birth control. However, there are a number of problems with this position.

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[42] www.news.bbc.co.uk, 30 January, 2001

Firstly, it argues for a male norm to which women should aspire. This shores up the construction of the female body as inevitably devalued in comparison to the male, and of maternity as the defining manifestation of that inferiority. Therefore, far from disrupting the construction of women as naturally reproductive, the liberal feminist position paradoxically shores up this perspective by positing female biology as something to be controlled or escaped. And secondly, it posits a unified category of "women" which is based upon the experiences of white, middle class women, and which fails to account for the differences among women. This universalised category is unable to account for the contextual nature of the meanings given to maternity (and non-maternity), as well as ignoring the wider social constraints which may prevent women from entering the public sphere, or which may make maternity a more preferable and higher status choice for women.

Perhaps more fundamentally, this discourse of "choice" fails to take into account the social and cultural context within particular choices are made. The largely western "pro-choice" campaigns for access to abortion or contraception have rarely taken into account the need to be able to assert the right *not* to have an abortion, or to use a particular form of contraception. In many developing countries, for example, women may find themselves coerced into having an abortion as a result of strict population control policies, or because they are carrying a child of the "wrong" sex (Hartmann 1995: ch.13; Hadley 1997: ch.6). In developed countries, women can encounter pressures to abort a foetus which has been identified with a serious disability (Lupton 1994: 151-2), or coerced into the use of contraceptives which cannot be reversed without medical intervention, such as Norplant or sterilisation (Raymond 1993; Tong 1997: ch.5). Race is highly significant here, and it is black women in developed countries who are most likely to be the targets of coercive or punitive interventions into reproduction, based on stereotypes of hyper-fertility and dependency on the state. As Ceballo (1999) notes, this assumption is also reflected in the difficulties black women experiencing infertility have in gaining medical assistance.

It is important to note, however, that feminist activism in the name of reproductive choice has done little to shake the pejorative characterisation in the wider social and cultural context of voluntary childlessness in women. Feminist studies of those living without children, either voluntarily or involuntarily, reveal that women are constantly

required to justify their reproductive choices in the face of derogatory stereotypes of selfishness and incompleteness (Faux 1984; Monach 1993; Letherby 1994; Morell 1994; Tyler May 1995; Lisle 1999; Morell 2000). The wider non-feminist liberal and popular discourses of choice continue to be intractably natalist in orientation (Farquhar 1996: 94). This can be seen, for example, in the reluctance of doctors to sterilise (white) women who have chosen not to have children (Campbell 1999: ch.4), or in the use of the term "family planning" to describe contraception.

While liberal feminists have critiqued reproduction as limiting women's opportunities in the public domain, the critique from socialist feminism has focused on the role of women's unpaid reproductive work in reproducing and maintaining the means of production (Rich 1977: ch.2). From this perspective, the incorporation of women into the existing social and economic structure is a misguided enterprise, since it leaves the oppressive structures in place. However, Shulamith Firestone (1971) argues that socialist revolution is only one element of the wider transition that is necessary for women to be freed from the burden of reproduction. Firestone argues that in reproduction, "Nature produced the fundamental inequality" (ibid.: 232), creating a "slave class that maintained the species in order to free the other half for the business of the world" (ibid.). The source of the tyranny, then, is not capitalism, but women's biology, the overthrow of which constitutes a substantial threat to the social unit of the patriarchal family lying at the heart of the capitalist system. Pregnancy for Firestone is "the temporary deformation of the body of the individual for the sake of the species" (ibid.: 224), and she argues that technological advance will eliminate the need to work (resulting in an end to the division of labour) and will also herald the end of biological reproduction. This embracing of technology and the utopian imagining of ectogenetic reproduction will be considered later in this chapter.

However, while Firestone constructs female biology as a natural disadvantage, other feminists have embraced reproduction as a source of female empowerment. While the liberal perspective aspires to equality with men (according to the male standard), this radical perspective emphasises fundamental differences between men and women – differences which have their origins in reproduction. Nancy Chodorow (1978), writing from a psychoanalytic perspective, argues that women are more caring, nurturing and preoccupied with relationships because they are raised by women. She identifies these

differences as problematic, and posits greater male involvement with the rearing of children as a possible solution. However, Carol Gilligan (1982) argues that the ethics of care that are associated with the mother are positive traits to be encouraged. The understanding of women as caring because they were mothered, and because they mother, has been embraced by eco-feminists (See, for example: Griffin 1984; Ruddick 1989; Mies & Shiva 1993; Merchant 1995; Warren 1996), who argue that women are both closer to nature and naturally peaceful, providing a standard in relation which men are deficient precisely because they do not bear or raise children.

Both the pro- and anti-natalist radical approaches are problematic because of their reliance on a universal female nature which exists outside of the social, cultural and historical context within which reproduction is experienced. These approaches are therefore unable to accommodate differences between women and the inflections of other axes of difference on the experience of maternity. Furthermore, neither perspective offers a satisfactory resolution to those who do not conform. In the case of the anti-natalist perspectives, the only resolution offered to those who have already had children, or who continue to desire biological parenthood, is noble suffering or collaborative false consciousness. Conversely, advocates of the pro-natalist perspective have no means of accounting for either voluntary or involuntary childlessness. Since maternity is positively constructed within this discourse as the essence of femininity, those who do not reproduce are automatically excluded from the elevated moral status which maternity is constructed as bringing. This is important in the context of this research because neither position is able to address the complexity of the experience of infertility. Furthermore, the association of womanhood with motherhood, and particularly with traits such as benevolence and caring, leads to a number of normative assumptions about women that are highly pertinent in the engagement with fertility treatment. This can be seen, for example, in the pressure on women to donate eggs for research, or for other women to use in their own treatment.

What is missing from the approaches described above is a nuanced perspective which is able to accommodate and address the ambivalence and ambiguity that many women experience in the context of reproduction and motherhood. Therefore, this thesis looks towards those studies which have drawn on women's own accounts of maternity, mothering and not being a mother. In particular, this thesis contributes to the extensive

and heterogeneous body of feminist writing of experiences of maternity and motherhood which fall outside of the conventional representations. These would include, for example, studies of those who have chosen to live without children (Morell 1994; Tyler May 1995; Campbell 1999; Lisle 1999; Morell 2000); involuntary childlessness (Stanton & Dunkel-Schetter 1991; Brian 1998; Carter & Carter 1998; Tyler May 1998; Inhorn 2000; Ratner 2000; Ulrich & Weatherall 2000); surrogacy (Ragone 1998; Roberts 1998; Ragone 1999); adoption (Sandelowski 1993; Modell 1999; Gailey 2000); fostering (Wozniak 1999); parenting children with disabilities (Landsman 1999; Landsman 2000); pregnancy loss (Layne 1999b; Layne 2000); and of "bad" mothering (Ladd-Taylor & Umansky 1998). These studies demonstrate the complex ways in which the institution of motherhood intersects with the practice and experience of motherhood, and the ways in which women manage those interactions in making sense of their own experiences. In this way, it is possible to understand motherhood (or non-motherhood) as a contextually specific product of both agency and constraint. Therefore, in this study, reproduction is understood not as a universally positive or negative experience, but as one which is ambivalent and contradictory.

Gender and Technology

There are strong cultural associations between gender and technology, with men conventionally understood as the creators, maintainers and users of technology. Conversely, women are constructed as inept and incompetent as users of technology, and as absent from the fields of maintenance and invention. As in most gender stereotypes, this does not begin to tell the story about the complex relationship between gender and technology, although the existence of the stereotype in itself points to the gendered power relations in operation.

Wajcman highlights the ways in which women's early contributions to technological developments were literally written out of history, since patent records tended to record the husband's name, or the name of the (typically male) patron (Wajcman 1991: 16). The attribution of particular technologies to their individual "fathers" has also facilitated the exclusion of a range of actors involved in developing those technologies. Therefore, one of the roles of feminist writing on gender and technology, as with feminist critiques of science, has been to uncover the gendered histories of particular technologies such as the telephone (Frissen 1995), the microwave oven (Cockburn & Ormrod 1993) and

reproductive technologies such as the contraceptive pill (Oudshoorn 1994; Marks 2000; Marks 2001) in order to highlight the input of women as technicians, consultants, research subjects and active users. Narrow definitions of what constitutes technology have also been central to the construction the relationship between women and technology in dominant representations. Nurses, for example, are engaged in highly skilled work involving high technical competence, and yet it is not considered to be a technically skilled job; the women who assemble computers and calculators are considered "nimble fingered", but not technically skilled (Wajcman 1991: 37).

Wajcman proposes a threefold understanding of technology: as a set of knowledges; as something that people do; and as hardware (Wajcman 1991: 14-15). This moves away from the understanding of individual technologies as static "things", independent of those who create, maintain and use them. Evelyn Fox Keller defines technology in literal terms as "reasoning about the art of doing" (Keller 1992: 24), noting that technology predates science and exists in many places without scientific input (ibid.: 31). This is important in the context of IVF because although scientific input is obviously considerable, the naming of IVF after the laboratory procedure obscures the work of women located outside of the scientific domain in both the development and delivery of the technology.

In theorising the relationship between gender and technology, the liberal perspective begins from the understanding of particular technologies as artefacts. What is at issue, then, is not the technologies themselves, but the different ways in which men and women are positioned in relation to technology (Gill & Grint 1995: 6). From this perspective, technology is potentially progressive when used well. This use / abuse models underpins the popular representation of the mad, lone scientist who is not to be trusted with the science and technology which he (and it is always he) has at his disposal. The archetype is Victor Frankenstein, and his most recent modern equivalent in the media is Dr Severino Antinori – the Italian fertility specialist who claims to be ready to clone human embryos and implant them. The Guardian newspaper described him as a "maverick", dubbing Antinori and his colleague, Panos Mavos, as "Dr Miracle and the showman"[43]. In the world of cosmetic surgery, Antinori's counterpart can be

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[43] *The Guardian,* 8 August, 2001

found in Dr Joe Rosen, who aims to be able to graft wings and tails onto human bodies in the next five years[44]. Within liberal discourse, legislation and codes of conduct secure the use and development of technology within socially acceptable boundaries, and it is in this spirit that Martine Rothblatt drafts an "International Bill of Genomic Rights", arguing that our fate lies "in our collective will to make living a wonderful experience" (Rothblatt 1997: 169).

From a liberal feminist perspective, women are disadvantaged in relation to technology because of gender stereotyping which excludes them from conventionally masculine areas of study such as mathematics and engineering, as well as the making of policy and legislation. One solution, then, is affirmative action and equal opportunities policies to enable women to achieve in those high status, influential public arenas. However, this perspective fails to account for other power dimensions, and assumes a male normative standard to which women should aspire. Furthermore, this approach fails to take a critical position towards the construction of the technology itself as neutral and unmarked by the wider social and cultural context. Domestic technologies, for example, which seemed to offer the promise of freeing women from the burden of domestic labour, proved to be deeply encoded with gendered meanings which specified not only the user, but also the location of those technologies. Domestic appliances were located primarily in the kitchen – the female realm – while communication technologies such as televisions and radios were located in family areas (Wajcman 1991: ch. 4). Equally, gender considerations can be seen as central in determining which technologies are funded and researched, as the focus of reproductive technologies on the female, and not the male, body demonstrates.

In contrast to the liberal approach to technology as a neutral artefact, some radical feminists perceive technology as fundamentally and irretrievably patriarchal, and therefore, dangerous. Within feminism, this position is represented most clearly by ecofeminists, as described in the previous section, who argue that technology is one means by which men try to dominate both nature and women in what Mary Daly describes as the "phallotechnic society" (Daly 1979: 9). Ecofeminists posit a uniquely close relationship between women and nature, and technology is understood as an

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[44] www.guardianunlimited.co.uk, 11 March, 2002

attempt to master nature (and therefore, women). This has lead to a focus on issues such as the military, environmental issues, and the NRTs.

Carol Stabile (1994) describes this position as "technophobic", although this problematically implies an irrational fear – an interpretation which fails to recognise their incisive commentary both of the ways in which technology is marked by gender, and also of the negative impacts of technologies that are assumed within the dominant discourse to be progressive and universally beneficial. However, this critical commentary is problematic because of its dependence on essentialised categories of men and women which fails to account for the ways in which gender intersects with other axes of power and difference in the ways that potentially dangerous technologies are developed and used. Furthermore, this perspective fails to account for women as active agents in the engagement with the technologies beyond direct resistance to them. Technologies are seen as statically and deterministically patriarchal, offering no space for resistance and negotiation. Therefore, this perspective, while offering an important critique of technology as gendered, tells us little about the specificities of individual technologies and the complex actions and interactions through which they are produced and experienced.

An opposing radical perspective can be found in the positive embracing of technology as a means of achieving liberation from oppression. From this perspective, even where current technological formations may be unsatisfactory, there is still all to play for (Ross 1991). One of the early advocates of the revolutionary power of technology was Shulamith Firestone (1971), as described in the previous section. For Firestone, "the future takeover by machines of increasingly complex functions" – what she described as the process of "cybernation" (ibid.: 218) - would transform the relationship between work and wages, eventually eliminating the division of labour. Furthermore, biological reproduction, she argued, would be replaced by ectogenesis, with the task of childrearing shared communally by both men and women. Firestone argues that the core problem with technology at present (or at least, at her present in the 1970's), is that humanity is at "the transitional stage between simple animal existence and full control of nature" (ibid.). The goal, then, is not to redress the "natural" balance, which she believes disadvantages women, but to replace it, but Firestone's embracing of technology is flawed by her failure to address the means by which these technologies

will fall within the control of women, or how their development will come to represent the interests of women (assuming the possibility of collective women's interests).

A more recent advocate for embracing technology as potentially liberating can be found in Donna Haraway's cyborg (the cybernetic organism) (Haraway 1991: ch. 8). Haraway sees technological advance and the subsequent restructuring of labour processes as "the emerging bases for new kinds of unity across race, gender and class" (ibid.: 173). She charges writers who celebrate "nature" with insisting "on the organic, opposing it to the technological" (ibid.: 174), and instead advocates "embracing the possibilities inherent in the breakdown of clean distinctions between organism and machine" (ibid.). Cyborgs, then, constitute liminal formations which undermine "the certainty of what counts as nature" (ibid.: 152), and which render machines not as threatening external threats, but as integral parts of ourselves[45]. For Haraway, technological advance is not to be feared, but should be seen as breaking down categories and static identities, including those of gender, race and class. Technologies, then, according to Haraway, are not deterministic. Instead, she argues that "We can be responsible for machines; *they* do not dominate or threaten us. We are responsible for boundaries; we are they" (ibid.: 180).

While Firestone's revolutionary vision had little following among feminists, the cyborg has become a dominant image within feminist theory, offering a useful means of deconstructing the gender relations of technology. In particular, it has proved to be a useful metaphor for exploring the complex relations between gender and technology in the context of reproduction, the body and sexuality (for example: Lykke 1996; Davis-Floyd and Dumit 1998; Wolmark 1999). However, Stabile argues that the cyborg has been created "out of circumstances distinctly not of our choosing" (Stabile 1994: 95), and therefore looks to the future, but "ignores history" (ibid.: 7). As with Firestone, it is unclear precisely *how* embracing technology will lead to being able to exercise responsibility for those technologies / machines. Furthermore, it could be argued that in asserting that she "would rather be a cyborg than a goddess" (Haraway 1991: 181), Haraway seems to be suggesting a new dichotomy between nature and artefact – a division which Lykke rejects in favour of the "monstrous sisterhood" of the two

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[45] Even cats can be cyborgs according to Sadie Plant, who notes that her cats have identification microchips under their skin (Plant 1998)

concepts in the form of "cybergoddesses" (Lykke 1996: 28). In occupying a "post-gender world" (Haraway 1991: 150), it is difficult to see how the transition to that world can be made, except for the elite with access to and control over technology, and it is therefore important to remember the status of the cyborg as being in part a fiction. I will return to this issue in Chapter 4, in the analysis of the ways in which the participants negotiated discourses of both reproduction and technology.

What the perspectives reviewed above lack in terms of the approach taken in this study towards technology is an understanding of technology having a history, but not being determined by that history. That is to say that there is nothing inevitable in the developmental trajectory of a particular technology. One of the features of technologies is that they evolve along unpredictable paths: radar technology led to the production of the microwave oven; the telephone was originally marketed as a business instrument, but women cultivated their own social uses for it which in turn impacted upon the development of the technology itself and its meanings (Frissen 1995). In the context of IVF, ultrasound scanning was a military technology initially, and the hormonal treatments for stimulating ovaries were transferred by Alan Trounson from techniques used in the breeding of prize sheep (Challoner 1999: 51)[46].

Susan Ormrod argues that while predispositions in culture, history or institutions may be part of the processes that create particular technologies, "they are never determining but only ever relevant in so far as they are actively enrolled as resources which help sustain a network" (Ormrod 1995: 45). Therefore, in studying particular technologies, it is necessary to look at how relations of power are exercised in order to sustain particular networks and formulations at particular points in time, and to attempt to appreciate the particular investments that individuals may have in positioning themselves within a particular discourse or network (ibid.). Where particular discursive practices are dominant and persistent, the possibilities for overt transgression may be ultimately constrained. However, that is not to say that there is no resistance, or that particular technological formulations are containable, since resistance is understood here in Foucauldian terms as constantly present. Instead, this is to argue that some discursive practices are so dominant as to *appear* static and inevitable. It is by looking in detail at

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[46] Alan Trounson argued charmlessly that in terms of fertility treatment, "a woman is just an upright sheep"!! (Challoner 1999: 51)

individual engagements with particular technologies that these strategies of resistance and transformations in technologies and their meanings, if only at the micro-level, become visible.

The New Reproductive Technologies

The final section of this chapter will focus on feminist approaches specifically to the reproductive technologies, against the background of feminist work on science, the female body, reproduction and technology.

As was discussed earlier in this chapter, the liberal focus on technology is on the ways in which men and women relate to technology, rather than the nature of the technology itself. It is in this context that Michelle Stanworth argues that the key issue is not whether or not the reproductive technologies constitute a technological invasion of women's bodies, but "whether we can create the political and cultural conditions in which such technologies can be employed by women to shape the experience of reproduction according to their own definitions" (Stanworth 1987: 35). From this perspective, it is only in unkind hands that the neutral technology becomes threatening to women – a problem that can be resolved by the engagement of women in the technological process, and increased access to information and resources.

Christine Overall describes the liberal position as "complacent" with regards to the problems of the reproductive technologies (Overall 1993: 10). This is particularly true in the context of choice, since while feminists working from this perspective recognise the social factors which shape women's choices, they are less willing to accept the technologies themselves as socially shaped (Wajcman 1991: 62). In particular, the liberal focus on access to treatment ignores the ways in which the technology itself has redefined infertility, generating an imperative to engage with those technologies as they become mainstream (Britt 2001). Prenatal ultrasound scanning is a powerful example of this, and it is increasingly constructed as an essential means of securing a healthy pregnancy (Lupton 1994: 154). Where scanning is "refused" – a loaded term reflecting the extent to which it is now the norm – the woman can then be held responsible for any negative outcomes. As with genetic tests such as amniocentesis, where scans detect a foetal abnormality, the implication is that the pregnancy will be terminated, with obvious eugenic implications concerning the social status of those who are born with

disabilities[47]. Kathryn Morgan notes the rise of this pressure to achieve perfection through technology in cosmetic surgery, arguing:

> *[as] surgically transformed women win the Miss America pageants, women who refuse to submit to the knives and to the needles, to the anaesthetics and the bandages, will come to be seen as deviant in one way or another. Women who refuse to use these technologies are already becoming stigmatised as "unliberated", "not caring about their appearance" (a sign of disturbed gender identity and low self-esteem according to various health care professionals) as "refusing to be all that they could be" or as "granola heads".* (Morgan 1998: 274)

This pressure is replicated in IVF, where couples engaging with treatment frequently cite the need to have "tried everything possible" before reconciling themselves (and others) to not being able to have the desired biological child. Infertility is redefined in this context as an illness to be treated, and where contemporary values assert the importance of taking individual responsibility for being maximally healthy, IVF becomes less a matter of choice than of necessity. Where the desire to have a child is constructed as "normal" and essential to feminine identity, then the "refusal" to engage with IVF blurs the boundaries between voluntary and involuntary childlessness, leaving the woman vulnerable to the suggestion that she was unwilling, and perhaps too selfish, to make the necessary sacrifices to be a mother.

Other factors can constrain the "choice" to have IVF, such as being unwilling to offend or alienate doctors by postponing IVF for fear of endangering the opportunity of further treatment – a source of pressure that is also significant in requests to participate in research projects in the course of treatments. Pressure is also experienced from partners or family members, or even, ironically, the provision of funding (Britt 2001: 90-92). Jakov Epstein and Helane Rosenberg, in their study of couple conflicts about fertility treatment, report a case where the male partner wants to stop treatment, but the female partner wants to continue because "We still have one more IVF attempt that the

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[47] It was recently reported in the news that in the UK, a cheaper, but less effective test for Down's syndrome was being used. However, a British Medical Journal article had argued for the cost

insurance will cover" (Epstein & Rosenberg 1997: 141). Although the UK does not have standardised funding and insurers will not cover fertility treatment, one of the implications of standardised provision might be that the known availability of a certain number of cycles would generate an imperative to pursue treatment that might not otherwise have been chosen. Finally, when recognised experts with high media profiles present the option of living without children as a tragedy which is "unequalled in any sphere of life", and that those living without children are "barred from contributing to the continuity of human existence" (Winston 1999: 2), the terms of the choice of whether or not to proceed with IVF can hardly be described as neutral. Consequently, Stanworth's aspiration that women will be able to shape the experience of reproduction according to their own definitions seems naïve and utopian.

Radical feminist critiques of the liberal approach have set out the constraints on individual choice in the engagement with NRTs at length. Janice Raymond argues that the engagement with the NRTs is not simply a matter of individual choice, since "by participating in the exploitation of the self, one contributes to the exploitation of others" (Raymond 1993: 105). This is a sentiment supported by Robyn Rowland, who argues that those who choose to use the NRTs "should not be supported if they place feminist principles and women as a social group at risk of losing control of procreation" (Rowland 1992: 299). Both of these statements reflect radical feminist opposition to the NRTs on the grounds that they are irretrievably patriarchal and damaging to women. The feminist response from this perspective has been vociferous and well-organised, and has been represented most vocally by FINRRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering), which was formed in 1984 by feminist authors, including Gena Corea, Jalna Hanmer, Renate D Klein, Maria Mies and Robyn Rowland (Wajcman 1991: 58)[48]. The fundamental principles of FINRRAGE are set out in the Resolution to the 1985 FINRRAGE conference, which states that "the female body, with its unique capacity for creating human life, is being appropriated and dissected as raw material for the technological production of human beings. For us women, for nature, and for the exploited peoples of the world, this development is a declaration of war. Genetic and reproductive engineering is another attempt to end self-

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effectiveness of the more expensive test, since the higher detection rate was presumed to lead to a cost-saving in caring for babies with Down's (*The Guardian*, 24 August, 2001).

determination over our bodies" (Spallone & Steinberg 1987: 211). The statement goes on to call on women "to resist the take-over of our bodies for male use, for profit-making, population control, medical experimentation and misogynous science" (ibid.), urging women to take "all women's healthcare back into the hands of women." (ibid.: 212). The conclusion is drawn, as in the statements at the opening of this paragraph, that all women should not engage with the NRTs because they are damaging not only to individual women, but also to women as a class.

Within this broad characterisation, radical feminist opposition to the NRTs has addressed a wide variety of concerns, highlighting related but easily invisible issues not only of gender, but also race and class. Gena Corea, for example, has written extensively on the link between the NRTs and the farming industry (Corea 1987; Corea 1989b), arguing in the context of surrogacy arrangements that "a class of breeder women" (Corea 1989b: 181) is being established to service white, middle class women. She also pursues this identification of race / class / gender divides in her analysis of the disproportionate burden of harm borne by women of colour in the testing and distribution of Depo Provera – a contraceptive not approved for use in the US – to women in developing countries (Corea 1989a). Edited collections written from this oppositional perspective routinely include contributions from / about women in developing countries and their often coerced engagements with the NRTs (see, for example: Corea 1987; Spallone & Steinberg 1987; Hynes 1989). This reflects a refusal to allow the conceptive technologies, which are associated in the popular imagination with white, middle class women, to be separated out from the contraceptive and ante-natal technologies which women in developing countries are more likely to encounter. Other concerns include: surrogacy (Corea 1988); genetic engineering (Bullard 1987; Mies 1987; Rowland 1992: ch.2); legislative frameworks (Spallone 1987; Raymond 1993: ch.6); experimentation on women (Crowe 1990); commercialisation (Corea 1987); medical science (Raymond 1993: ch.5); and strategies for resistance (Jansen 1987).

In many ways, this radical opposition to the NRTs is very compelling in its determined centralising of women in the debates, the uncovering of the gender politics that structure

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[48] See, for example: Corea, Klein et al. 1987; Klein 1987; Spallone & Steinberg 1987; Corea 1988; Klein 1989; Rowland 1992; Raymond 1993

the technologies, its intolerance of harm to women and an insistence on the need to focus on the causes of infertility. Equally compelling, but ultimately misleading, is the certainty of the opposition they express, which is highly seductive in the face of the highly troubling nature of NRTs for women. However, this seductive certainty is deceptive and ultimately reductive since the refusal to acknowledge that the technologies might not be all bad for all women renders those who do seek treatment as the delusional dupes of patriarchy and fails to account for the different meanings that engagement might hold for individual women. While it may be possible to say that every encounter with the reproductive technologies may involve some problematic aspects from a feminist point of view, it is also true that those aspects are never all there is to the story, and furthermore, that those aspects never impact uniformly on women. This failure to account for the complex and contradictory meanings of technological interventions in reproduction both for those who do and don't become parents represents a significant limitation to this perspective. This is particularly apparent in the adoption of an international perspective, which, even while offering an important insight into the global reach of particular technologies (and ideologies), relies upon assumption of uniformity in the experience of those technologies. However, as Browner and Preloran (2000) and Lisa Mitchell and Eugenia Georges (2000) demonstrate in their cross-cultural studies of ante-natal ultrasound scanning, the technologies do not translate unchanged between contexts.

A further problem with this perspective, as is evident from the extracts from the 1985 conference resolution, is the belief in a womanhood which predates patriarchy and which exists outside of power relations. This is a position which undermines the rigorous critique which is offered by these feminists of the ubiquity of gendered power relations in the development of, and engagement with, treatment. Furthermore, in positing women's "unique capacity for creating human life" as defining womanhood, this perspective has little to offer those who are unable to reproduce, whose needs and desires the statement fails to address except for the assertion that they deserve "compassionate treatment" (Spallone & Steinberg 1987: 212).

Jana Sawicki (1991) employs Foucault's concept of biopower as a means of understanding the NRTs as something other than a violent exercise of male power over women. For Foucault, biopower is reflected in the "numerous and diverse techniques

for achieving the subjugation of bodies and the control of populations" (Foucault 1978: 140). Power, in this context, is "everywhere; not because it embraces everything, but because it comes from everywhere" (ibid.: 93), and is not exercised as overt violence, but emerges through disciplinary practices over individual bodies, and regulatory practices over populations (ibid.: 140). It is the former aspect of biopower that is of particular interest here, and Sawicki argues that the NRTs should be seen as a series of disciplinary techniques which work not through violent imposition, but by "creating desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviours and bodies are judged and against which they police themselves" (Sawicki 1991: 68). In the engagement with IVF, women's bodies become the intense focus of medical surveillance, which is matched by women's rigorous policing of their own bodies. However, this watchful docility can also be perceived as empowering by those seeking treatment, since it marks the fact that they are taking action they perceive as positive and as bringing them closer to the identity of biological parent. Women engaging with IVF are never entirely without power, although they will always be individually located more or less favourably to it. Therefore, while always constrained, the possibility of resistance, if only at the micro-level, is always present. The premature closure evident in the radical position is unable to accommodate the ambiguity of the co-existence of both agency and constraint, and therefore remains dependent on an all or nothing understanding of the engagement with the NRTs.

In the context of cosmetic surgery, Kathy Davis argues that undergoing surgery should be treated "as a dilemma rather than a form of self-inflicted subordination", since this offers a route to understanding "what makes it both desirable *and* problematic for so many women" (Davis 1995: 180). Even though surgeons themselves might be working from "an shakeable belief in a Westernised notion of "natural" beauty (Balsamo 1999: 78), this is not necessarily the way in which surgery is being used by the women who undergo it, and Davis reports her respondents as seeking "normal", not beautiful, bodies, for example. In the context of IVF, this difference in purpose is also apparent. Although both doctors and patients have the shared goal of that treatment will result in a live birth, for patients, the achievement will give them the parenthood they desire and identify them as "normal", whereas for doctors, this live birth will contribute to their statistical success rates, confirming the efficacy of their techniques and contributing to

their own professional status and the prestige of the clinic (Modell 1989: 129). Patients become expert at making the "right" case to doctors in order to obtain the treatment that they desire – a strategy that is apparent in IVF (Cussins 1998), cosmetic surgery (Davis 1995), gender reassignment (Prosser 1998) and abortion (Hadley 1997), and one which reflects the possibility of a disparity between structure and experience. This can be seen as a form of "parodic repetition" (Butler 1990) which exposes the constructed nature of those standards to which they are performing their conformity.

In spite of the persistence of the dominant discourses of nature and science which continue to structure the dominant representations of the reproductive technologies, the "truth" status of those discourses is unsustainable and ultimately uncontainable. Indeed, it is precisely this uncontainability that leads to the constant generation of new ethical, moral and legal dilemmas in relation to the technologies. In seeking to affirm the unified reproductive categories and identities, the reproductive technologies have fractured identities that have been constructed as self-evident and unified, and have created legally, morally and ethically confounding new identities.

The Salomone case discussed in the introductory chapter of this thesis is one extreme example, but IVF routinely fragments the central and unitary concept of motherhood into social, gestational and genetic motherhood through the technologies of egg donation or embryo transfer, and the status of frozen and stored embryos remains highly contentious. The law is called upon to rule upon disputes over the "custody" of embryos (Overall 1993: ch.5), the status of "orphaned" embryos (Hartouni 1997: ch.2) and over the competing claims of different "mothers" in surrogacy cases (ibid.: ch.4); and the advent of pre-implantation genetic screening techniques raises challenging questions about the nature of difference and the characteristics which could be justifiably selected out[49].

The uncontainability of the reproductive technologies diffuses the oppressively negative power attributed to them by the radical position, facilitating an appreciation of those technologies as the product of a range of discursive practices. This deconstruction of

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[49] For a more detailed consideration of the ethical, legal and moral dilemmas of the reproductive technologies from a feminist perspective, see, for example: Boling 1995; Callahan 1995; Purdy 1996; Steinberg 1997; Tong 1997.

self-evident "truths" of the reproductive technologies is an essential element to understanding the complex ways in which they are discursively and materially sustained, both by those developing and providing treatment, and by those undergoing that treatment. In the context of this study, I would argue that although less striking than, for example, a dispute over whether a gestational, genetic or social mother has the superior claim over a child, a focus on the failure of IVF and the decision stop treatment is equally disruptive of the dominant representations. In the popular and medical discourse, IVF resolves the tension inherent in the bringing together of nature (reproduction) and culture (technology) in the concept of "giving nature a helping hand", but when IVF fails, this fragile resolution is breached, and the self-evident nature of both concepts is challenged.

Given that one of the effects of the dominant IVF discourses is the erasure, or at least, suppression, of treatment failure, even creating the space for that experience to be heard has value in disrupting the dominant representations of the technology. Occupying a space "in the gaps between the stories" (Balsamo 1999: 114), those for whom treatment fails are uniquely and ambivalently positioned in relation to discourses of reproduction and technology, and in accounting for the decision to end treatment, those discourses are strategically both used and resisted. This offers valuable insights into both the ways in which power relations are produced and sustained in the context of the reproductive technologies, but also into the ways in which the failed engagement with reproductive technology has material consequences for women.

Conclusion: a feminist approach to IVF

In this chapter, I have attempted to set this thesis in the context of the key feminist debates which form the backdrop to the research presented here. The chapter will conclude with a brief exposition of four core features of this approach.

Firstly, as has already been stated, this research identifies as feminist, in that it takes the experience of women as its central (but not exclusive) focus. This is a response to the relative invisibility of women in the dominant discourses of IVF. This feminist orientation is also based on the long history of injurious, experimental and instrumentalist interventions into the female body (Moscucci 1990; Dally 1991), and the

thesis is therefore based on the assumption that the NRTs are, at least potentially, dangerous for women. This understanding makes it important to understand the power dynamics at play in the engagement with IVF and to find ways to assist women in managing the competing pressures which the experience of infertility generates.

The second feature of my approach is that the technologies themselves are not neutral artefacts – things to be used or abused – and nor is there anything inevitable or determined about their developmental trajectories or impacts. However, this is not to argue that the meanings of the technologies are free-floating, but rather, that the dominant discourses of reproduction and technology constitute a set of resources at any given time that are constraining, but always provisional and never absolute. Therefore, the trajectories of particular technologies are always uncontainable and unpredictable. IVF, then, is understood here as both product of, and productive of, discourse, and its meanings are always contextual and never static. This is not, however, to argue that as products of discourse, particular technologies are not of material significance. Instead, the material and the discursive are understood as mutually imbricated and ultimately inseparable.

The uncontainability of IVF points towards the third feature of the approach outlined here – that women are not passive in their encounters with IVF. Instead, women should be seen as *users* whose engagement with IVF is not characterised simply by passive compliance, but instead, which should be seen as fundamental to the production of the technologies and their meanings (Saetnan, Oudshoorn et al. 2000). IVF, then, should be seen not as something that is done to women (by men), but as something that they do in conjunction with others. This status as users of IVF should not be understood either as complicity, naivety or compulsion, as radical feminist opposition might understand it, or as unconstrained choice. Instead, it is viewed here as a form of material-discursive action which uses all the resources available. This approach makes it possible to explore any negative and troubling aspects of IVF without locating women either as masochists or dupes. Instead, it facilitates a shift away from woman-blaming or female victimhood towards a focus on the power relations within which IVF operates.

This points to the final key aspect to the feminist approach to IVF outlined here – the identification of IVF as a form of disciplinary power. By conceptualising IVF as a

disciplinary technology, it can be understood not simply as repressing women, but as "producing new objects and subjects of knowledge, by inciting and channelling desires, generating and focusing individual and group energies, and establishing bodily norms and techniques for observing, monitoring, and controlling bodily movements, processes and capacities" (Sawicki 1991: 83). Where control is understood as exerted through the creation of new norms and identities, rather than through violence, it is possible to understand those engaging with IVF as active agents rather than collaborators lost in a fog of false-consciousness. Furthermore, a focus on the complex and constantly shifting discursive mechanisms by which the disciplining of the female body is accomplished opens up the possibility (but not inevitability) of strategies of resistance to the more pernicious aspects of the engagement with IVF. However, it is important not to overstate this transgressive potential, since IVF remains deeply embedded in dominant discourses of women as mothers, of IVF as successful, and of science and technology as benign and progressive. There are risks attached to transgression of the social norms and identities which these discourses produce, and therefore, in seeking transformation, it is important not to place the burden of this transformation onto those who are already at risk of being identified as "abnormal".

Chapter 3: Methodology

In the previous chapter, I outlined a feminist approach to IVF which identified as feminist, and which understands the meanings of the technology and the engagement with it as under constant negotiation, whilst being deeply embedded in dominant social and cultural discourses of gender, technology and the body. This chapter will focus on the research project itself, and specifically on the theoretical basis for the research in light of the approach outlined in the previous chapter, and the practical implementation of this theoretical framework. The chapter will begin by discussing the epistemological basis for the research, and will then explore some of the issues which this raises in terms of the use of empirical data for the analysis through the work of Donna Haraway, Elspeth Probyn and Rosi Braidotti. This will be followed by an outline of some of the features of discourse analysis, and will set out why this is an appropriate analytical approach for this study. The remainder of the chapter will describe the study itself, and will discuss some of the problems encountered.

"Situated knowledges"

In epistemological terms, this research is grounded in the "turn to language" that was precipitated by the postmodern challenge to epistemology, and post-structuralist critiques of realist views of language (Gill 1996: 172-3). While knowledge within the dominant, scientific paradigm is viewed as discoverable through the rigorous application of the scientific method, and as uncontaminated by subjective influence (Alcoff and Potter 1993: 1), postmodern perspectives seek to "distance us from and make us sceptical about beliefs concerning truth, knowledge, power, the self, and language that are often taken for granted within and serve as legitimation for contemporary western culture" (Flax 1990: 41). The postmodern perspective, then, broadly speaking, claims that "the very criteria demarcating the true and the false, as well as such related distinctions as science and myth or fact and superstition, were internal to the traditions of modernity and could not be legitimised outside of those traditions" (Nicholson 1990: 4). Knowledge from this perspective is a product of discourse (and therefore, power) rather than discovery, and is therefore always contingent and partial.

The critique of the scientific paradigm that this perspective offers is therefore distinct from the empiricist critique, which (as described in the previous chapter) argues that biases can be eliminated by strict adherence to the methodological norms of scientific inquiry (Harding 1987: 182). From an empiricist perspective, research is flawed by "bad science", where "good science" and discoverable truth remains a possible, or at least worthy, if elusive, goal. From a feminist perspective, the targeting of "bad science" has sought out androcentric and sexist biases, although there remains a constant tension between the feminist endorsement of politically informed research whilst adhering to a methodology which requires value-neutrality[50]. In the context of this thesis, the distinction between research conducted from an empiricist and a postmodern perspective is an important one to make. By addressing an issue that has largely been ignored, this research could be perceived simply as filling in another piece of the IVF picture, and therefore contributing to a clearer understanding of the "reality" of IVF. This is particularly true since the research presented here draws on empirical data in the form of interviews – an approach which implies a legitimacy to the category of experience – and I will address this issue directly later in this section. In contrast to the "better science" approach, this research begins from the understanding that the invisibility of treatment failure (or indeed, of other IVF stories outside of the dominant narratives) is not simply a matter of biased oversight, but is fundamental to the construction of IVF itself, based upon the dominant discourses of technology as progressive and efficient, and of women's bodies as inevitably reproductive. Therefore, from a postmodern perspective, the focus on treatment failure does not add to a more complete picture, but disrupts the existing picture – a picture whose meaning is predicated on the exclusion of narratives of failure, other than stories of persistence, where failure precedes success, or stories of emotional, financial and relationship devastation.

Linda Nicholson proposes that postmodernism should be considered a "natural ally" of feminism in the critique it offers of universal knowledge claims, the objectivity of the academy, the autonomous self, and the assumed neutrality of agents involved in the production of knowledge (Nicholson 1990: 5). However, other feminists have expressed concern about postmodernism's utility for feminism, arguing that that it entails a

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[50] For a detailed discussion of feminist empiricism, see for example, Harding 1987; Longino 1990; Nelson 1993; Tanesini 1999.

descent into relativism which negates the agency upon which feminism as an emancipatory project is dependent, leading to a "complete debunking of the concepts of selfhood, agency and autonomy" (Benhabib 1995: 21). Donna Haraway recognises this potential risk, arguing that strong deconstruction constitutes a "kind of epistemological electro-shock therapy, which far from ushering us into the high stakes tables of the game of contesting public truths, lays us out on the table with self-induced multiple personality disorder" (Haraway 1991: 186). For Haraway, an epistemology which accepts the possibility of objective, discoverable truths uncontaminated by social or cultural bias – "the god-trick of seeing everything from nowhere" (ibid.: 189) – stands at one pole of what she describes as the "objectivity problem" (ibid.: 186). Relativism – "a way of being nowhere while claiming to be everywhere equally" (ibid.: 191) - sits at the opposite pole. For Haraway, both of these positions "deny the stakes in location, embodiment and partial perspective; both make it impossible to see" (ibid.). The challenge which Haraway identifies, then, is "how to have *simultaneously* an account of radical historical contingency for all knowledge claims and knowing subjects, a critical practice for recognising our own 'semiotic technologies' for making meanings *and* a no-nonsense commitment to faithful accounts of a 'real' world [...]" (ibid.: 187). In choosing to conduct research which begins from a postmodern perspective but which draws upon empirical data, this dilemma is duplicated here.

The use of accounts of people's experiences of IVF failure was described in the previous chapter as offering a particularly productive perspective from which to explore IVF and the discourses which it is both produced and maintained by, and productive of. However, this is not to adopt a feminist standpoint approach, which conceptualises women's experiences as providing "a potential grounding for more complete and less distorted knowledge claims than do men's" (Harding 1987: 184-5). This perspective has its roots in Marxism and the concept of the proletarian standpoint. For Marx, the social positions occupied by different classes give them different perspectives on social reality. However, these standpoints differ not only in content, but also in accuracy, with the working class perspective – that from below – as less distorted, since their social marginality ensures that they have no vested interest in preserving the system by being blind to its shortcomings (Tanesini 1999: 139). Therefore, from the perspective of feminist standpoint epistemology, female experience, as distinct from that of men, is able to produce a version of social reality that is morally and epistemically superior.

This approach is problematic, firstly, in that it remains committed to the possibility of greater and lesser truths, and secondly, in that it assumes a sufficient degree of shared experience to constitute a standpoint. However, focusing on shared experiences underestimates the importance of differences, and the difficulties from this perspective of elaborating linkages between different oppressed groups constitutes a significant limitation (Nicholson 1990: 7). Indeed, in the context of this study, the possibility of an understanding of an epistemological position based on shared experiences of subordination soon becomes unsustainable as a means of making sense of IVF experiences because of the infinite range of differences among those experiences, depending on the cause of the inability to conceive, the attribution of male or female factors, access to treatment, success or failure, age, race, class etc., or in the case of surrogacy arrangements or the use of donated eggs, where more than one woman is involved, often in circumstances of dramatically asymmetrical power relations.

Nevertheless, even though I am not arguing here that the accounts upon which this research is based constitute an epistemically privileged window to truth or reality, I do wish to make claims for these accounts as offering a particularly productive perspective on IVF. In Donna Haraway's terms, these accounts can be described as "situated knowledges" (Haraway 1991: ch.9). For Haraway, the situatedness of knowledges (as opposed to universal knowledge) becomes clear through the reclamation of vision, which for Haraway is not understood as the passive view from nowhere which aims at disembodiment, but as an active, engaged and embodied view from somewhere particular. These situated knowledges are "partial, locatable, critical knowledges" (ibid.: 191) which resonate with knowledges from other vantage points in "conversation" (ibid.: 195). These "views from somewhere" (ibid.: 196) are always partial and contingent, but rather than disabling knowledge (and politics), Haraway argues that this prevents the "politics of closure" (ibid.), becoming instead "a process of ongoing critical interpretation" (ibid.) between "material-semiotic actors" (ibid.: 200). From this perspective, accounts of the "real" have value not as a means of discovering truths, but as a means of exploring the power relations which are produced by, and are productive of, particular experiences. Situated knowledges, then, do not require validity through coherence, and nor do they constitute a celebration of difference / diversity for its own

sake. Instead, they constitute an ongoing series of dynamic interactions between different locations and the knowledges which they produce.

The accounts upon which this thesis is based can be usefully understood as situated knowledges, in that they constitute "*faithful* accounts of a 'real' world" (my emphasis) (Haraway 1991: 187) as experienced and made sense of from particular locations. The term "faithful" is important here, because it establishes an important distinction between construction and fabrication. That is to say that just because a particular account cannot be said to constitute an unmediated, discovered truth, it still has everything to say about the ways in which those giving their accounts experienced (and continue to experience) IVF failure, and the material-discursive resources at their disposal in order to make sense of those experiences. This process of meaning construction is ongoing and dynamic, and the resistance to the closure of meaning embraces unapologetically the ambiguous and often simultaneously contradictory ways the failure of treatment is experienced. The participants in this study are not required, therefore, to "get their story straight" for their accounts to be considered meaningful. On the contrary, it is their particular and extraordinary location on the boundaries between the often contradictory dominant discourses of gender, science and technology that makes these accounts particularly productive perspectives from which to think about IVF. These accounts do not, then, form the basis of this study because they offer an innocent and epistemologically privileged view from below, but rather, because they constitute situated knowledges whose liminal, boundary location produces new ways of seeing IVF.

In asserting the view from somewhere, moreover, the awareness of a particular location is not meant to imply that that position is static. The liminal, boundary location is produced not by exclusion from particular categories, but by the movement between those categories – a movement which generates movement in the categories themselves. Elspeth Probyn conceptualises this in terms of "outside belonging" (Probyn 1996), arguing that the desire to belong "propels, even as it rearranges, the relations into which it intervenes" (ibid.: 13). This is important in the context of this research because it facilitates an understanding of those for whom IVF fails and who subsequently stop treatment not as passive, tragic victims who are perpetually excluded from belonging,

but as actively engaged in the production and (potentially) the transformation of those categories of belonging.

Rosi Braidotti also finds transformative potential in the "multiple criss-crossing" (ibid.: 15) between categories, as articulated through the "figuration" of the nomadic subject (Braidotti 1994) - "a political fiction that allows [her] to think through and move across established categories and levels of experience: blurring boundaries without burning bridges" (ibid.: 4). Braidotti argues that the nomadic consciousness opens up the possibility of "new forms of inter-relatedness and collective political projects" (ibid. 5) – a project which is articulated in the context of life experiences in order to avoid "falling into solipsistic language games" (ibid.: 6). Experience here is embodied, not in the biological terms of "women's experience", but as the "overlapping between the physical, the symbolic and the sociological" (ibid.: 4). In the context of this study, the understanding of experience as mediated by language but also as located in the physical / material is crucial given the extensive interventions into women's bodies that IVF entails.

However, while Braidotti celebrates the transformative potential of the nomad, she also acknowledges the limitations of this "political fiction", acknowledging that the location at the boundaries is not inevitably transformative: "it is crowded at the margins, and nonbelonging can be hell" (ibid.: 20). This a timely warning against the naïve celebration of boundary locations, and raises important ethical issues in terms of the identification at the theoretical level of potentially transformative spaces in experiential accounts of those for whom conformity to, rather than transformation of, categories is a primary goal. As such, nomadic consciousness should be understood as a privileged, and, perhaps, idealistic, perspective, in that the transgression of conventions that this location offers can only be relished when there is security in that boundary location.

This brings me back to Haraway's concept of situated knowledges, which offers an important reminder that the accounts upon which this thesis is based always come from somewhere. Therefore, an experiential account as a social text can never be separated out from that person's lived (and often physical) experience, and what might offer important theoretical or political insights (as I believe the accounts used here do), may also represent a deeply personal tragedy, the feminist political theorising of which may

be unwelcome. The inclusion of the lived experience of the participants, then, carries with it both an ethical and intellectual responsibility to acknowledge the faithfulness of the accounts and the participants' personal investment in them in order to retain the richness and complexity of the texts and to offer an interpretation which reciprocates that faithfulness whilst pursuing inquiry at the theoretical level simultaneously.

The need to appreciate the richness and complexity of texts makes discourse analysis a highly appropriate analytical framework for this research, as the following section describes.

Discourse analysis

Discourse analysis is a broad church, but it can be described as having the following four themes: firstly, it takes discourse itself as its topic, where discourse is used to refer to all forms of talk or text; secondly, language is viewed as both constructive and constructed, and is manufactured out of pre-existing linguistic resources; thirdly, all discourse is understood as social practice – that is, as a practice in its own right, that people use to *do* things; and fourthly, language is organised rhetorically in order to be persuasive (Gill 1996: 141-143). Therefore, since language cannot be understood as reflecting or describing an external reality, the key question in conducting a discourse analysis is not *what* is being said, but what that discourse is intended to achieve and how[51]. As an analytical approach, discourse analysis is particularly well suited to this research project.

Firstly, discourse analysis assumes texts to be *doing* something, and therefore, in constructing their accounts, the participants in this study can be seen not as passive narrators of a past event whose meanings have already been fixed, but as both producing and resisting meanings in an ongoing, iterative process. This offers a means of exploring the ways in which the experience of IVF failure changes over time and in different situations, rather than attributing a static, and therefore, inescapable meaning to that experience. Furthermore, it resists the categorisation of those who have engaged with treatment either as victims of patriarchal violence or as unconstrained agents exercising free choice.

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[51] For a more detailed discussion of discourse analysis, see, for example: Potter & Wetherell 1987; Burman & Parker 1993; Gill 1996; Gill 2000; Wood & Kroger 2000)

Secondly, discourse analysis is able to accommodate ambiguity and contradiction, acknowledging a range of discursive strategies at work simultaneously, although not necessarily oriented towards the same task. Indeed, a discourse analyst would become suspicious if confronted with a entirely coherent set of accounts. This facilitates an analysis that is able to embrace contradictions both between and within accounts, not as anomalies, but as fundamental to the rhetorical function of the text, and demonstrative of the discursive resources available to the narrator. This offers valuable insight into the wider social and cultural context within which particular experiences are given meaning, and the power relations in operation in that process of meaning production. As described in Chapter 2, those for whom treatment fails occupy an ambiguous location in relation to dominant (and often contradictory) discourses of gender, technology and the body, meaning that an approach which is able to embrace rather than deride the resulting contradictions in the accounts is essential.

Thirdly, while there is nothing inherently feminist in discourse analysis, it has much to offer from a feminist perspective. Discourse analysis offers an opportunity to render aspects of women's lives which have been rendered invisible visible, not in the sense of providing a truer version, but by laying bare the power relations through which that exclusion, and its exclusionary effects, are achieved. This opens up the possibility of locating the "gaps between the stories" (Balsamo 1999: 114), which have the potential for new connections and political identities, however contingent and provisional. Consequently, far from the focus on the accounts as texts constituting a retreat into "solipsistic language games" (Braidotti 1994: 6), a discourse analytic approach to accounts of IVF failure is able to acknowledge the dilemmas that those engaging with treatment face, and to identify what Braidotti describes as "points of exit" (ibid.: 39) from those dominant discourses. This may, as Keith Grint and Steve Woolgar suggest, not be "the kind of philosophy to start revolutions in pursuit of utopia" (Grint & Woolgar 1995: 67), but it does facilitate the asking of new and challenging questions about seemingly self-evident truths. In the field of the NRTs, where the dominant discursive practices within which the technologies are constructed, legitimised and experienced continue to be deeply entrenched to the point of appearing inevitable, this kind of thoughtful questioning is imperative.

In the first part of this chapter, I have set out the theoretical approach to this research project. The following section will describe the project itself, including some of the problems that I encountered in implementing this theoretical framework in practice.

<u>Study Design</u>

The primary goal in the setting up of this study was to generate a rich body of data relating to as broad a range of experiences of IVF failure as possible in a manner that was as ethically responsible as possible. At the outset, it was decided that the study would take the form of in-depth, semi-structured interviews, and that where possible, both the male and female partners would be interviewed, either together or separately according to their preference, in order to facilitate the exploration of the ways in which gender was a significant factor in their experiences. Interviews were chosen over the use of focus groups, for example, in order to enable me to talk with participants in a confidential atmosphere, and to give each participant the space to talk in detail about this intensely personal issue. Two interviews were planned for each woman or couple, six to eight months apart, both to assess any change in attitude or circumstances during the intervening period, but also to explore issues that had arisen out of the first round of interviews in more depth, since the exploratory nature of the study meant that it was impossible to predict which issues the participants would consider most important.

It was planned to interview only those whose most recent cycle of treatment had taken place at least two years previously in order to explore the participants' reflections on that experience over time, rather than at the point of withdrawal. In addition, it was assumed, not entirely correctly (see below), that after two years had passed, participating in interviews would be less likely to interfere with the long term coping process, particularly in terms of disrupting the decision to end treatment.

In the design stage of the project, it was initially planned to recruit participants from both NHS and private sector IVF clinics, but one of the chief difficulties encountered in the participant recruitment process was finding **any** clinic, NHS or private, which was willing to allow access to the dormant patient records. In the end, only one – a specialised clinic in a large NHS teaching hospital – was willing to support the project by providing the necessary access. There are several possible explanations for this. Firstly, IVF provision is regulated by strictly enforced legal confidentiality

requirements, and therefore, any breach of those requirements by an external researcher could leave the clinic exposed to legal sanction; secondly, the study is obviously about an aspect of treatment that providers of IVF are not necessarily keen to explore in depth; and thirdly, the qualitative methods being used in the research were considered, even by the clinic that did agree, to be unscientific and therefore of dubious value.

The initial expression of interest by the clinic that did respond positively was followed up with a meeting with the clinic director, who advised that a research protocol be prepared and presented to the clinic staff to gain their approval prior to continuing. Once this was done, an application was made to the hospital ethics committee, and after their approval had been received, my name was added to the clinic's license. The purpose of this was not only to legalise my access to the dormant patient records, but also to ensure that, as the clinic director succinctly put it, if I breached confidentiality in any way, it was me who would go to prison, not him. It had also been hoped that some participants would be recruited through Foresight – a pre-conceptual nutritional counselling organisation – and this had already been agreed in principle with the organisation. However, as part of my discussions with the clinic, it became necessary to exclude Foresight as a possible source of participants, since the clinic director viewed the organisation with great cynicism, describing them as "charlatans", and did not wish to be involved in a project of which they were a part.

The process of setting up the study, and particularly in arranging access to the records, proved to be a lengthy one, not least because the tentative inquiries to a range of clinics had to take place well in advance of the time when the study was ready to proceed, since it was necessary to establish early on whether it would even be feasible to access patient records at all, or whether alternative methods of recruitment would need to be devised. The initial exploratory inquiry to the clinic was made in March 1998, and the presentation of the research proposal to the clinic staff was made a year later. The application was reviewed by the ethics committee in June 1999, with final approval given in September 1999. The interviews began in November 1999 and ended in December 2000.

At the design stage there was concern over whether there would be a sufficient number of positive responses, and the clinic staff had expressed reservations about this based on

their own experiences of trying to contact people in order to maintain their statistical records on IVF outcomes. The study design assumed a need for between 20 – 40 women or couples and any less would require further recruitment from other sources such as newspaper or radio advertising. In the unlikely event that there were more than 40 positive responses, participants would be selected with the intention of including the widest possible range of experiences and situations, as well as, where possible, including participants from the ethnic minorities in order to reflect the vibrant ethnic mix of the hospital's catchment area. However, assuming that there would be no choice over who was interviewed, I would have no control over the demography of the sample, as proved to be the case. The difficulties of recruiting a participant group that is not over-represented by white, middle-class women and couples educated to degree or professional level has been well documented in the study of reproductive technology (Sandelowski 1993; Daniluk 1996; Franklin 1997), and there was little cause for optimism that this study would prove any different. This reflects not only the exclusivity of IVF itself, but also the emotional and time demands of articulating those experiences in a research context. The hospital is situated in an area where the ethnic minorities are well represented, and approximately half of all the IVF cycles performed by the clinic are health authority funded, and it was hoped that this might help to improve the mix of the participants. However, as is discussed in the next section, this was only very partially successful, although this was viewed as regretful rather than prohibitive in terms of the feasibility of the study as a whole.

The staff of the clinic also expressed concern over the emotional consequences for the participants of discussing such a potentially distressing topic, and there was doubt over whether people would be either willing or able to talk in sufficient depth about IVF failure. In response to these concerns, it was agreed with the clinic that all the participants would be given the contact details of the independent counsellor (who was aware of the study) prior to the first interview, and a warning was included in the consent form and the patient information sheet of the possibility that the interviews might raise issues that could be upsetting to them. Furthermore, participants were assured of their right to not answer particular questions, or to withdraw from the study at any time, and these assurances were reiterated at the beginning of the interviews or at points during the interviews if participants became upset. In hindsight, it would have been better to have obtained the co-operation of a second counsellor with no connection

to that clinic, since it became clear as the interviews progressed that returning to the clinic for counselling would have brought back too many difficult memories for some of the participants.

The possible reluctance to talk in depth about IVF failure was broached primarily in the structure of the interview schedule, which began with the more factual elements concerning the treatment history. This gave participants an opportunity to speak descriptively about what had happened, with the more emotional aspects coming later in the interview, when both the researcher and the participants were more familiar with each other. It was also assumed that the interview schedule would be treated flexibly by the researcher, so that as much as possible, the interview could progress in a conversational style that was more informal than rigidly structured around questions and answers. The second interview schedule was not designed at the outset of the project, but was drawn up based on issues that had become apparent in the first interviews. However, this interview schedule replicated this structure of beginning with the more descriptive elements such as updating on events since the last meeting, and clarifications from the previous interview.

Implementation

Recruitment

Unfortunately, the records at the hospital are not computerised, so possible participants had to be identified by sorting manually through dormant patient files, packed in dusty boxes into shelving space in every possible corner of the staff offices[52]. It was a stroke of luck that I was able to do even this, since the clinic was in the process of transferring all the records into remote storage, and recalling each record would have been prohibitively expensive. The staff member in charge of the transferral generously adjusted the order in which the records were transferred to allow me the time to obtain the information that I required. The records were examined for patients whose last cycle of IVF had been unsuccessful and had taken place between 1992 and 1997. Some patients were excluded from the list of prospective participants even where they met those criteria where it was known that they had experienced particular traumas such as late miscarriage, relationship breakdown or the death of a partner. Two of the

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[52] A system which clashed with the high-tech image of the technology.

consultants took the time to review my list of prospective participants in order to check that nobody had been included who they knew had had a particularly difficult time, but where that was not necessarily on the medical record. This led to the removal of two women, both of whose partners had died[53]. In total, 350 letters were sent out on hospital headed paper signed by both the clinic director and myself. A Patient Information Sheet was also included, along with a reply card where they could indicate yes / no to whether they would like to participate. Those who responded positively were then sent two questionnaires – one covering basic demographic information, and a second covering the treatment history – plus a consent form for each participant. Once these had been returned, the interviews were arranged by telephone[54].

Initially, there were 36 positive and 32 negative responses, with 45 letters returned to sender. Of the negative responses, most simply marked the "no" box on the reply card, although several added notes explaining either that they had gone back into treatment, or that they did not wish to relive the experience again. There was only one complaint, which came from a couple whose IVF four years previously had resulted in a pregnancy that had ended in a tragic late miscarriage, of which the clinic was unaware. The male partner expressed his anger at being contacted both to myself and to the clinic director. Unfortunately, there was little we could do except apologise and guarantee that he would not be contacted again, but the incident was a sobering one.

Of the positive responses, eight subsequently failed to return the questionnaires. In two cases, a follow-up letter from me established that their circumstances had changed making it difficult to participate, and two others simply felt that they no longer wished to continue. No further communication was received from the remaining four, and after several months, they were removed from the participant list. The final list of participants included 15 women whose partners did not wish to participate, and 13 couples.

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[53] Men diagnosed with cancer can deposit sperm in advance of treatment, which causes sterility, and then the couple can undergo IVF at a later date. In both of these cases, this had happened and the male partner had subsequently died since the unsuccessful IVF attempt.

[54] These documents are all contained within the appendix. The letters have been printed out onto plain paper because the confidentiality requirements prohibit the name of the clinic becoming known. This is to protect the anonymity of the patients, rather than the clinic.

As had been predicted, in spite of including as many patients from the ethnic minorities as possible in the initial list of possible participants, the sample was predominantly white, with one participant of Afro-Caribbean origin, and one who was Nigerian. Class representation followed a similar pattern, with the majority of the participants being middle class and well-educated. Of the 28 women or couples involved in the study, 15 had children living with them at the time of the first interview. Seven of these were born prior to the final unsuccessful IVF cycles, conceived through fertility treatment or natural conception, either in the current relationship or in previous relationships. One child was adopted from China following the end of treatment, and the remainder were conceived either spontaneously or following conventional or alternative treatments other than IVF. One of these children was the result of a surrogacy arrangement with the female participant's sister. Apart from one participant who was separated from her husband, and another whose relationship broke down in between the first and second interviews, all the participants were in established heterosexual relationships. The number of cycles undergone ranged from one to 12, and many of the participants had received treatment at a number of different hospitals, both NHS and private. Expenditure on treatment ranged from very little up to well over £20,000.

The Interviews

With the exception of two of the participants, for whom it was more convenient to be interviewed at their offices, all the interviews took place in the participants' homes, facilitating an atmosphere which was as relaxed as possible. However, the hospital through which the participants were recruited attracts patients from across the region, and therefore, getting to the interviews often involved driving considerable distances. As a rather timid driver (at least at the outset) with an atrocious sense of direction, this was quite a stressful and exhausting aspect of the interview process[55]. However, armed with a mobile phone and the maps and instructions which the participants had provided, I always managed to arrive safely, if a little ruffled around the edges.

On arrival I was always treated with unfailing hospitality, and the interviews took place either in the living room or around the kitchen table over coffee. Although the interviewees were not paid for their participation, a small gift of chocolates was given at

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[55] In total, I drove over 3000 miles in the course of the year, by the end of which, if nothing else, my sense of regional geography had certainly improved.

the beginning of the first interview in recognition of their assistance with the study. Unfortunately, one of the consequences of the warning that the interview could be upsetting and raise difficult emotional issues was that several of the women were extremely nervous and reported having lost sleep in the days prior to the first interview. However, when it became clear that the interview was going to take a conversational, rather than interrogative, tone, much of this tension was dissipated. This nervousness was not apparent for the second interviews. It was also notable that many of the participants spoke more frankly and openly in the second interviews, suggesting that their responses had been slightly more guarded in our first meeting.

The tape recorder also had an inhibiting effect on several of the participants, who were reticent while being recorded, but voluble once it had been turned off. I never felt that this was due to not wanting to speak "on the record", but had much more to do with worrying about sounding strange or inarticulate. This concern about appearing inarticulate was also reflected in the response of many of the participants to the transcripts of their interviews, where they were horrified to see the usual peppering of hesitations, false starts, ums and ers of conversation[56].

As was mentioned above, the approach to the interview guides was very flexible, and themes that were highlighted in the guides were generally pursued in an order dictated by the path the conversation was taking. Furthermore, as a qualitative rather than a quantitative study, it was not deemed important to replicate the form of questions exactly between interviews, and although all the themes were covered to some extent for all the interviews, questions were omitted where they were not relevant, or where participants were clearly unwilling to pursue that line of inquiry. Although the interviews were clearly structured to some degree, with the conversation occasionally being looped back to a theme that had not yet been covered, the tone remained primarily conversational, full of interjections, reciprocal questions and detours. Furthermore, even though sadness was inevitably a feature to a greater or lesser degree in all the interviews, they were also punctuated by good humour, knowing irony, jokes and laughter. I was also asked questions about my own reproductive history, marital status and so on, which I was happy to respond to. I also shared the fact that I suffer from

endometriosis with those who also have the disorder. The interviews, then, should be seen as dynamic events, full of activity, rather than a simple information gathering exercise.

Where male partners participated in the interviews, the couples were always interviewed together. I had originally planned to allow them to choose whether to be interviewed together or separately, but it soon became clear that this only added to the initial anxiety felt by some of the participants, who felt that separate interviews constituted something of a "test" of the veracity of their accounts. In addition, several of the male participants found it quite difficult to talk about their experiences, and my feeling is that the prospect of a one-to-one interview might have led them to withdraw their participation. Finally, since many of the couples lived some distance away, it was logistically simpler for me, and far less time-consuming for the couple, if we all met together.

The Transcripts

The interviews were transcribed orthographically (Wood and Kroger 2000: 83) – that is, using standard spelling, with bracketed descriptions of key non-verbal responses such as laughter, crying or pausing to think. This method of transcription was selected primarily because of the difficulty of reading phonological transcriptions. The participants were all sent copies of their interview transcripts, and their corrections and further comments were invited, and therefore, it was important to use the most accessible transcription system possible. The intention to make the transcripts as accessible as possible to the participants reflects the feminist orientation of the project, which aimed to involve the participants to the greatest degree possible, and to provide the maximum opportunities for their input. This also provided a means of allowing the participants to withdraw or amend particular statements, which I perceived as a fundamental part of my ethical responsibility towards them. Even with the orthographic transcription, many of the interviewees found the transcripts impenetrable, and found the hesitations and repetitions of conversation distracting (and embarrassing). As such, the reviewing of the transcripts was perceived by several of the participants as an unwelcome chore, and when I realised this, I began returning the transcripts with a note saying that if I didn't hear from them with any changes, I would assume that they were happy with it. Some

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[56] However, several also noted with relish the embarrassing regularity with which I say, "Right..." during

picked through the transcripts rigorously, adding afterthoughts and dates, and making small changes, while others chose not to read them.

Very few of the participants reported showing the transcript to anyone else, including the male partners who did not participate, although most reported discussing it with their partners. One couple had shown the transcript to friends as a means of communicating their experience to them, and another asked for a copy of the tape. The interview included a lengthy description of their decision to have a child through surrogacy and they wanted to play this to the child when she was older.

Confidentiality

Aside from a clear ethical responsibility to respect the confidentiality of the participants, there was a strong legal imperative to maintain confidentiality. Shortly after the recruitment letters had been sent out, the HFEA issued a memo about giving outside researchers access to patient records. The HFEA has ruled that simply adding the researcher's name to the license is not sufficient, and that the patients must be contacted by the clinic in order to obtain their consent. Although the initial letter I sent out was from the clinic, co-signed by the clinic director and myself, the fact that I selected out the addresses from the records is probably in breach of the new guidelines.

The confidentiality of the interviews was a point that was often confirmed by the participants before saying something particularly critical of one of the clinics they had visited, or while confessing to some small dishonesty which had been used in order to speed up the process of obtaining treatment[57]. All identifying information, including the interview tapes, was kept in a locked cabinet for the duration of the research, and on completion of the study, the tapes are to be destroyed. Pseudonyms have been used throughout the writing of the thesis and any other papers, and I have aimed to remove any other identifying information. On one or two occasions, I have referred to incidents without using a name for the participant at all, particularly regarding information which was intended to be kept secret from their partners.

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the interviews!

<u>The Role of the Researcher</u>

The possibility of the impartial interviewer as discrete from the interviewees and their responses, or of the elimination of power differentials between the two, has been widely denounced (Oakley 1981; Maynard and Purvis 1995; Rubin and Rubin 1995; Kvale 1996; Wilkinson and Kitzinger 1996; Woollet 1996). This study is no exception, and some of the ways in which the experience of being interviewed, as well as perceptions of the researcher, influenced the responses of the participants were easily apparent.

Firstly, the association of me with the hospital could be seen to be inhibiting the participants' willingness to criticise the hospital, particularly if the possibility of seeking further treatment still remained. Furthermore, several of the participants perceived me as a potential source of information about new techniques that might be available or even, in one case, as a means of acquiring "brownie points" with the hospital which might lead to priority access to any new treatments. I corrected these false assumptions as soon as I became aware of them. Secondly, in two cases, the participants cited the first interview as having given them the motivation to return to treatment (although not necessarily to IVF), and in one case this was being done behind the partner's back. This was obviously very disturbing to me, and was an outcome that had been identified in the project design as highly undesirable. However, closer examination of the interviews with these two women suggests that even at the outset of the interviews, they were still not resolutely committed to the idea of stopping treatment, even though circumstances had prevented them from continuing at the time. Consequently, it was felt that although the interview clearly was a catalyst for the decision to return to treatment, it is probably a decision that would have been reached in any event. Nevertheless, it was a sobering reminder of the potentially disruptive effects that being interviewed can have on the interviewee. The third area where the interview became embedded in the narrative itself was when the experience of being interviewed was perceived as having facilitated greater communication and understanding between the couple. For several of the couples, the interview provided an opportunity to explore lingering doubts about their partner's feelings about the treatment, and was perceived by them as cathartic. For others, the interviews had raised issues which they had not previously considered, but

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[57] It was quite common, for example, for women to exaggerate to their GP's how long they had been trying to conceive for fear that they would be forced to wait before they could be referred to a consultant. Deception about smoking habits was also common.

which they then discussed together after the interview was over. This was not always a positive outcome, however, and in one case, the first interview (with just the female partner) led to the raising of several painful issues between the couple, who subsequently separated. As in those cases where participants returned to treatment, I believe that my role here was as one of any number of possible catalysts, but nevertheless, this is a sad outcome which I deeply regret. More positively, several of the participants reported themselves to be now considering the use of contraception, and others reported having felt more able to talk openly to friends and family about the treatment, secure in the knowledge that they could now talk about it without becoming very upset. Of course, these are only the most apparent examples, but it can only be assumed that more subtle manifestations of the interactive nature of the relationship between interviewer and interviewee remain embedded in the talk that was produced.

The Interview Schedule

The study set out to answer three key questions, as described in Chapter 1:

1. What are the factors informing the decision to stop treatment?
2. How does the experience of IVF failure impact upon perceptions of the technology?
3. How does the experience of IVF failure impact upon the ways in which involuntary childlessness is experienced?

These key questions suggested a number of themes around which the interviews could be loosely structured. These are set out below, with a brief description of the rationale behind each theme and some of the key areas of questioning incorporated into it. Copies of the interview guides for both interviews can be found in the appendix.

First Interview

The first interview was structured largely chronologically to facilitate the telling of the participants' stories whilst creating openings for further exploration and discussion within that narration. The interview can be divided into four main sections: treatment; withdrawal from treatment; after IVF; and future plans. The interview was brought to a close with a brief discussion of the participants' motivations for taking part in the study.

Treatment

The process of seeking IVF treatment is frequently lengthy and complicated, and it was important for the interviewer to be able to share reference points in the treatment history in future sections of the interview. It was also anticipated that further themes would emerge from within the narrative which could be explored either during this interview, or postponed until the second interview. The largely narrative responses required by the questions in this section also created space for both the interviewer and the participants to become more familiar with each other and establish a degree of trust before approaching the more emotionally challenging aspects of the interview. Questions focused on aspects of clinic selection, expectations of IVF and the extent to which the actual experience matched those expectations, information-seeking behaviour and the perceived degree of control over the process.

Withdrawal From Treatment

This section covered four main areas: the decision to withdraw; the role of friends and relatives; the significance of money; and the role of the clinic.

The decision to withdraw

The key focus of this section was the extent to which a definite decision to withdraw is perceived as having been made and who took responsibility for making that decision. It was anticipated that this area of questioning would create opportunities to explore the gender relations between the couple, as well as identifying a range of factors that have a bearing on the ending of treatment. Questions covered the establishing of limits prior to starting treatment, the making of the decision and the degree to which it was perceived as mutual, the retrospective view of that decision, and the extent to which the decision could be said to be final.

The role of friends and relatives

Friends and relatives are conventionally assumed to be valuable sources of emotional support during times of great stress. However, this section was designed to explore the degree to which that assumption was true, particularly in the context of the decision to end treatment. This also involved a more general discussion on the involvement of family and friends before, during and after treatment. Questions explored who was told about the treatment and the ways this information was presented or kept secret; the

response of family and friends both to starting and stopping treatment; and the involvement of people outside the couple in decision-making.

The significance of money

Financial limitations are perceived within the dominant representations of IVF as a crucial factor in the decision to continue or withdraw from treatment programmes, and the questions here explored that assumption. Questions focused on the financial sacrifices that had been made to pursue treatment, the significance of financial factors in the decision to end treatment, and how that expenditure was perceived in light of the fact that the treatment had failed, given the centrality of "getting your money's worth" in consumer culture.

The role of the clinic

The structural positioning of doctors in relation to patients creates a power difference that gives the doctors considerable influence over the decisions that are made by the patients. Consequently, it was assumed that doctor-patient interaction would play an important role in the decision to end treatment. The questions in this section were intended to consider the kinds of advice patients wanted and received from clinics, as well as the influence that the level of satisfaction with regards to the delivery of treatment had on the final decision to withdraw. Questions also considered the extent to which counselling and support groups, both within and external to the clinic, played a role in the participant's management of treatment failure and the decision to end treatment.

<u>*After IVF*</u>

Given the exclusion of IVF failure from the dominant representations of IVF, very little is known about what happens after treatment has failed and the decision has been made not to undergo any further treatment. The only images that we are given of those for whom treatment has not worked present women, in particular, as defined by the perpetual lack of a child and irretrievably sad and trapped within that definition. This section aimed to explore the veracity of that discourse. Questions focused on the making of plans for the future; the kinds of support that were drawn on; feelings of regret in relation to having engaged with IVF; perceptions of the self as infertile;

perceptions of IVF; and responses to high profile media stories about IVF once treatment had ended.

The Future

IVF is big business, and considerable resources are being invested into research and the development of new techniques. This contributes to the discourse of science and technology as progressive, and this section was concerned with whether the promise of future developments rendered any decision to stop contingent. Questions explored the extent to which participants followed new developments, either out of interest or searching for new treatments that might help them, and the likelihood of returning to treatment if a suitable new treatment did become available. The possibility of returning to treatment if financial constraints were removed by increased health authority coverage, for example, was also considered.

Participation in the study

All the participants were asked their reasons for participating in the study. This was primarily with the goal of understanding the ways in which their perceptions of the study and their role in it might have a bearing on the responses that they gave.

Second Interview

The second interview guide was drawn up when all of the first interviews had been completed and the transcripts had been carefully studied. Based on this, the following broad areas , including both issues raised in the first interview that needed further exploration, and issues which had been unanticipated but which had become apparent in the course of the first interviews were identified: update; clarifications; approach to infertility; negotiation; confiding; relationships; children; the body; advice to others; and being interviewed.

Update

The second interviews all began with an opportunity for the participants to fill me in on any significant changes that had taken place in their lives, either around the fertility issue, or in consolidating their lives without children, or the desired number of children. Participants were asked specifically about whether new cycles of treatment had been started, planned or considered, and more generally about any changes in circumstances.

Clarifications

This section presented an opportunity for factual details such as the number of cycles or where different cycles had taken place to be clarified, since these details often became lost in the telling of long, complicated treatment histories. It was also a good opportunity to raise the issue of money, which had proved to be a very sensitive subject about which many of the participants were very reluctant to speak. The questions here were designed to explore the extent to which money and the control of it became significant when the male and female partners disagreed about whether or not to pursue treatment. Participants were asked whose money had been used to pay for treatment, whether household finances were separated, and who was responsible for money within the household.

Approach to Infertility

Infertility is commonly defined in a static way as the biological inability to conceive and carry a baby to term. However, the first interviews had demonstrated that the ways in which that experience was perceived at different stages of the process changed. In particular, it had been interesting to note the almost universal rejection of the label of infertility, even where it was accepted that they would never have a child. Therefore, the questions in this section considered changes in their attitudes towards their inability to have the family that they had hoped for; contraceptive use as a means of putting an end to any uncertainty over future conception; and continuing hopes for spontaneous conception.

Negotiation

While IVF is assumed within the dominant discourse to be a couple's technology where both parties act out of common interest, the first interviews revealed the extent to which those interests could differ between the male and female partners, and the complex use of negotiating strategies in the decision-making process. Gender relations proved to be central to these negotiations, and this section encouraged the participants to consider these issues further. Participants were asked to describe how they make decisions as a couple, not only in the context of IVF, but also more generally, and they were asked who, if anyone, was understood as taking the lead in decision-making.

Confiding

The first interviews had revealed the issue of confiding in friends and family to be a very difficult one for the participants to manage, and this section encouraged the participants to elaborate on this further. In particular, it was hoped that this would illuminate further the extent to which reluctance to tell people was related to feelings of shame associated with having IVF, or whether it was more pragmatically motivated, in order to retain privacy and to limit social awkwardness when treatment failed. Questions included whether confiding is made easier by increased public awareness and acceptance of IVF; whether they considered themselves to have made the right decisions with regards to telling people about the treatment; whether they were ever given any advice in coping with the problems associated with the decision of whether to confide or not; disagreement between the couple over who to tell; advice to others; and if they had been successful, whether they would have told friends and family that the child was conceived through IVF.

Relationships

The questions here were aimed specifically at those who either had no children, or who had expected to live without children. Many of the women in this situation had spoken in the first interview of the social exclusion of living without children when most of their friends had children of their own, and this section aimed to establish the extent to which living without children had affected the social relationships which they had chosen to actively pursue. Questions focused on the ways in which the experience of infertility had led to a change in their social circles.

Children

This was perhaps one of the most sensitive sections of the interviews, and it explored the participants' motivations for wanting to be parents. In particular, it was hoped that these questions would explore the extent to which a personal sense of identity was invested in the concept of parenthood and the impact of this on coping with childlessness, or living without the desired number of children. Participants were asked why they wanted children; whether they had ever explicitly considered those motivations during or after the IVF process; the importance of social inclusion in the decision to have IVF; and the importance of genetic continuity. Questions also explored the extent to which, if at all, and at what stage, the prospect of living without children

had been seriously considered, and whether there were any significant role models in their social, family or working lives of women and couples who had lived without children. Concepts of parenthood, particularly for women, were also explored in terms of plans to return to work, had the treatment been successful.

Body

One of the most significant and shocking outcomes of the first interviews was the extent to which women, in particular, took responsibility for the failure of treatment onto themselves, even where male factor infertility was confirmed. This section was designed to explore the extent to which perceived bodily failure impacted upon the relationship between the body and the self. Perceptions of the male body were also explored, particularly in the context of the common association between male fertility and virility, and the impact that this had had on the attribution of responsibility for treatment failure by both male and female partners. Questions encouraged participants to consider where they saw the treatment failure as lying; the role of doctors in the attribution of responsibility for the failure of treatment, both implicitly and explicitly; the perceived effects of that failure on the sense of self; and the gendered impact of treatment failure. This section also considered the role of IVF as a means of achieving resolution around the issue of infertility by having done everything possible. This was frequently referred to by the participants in the first interview, with many stating that they did not wish to look back with regret in later life. The final questions in this section explored the extent to which this goal was perceived to have been accomplished and the role that this discourse played in defending themselves against the negative images of those living without children.

Advice to others

It soon became clear in the first interviews that the majority of the participants had received very little constructive advice from the providers of treatment about dealing with IVF failure and the withdrawal from treatment. However, even at that early stage it was becoming apparent that strategies such as the setting of tentative limits to treatment, provisional planning for a future without biological children, and early consideration of the consequences of telling or not telling family and friends about treatment were all useful when it came to managing the tragedy of treatment failure. In almost every case, these strategies had been developed by the couples themselves, rather than on advice

from the clinics. The questions in this section aimed to identify strategies for coping with IVF and its failure which their own experience had taught them was useful, or not, which might be useful to future patients.

Being interviewed

One of the primary concerns from the outset of this study was the impact that being interviewed on this issue might have on the participants, both in terms of emotional well-being and also in terms of future decision-making. In addition, it was felt that feedback from the participants on the experience of being interviewed would be a useful learning experience for me. Questions explored the participants' feelings about the interviews and the transcripts; whether the interview or the issues raised in it had been discussed between the couple after the interview; whether the possibility of returning to treatment had been revisited following the interview; the extent to which the interview had been upsetting to the participant; and whether the transcript had been shown to partners who had chosen not to participate.

Analysis

The analysis of the data began with repeated re-readings of the interview transcripts, taking notes of recurrent themes. The data was then organised using NUD*IST, a qualitative data analysis software package. All the interview data was transferred to the NUD*IST database, and then coded into ten broadly thematic categories according to the framework included in the appendix. This initial process facilitated the breaking up of the extensive transcripts and laid the foundations for a more iterative analytical process by which the relationships between those coding categories became more apparent. At this point, the slightly disappointing reality that I have never fully managed to make the transition from pen and paper to computer screen became apparent, and I found it impossible to think analytically about the transcripts by reading the text, or coded sections of text, on screen. So, somewhat embarrassingly[58], I ended up printing out the coded content of each of the categories, creating ten large themed books of transcript extracts. I then worked through each of these, picking out recurrent themes through repeated re-readings, and marking them with coloured highlighters and post-it

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[58] Although why I feel I should use the computer (aside from having paid a large sum of money for the software) is another issue to think about in terms of the status of technology.

notes. A little messy, perhaps, but effective. It was in the course of this process that I arrived at the themes which form the basis of the four analytical chapters of this thesis.

Throughout the analysis and writing-up process, the problem of how to represent the participants without giving up my own responsibilities as a researcher to think critically about the interview data was a persistent problem[59]. If research is to be more than plain narrative without analysis, the voice of the researcher will inevitably become dominant, not only in the selection of illustrative narrative, but also in its interpretation (Acker, Barry et al. 1991: 136). It is therefore possible that the conclusions may not be acceptable to individual research participants. This was demonstrated in the work of Verta Taylor and Leila Rupp (Taylor & Rupp 1991), who found their respondents unwilling to identify as feminists even though this is the identification they wished to use to describe them. In the context of this study, I felt (and continue to feel) uncomfortable about making interpretations which might appear to be calling into question the participants' interpretations of events. One effect of this concern can be seen in my relative willingness to assess critically the actions of those men who did not take part in the study (based on interviews with their female partners), while I was far more ready to seek out alternative explanations for similar actions in male interview participants, to whom I felt (and indeed, had) a greater obligation. Aside from suggesting a need to be more sensitive to portraits of individuals whose stories I have only heard second hand, this also made me appreciate the impulse to censor myself to avoid conclusions which particular participants would probably find unpalatable. I have tried to achieve a balance whereby I demonstrate the process by which my conclusions were reached whilst reflecting dissent (or the expectation of it), including textual examples where possible. However, this is a difficult balance to strike and one which I have only (inevitably?) imperfectly achieved.

Distributing the Results

Lorraine Code argues that the feminist researcher is responsible not only for the production of knowledge, but also for the whole process, including the distribution of those findings, requiring her to consider how that information enters the public arena (Code 1993: 30). This should be considered not only from the perspective of the

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[59] The problems of representing others in academic and political writing are addressed in Sue Wilkinson and Celia Kitzinger's edited collection (1996) .

channels which are used to distribute the information, but also the form in which it is presented.

There are four key target audiences for this research: the treatment providers, the counsellors, the patients, and the feminist academic community. The preliminary results of this study have already been reported to the doctors at the clinic through which the participants were recruited, and several recommended changes to the delivery of treatment were discussed at this time. These included: proposals to assign a particular nurse to each patient in order to offer some continuity of care; changes in the geographical layout of the clinic; the reconsideration of the use of "baby pictures" as decoration; including stories of "successful failure" in the clinic literature; arranging an introduction to the counsellor at the earliest possible stage in the treatment process; and changes to the system in place for the provision of sperm samples. This meeting also led to the re-drafting of some of the patient literature distributed by the clinic, with particular focus on clarifying the role of the counsellor and how to access her services. All the participants will receive a short summary of the research findings. Other intended distribution channels include the academic journals of fertility counselling bodies; infertility support group publications; feminist academic journals; and books aimed at academic and popular audiences.

Conclusion

This chapter has set out the methodological framework for this research project and the ways in which this was implemented. This framework is one which complements the approach taken to IVF as described in Chapter 2, and is intended to facilitate a feminist politics which aims not at universalising statements about women, or reproductive technology, but instead, which seeks out spaces between the dominant discourses, or points of exit from them. It is argued that this approach potentially opens up new ways of thinking about, or seeing, IVF which extend beyond exclusive and over-arching categorisations of benign or malevolent.

As a piece of research which has its foundations in the postmodern suspicion towards truth claims, there is nothing definitive in the analysis which follows on from the methodological position outlined here. Instead, the analysis should be understood as an *interpretation*, and as such, the data presented here remains open to alternative

readings. This resistance to closure around meaning, and the refusal of definitive knowledge claims is fundamental to the "conversation" which comprises "situated knowledges". For reasons of participant confidentiality, it is not possible for others to have access to the tapes or transcripts, and I have therefore included substantial excerpts from the transcripts in the analytical chapters as a means of maintaining this openness, although I am inevitably present in the selection of passages.

It is to this analysis that I now turn, and which forms the substantive body of the thesis.

Part II: Analysis

As described in the previous chapter, the analysis itself draws heavily on the interview data, and focuses on four key themes: the negotiation of discourses of nature and technology; the identity of the IVF patient as a consumer; the distribution of responsibility for IVF and its failure; and the seeking of resolution when IVF fails and treatment ends. These were selected as the broad themes around which the analysis would be structured, based on their identification in the accounts as issues of importance to the participants themselves, recurring repeatedly across a number of topics throughout the interviews. Each of these chapters can be read independently, although they are linked by core issues which emerge across these themes, including: the misrepresentation of IVF in popular and medical discourse; the ambiguous location of the participants between contradictory discourses; the desire for "normality" among the participants; and the intractability of reproductive normativity, particularly for women.

The research generated an enormous amount of data, and inevitably, not everything of importance could be included in depth. There are a number of issues that are alluded to briefly in the thesis, but which are not explored at length. These include: the management of risk; the problems of who to confide in about the treatment; employment and IVF; secondary infertility and IVF failure; the meanings given to statistics by the participants; and "the family". It is planned to develop the analysis further by focusing on these issues at a later date. The number of themes that it was impossible to include in depth testifies to the amount of work that there is to be done on the important issue of IVF failure, and I have made a start on this in the analysis that follows.

Chapter 4: Negotiating Nature and Technology

The concept of reproductive technology embodies a tension between that which is constructed as supremely natural (reproduction) and that which is rational and progressive (technology). As described in the introductory chapter, this tension finds an uneasy resolution in the notion of "giving nature a helping hand" for as long as the final outcome is a baby. The gametes, the end product and the desire for a child are still understood as "natural", and the use of technology to facilitate this outcome is rendered invisible once the child is born, since there is nothing to mark an IVF baby out from any other[60]. However, this resolution is extremely fragile, and unsuccessful IVF confronts the women and couples who make use of it with a general unease about the use of technology for reproduction, both in themselves and others. This chapter will consider the ways in which the tension between nature and technology is negotiated in the participants' accounts, and the implications of this for feminist theorising of the relationship between nature and technology.

Chapter 2 addresses the emergence of the "cyborg" in feminist theory, and its growing importance as a means of making sense of the relationship between nature and technology, and by extension, gender and technology. Donna Haraway argues that modern medicine is "full of cyborgs, of couplings between organism and machine" (Haraway 1991: 150) – a coupling that is starkly apparent in the context of reproductive technology. As a product of theory, the cyborg is a seductive "feminist figuration" (Braidotti 1994: 3) which offers a new way of expressing "feminist forms of knowledge that are not caught in a mimetic relationship to dominant scientific discourse" (ibid.:75). Like Rosi Braidotti's figuration of the nomad, the cyborg offers a means of "blurring boundaries without burning bridges" (ibid.: 4) – a boundary confusion which Haraway identifies as a potential source of "pleasure" (Haraway 1991: 150). For Haraway, the cyborg is her "blasphemy" – an ironic piece of "serious play" (ibid.: 149). However, its status as a "political fiction" allows the concept of the cyborg to transcend social costs of blasphemy. The accounts in this study demonstrate the strong awareness among the participants of the risks inherent in the claiming of technology as a reproductive resource, particularly for those already exposed as "unnatural" by their failure to reproduce. Consequently, while the end result may be a blurring of the boundaries, the

accounts should be seen as aiming at a *clarification* of those boundaries, subsuming IVF within the natural (and therefore, normal) realm, whilst still retaining the oppositional category of technology against which to define the natural domain within which the participants wished to locate themselves. This highlights the tension that is constantly present in the use of lived experience as a basis from which to draw theoretical (and political) insights.

Chapter 1 described the ways in which, in tandem with representations of NRTs as benign and progressive, reproductive technology is strongly associated in social and cultural discourse with the commodification of life (Hirsch 1993: 115), and the risk of a rogue scientist attempting to create a "master race" (ibid.: 99). These fears find expression, for example, in repeated media references to the misnomer, "test-tube babies", provocatively suggestive of the dystopian ecto-genetic reproductive production lines imagined in Aldous Huxley's *Brave New World* (1932), or in the agitated responses to developments in genetic engineering, or every tabloid's favourite, cloning. The film *The Boys from Brazil*, where an army of Hitler clones is generated with a view to achieving world domination, offers a powerful example of this fictional re-enactment of the "master race" fears that Hirsch identifies. The atrocities in Nazi Germany in the name of eugenics remain a focal point in the concern over the eugenic implications of the NRTs[61], alongside contemporary concerns about the pernicious effects of racism or discriminatory attitudes towards those with disabilities.

But as described in Chapter 1, the fertility patient herself, and to a much lesser extent, her (conventionally male) partner, is the new villain of the piece. Within the dominant discourse, socially sanctioned reproduction is situated firmly in the natural domain, although what actually constitutes that domain is heavily contingent, and the boundaries are constantly shifting and mediated by age, race and class. In this context, nature is conflated with normal, where normality, which is constructed as self-evident, is always

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[60] The exception to this would be if there was a large multiple birth, although this is not possible with IVF in the UK, where the number of embryos which can be transferred is legally limited to two.

[61] The substantial UK and US role in the development of eugenic ideas remains less well known. Marie Stopes, for example, is renowned in the UK for her work in establishing the world's first birth control clinic, but it is not so well known that she was a life-long Fellow of the Eugenics Society (now the Galton Institute). The continued location in the popular imagination of eugenics in Nazi Germany constitutes an act of Othering which sanitises contemporary technologies with potentially eugenic applications in other national and temporal contexts.

normatively determined[62]. The excoriation of women who have engaged with NRTs outside the prescribed boundaries is a media commonplace, with post-menopausal women who have conceived through IVF making particularly easy targets, since they are, by definition, reproducing outside of their naturally reproductive life-span[63]. However, the accusation of unnatural reproduction is equally targeted at those reproducing outside of a stable, monogamous, heterosexual context, or those who undergo contract pregnancies specifically with a view to giving up the baby (Ragone 1998; Ragone 1999). Consequently, while the NRTs can be seen as a potential site of resistance or politically transformative transgression which is able to blur boundaries which appear static, they are not always explicitly articulated and intended as such by those undergoing treatment. To return to Braidotti's reminder, "nonbelonging can be hell" (Braidotti 1994: 20), and not all transgression is transformative; counter-normative applications of the technologies can have serious social and material consequences.

The construction of a distinction between justifiable and unjustifiable IVF based on the criteria of what would occur in nature – i.e. that lesbians and post-menopausal women would not reproduce, and young, heterosexually partnered women would – does not stand up well to scrutiny, since it ignores the problems inherent in determining what constitutes the natural. Indeed, many would argue that IVF is in and of itself going against nature[64]. This ambiguity means that there is always risk in the engagement with IVF of the charge of meddling with nature – a course of action which is assumed *a priori* to be beset with dangers. However, those whose treatment fails are caught in a "double bind" (Britt 2001: 11-14), since they are rendered doubly unnatural (and therefore, abnormal), firstly for engaging with technology for reproduction, and secondly, for being unable to reproduce. Indeed, it can be argued that IVF foregrounds that inability to conceive when IVF fails.

This chapter takes the discursive management of this double bind as its subject, and will explore the ways in which the participants deployed and resisted a range of often

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[62] See, for example, Margrit Shildrick's discussion of definitions of monstrosity in relation to conjoined twins and the assumption of the need for surgical separation (Shildrick 2000)

[63] It is important to note, however, that the distinction between a "normal" menopause (and therefore not warranting treatment), and an early menopause (warranting treatment) is in itself an arbitrarily drawn distinction. Nelly Oudshoorn describes a similarly arbitrary process by which 28 days became the determined length of the menstrual cycle (Oudshoorn 1996).

contradictory discourses in order to negotiate the tension between reproduction and technology. It will be argued that the primary purpose of this discursive labour on the part of the participants is to locate the self as normal, and therefore implicitly within the privileged natural domain, but as rational agents within that natural domain. This task of locating the self as normal is one which recurs throughout the analysis, and is considered more broadly in Chapter 7 as a means of pulling together many of the threads that have emerged in the course of the analysis. However, this chapter will focus specifically on the (normative) association of the natural with the normal, in opposition to the technological. The analysis which follows focuses on five key strategies: (1) drawing on the high status of science and technology in western society; (2) the demystification and naturalisation of treatment; (3) the definition of treatment in terms of medical necessity; (4) the claiming of the natural female body; and (5) the construction of the self as rational and moderate. These discourses should not be viewed as mutually exclusive and are used in combination within accounts, often with apparent contradiction, in order to achieve specific strategic ends. This chapter will consider these strategies in terms of their implications for the participants, and also in terms of feminist theorising of the relationship between nature and technology.

The High Status of Science and Technology

One of the most striking features of the accounts in this study was the reluctance of the participants to acknowledge the technological aspects of IVF. Instead, the technological aspects of the treatment were either played down, ignored, or subsumed within the natural domain. The possible reasons for this will be discussed later in this chapter. However, the exception to this is the strategic claiming of the technology as a means of establishing the mainstream status of IVF within a tradition of benign scientific progress, thereby diffusing the tension around the use of technology for reproduction. This is a strategy that conforms most closely to the ways in which IVF is represented by providers, and, unusually in these accounts, depends on laying claim to the highest technology possible. Largely as a consequence of western political and economic power and its overlap with the discursive strategies of scientific investigation, western medicine – and high technology medicine in particular – has become "uniquely

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[64] See, for example, the parliamentary debates on the HFEA (Franklin 1993; Challoner 1999), or the broader bioethical debates (Purdy 1996; Tong 1997).

powerful" (Porter 1999: 6), leading to the assumption that the high technology medical response is the last word in treatment – if that won't do it, nothing will:

> *Melissa: I mean, personally, I felt that going to [hospital], having the IVF and the ICSI, we had actually done the best we could try.*

The hospital where Melissa had her treatment is a major teaching hospital with an excellent reputation for its research. Furthermore, the consultant who heads the unit is a recognised expert in his field, with a high media profile, often appearing on television and radio debates. At the time she underwent ICSI, it was a very new procedure, and certainly the most sophisticated treatment on the market at that time, meaning that, for her, the treatment was as complete as it could possibly have been. The state of the art reputation of IVF, therefore, serves as a useful, demonstrative shorthand for having tried everything[65].

However, while this strategy of reifying the technology may be effective in deflecting criticism in the short term, it is not without consequences, including: (1) confounding the decision to stop treatment by the future promise of success; (2) generating misplaced linear expectations of the scientific process; (3) focusing on high-tech treatment over low-tech prevention; and (4) placing the doctors in a win-win situation which absolves them of the responsibility for treatment failure.

The future promise of IVF

The assumption of medical technology as constantly progressing generates the promise of more effective treatment in the future, making it impossible to find an ending to treatment:

> *Alice: [...] I'm probably 10 years behind everything, because these things are cropping up just as I'm reaching the too-old stage for it all, and in 10 years time, it will probably be so run-of-the-mill that it will be happening all over the place, and I'll be looking back thinking, "Why am I just 10 years too old for*

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[65] "Doing everything possible" is considered in detail in Chapter 7.

*everything?" But erm...I feel like I'm trying to sort of catch the tail of kite, you
know, and it's always just fluttering out of reach. But I might grab it, you know.*

*Liz: I think, in a way, you might kick yourself in 10 years' time when they find out,
"Gosh, you could have just taken a vitamin B6 while you were there. It would
have made all the difference." You know, like they found out about spina bifida
and folic acid. A simple little thing like that.*

At 47, Alice was the oldest of the participants still to be considering treatment, but she
remained tantalised by the prospect of having that one last opportunity, and was
searching with increasing urgency for a procedure that would enable her to receive
treatment using her own eggs, since her husband was very resistant to the idea of donor
eggs. At the time of our second interview, she was considering travelling to Italy to
undergo a controversial experimental treatment that involved removing the genetic
material from one of her own eggs, and injecting it into a donor egg that had already had
its genetic material removed. Any child that resulted would still be genetically hers,
although with the greater survival chances, in theory, of the egg of a younger woman.
As her age advanced, bringing a decline in fertility that compounded her other fertility
problems, Alice turned to increasingly high technology procedures in the hope of
successful treatment, and was frustrated by the tantalising idea that in just a matter of
years, all these treatments that she was chasing would be routinely accessible. For Liz,
however, the imagined future resolution was surprisingly low-tech, with fertility
problems resolved by Vitamin B6 - a simple dietary supplement. This was a common
vision among the participants, many of whom felt they were so close to pregnancy, with
only one small, apparently insignificant obstacle standing between them and success.
This provides an equally strong incentive to continue with treatment, inspired by the
belief that one tiny tweak of the treatment protocol could tip the balance in their favour.

Science as linear

However, the pressure to continue with treatment does not only come from the promise
of future technologies, since IVF brings with it the conviction that each cycle of
treatment will add to the doctors' understanding of the particular circumstances of their
inability to conceive, leading to a gradual refinement of treatment protocols within the
existing technology:

Lisa: You [husband] were great...because he was very realistic. Every time...after
every cycle, when something had gone wrong, and I was distraught, Simon would
say, "This is great, because we're getting closer each time to finding out what the
problem is. And here we are...we should look upon this as a positive thing."
Simon: Business teaches you that 99% of solving a problem is recognising what
the problem is. So all the time, we were trying to uncover what the problem was.

Simon takes a "common-sense" approach to resolving their fertility problem, isolating
out the problem, strategy and outcome, mirroring the scientific approach which
identifies the natural body as ultimately knowable. However, this linear perception of
the treatment process does not reflect the reality of IVF, which the interviews
demonstrated as producing dramatically varying results between cycles:

Susan: [...] At what point do you call a stop? And especially as it's not like an
exam, is it, where you think, "Well, I've got 50% this time, therefore next time I'll
get 100" You know, I had no...If it was going to happen, it could have happened
at any one. And I thought, well, the first one...and also, we reacted differently
three different times, didn't we.

While the scientific and technological context of treatment seems to suggest incremental
progress, driving IVF patients towards further treatment, the reality of the experience
proves otherwise, although it may take several cycles before a couple fully
comprehends the random nature of IVF success or failure. For a very small number of
the female participants, this realisation that fertility was not within the remit of
individual agency came as something of a relief:

Melissa: I am used to the idea. Erm...you know, we've lived with it for quite some
time now. I'm fairly comfortable. But there is still that ...it's something I
personally cannot do. Anything else, you'd just go out, get some training. You
know, you want to learn a language, you'd go and do it. There's absolutely
nothing that we can do.

Liz: I think [I felt] frustration because it wasn't ...it wasn't something that could be put right in a way of erm... maybe I've gone to do something and I've made a complete hash of it, so I will come back and there is no way that I would make that mistake again. I will find out where I went wrong and I will rectify that and the next time that I do that, that will be perfect. Erm...so I think not having that ability to correct that failure, and that sense of frustration of...you have to accept, erm...that you failed and you...I won't get any better. You won't be able to put it right.

Both Liz and Melissa were accustomed to setting and achieving personal goals. Consequently, the realisation that nothing more could be done, and that the equation of "effort = outcome" did not apply, was significant in their decision to move on from treatment. Both eventually returned to education, in Liz's case to obtain a professional qualification, and in Melissa's case to pursue her interest in horticulture. However, it is important not to overstate this sense of relief, and they are unusual among the participants in this, with the majority of the female participants experiencing profound feelings of guilt and responsibility with regards to treatment failure[66]. Furthermore, Liz and Melissa both had access to considerable financial and educational resources that facilitated this process of establishing new and achievable goals – resources which not all the participants had available to them.

High-tech cures over low-tech prevention

Another problem associated with the focus upon high technology is that it directs research interest and money away from the development of treatments which address the *causes* of infertility, including, for example, the early identification of endometriosis and pelvic infections, which can cause permanent tubal damage. In fact, several of the participants in this study were seeking treatment to circumvent scarring caused by infections resulting from the use of IUD's, or from undiagnosed and untreated endometriosis or infections. One of the patients even lost an ovary in the course of IVF treatment following an infection. Similarly, relatively little research is conducted into the influence of environmental and lifestyle factors, such as pollution, smoking, poverty or inadequate nutrition (Farquhar 1996: 42).

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[66] This is explored in Chapter 6.

From the perspective of the practitioner, the lower the technology involved, the less specialised the practitioner needs to be, meaning that professional status depends on complex high technologies, which are inherently more glamorous and heroic than preventative sexual health education, for example. Pfeffer notes that when general practitioners in the 1970's were asked to distribute contraception, they were resistant "…on the grounds that such as activity reduced their professional status to that of a barber or retailer of rubber goods" (Pfeffer 1993: 154). While IVF practitioners undoubtedly share the goal of their patients of a successful pregnancy, what is an end in itself for the infertile couple is also a means to an end for the practitioner in terms of economic success and professional status, leading inevitably to an emphasis on specialist technology which will always be exclusive of the majority of people who might identify themselves as candidates for treatment. It is also clear that the technology is developing beyond the treatment of infertility, particularly with the advent of PGD, and advances in genetic medicine that appear to offer future treatments for a range of serious illnesses.

Win-win for the doctors

The high status afforded to the NRTs relative to less glamorous methods, places practitioners in a win-win situation, where they cannot be held responsible for the failure of treatment (leaving the women to shoulder the blame), but can claim responsibility for its success. The constructed infallibility of science, coupled with the obvious fact that with over 50,000 IVF babies now having been born in the UK alone, the treatment *is* successful sometimes, the responsibility for the failure falls, even if only implicitly, onto the woman receiving treatment[67]. However, when the treatment is successful, it is a different story:

> *The birth [of Louise Brown] was announced at a press conference held at Prestwich Hospital, and Edwards and Steptoe gave interviews to television crews. Steptoe later recalled, in his own account of the birth: "It was Bob's [Edwards] brain, skill and perseverance and Jean's [Purdy (assistant to*

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[67] As described in Chapter 6.

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Edwards)] hardworking devotion which led to this wonderful moment of
achievement (Challoner 1999: 46)

The contribution of Mrs and Mr Brown, as well as that of all the couples preceding them without whom the procedures could not have been developed, remains unnoticed in the excitement. Similarly, while the responsibility for treatment failure is carried predominantly by the female patients, it is the clinics, and not the patients, whose successes are recorded. Nelly Oudshoorn records how "women" were written out of the reporting of early clinical trials of the contraceptive pill, in favour of the universal "cycle" (Oudshoorn 1996). This is replicated in the standardised statistical success rates, which measure the live birth rates per cycle of treatment started.

However, although many of the interviewees use the discourse of the certainties of science and technology extensively in their accounts, it is also clear that this discourse is being used selectively and with cynicism[68]:

> *Rachel: I still find it quite strange that in this day and age, and all the things*
> *that we can do and all the sort of technological advances in other areas,*
> *there still is this black hole over infertility [...] There's been sort of*
> *amazing, some amazing advances in the field, but even now, you know,*
> *doctors, specialists and that, they're still saying, "We just don't know." And*
> *even some of the treatments that are around, some of the things that they*
> *can do, they still don't seem to know quite how it works or why it works.*
> *And sometimes it does. And I just...frustration, I think. I just think*
> *sometimes that's really frustrating, that you know, you can do all these*
> *other marvellous things, but really we still don't know why there's*
> *infertility, and why there's so much of it about.*

While IVF was used by many of the interviewees, including Rachel, as offering the final word on their reproductive capacity, a certain realism remains about the limited capacity of technology and modern medicine to fully comprehend the mysteries of human reproduction. This echoes a more general cynicism in UK health discourse of

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[68] Hindsight is very important in this scepticism. Many of the interviewees reported that the experience of failed treatment led to the adjustment of their expectations of science and technology.

scientific assurances of safety, as in the uncertainty concerning the relationship between BSE, vCJD and meat consumption, or the ongoing concerns about the safety of the triple MMR vaccine and its possible relationship to the onset of autism. Margaret Sandelowski highlights the fact that a third of all infertile couples never have any explanation for their infertility, and treatment protocols that have repeatedly failed may suddenly, and unexpectedly, succeed without explanation (Sandelowski 1993: 15). For some, as discussed in the following section, this limited knowledge served to confirm the predominance of nature in the reproductive endeavour and was therefore discursively useful once treatment had ended. However, for others, this represented a gender bias in research initiatives. As Mary succinctly put it, "I think if it affected men's penises, I think we would have spent millions on it by now."[69] It will be interesting to see whether this scepticism becomes increasingly widespread in response to the growing consumer activism in relation to health following the Bristol heart surgery scandal, where high death rates for heart surgeries on babies went apparently unnoticed, or the scandal at Alder Hey Hospital, where babies' organs were retained for research without parental consent.

The normalisation of reproductive technology

For those for whom IVF does produce a child, the presence of a visibly unmonstrous child, posing no obvious threat to anybody, counters many of the widely held concerns about reproductive technology and its possible consequences. However, the normalisation of the technology and those engaging with it that is effectively performed by the presence of the baby when treatment is successful has to be performed more explicitly and discursively by those for whom treatment doesn't work:

> Tim: It seemed quite a simple technology really, to us. It didn't seem
> particularly...they made it seem quite straight forward. They just
> collect...they give you some drugs to make you produce eggs, then they
> collected them, then they fertilise them, put them back. I mean, that's
> simplistic, but that's what they were doing [...]

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[69] Rates of male and female factor infertility are approximately equal, but the technologies have been developed focusing on the female body. Therefore, while men are equally likely to be infertile, they are far less likely to be the object of medical intervention as a result.

Tim's construction of IVF as fundamentally low-tech stands in stark contrast with the claiming of high technology that was described in the previous section. The emphasis on the treatment as mundane supports the normality of the choices they have made to pursue it, and Tim later comments that all the more extreme stories in the media "give us IVF-ers a bad name", claiming a legitimatising and normalising group identity in accounting for the engagement with treatment. This normalisation of IVF is achieved through two strategies: (1) the construction of IVF as just another technology; and (2) IVF as simulating and facilitating natural processes.

Everyday technology

IVF is normalised in the accounts by its identification simply as another technology in a society where technology, and particularly medical technology, is omnipresent:

> *Paula: For years, people have been doing all sort of things to help conception, or hinder conception, or whatever. I've had lots of operations...just...nothing nasty...things like ligament reconstructions of the ankle, and wisdom teeth. I've just had 7 moles removed from my body under local anaesthetic.*

> *Tracy: If my computer goes down, I can't work. You ...I mean, it's inevitable that you are going to get things. I mean, people are going to live a hundred years. The turn of the century, people's average age was 60, and now it's 90. You'll always get that, and I don't think you can stop progress. And, you know, why would you? I have a very good friend who's had leukaemia twice. She's still here, thanks to technology.*

Both Paula and Tracy see IVF as part of a progressive scientific continuum. By positioning IVF alongside other, less controversial, medical technologies, the particularity of IVF and the concerns that surround it are diffused on the grounds that it is simply part of the unstoppable, benign march of progress. Conversely, it is precisely this technological continuum that is cited by radical feminists in opposition to the new reproductive technologies, who argue that there is nothing new about IVF at all, and instead, its pedigree can be traced back through a series of conceptive and contraceptive technologies that are abusive of women and damaging to their health (Klein 1987). However, when used in defence of IVF, the alliance of the technology with the vast

array of medical technologies now available is a powerful strategy in demystifying IVF whilst simultaneously drawing on its status as progressive and beneficial. This is particularly true when "normal" IVF is now being superseded by other more controversial technologies such as PGD, or even cloning.

Simulating nature

Another strategy for normalising the technology is to highlight the extent to which IVF can be seen to mimic the natural process of conception. Technology, here, is doing nothing that nature would not "normally" do:

> *Tim: We considered the IVF that we were having was just helping us to do something that was natural ... really still a natural act, but just taken out...the natural act was being done outside the body and being put back. It was us...it was still all of our bits that were being involved in it. All we were having was technology helping us. We weren't altering with technology.*

> *Cathy: [...] You know, all you're doing is putting mine and his together and doing what normally would have happened, but I can't do it because of other things. So, it's a natural process.*

> *Robert: It was natural...it was just the mechanics of it that were assisted. It wasn't like cloning a sheep, or growing ears on the backs of mice, or things like that.*

A distinction between *helping* nature and *tampering* with nature is crucial to the construction of IVF as fundamentally natural, with IVF functioning within this discourse as low rather than high tech; mechanical rather than technological. Sarah Franklin suggests that conventional IVF discourse renders nature and technology "not only commensurate, but substitutable", in that "[just] as IVF clinicians 'learn' from nature how to improve their techniques, so 'nature' can be improved by scientific and technological assistance" (Franklin 1997: 209). However, the awareness demonstrated by the participants of the dangers of *too much* technology reveals the limitations to this substitutability. It is "nature" that provides the discursive benchmark for the

acceptability of particular levels of engagement with reproductive technology, with technology strategically subsumed within that constructed domain.

It is also very much in the interests of practitioners to naturalise (normalise) IVF, although not necessarily for the same ends as the IVF patients. As will be explored in detail in the next chapter, IVF is big business (Moore 1999) and clinics, particularly in the private sector, are forced to compete for patients in the open market, rendering it against the interests of practitioners to articulate clearly the downsides of treatment. Furthermore, once a treatment appears normal and routinised (and therefore, presumably, safe), it is assumed that women will be more likely to demand that treatment (Wajcman 1991: 71).

The case of egg collection is a good example of this attempt to soften the impact of the treatment. Robert Winston, as discussed in Chapter 2, confidently asserts that "[there] is seldom any *real* pain" (my emphasis) (Winston 1999: 9) in the egg collection procedure, and this is endorsed by promotional clinic literature, which rarely concedes little more than the possibility of "discomfort", or "light twinges"[70]. This denial of female pain[71] is paralleled by the diminution of the pain of childbirth (or at least, the over-estimation of women's capacity to cope with childbirth) (Bendelow & Williams 1998), which was seen by one of the male participants as an unmissable part of the whole maternal experience – a view that his wife, who had experienced the protracted vaginal delivery of their daughter, disputed. The medical descriptions of the egg collection procedure differ sharply from the descriptions of the procedure by women who have experienced treatment (see also: Franklin 1997: 117):

> *Sarah: [...] and they said there were 13 follicles, and then they took me in*
> *and they had to take the eggs out. That was **excruciatingly** painful.*

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[70] Several of the male participants were also very reluctant to acknowledge the pain of this procedure, although one explanation for this is their own feelings of guilt at their female partners having to be the object of medical intervention.

[71] Ann Dally described how the capacity to feel pain was associated with civilisation, with women, therefore, less able to feel pain than men. This convenient explanation was used to justify the use of black female slaves for the development of surgical techniques (before the advent of anaesthesia) to treat fistulas, since they were doubly uncivilised by virtue of their race and gender (Dally 1991: 5).

Catherine: And we went in, and she did the operation to collect the eggs,
and I've never had so much pain in all my life. I could feel her, like, going
up into the ovaries and things.

Furthermore, the egg collection is only the final stage of a lengthy process of daily injections which have to be carefully timed and are often self-administered. The entire process of IVF is described by those who have experienced it as an "obstacle course" (Franklin 1997: ch.3), with the constant possibility of failure at every stage. The linear narrative, and particularly the casual alignment of egg and sperm collection is an oversimplification of the reality of IVF – a simplification resented by many of the participants, and particularly the women who have been on the receiving end of treatment. As Susan understatingly pointed out, "it's not like a picnic where you take a couple of tablets". This recognition of the technological nature of IVF, particularly on the part of the women who have been on the receiving end of it, conflicts with the construction of IVF as essentially natural, illustrating the way in which contradictory discourses are recruited to address specific problems. The discourse of IVF as fundamentally natural diffuses the tension around the use of technology for reproduction, while the emphasis on the arduousness of IVF demonstrates the lengths to which they went to try to achieve parenthood. IVF may be natural, but it is not to be understood as an easy option.

The closeness of the delivery of treatment to the natural process of conception is also exploited by both the users and the providers of treatment to refute the accusation that IVF is a failed technology because of its low success rates[72]. Challoner, in his pro-technology history of IVF, asserts that "a woman's body naturally rejects most embryos that reach this stage [cell differentiation]" (Challoner 1999: 32), and even for those embryos that do progress but fail to implant, "failure to implant is common in those produced naturally, so this negative result did not necessarily indicate that the IVF procedure was to blame" (Challoner 1999: 38). The same argument is used later in the book as part of his defence of cloning technologies, arguing that many animals reproduce asexually (Challoner 1999: 137). The equation of the natural failure to

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[72] This same strategy was used by Gregory Pincus to ease political concerns about the contraceptive pill he was developing. By allowing for menstruation by incorporating a five day break without pills into the

conceive and that failure to conceive through IVF fails to acknowledge the fundamental differences between the two processes and the differential physical, emotional and financial costs of those failures. Nevertheless, it is a strategy that was also useful to the participants in establishing the failure as a natural outcome which serves to diminish the technological effects of the process:

> *Paula: But...I don't know. While there's not perfection, I guess it in some kind of way still feels natural. It's not a perfect process, even without anybody getting involved. When it's just the man and the woman, it's still not a perfect process. All sorts of things can go wrong, and this was just an extension of that, I guess.*

The accounts given in this study also demonstrate that even while drawing heavily on the normality of the treatment, what actually constitutes normality is extremely fluid, both within and between accounts. Many couples went into treatment with a limit as to the level of technology they were prepared to use, especially with regards to the freezing of embryos and the use of donor gametes. Decisions not to continue treatment past a certain age, or placing a limit on the number of cycles of treatment were also common. These limits not only varied enormously between interviewees, but were also often transgressed once they had embarked on a treatment programme, illustrating the constructed and contextual nature of the normality to which the interviewees wish to ascribe.

Infertility as a disease

As described in the first section of this chapter, technological intervention for medical reasons is a common feature of western society, and medical intervention into involuntary childlessness has a lengthy precedent (Pfeffer 1993: 1). Therefore by constructing infertility as a disease, those who engage with IVF are able to deflect much of the unease about using technology for reproduction.

> *Karen: What's your general view of the technology itself? I mean, do you see it as a positive thing?*

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process, he was able to argue that the pill was simply mimicking the natural process (Oudshoorn 1994: 121)

Courtney: I wouldn't have said that 10 years ago, because of having a child
of my own, I'd see it, you know, as abnormal and...but to help people, I
think, when people can't have kids, it's not just that...it's a disease and
people should help it, not just, "Oh, go away!" You know. It's...it can't kill
you, you know, like cancer and everything else. But it's still a disease, that
people need help.

Beth: [...] And this is just another medical treatment to help people
overcome a physical problem that they've got, and I don't see why it should
be any different from any other treatment.

The positioning of IVF within the medical system validates this interpretation, and on entry into the medical system, the IVF candidate is quickly identified as a *patient*. The prospective patient follows an established routine for seeking medical care by visiting first a GP, undergoing preliminary tests, then being referred on to see a hospital consultant where necessary. On starting treatment, she finds herself in daily contact with the paraphernalia of medical treatment, even outside of the hospital environment, because of the daily injections, and as the treatment process progresses, she is subject to scans and surgical interventions, all within a hospital environment. The treatment records are explicitly *medical* records and subject to the same stringent confidentiality laws as any other medical record. These records are held in the name of the female partner, highlighting the medical focus of IVF on the female body. All the signals that treatment delivery sends out are of infertility as a disease that has a valid claim to treatment, and these signals were drawn on extensively by the participants in their accounts.

The reservations that Courtney had about IVF prior to her own experience of infertility – that the treatment was abnormal – are put aside with the understanding of treatment as "to help people" who are suffering from a disease, although this is quickly put into perspective, in that it's not cancer, and it can't kill you. Although not perhaps one of the most serious diseases, the listing of the social and medical sequelae of infertility was a common feature of the accounts, including depression, suicide and relationship breakdown, although with the exception of depression, these are largely social and not medical consequences. This catalogue of negative outcomes is used to reinforce the

status of infertility as a disease, and therefore to justify treatment. This need for justification stems in part from the tension that currently exists around the use of NHS resources to provide fertility treatment, and these issues are considered in detail in the following chapter. However, the key point here is that the use of medical technology to treat illness and disease is an established aspect of contemporary western culture, and therefore, by establishing infertility as a disease, the tension which exists around using technology for reproduction is circumvented.

The treatment also gained legitimacy in the accounts from the fact that it is subject to regulation by the HFEA:

> *Angela: [...] you know that the HFEA is spoken about, you know that it's being controlled. You know you're not, you know, there's not some wacky doctor doing, you know, ... You know you are in a controlled environment, that it is regulated. They're not allowed to put more than three embryos back in, and all that sort of thing.*

Regulation not only serves to limit maverick practices and to prevent IVF being used beyond delineated bounds, but it also offers legitimacy to IVF, producing its mainstream status. For Susan and Matthew, this established status was very important in resolving their concerns about the technology:

> *Matthew: [...] If we were the first ones to have used the technology, I think that might have been different, but erm..*
> *Susan: Yes, we're not brave enough to do something like that.*
> *Matthew: To be guinea pigs. But this is technology that's already in use.*

By following the example of others, Susan and Matthew are defining themselves as conventional and part of a large community of people who have made similar choices. IVF is, in this sense, a profoundly normal choice. For several of the participants, the fact that a close friend had undergone treatment performed a similar function, providing them with an opportunity to air their doubts and be persuaded[73].

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[73] In the context of cosmetic surgery, Davis notes the key role of close friends in accounts of the decision to have surgery, with the friend constructed as the persuader, and the narrator as having dilemmas over

The assertion of the mainstream status of IVF was used in reference to all aspects of the delivery of treatment, but particularly the use of hormonal drugs, the long term effects of which are still uncertain. The construction of IVF as located within mainstream medicine, and therefore assumed to be thoroughly tested, facilitated the management of risk in relation to those drugs. Not everybody would agree, of course, that IVF is no longer experimental. Indeed, this is one of the key issues raised by radical feminists in opposition to the new reproductive technologies, since the distinction between research and practice in IVF is very blurred[74]. IVF routinely generates an excess of embryos, which practitioners, with consent, can use for research purposes up to 14 days, and the production of embryos for research is an important income-generating activity for many clinics (Moore 1999). The distinction is further blurred by the offers of free treatment in exchange for participation in certain research programmes, which raises significant issues concerning informed consent, since there is clearly a strong financial incentive to participate. This is compounded by the obvious desire to stay on the good side of those providing the treatment (Cussins 1998: 113).

Although the pathologising of infertility can be seen as an effective and powerful justificatory strategy for introducing medical technology into the "natural" reproductive process, it can also be risky, particularly for women. In the long term, once treatment has ended without success, the pathology remains even after the treatment has ended and she is no longer presenting herself as a candidate for treatment. This residual pathology is problematic for women because while contemporary culture accepts the use of medical technology to treat disease, there is also a potent social imperative to remain healthy, and this is combined with an assumption that an individual's health is determined largely by the extent to which they are prepared to take responsibility for it (Sontag 1978; Coward 1989; Stacey 1997). As Bettina Leysen argues in the context of her research into the menopause, "...[the] message of popular culture is to be fit, healthy and active at whatever age or stage in life" (Leysen 1996: 173), but the

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whether to go forwards. This enables the narrator to demonstrate the thoughtfulness with which they have approached surgery, as well as having received the stamp of approval from significant others (Davis 1995: 125).

[74] In her study of sex hormones, Oudshoorn notes that hormonal preparations were never fully tested, fixed products before becoming available, and were developed in an ongoing process of testing and research (Oudshoorn 1994: ch.6)

responsibility for achieving that state of health lies with the individual, making the failure to meet the healthy ideal a matter of personal failure:

> *Melissa: [...] I think I always...this sounds really awful...but I've always seen it as a bit of a weakness. If you're ill or you have something wrong with you, it's a kind of a weakness. I don't actually think that about other people...honestly, I don't, but in myself, I do, and I just really didn't want anyone to know.[...] So, to actually admit something like that, no, no...*

The pathologising of infertility synecdochically pathologises the whole woman, defining her entirely by her inability to reproduce, and by declining treatment, or stopping it, the woman herself becomes responsible for that pathology by refusing to treat it (Raymond 1993: ch.1). Ironically, even where male factor infertility is implicated, it is still the woman who is identified as the object of treatment. This reflects the wider identification of the female rather than the male body as defined by reproduction, and therefore the object of reproductive medical intervention, as discussed in Chapter 2. A further irony is that while the identification of infertility as a disease warranting treatment is central to the claim to IVF, the technology is unusually situated in that the ideal patient is a *healthy* one[75]. Indeed, many of the participants cited their own good physical health as enhancing their status as good candidates for treatment. This highlights the conventional and contradictory construction of the normal female body as unstable and unruly and therefore requiring medical management. This is particularly true in the context of hormones, as the next section will discuss.

The Natural Female Body

Women are conventionally understood as being at the mercy of their hormones (Oudshoorn 1994), which are constructed as driving them towards reproduction[76]. The construction of the maternal drive as hormonally fuelled provides a strong justification for the use of technology for reproduction, since this retains the dominance of the natural in the reproductive endeavour, with technology appearing to function simply as

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[75] Oudshoorn observes that the contraceptive pill was the first drug to be administered to healthy people for a social purpose (Oudshoorn 1994: 112)

[76] Hormones are also considered responsible for "unpredictable" behaviour by women, and this issue is explored in detail in Chapter 6.

a means to an end[77]. However, the very need for a strategy of justification testifies to the dilemmas and risks inherent in engaging with that technological intervention and the need for careful discursive management.

In the context of this study, the hormonal discourse had very different implications for the male and female participants, and it was in the accounts by the male participants that it emerged most directly. The construction of an irrepressible maternal drive enables the male partners to create a distance between themselves and the technology, since the technological means becomes subordinated to feminised natural ends:

> *Martin: I think it's been a bit of a burning desire for Nancy to have a child. But if I'm honest with myself, I'm very much…I was very much, if it happens, it happens. If it doesn't, it doesn't.*

> *Brian: Why go with all that stress? Be happy with what you've got, which was always what I said. Obviously, you have to, erm, put that against the maternal instincts, and so on […]*

Both Martin and Brian contrast their own fatalistic approach with the "maternal instincts" of their wives, making it clear who the driving force in the treatment was. In both cases, the men take on the conventional masculine role of obliging protector, doing whatever was necessary to make their partners happy. They are witnesses to the natural drives, rather than being subject to them. This enables them to distance themselves not only from the engagement with technology, but also establishes an emotional distance from the unsuccessful outcome. This functions as one of the primary discursive mechanisms for maintaining the equation of femininity with the desire for a child in the wider IVF discourse, as well as shifting the responsibility for the decision to engage with treatment onto the women.

The doctors confirmed this irrepressibility of the maternal drive:

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[77] The hormonal discourse is also evident in popular discourse about "career women", and *The Daily Telegraph* (23 April, 2001) reported research which claimed to have shown that women are genetically programmed to have children at an early age. Dr Ian Owens, the researcher, insisted: "When women talk about the ticking body clock, that is true. Everything is saying reproduce now, but they are putting it off for cultural reasons, to keep their careers going and so on."

Lisa: I remember that first meeting, he [the consultant] was very sympathetic, and he said, "I do understand that secondary infertility is actually more distressing than being infertile, because your body is screaming out, because the hormones have already been through the process of being pregnant and having a child. Your body wants to do it again."

According to the consultant, Lisa's body is ***demanding*** to be pregnant, embodying the traditional medical view that women are controlled by their bodies, rather than the other way round as is assumed to be the case with men[78]. Her body is credited with volition and voice, and its "screaming out" for a baby is to be taken seriously, although this acquiescence to the presumed demands of the body is notably absent in other areas of women's lives, such as diet or sexuality, where pressure to control and silence the unruly female body is more commonplace.

In terms of withdrawing from treatment, the discourse of an irrepressible maternal drive is highly problematic, since it is constructed as a fundamental drive that will not go away and therefore must be pandered to. Imagining and creating a positive future without children, or the desired number of children, is therefore impossible within this discourse. Consequently, even though the discourse of biological drives is used by women when they are undergoing or waiting for treatment (Ulrich & Weatherall 2000), when treatment fails, an alternative strategy is required, particularly by the female participants, in order to facilitate a positive passage out of IVF. In this study, this was achieved not so much by rejecting the idea of a biological drive, but by laying claim to the conventionally male prerogative of the Cartesian mind-body distinction and adopting a medicalised focus on particular, malfunctioning body parts:

Alice: It's sort of...none of my bits are useful for what they're supposed to be used for, for whatever reason.

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[78] The obvious exception to this would be the construction of male sexual desire, which is conventionally constructed as controlling men, rather than being controlled by them.

This focus on "organs without bodies" (Braidotti 1994: ch.1) enables Alice to distance herself from her "bits". The idea of those "bits" being unable to fulfil their purpose recurs in other accounts:

Beth: The things I've been put here for don't work.

Stephanie: At the end of the day, we're women and we're here to reproduce.

Liz: [...] you know, you're there, and your role in the big scheme of things is to produce, keep the race going. Erm...which is probably a bit Neanderthal, but I suppose it's there.

In this study, it was only very rarely that women laid claim to a biological *drive* to reproduce, articulating their desire for a child not in terms of drives, but in terms of a wider, externally-determined role in the "big scheme" which they were unable to fulfil because of their "bits". This performs the function of demonstrating their active *intention* to conform to their assigned role in the natural order, but also releases them from the perpetual craving implied by the hormonal discourse. It is also significant to note that the technology and its failure is necessarily absent from this strategy. This has the effect of disguising the significant role of reproductive technology in confirming the intractability of the malfunctioning body parts, focusing instead on the *desire* to reproduce. This marks a redrawing of the reproductive norms to include intention, rather than parenthood, with intentional non-parenting as the abnormal Other against which that normality is defined.

Another strategy used in response to the "maternal drive" discourse was to question the nature of that drive, positing it as a social, rather than a natural, phenomenon:

> *Graham: Well, the woman's got the biological clock ticking, and they've got a lot more hormones floating around. I mean, I think it's easier for a man.*
> *Karen: Being childless, or not being able to have children?*
> *Graham: It's easier being childless for a man. A woman's expected to be a mother figure. You reach a stage, you know, married – you're engaged, married,*

house, kids. You know, nice loving mum and kids. [inaudible] It's just…there is more pressure as well.

Denise: Or do you think it's more acceptable that men haven't got children?

Graham: Yeah, because there are a lot of men about that are divorced, that are part-time, weekend dads. Men sort of…you know I think it's more of a woman thing. They're supposed to be mothers.

Denise: Yeah, we're expected to want children as well.

Graham shifts from a biological to a social explanation, commenting later that the pressure to have children is "unbelievable". Many of the female participants recalled incidents from early childhood where the link between reproduction and femininity was made:

Claire: […] I remember thinking right back to being a little girl – you get a doll for Christmas and your mum says, "Oh, well, you know, if you look after this, you'll be able to give it to your little girls when you have one.

The doll offers an opportunity to practice caring – a feminine trait – and also represents her future children. For Susan, reproduction was linked directly to her body by her mother when she developed breasts at age 9:

Susan: I was a very…erm…mature little girl. You know, I mean, I was….I'd developed by the time I was 9, so I was a very…you know, "Why do I have these things with my tummy? And why do I have these chests? And why…?" "It's for when you have babies when you're older." So from 9, it was always, "this is what happens".

The message Susan constantly received was that she would reproduce, and that that was what her body was explicitly designed to do, with her early puberty cited as evidence of that future. For others, the social messages were more omnipresent:

Charlotte: […] one thing that I did notice, when we wanted children, there seemed to be children all around, in the media and television, and it sold the wrong idea. It sold this idea of marital bliss, children […] And you think, "What a

load of crap!" You know – little babies in their Pampers, with their mums looking
unharrassed. And you think, "Why does society sell...?" It's an illusion, isn't it.

Making the direct link with consumer culture, Charlotte interprets the ideology of
motherhood as a product which is literally sold to women, and therefore, as something
to be treated with scepticism. It is important to note that it is the *ideology* of
motherhood, rather than practice of motherhood (see, Rich 1977), which is the target of
these critiques, allowing them to lay claim to the desire to reproduce, whilst distancing
themselves from the imperative to do so. Claire recognises the usefulness of this
resistant position as a coping strategy for dealing with her involuntary childlessness, and
speculates whether this is all "a big defence mechanism":

> *Claire: Whether it's because I've intellectualised [the biological urge to*
> *reproduce] out because it was helpful to me to think that it was socially*
> *imposed...you know, "I'm not going to be conditioned!", because it actually helps*
> *me to move on away from the children issue. I don't know.*

While an understanding of the socially constructed nature of the reproductive drive was
strategically useful to many of the female participants, this also risks diminishing the
significance of such a thorough-going normative construction. Ironically, this can
become a strategy which ends up in self-recrimination, with the woman berating herself
for "allowing" herself to be conditioned. However, this is to underestimate social
construction, and the ideology of motherhood is no less potent for being socially rather
than naturally produced.

Moderation

While it was important to those whose treatment had failed for others to know that their
childlessness was involuntary, it was equally important that others' perceptions of
involuntary childlessness were carefully managed. One of the most common popular
stereotypes associated with the experience of infertility is that of the desperate woman
who is willing to do *anything* to have a baby, even if it means exploring the full range
of technological opportunities, borrowing money to the point of financial ruin, and
focusing entirely on that endeavour to the irreparable detriment of personal
relationships, frequently resulting in marital breakdown. The desire for a child in

women is assumed within the dominant cultural discourse to be entirely normal, and yet, when that desire impacts upon the woman's ability to act *within reason* in other aspects of her life, then the desire for a child is deemed out of control. The desperate, infertile woman, the story goes, is not in control of herself, and this lack of self-control automatically places her outside of the normative standards of motherhood.

Consequently, while discourses of desperation can be useful rhetorically in asserting the strength of desire for a child, therefore providing some justification for turning to IVF, the denial of desperation was a key feature in the accounts given by the participants. This denial serves two primary functions. Firstly, it diffuses some of the tension around the use of technology for reproduction, since for as long as the engagement with IVF is tempered by moderation, there is less danger of allowing the naturalness of reproduction to be subsumed by the technology; and secondly, the discourse of moderation limits the extent to which an individual is defined solely in terms of infertility, facilitating the transition towards a life without (biological) children, or the desired number of children. There are four aspects of the engagement with IVF treatment and its failure that were perceived by the participants as potentially indicative of desperation, and therefore as sites for the assertion of moderation, and these will be considered in turn below: (1) the number of cycles; (2) the use of alternative and complementary therapies; (3) the use of counselling services; and (4) the pursuit of parenting alternatives.

The number of cycles

As has already been noted, the reality of the experience of IVF, even where the treatment is eventually successful, is one of repeated hurdles, failure at any of which necessitates returning to the beginning again. For those who are not successful, the cyclical nature of the treatment makes it difficult to stop, because of the inherent "maybe next time" promise of future success. Even practitioners acknowledge that the first cycle of treatment is largely experimental, providing useful information for future cycles, encouraging the couples to persist, and this pressure is compounded by the use of deceptive cumulative success rates, which can reach up to 70% for four cycles of treatment (Brian 1998: 90). The misunderstanding of the statistical odds and the interpretation of the odds as improving with each cycle provides a distinct incentive to continue with treatment (Modell 1989).

But for all the pressures to continue, the stereotype of the desperate, infertile woman who is unable to stop looms large:

> *Susan: I didn't want to be one of these women that you saw on television, that are sort of in their 50's, that have had sort of like hundreds and hundreds of it. And it does take over your life. I didn't want to be...I mean, we did get obsessive, but I didn't want to be one of these completely obsessive people that that's all they live for. And we had to have some sort of ...reality. You know, we had to have some sort of life. Although it did take over, that sort of three seemed... I don't know. Three just seemed a good control number, a good sort of, you know, that's your best shot.*

The hyperbolic caricature of the ageing woman doggedly pursuing endless cycles of treatment featured regularly in the accounts[79], and Susan positions her moderate three cycles in stark contrast. This is reinforced by her use of the language of science – "a good control number" – to support the decision. She recognises in herself the potential for becoming "completely obsessed", and the limit is her means of preventing this and distinguishing herself from others who are less able to retain a sense of perspective. It is important to note, however, that she acknowledges that their engagement with IVF was marked by a degree of obsession, and this emphasises that moderation is not to be confused with apathy. Stopping at three is to be understood as an act of strength rather than weakness, marking the assertion of rationality over the overwhelming desire to have a child.

For those who set relatively high limits to the number of cycles they were willing to undergo before stopping, or those who did not set limits and subsequently underwent a high number of cycles, the strength of character lies not in stopping, but in keeping going:

> *Katy: [...] that target of 6 [...] it probably spurred me on, because I'm not a defeatist. So whereas each treatment got more difficult because of the injections*

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[79] Kathy Davis identifies a cosmetic surgery counterpart to the "desperate infertile woman" in the "surgery junkie" or "scalpel slave", who was cited by her interviewees in order to highlight their own

and knowing what you have to go through, the disappointments and so on, I had
sort of, that was my target. I suppose that kept me going. And also, maximising
your chances, because after three goes, they were prepared to put more than two
eggs back, so I think that's what spurred me on. I'm not a giver-upper.

For Katy, IVF is an activity that is an act of will, where it is her strength of character rather than weakness that enables her to persist with treatments that become increasingly difficult to undergo. This understanding places the IVF within the control of Katy herself, thereby distancing her own experience from the out-of-control engagement with the treatment that signifies desperation. Furthermore, she calculates her chances as increasing through her perseverance, making the choice to continue a logical rather than a desperate one – a fact that is reinforced by the fact that she did stop at five cycles when she became unwell.

The actual determination by the participants of what constitutes an excessive number of cycles of treatment varied hugely. However, the actual number of cycles proved to be far less important in the accounts than the discursive construction of that number as moderate, reasonable, subject to the control of the individual, always related to and regulated by the excessive "not me".

The use of alternative therapies

The use of alternative and complementary therapies for the treatment of infertility is not encouraged by IVF practitioners. The majority of these therapies are unregulated and evidence of their efficacy is ambiguous. Consequently, many doctors express concern that the use of unproven, alternative therapies will generate false expectations for those experiencing infertility (Winston 1999: 40), although it could also be argued that this resistance also reflects efforts to shore up the high status of western, high technology medicine in the face of less glamorous or technologically specialised therapies. This suspicion of the alternative therapies was largely endorsed by the participants, with alternative therapies often perceived as lesser, and therefore unnecessary, treatments, the use of which is indicative of unacceptable levels of desperation:

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rationality and moderation in their engagement with surgery. In the context of IVF, this figure of desperate excess reappears as the compulsive consumer of IVF, as is discussed in the next chapter.

Susan: Don't get me wrong. If suddenly, there's something new and they've still –
you know, if you stand on one leg and drink a bottle of mistletoe extract [it will]
get you pregnant, then I'd probably do it. But...most of them, I'm not really...I
don't not believe in them particularly, but I wouldn't...I'm not like that...

Claire: And then there was a bit of me that thought, "Oh, maybe I should give it
[alternative medicine] a try", but really I'm too cynical about alternative
therapies, and I think, I could have done it, but in a way it would have been me
saying "You're that desperate that you're clutching at all these straws." Perhaps
I didn't want to. Perhaps I wasn't that desperate...

Susan undermines the idea of alternative medicine by using an extreme and outlandish example whilst apparently imagining even more outlandish therapies which she would not do, and although she is unwilling to condemn alternative medicine out of hand, its use is associated with being "like that" and therefore to be avoided. However, it is the unproven nature of the therapy rather than the form of the therapy that forms the basis for the objection, thereby locating herself discursively in the realm of determined rationality rather than uncontrolled desperation. Claire, however, is more explicit about what being "like that" actually means – desperately clutching at straws – and her description of herself as cynical distances herself from that image.

For those who did make use of alternative therapies, the use is downplayed and rationalised:

Sarah: I had a friend who used it [Foresight – a preconceptual nutritional
programme], and had this baby. You can imagine.
Karen: Really? And she had fertility problems?
Sarah: Yes. And she had to [inaudible], plus all the other stuff they tell you not to
do like not drink, and get fit, all the rest of it. All of that [...] can't not help [...]
and I thought, "Well, again, this isn't going to harm us." So we went along and
had the test [a hair strand test for nutritional deficiencies]. They take your hair
from under there [pointing to the back of her head]. And they make, they design
you this programme [of diet and supplements]. It was kind of about me
persuading [husband] not to drink [both laugh]. He's very sceptical about these

things, but because I was keen to do it, he went along with it. And so we did it, and it must have been the beginning of the year by the time it didn't work out, but we felt absolutely fit and healthy at the end of it.

For Sarah, the decision to try the Foresight programme is legitimated by her friend's successful experience, and she is also careful to stress the positive outcomes of following the programme – being fit and healthy – which justifies her initial position that it can't hurt to try. The engagement with Foresight is also presented as performing a secondary function of curtailing her husband's alcohol consumption, meaning that she is able to endorse the nutritional approach in that it is a means of achieving an outcome that is broadly accepted without necessarily endorsing the whole philosophy of Foresight, which is fundamentally opposed to IVF.

There was only one case in the course of the interviews where the male partner had taken the initiative in seeking out alternative therapies, and he had sought the help of a Chinese herbalist in order to treat his low sperm count. More generally, the male partners either participated on the initiative of their partners, by taking supplements (which were provided for them), or on medical advice by making lifestyle changes such as cutting down on tobacco or alcohol, wearing loose underwear or not taking hot baths, although compliance rates with these recommendations were low. The reluctance of the male partners to engage in measures intended to improve sperm quality is considered in more detail in Chapter 6. However, what is of interest here is that where the female partners had used alternative therapies, this was frequently met with scepticism by their male partners:

> *Tim: I like things to add up, so if they don't add up... If ...I can't understand how waving hands over bodies is going to help people. I mean, that's simplistic, but I ...Obviously, I think for some people there's a stroke of luck.*

> *Jeff: We've got a couple of witches' brews out there.*

The women interviewed were highly aware of the taint of desperation that the use of alternative therapies exposed them to, and in a number of cases, this motivated them to keep their use secret from their partners. The reason most commonly given for keeping

it secret was simply not to appear "silly", but this reveals a far greater concern that they will be judged unstable and desperate by their partners, who might then choose to exercise a veto on further treatment on the grounds that it had got out of hand[80]. Melanie, who suffers from polycystic ovaries, had tried a broad range of therapies including a hypnotherapy, a Chinese herbalist and crystals, most of which she did without telling her husband, Paul:

> *Paul: Reading between the lines, you might have realised that I'm not a believer in anything like that [alternative therapies]*
> *[...]*
> *Melanie: A lot of this I've told Paul since. I did it off my own back.*
> *Karen: Oh, right, so you didn't know she was doing this?*
> *Melanie: The crystals, I didn't tell you. And the Chinese one, I didn't tell you about. I think I might have told you once I'd started.*
> *Paul: I know you went to the hypnosis. I honestly can't remember about the others.*

Melanie was very selective about which therapies she told Paul about, since he already had teenage children from a previous marriage and he was not as keen to pursue treatment as she was. Knowing that he was very cynical about alternative therapies, she was careful not to give the impression of desperation. In general, the doctors were also not told, in part because most of those who had used alternative therapies had tried them *before* seeking medical help, or in order to achieve a sense of purposeful activity whilst on waiting lists. However, those participants who were using alternative therapies in tandem with medical treatment, did not share that information with their doctors, partly to avoid appearing desperate, and also to avoid casting any doubt over their commitment to IVF in the eyes of the medical staff[81].

Counselling

The availability of independent counselling to all patients is a condition of a clinic's HFEA license, although it is not mandatory for the patients, except in cases of the use of

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[80] See Chapter 6 for a further discussion of this issue.
[81] It is also quite likely that the desire not to be seen as desperate by me may well have inhibited some of the participants from telling me about alternative therapies they had tried.

donor eggs or sperm, and in some cases where a GP has raised concerns relating to the welfare of any children that result from the treatment. Some clinics also run support groups, and there is also a wide range of national organisations providing support and advice. However, rather than being embraced as a useful resource, counselling was interpreted by the majority of the participants as indicative of desperation and mental instability and was therefore avoided:

> *Karen: How about support groups, sort of, general support groups or counselling?*
> *Melissa: No, I'm not like that.*

> *Karen: Did you ever make use of any of the support groups?*
> *Courtney: No.*
> *Karen: Why was that?*
> *Courtney: I don't need them. I'm normal...probably.*

Being normal, or not being "like that", is essential to the construction of the self as not engaging immoderately with IVF, with counselling seen as evidence of social failure and therefore of unsuitability for parenthood. This perception of counselling as being only for those who are unstable was inadvertently reinforced by medical staff, who usually would recommend (or in one case, insist on[82]) counselling following one of the patients becoming very upset or angry. The attitude of the doctors is crucial here because those seeking treatment are acutely aware of an image to which they feel they must conform in order to be approved (Cussins 1998). If patients feel that they will be considered unstable and therefore unsuitable for treatment if they seek counselling, then they are unlikely to engage with it. Furthermore, in the case of the clinic through which the participants were recruited, the independent counsellor's office was located outside of the clinic itself (although on the same floor of the hospital), which isolated her from the day to day work of the unit and located her as literally peripheral to the treatment process. It is important to note that very few of the participants expressed scepticism

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[82] Charlotte became angry when she was told that she would have to take one of the hormonal drugs for an extra five days in order to fit into the clinic's timetable. Concerned about the long-term effects of the

towards counselling in principle *for those who needed it*, with that need characterised by social isolation and personal weakness. Several of the participants seemed unsure as to the purpose of counselling, and saw it simply as an unwelcome and unproductive opportunity to "get upset", or to be told what they already knew:

> *Alice: [...] sometimes I thought I'd like to [see a counsellor], and other times, I thought I was upset enough on my own without talking about it and making myself worse. I think, because I had to talk about it at work when I didn't want to, I didn't want to go somewhere and talk about it and get upset on purpose.*

> *Courtney: [...] I don't think whatever you say to a counsellor is going to change the way you feel, apart from you're shouting at someone different! I just don't think they can change what's going on. No-one can turn round and say to you, "Take this and you'll be okey-dokey." I just don't think they can change it.*

Only two of the participants, both female, expressed a general support for counselling as potentially beneficial to everybody, and had made extensive use of it throughout their adult lives. One of these, Anne, was a social worker[83], and the other, Denise, had become a fully qualified counsellor herself following her decision to end treatment.

Another problem cited in the interviews was simply having access to appropriate counselling, although it could be argued that problems of access also provided a convenient "excuse" which brought an uncomfortable line of questioning to a close. The clinic offers independent counselling, but few women want to return to the clinic after having made the decision to stop, and there was also some confusion about whether those who had stopped treatment, or who were thinking of stopping, would have to pay for counselling[84]. Cathy, a psychiatric nurse, sought counselling through her GP after suffering from depression following the decision to end treatment, but was referred to the community psychiatric nurse – a colleague – and decided against pursuing it; and Rachel was seeking a counsellor to help her to stop treatment, but her GP referred to a

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drugs, an argument with the consultant ensued, and he refused to treat her until she and her husband had met with the counsellor.

[83] Anne's husband did not take part in the interviews.

[84] There is no charge for the counselling, and in the light of this research finding, the patient information leaflet which introduces the counselling service has been amended in order to make this clear.

counsellor who was trained in providing relaxation techniques to enhance fertility. This indicates a lack of understanding on the part of GPs about counselling and the counselling needs of patients.

Social support in the form of networks of family and friends, as well as from partners, is recognised as an important aspect of coping with IVF (Adler, Keyes et al. 1991), and the presence of social support networks was frequently cited in support of the decision not to make use of counselling services. However, it is also important to note that this assertion was not necessarily matched with a great deal of social support in practice, either because it was not sought, or because it was not available. This was not an uncommon paradox, and one interpretation of this is that the social networks provide a more general sense of being valued, and therefore that the extent to which family and friends were involved in the IVF specifically does not necessarily reflect the degree to which they perceive themselves as being supported[85]. It is also important to note that keeping the treatment secret is not necessarily an issue of shame, but more likely a desire for privacy (Klock 1997: 168). Many of the participants expressed their frustration at having to tell doctors, friends and colleagues every detail of their attempts to conceive, since, as Anne succinctly put it, "all they have to do is have sex."

The pursuit of parenting alternatives

Domestic adoption of very young children within the UK is relatively rare. Contemporary social policy aims to assist the mother to keep her child rather than to encourage her to give it up, as was the norm in the 1950's and 60's. Domestic adoption, then, generally refers to older children, and often to children who have had very difficult early lives and who have disabilities or behavioural problems. Furthermore, the adoption process itself is lengthy and frequently perceived as intrusive and judgmental, running the risk of a final judgement by social workers that they are not fit to parent. In addition, while approval for adoption was perceived as offering a prized endorsement, there was also a fear of being approved and then being unable to love the child completely, having invested so much time, energy and money into being a biological parent:

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[85] Also, many of the participants described how involving others can actually generate *more* responsibility for the person undergoing treatment, managing other people's stress and inability to cope with the grief of others. This issue is addressed in Chapter 6.

Beth: [...] I'd feel like I'd failed. Do you know what I mean? If I didn't feel 100%
committed to that child, bringing it up as my own, then I think that I would feel a
failure, and I know that...you can love somebody, but not in the same way [as if it
were your biological child].

The construction of adoption as an act of desperation was a common explanatory
strategy regarding the decision not to adopt:

Melissa: I think, erm, much as I want children, erm, I think it's ....you have to sort
of go back to why you want children, and I don't want children just for the sake of
children. I wanted my husband's baby. And I don't want a baby or a child at any
cost. And seeing [husband's] sister and her husband go through the adoption
process, I couldn't go through with it.
Karen: Really? What about it?
Melissa: It's just all that sort of preparation and all the different classes and the
things you have to go through. It's just...it's too much. It really is. It obviously
proves I don't want a baby that badly. And I know [husband] isn't keen on
adoption either.

Melissa rejects the idea of herself as wanting a baby "at any cost", and highlights
instead the centrality of her relationship with her husband in the desire for a child. It is
his child that she wants, not ***a*** child, and this is reinforced by her assertion that this is a
view that he also shares. She supports her decision by displaying her broader
knowledge, referring to the experience of her sister-in-law, who had adopted two
children, both of whom had had very difficult early lives. This claim to insider
knowledge of the realities of adoption legitimises the decision not to proceed. Another
strategy was the use of the "horror story" of adoptions which had failed or which
destroyed families, either in relation to specific friends and acquaintances, or more
apocryphal terms.

While the rejection of adoption was frequently cited as demonstrative of a continued
sense of perspective concerning the desire to be a parent, it could also be argued that
this discourse is being used to side-step the significant (and unfair) pressures on

involuntary childless couples to adopt (Sandelowski 1993; Braverman 1997; Franklin 1997). Many of the arguments that couples apply in order to justify access to IVF, such as the strength of the parenthood motivation, or the ability to provide a loving home, often open them up to questions as to why they have chosen not to adopt, since there are clearly plenty of children currently living in care who could benefit from adoption into just such an environment. However, this is to ignore the significant challenges of taking on troubled or disabled children, not to mention the need to undergo a lengthy and intrusive assessment process. Sandelowski, in a chapter potently titled "Tick...Tock" (Sandelowski 1993: Ch.10), highlights the liminal space in which those entering the adoption process find themselves as they work through this process and then wait for a suitable placement. Katy and Tim were in the middle of this process when I interviewed them, and Tim remarked wearily, "it just goes on and on...much like IVF really."

Conclusion

This chapter has explored some of the ways in which the participants managed competing discourses of nature and technology. I have argued that the desire to locate the self as normal is the fundamental goal of this management task, where "natural" and "normal" are treated synonymously. The primary discursive move in the accounts is to naturalise the technological aspects of IVF. This constitutes an extremely fragile resolution of the tension between reproduction and technology, and one which requires constant maintenance. Although nature and technology appear at particular moments, and particularly within the dominant discourse, to be interchangeable, it is precisely the fact that nature and technology are *not* the same thing that necessitates this discursive management. While what constitutes the natural can be discursively renegotiated to include particular reproductive technologies, the social acceptability of those interventions, and therefore the extent to which they can be subsumed into the natural domain, is defined against the (unnatural) technological. It is nature and not technology which predominates as the legitimising domain for the unsuccessful engagement with IVF. This analysis has implications for the feminist study of technology, particularly in terms of other medical technologies which intersect with normative femininity such as cosmetic surgery (Davis 1995; Davis 1997; Morgan 1998; Gilman 1999), or surgical or medical interventions into obesity (Cooper 1998; Ackerman 1999; Beauchamp-Parke 2002). In particular, it offers a means of understanding the technological "creep" towards increasingly sophisticated interventions through the normalising effect of

precedents, and suggests the need to consider who the beneficiaries of that normalisation process are and how it is achieved.

The second point which this analysis highlights is that, in spite of its current prominence as a means of theorising the relationship between nature and technology, the cyborg emerges in the context of this research as idealistic and distant from the lived experience of those confronted with the task of managing that relationship. There are many aspects of the accounts that lend themselves to the interpretative language of the cyborg. In particular, the accounts reveal a flexibility in the boundaries between nature and technology, with technology being drawn into the natural domain. The very malleability of those boundaries exposes their normative constructedness, undermining the nature-technology dichotomy which they are attempting to manage through the narratives. However, although the participants in this study can be described as cyborgs in their fusion of machine and organism, they are *unwittingly* so, and conformity, not blasphemy, is their primary goal.

Significantly, then, while Haraway would "rather be a cyborg than a goddess" (Haraway 1991: 181), this offers little assistance in finding ways to think about those who would rather be goddesses, no matter how disruptive that aspiration may be to the normative standards along the way. From this perspective, it is important to remember that the cyborg is an idealistic political *fiction*, in pursuit of which a seemingly infinite range of imagined discursive resources are available. This recalls Braidotti's warning about the figuration of the nomad, which she argues is predefined by political consciousness and security in its boundary location. The majority of the participants in this study were constrained by a more limited stock of resources with which to make sense of their experiences, retaining what Haraway describes as "the mundane fiction of Man and Woman" as the most, rather than the least, desirable outcome.

A close analysis of the dilemmas confronted by those experiencing IVF failure reveals that the aspirations and discursive achievements of the participants are far from mundane, however. The negotiation of the relationship between nature and technology in the accounts results not in more or less successful acts of assimilation into a static norm, but actually enacts a reworking of the categories themselves. This reworking is a product of the very specific and ambiguously liminal location of the participants in

relation to the dominant discourse, which they are at once within and outside. In this context, they can be described, in Elspeth Probyn's terms, as "outside belonging" (Probyn 1996) – a site of "ongoing betweennness" (ibid.: 6) which offers "immense political possibilities" (ibid.: 9) in its capacity to both capture and to propel the movement not only between categories, but also of the categories themselves. These small movements lack the spectacular gestures of the cyborg, yet produce new ways of understanding the material and the social contexts within which IVF failure is experienced, and reflect the status of those undergoing treatment as constrained agents in the IVF process rather than passive victims. This is particularly important in relation to radical feminist argument against the new reproductive technologies, reflecting instead the diffuse patterns of resistance, agency and constraint in the micro-level operations of biopower.

Chapter 5: Coping with Consumption

IVF is big business in the UK. There are currently 116[86] clinics in the UK licensed to provide fertility treatment, with 75 of those licensed to perform IVF and donor insemination (DI), 29 providing DI only, 9 licensed only to store sperm, and 3 holding research licences[87]. Of the 75 clinics performing IVF, 28 offer fee paying services only, while the remainder offer a combination of fee paying and non-fee paying services. However, the National Health Service (NHS) is unable to meet the demand for IVF, and the limited availability of health authority funding means that over 80% of all IVF cycles in the UK are privately funded (Challoner 1999: 58)[88]. The relative lack of publicly funded treatment automatically places IVF out of reach of many who would seek it if it were readily available through the NHS. Indeed, the most common experience of IVF is most likely not of treatment failure, but of not being able to have it.

The funding of IVF is currently decided by individual health authorities, leading to postcode prescribing. This is a contentious issue[89], and at the time of writing, the National Institute for Clinical Excellence (NICE)[90] is developing guidelines for the national standardisation of treatment provision[91]. However, this does not necessarily equate to an overall increase in treatment provision, which remains a relatively low priority in a climate of NHS rationing. A recent report by the British Medical Association (BMA) categorised fertility treatment alongside tattoo removal, gender reassignment, and drugs for baldness and impotence as draining resources away from essential services, and therefore, as candidates for exclusion from NHS provision[92]. Furthermore, even for those living within a health authority which is able to fund treatment, extensive qualification criteria prevail, including maximum age limits (for

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[86] As of 31 August, 2000. These are the most recent statistics currently available.
[87] www.hfea.gov.uk
[88] See, for example, Pfeffer 1993; Franklin 1997 for a detailed discussion of the expansion of fertility services in the private sector in the context of extensive health service restructuring under Margaret Thatcher.
[89] Arguments about postcode prescription are not confined to fertility treatment, as has recently been highlighted in debates about nationally inconsistent access to beta interferon – a drug which many claim lessons the symptoms of MS.
[90] www.nice.org.uk
[91] Interestingly, the project to develop the guidelines is being conducted under the clinical theme of "Women's and Children's Services", highlighting the extent to which IVF specifically, and reproduction generally, are considered to be female activities and concerns.
[92] www.guardian.co.uk, 7 February, 2001

women), current family size and constitution, body mass index (for women) and relationship status. For those who do meet the stringent criteria, waiting lists for health authority funding often stretch to two or three years, providing a further incentive to turn to the private sector in the intervening period in order not to compound any existing fertility problems with the age-related decline in fertility, or to avoid older new parenting.

The previous chapter described the way in which the participants identified themselves as "patients" receiving medical care as a strategy for justifying the engagement with IVF. However, whether treatment takes place in the private or the public sector, the reproductive endeavour simultaneously becomes an act of *consumption*. This creates a fundamental problem for those seeking treatment in that the redefinition of the IVF patient as a *consumer* contravenes normative standards of parenthood in general, and motherhood in particular, through the introduction of commercial exchange into the reproductive process (Layne 1999a: 3). The ideological selflessness of motherhood, in particular, does not sit easily with the individualism of consumption, and this chapter will explore the ways in which the participants both claim and resist their status as consumers in their accounts.

There are two features to discourses of consumption which make this perspective particularly relevant to this thesis. Firstly, consumption is strongly marked by gender, both in terms of what is consumed, and by whom. Shopping, in particular, is constructed primarily as a female activity and responsibility (Bowlby 2000; Scanlon 2000), and importantly, as an arena within which women are unable to exercise control. Rachel Bowlby argues that periodic female madness in relation to consumption – in the sales, for example – is constructed as a facet of *normal* femininity, in contrast with the stability of male sanity and reason (Bowlby 2000: 124). This parallels the understanding of the female hormonally regulated body as cyclically (dis)ordered, in comparison with male hormonal stability (Oudshoorn 1994: 146). However, the normally disordered consumption of sale shopping is constructed as distinct from the compulsively disorder behaviour of the kleptomanaic "lady" shopper (Ableson 2000), or the shopaholic. It is a fine gendered balance to strike.

In the context of IVF failure, this perception of women as lacking restraint and prone to excess in relation to consumption gains particular salience in terms of "knowing when to stop". When treatment is successful, the number of cycles undergone is easily established as "just enough", but when treatment fails, the boundary between enough and too much remains obscured. For those who choose to stop treatment, this boundary has to be discursively fixed, either retrospectively in order to facilitate closure around the experience of IVF, or in the future, in order to bolster an argument for further treatment when the end of treatment has been unwelcome and imposed. This chapter will explore the ways in which the gendering of the IVF consumer intersects in the accounts with the wider social and cultural discourses of both consumption and infertility, and will consider some of the implications of these interactions.

The second important aspect of consumption in the context of this study is the understanding that consumption is not so much a reflection of pre-existing identity, but creates identity (Probyn 2000; Scanlon 2000: 101). IVF plays a fundamental role in establishing an individual or couple as infertile. If infertility is to be understood as defined by the *active desire* for a child (as discussed in Chapter 1), then IVF constitutes purposeful activity towards the resolution of the problem of childlessness. It can be seen, therefore, that IVF establishes a couple's credentials as infertile, marking out their difference from those who have chosen to live without children. However, the perceptions in the wider social context of particular acts of consumption are not fixed and containable, and the engagement with IVF can equally be received by others as desperate, self-indulgent, pitiful, or even murderous[93]. Similarly, the decision to stop IVF can be understood as an act of either weakness or resolve.

From this perspective, it is clear that even when treatment fails, those undergoing IVF are never back where they started. Both the experience of infertility and the identities of those undergoing treatment are marked by the unsuccessful engagement with IVF, and this chapter will explore the ways in which a range of possible identities conferred by unsuccessful IVF and its failure are managed by the participants in an attempt to control the ways in which that engagement is understood by themselves and others. It is also important to note that the participants are never only located within consumer culture,

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[93] For example, the so-called "pro-life" lobby would argue that IVF is murderous in creating "life" (embryos) and then destroying those not used.

and the chapter will consider how consumer discourse interacts with traditional health discourses in this process of discursive management and negotiation.

The chapter is divided into four sections. The first section addresses the participants' concerns about the uneasy fit between the reproductive endeavour and the introduction of financial exchange into the process; the second section considers the ways in which the participants identified themselves as "sensible shoppers" in order to distance themselves from the suggestion of excess; and the third section highlights some of the ways in which the unsuccessful engagement with IVF is distinct from other forms of consumption. These three sections focus primarily (although not exclusively) on privately funded treatment, including self-funded treatment in NHS hospitals. The fourth section focuses specifically on the problems of being a consumer of public resources in the engagement with IVF.

Bringing money into it

For many of the participants, simply bringing money into the reproductive endeavour was problematic. The interviews revealed a pervasive discomfort around the financial issues which result from the decision to pursue IVF, even where that treatment was performed within an NHS context. At the heart of this discomfort lies the perceived disjuncture between reproduction, which is constructed as natural, selfless and morally privileged, and the marketplace, which is understood as a corrupt and impersonal arena thriving on individual self-interest. This is not, of course, to argue that consumption in relation to parenthood is always constructed negatively. In fact, it is hard to escape the advertising messages which equate consumer goods for children in general with acts of caring. Instead, the negative representations of consumption relate to spending money on the self – a distinction that becomes blurred in the context of IVF, particularly when that treatment fails.

The inescapable centrality of money to the experience of IVF emerged as a source of both embarrassment and tension in the accounts:

> *Susan: I mean [...] apart from the cost implications, which sounds awful, but on the other hand, you think, at what point [...] you know, you get a bonus, or you*

come into some money, or you earn a bit of extra money and you're thinking "Ah! Treatment!"

Susan is embarrassed to have even raised the possibility of cost having played a role in the decision to withdraw from treatment and feels that it reflects negatively on her. However, it is also apparent that her concerns over money relate not only to the absolute sums that they have spent, but also to the fact that their own relationship towards money had changed, and all their disposable income had come to be valued only in terms of the treatment it could buy. She was particularly horrified when, after her friend had had a new kitchen fitted, on hearing the price, her reaction was immediately to quantify the sum in terms of treatment cycles:

> *Susan: And I'm thinking, "God, I could have had three treatments with that!" You know, and you, I thought, I don't want to be like that.*[94]

For Courtney, the prominent role of money in the provision of IVF caused the attention of the providers to drift away from the patients and onto the money they might make from them:

> *Courtney: I know that if I go through IVF again, I've got to pay, but I want them to look at me, not my money, because unfortunately, it is all to do with money, **which it shouldn't be.*** (my emphasis)

Courtney's treatment cycle was self-funded at the NHS hospital, and she recalled handing over the money in the corridor, "just like we [were] in a back street". The sordid appearance of the transaction did nothing to quell her concerns about the sullying effect of financial exchange on the reproductive process.

However, for some, the large sums involved in undergoing IVF in a private clinic were not just distasteful, but were potentially corrupting:

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[94] This brings to mind a conversation with a friend working in health journalism, who described "the hip" (replacement) as the most common unit of currency in health discourse – as in, "You could do 75 hips for that…"

John: [...] treatments like IVF, where it's done almost on the basis of people's
desperation, I think...can leave themselves wide open to abuse by other
unscrupulous people.

John saw private medicine, in general, as offering a perfect opportunity "to fleece people that were in a desperate situation", perceiving the inevitable financial and professional self-interest of the practitioners as incompatible with the motivations of the patients, particularly when they were vulnerable. John's articulation of his suspicions highlight a key gender difference which emerged in the accounts. While the female participants' concerns focused primarily on the ways in which the involvement of money disrupted the construction of the reproductive endeavour as natural, normal and fundamentally altruistic, for the male participants, value for money and not being taken for a ride emerged as primary concerns. In John's case, this also worked as a strategy for distancing himself from the decision to proceed with treatment that had ultimately failed, constructing himself as knowingly sceptical, but participating for the sake of Cathy, his wife.

The suspicion that both Courtney and John express towards the corrupting or distorting influence of money over the delivery of IVF is also extended to GP services by Nancy and Martin. Their GP had been supportive of their IVF treatment, and had provided the necessary drugs. However, after the practice had become fund-holding, they were refused further drugs:

Nancy: We never would have got them again, because they edged him out, didn't
they. I think that's why – because he was so interested in fertility.
Martin: He seemed like the old school.
Nancy: Obviously, the ones that are there now are interested in their pockets. You
know, fertility drugs cost a lot of money.

Nancy and Martin contrast the "old school" ethics of their doctor, who they experienced as patient-focused and supportive, with the newly structured practice guided by their interest "in their pockets". It is this fear of the capacity of financial incentives to cause treatment providers to lose sight of their patients' own priorities that makes treatment

within the NHS so appealing, even where this treatment is self-funded, since only a fraction of the cost at private clinics was charged, simply to cover costs:

> *Nancy: So I was quite happy to go to [the NHS hospital] because they were doing something because they wanted to do it, rather than just a money-making venture.*

This preservation of the purity of motives and the construction of IVF provision as altruistic rather than self-interested was a repeated feature of the interviews, and the introduction of money beyond the covering of costs was perceived as potentially damaging to that. This is particularly true where IVF has failed, since as described in the previous chapter, the naturalising presence of a baby is absent to counterbalance the discomfort which exists around the transaction itself. This is significant because it runs counter to the usual expectation of private health care (and the purchase of other services or products) that a higher price guarantees a higher quality of service or care.

The interviews revealed two incidents of obviously unethical practices. Alice had paid an expensive private clinic to perform assisted hatching[95], but after the egg collection procedure, the consultant announced that he would not do assisted hatching and would require an extra £700 on the spot in order to perform ICSI. This all happened while Alice was still coming round from the anaesthetic, but her husband paid the money immediately, since they were both afraid that the doctor might dispose of eggs that had been collected if they did not do as he wanted. The second case was in a private clinic that Denise and Graham attended. Denise reported that the egg collection procedure was excruciatingly painful, and that clinic itself was "like an office block [...] You just went in and laid on the couch. It didn't seem sterile even." This took place before IVF was subject to HFEA legislation, and the clinic was subsequently closed down following complaints and a critical television documentary. Denise and Graham felt they had had a lucky escape, since many women contracted infections through treatment at the same place.

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[95] Assisted hatching is a procedure where a hole is drilled in the zona pellucida – the outer "shell" of the egg – weakening it. It is thought that the eggs of older women have thicker than average zona, meaning that it does not break as easily as it would normally do at about 5 days after fertilisation (Winston 1999: 126). The procedure was not widely available when Alice was seeking treatment, and this was the only accessible clinic.

But even though these were the only reported incidences of blatantly unethical practice, the majority of the participants assumed dishonesty in the self-presentation of clinics, including those operating within the NHS. In particular, the use of statistics in promotional or informational material was considered highly suspect:

> *Angela: I'm not a great believer in statistics. I feel, because I used to work in a bank, and I always felt that the statistics men can sort of, you know, tweak them wherever they wanted to [both laughing]. So, I'm not a great ...I don't have a lot of faith in statistics.*

A large majority of the participants were unaware of the standardisation of core statistics such as the live birth rate per cycle that all clinics are obliged to provide as part of their licensing under the Human Fertilisation and Embryology Act of 1991, and it was widely assumed that chemical pregnancy rates[96], or even fertilisation rates, are used in order to create the illusion of greater success than was actually being achieved. Furthermore, it was widely believed that the need to be able to publish competitive success rates, both to bolster professional reputations and to maintain a healthy bottom line, was a deciding factor in decisions determining whether patients for whom treatment had failed would be allowed to return for further cycles of treatment. When Liz discovered that the words "Poor performer" had been written in large letters across her medical records, her immediate reaction was that the doctors examining that record with a view to offering further treatment would not possibly accept her on the grounds that she wasn't going to "make their league tables look any better". Robert Winston's remarks at the Millenium Festival of Medicine in London in November 2000 would seem to support this suspicion. He described the tables showing success rates as "fundamentally flawed and useless", suggesting that clinics modify the figures, and turn away women who are judged unlikely to be successful[97].

While the financial aspects of IVF were perceived by many of the participants as, at best, distracting the practitioners from the goals and priorities of patients, and at worst, leading to outright corrupt practices, money was also (and perhaps more significantly) seen as having the potential to corrupt the *consumers* of IVF. As in the case of the

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[96] Temporarily raised hormone levels indicative of a pregnancy, but not sufficient to sustain it.
[97] www.netdoctor.co.uk, 8 November, 2000

providers of treatment, this perceived corruption, or risk of corruption, was seen as residing in the risk of losing sight of the higher goal of reproduction as a fundamentally natural activity. These fears were voiced in particular in reference to the dramatic and salacious media coverage of extraordinary stories of post-menopausal motherhood, unusual family structures, intra-familial and inter-generational donorship and surrogacy arrangements, and catastrophically large multiple pregnancies. In such stories, those seeking treatment outside of the conventional social reproductive norms are constructed as commodifying babies, and reportage is traditionally redolent with the rhetoric of consumerism – designer, convenience, tailor-made – all of which construct the engagement with IVF as indulgent and whimsical. Treatment in these contexts is privately funded, often at great cost, frequently transcending national borders in order to avail themselves of a less regulated treatment environment. In addition, those undergoing treatment are frequently accused of actually trying to *make money* by attracting media attention. The IVF baby emerges within this discourse as the perfect accessory, the ultimate impulse buy, and when the first IVF baby born using an egg which had been frozen and thawed in March 2001, "pro-life" campaigners warned that it would lead to "babies on order", which can be "picked off the shelf at any time"[98]. For most people without any direct experience of IVF, these media images form the basis of their knowledge, and therefore, the participants found their own engagement with the technology tarred with the same brush in the eyes of those around them, in spite of the fact that their own treatment had failed:

Matthew: But some people looked at [those stories] and started... "They're disgusting, paying for this, and paying for that." And I just think it gave IVFers, in general, it gave them a bad name.

Susan: [...] People sort of, "Oh, it's an accessory. People that just want IVF – it's an accessory. You've got the car, you've got the house, you want children, so you just go off and have IVF." And it's not like that

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[98] *Daily Mail*, 12 March, 2001

Beth: [...] Tailor-made babies – they just...anyone can go now – the 60 year old woman can go and have IVF, and the woman up the road who just wants a couple of kids can go and have IVF. It sort of put a bit of a slur on it, didn't it.

The primary concern here is not the behaviour of those who have transgressed the reproductive normative standards *per se* but instead, it is the way in which that behaviour is judged to have marked their own engagement with IVF, exposing them to unfair criticism. The participants defended themselves indignantly against being indiscriminately lumped together with those whose engagement with treatment was remarkable for its deviation from the normative standards. The involvement of money complicates the efforts to construct a distinction between *just* wanting a child, and the morally legitimate pursuit of treatment since it carries with it the culturally recognised suggestion of selfish indulgence, as well as exposing the class distinctions in access to treatment in terms of purchasing power.

Ironically, the argument that money corrupts the reproductive endeavour is counterbalanced, particularly for women, by the characterisation in popular culture and discourse of childlessness as a fundamentally selfish existence. Consequently, while the willingness to pay for treatment can expose people experiencing infertility to accusations of the selfish distortion and commodification of reproduction, the decision not to pursue treatment can also be read as unwillingness to make the sacrifices necessary to achieve the natural state of parenthood, leaving the individual to indulge selfishly in more conventional consumerist acts:

Melanie: And I wanted to give her a good shake, because she won't pay for IVF treatment. She thinks it ought to be free, and so she's had all the same emotions that I went through – all the being desperate for a baby. But she'll spend £2000 on a holiday, or X amount here. It just annoys me – you can't want something that much [...]

Although assumed by Melanie to be able to pay based on the fact that she had taken an expensive holiday, Melanie's sister had chosen not to, apparently on political grounds, and this was a source of anger and frustration to Melanie, who was highly critical of her spending priorities, assuming a correlative relationship between the degree of desire for

a child and the willingness to pay for IVF to resolve that unfulfilled need. However, whilst expressing her frustration, the telling of her sister's story also shores up Melanie's presentation of herself as possessed not only of a powerful drive to have a child, but also as being determined to act on that by making the necessary sacrifices, financially, physically and emotionally, in order to attain that goal[99]. More generally, this highlights the fact that each act of consumption takes place within a situationally specific and contextually determined moral framework and is subject to the disciplinary surveillance of others.

Beth expressed her own frustration at the suggestion that expenditure correlates with the desire for a child:

> *Beth: And people say to you, "If you wanted it that bad, you'd borrow £10,000 and go and do it", but it's not as easy as that!*

Beth desperately wanted to pursue further treatment and was depressed and frustrated that she was unable to do so without taking financial risks that were unacceptable to her. Her health authority would not fund a second cycle, and with an adult son from a former relationship still at college and her partner recovering from a long and serious illness and therefore not able to contribute financially to the household, there was little possibility of her being able to raise the money to return to treatment in the foreseeable future. For her, the idea that her reluctance to get into unmanageable debt reflected an insufficient desire for a child was highly offensive and caused her considerable distress at a time when her involuntary childlessness was increasingly dominating her life and relationships[100].

The accounts (and particularly of those participants who were living without children) revealed a marked sensitivity to the appearance of other forms of consumer spending, fearing that they would appear self indulgent and selfish, and that others would suspect them of having chosen to live without children rather than having had it forced upon them:

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[99] After two miscarriages and a number of failed IVF attempts, Melanie and Paul went on to have a daughter through a surrogacy arrangement with her other sister.

Claire: [...] I can say, "At least I tried." So there can be no stage in the future when I might say to myself, "Oh well, if only I'd tried, it could have been different." Erm...it's almost like I can say to society, "Look, I tried to be the typical female, I tried to be the mother, you know, but it conspired against me, so I now have the right to go off and spend my money on nice holidays or whatever and don't need to feel guilty."

For Claire, the freedom for her and her husband to enjoy the advantages of living without children can only be enjoyed for as long as others are aware that she "tried to be the typical female". In this sense, IVF performs a confessional function (Foucault 1978: 62), whereby the non-conformity of childlessness (and the (stereotyped) associated lifestyle) receives social sanction. However, the need for confession exposes the moral status afforded to parenting, and particularly mothering, relative to other life choices. It is also important to note that the assumption that the alternative life path once treatment has failed is "nice holidays" or other forms of consumption is a false one. Naomi Pfeffer notes that the infertility counsellors she interviewed saw debt counselling as central to their work (Pfeffer 1993: 230), and even for those who do not get into debt, their childlessness does not necessarily equate to a large disposable income. Conversely, several of the female participants in this study had spent many years in low-paid, casual employment, expecting to leave or work part-time once they had become pregnant. Consequently, the experience of unsuccessful IVF had opportunity costs, as well as direct financial costs, which impinged on their future earning capacity.

This section has demonstrated the ways in which the introduction of financial exchange into the reproductive endeavour is highly problematic for those who engage with it, since it is perceived to mark that endeavour in a pejorative way, either by corrupting the delivery of treatment, or distorting the priorities of those who receive treatment. Even those who construct themselves as free of that distortion perceive themselves and their engagement with IVF to be tainted in the public eye by the less "pure" encounters of others with treatment. Consequently, a marked feature of the accounts is the

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[100] As described in Chapter 3, these tensions reached something of a crisis between the two interviews. Beth left her partner, and I subsequently lost touch with her.

construction of the self as a recognisably rational and moderate consumer of IVF, and this is achieved primarily through the discourse of the "sensible shopper", which is the focus of the following section.

The Sensible Shopper

Competition is the cornerstone of enterprise culture, and is perceived as guaranteeing maximal choice and value for money for the consumer. The glossy brochures distributed by the private clinics appear at first glance to conform to this discourse. The pages of the brochures are redolent with glistening technology and pristinely white-coated medical staff interspersed with smiling families and plush soft furnishings. At first glance, buying IVF is no different to buying an attic conversion or a holiday – you solicit brochures, review what is on offer, make a decision as to which offers the best value for money according to the priorities you have drawn up, and then you make your purchase. As Rachel described it, "…it turned out to be a little bit like buying double glazing, because there's so much on offer, and you get so many glossy brochures…"[101]. The purchase of IVF confers not only a product, but also an identity on to the consumer – an identity which is characterised by the commitment to parenthood (and therefore, social conformity), and also by being discerning and thorough in the process of consumption (and therefore, fit to parent). However, when treatment fails, this also raises the possibility of the wrong selection having been made. Shopping for IVF, then, is a big responsibility, and this was a responsibility that fell almost exclusively to the female participants.

It is important to note that the proliferation of choice which the brochures seem to offer is deceptive, not least because many potential patients will automatically be excluded by financial constraints. In this context, the shopping discourse is already an exclusive one and not at all representative of the wider experience of infertility. Furthermore, depending on the geographical location, those seeking treatment may simply not have a wide array of clinics from which to choose. There is a concentration of clinics in the London area, which has 18 of the 75 licensed clinics, and 10 of these offer non-fee

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[101] At the beginning of this project I wrote to all the NHS and private clinics in the region asking for information about their fertility services (and not disclosing myself as a researcher), and received thick information packs and booklets by return post from the majority of private clinics, and these were followed up for at least a year with regular invitations to presentation evenings. While this could not be

paying as well as fee paying treatment[102]. Therefore, those living within reasonable travelling distance of the metropolitan centres have a greater range of treatment providers from which to choose, compared to other less well-served areas. Furthermore, while limited access to clinics (either geographically or financially) can constitute an absolute constraint in terms of being able to undergo IVF, the limitation of treatment options impacts upon the power relations between the customer and the clinic – a relationship already marked by the asymmetrical doctor-patient power dynamic. If the patient is able to withdraw her custom and seek treatment elsewhere, then, potentially, she is able to exercise more control over the treatment process. Anne, for example, was able to insist on having the egg collection performed under a local anaesthetic rather than a general, against clinic policy – a victory which she put down to "being a private patient", and therefore, in principle at least, able to take her custom elsewhere. However, the same request by Alice (whose bad experience with a clinic was described in the previous section) was given short shrift by her expensive private clinic, and she was unable to withdraw her custom because this was the only accessible clinic able to perform assisted hatching. Consumer choice in the context of IVF, then, is not universal, and nor does the status of consumer necessarily disrupt the doctor-patient power dynamic.

These caveats notwithstanding, the familiarity of the consumerist discourse and its centrality to contemporary UK society offers those who pay for IVF treatment a readily intelligible means of negotiating the tension inherent in the introduction of commercial exchange into the reproductive process. There are two key aspects to the discourse of "shopping sensibly": (1) getting a bargain, and (2), not spending more than you have or can manageably borrow.

Getting a bargain

Even where IVF treatment is health authority funded, it is never entirely without financial cost, if only in travel expenses, loss of earnings for time taken to attend the clinic, or, as in the case of several of the participants in this study, as a result of "treats" of short holidays or favourite foods and drinks to ease the disappointment of treatment

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described as a hard sell, the marketing was swift and efficient, and I was left in no doubt that these were first and foremost businesses.
[102] www.hfea.gov.uk

failure. The cost of undergoing IVF can extend from minimal up to several thousands of pounds per cycle in the private sector, depending on the exact procedure involved[103]. Consequently, in order to increase their competitive edge and attract patients, private clinics have begun to offer treatment packages using the familiar marketing technique of the special deal, offering three cycles for the price of two, or no baby, no fee packages. However, in the finest tradition of the special offer, conditions apply, and, generally speaking, the packages do not include the cost of the drugs that are integral to the IVF process (although these costs may be covered by the patient's GP), and there are often age restrictions which maximise the chances of success for the clinic, thereby minimising the risk of having to provide treatment at a loss.

However, the most common "bargain" made use of by the participants in this study came in the form of schemes within NHS clinics which provide treatment at cost, meaning the treatment costs were reduced to less than £1000 per cycle, which represents excellent value in comparison to the cost of services within the private sector:

> *Angela: this was the friend that I mentioned earlier, and she said that [hospital] were doing a special offer at the time [laughing] for £500...*

> *Sharon: [...] and I remember reading something in a magazine, and it...well, I can remember it – it said, "Cut price IVF", and of course, my eyes sort of went straight to it, and [hospital] was offering a cycle of £530, which we had been paying about £2000 up at the [private clinic], so to us, that was a big difference.*

In these accounts, neither participant was actively bargain-hunting, but instead have an eye for a bargain which they can opportunistically snap up – the art of the good shopper. The ultimate bargain, of course, is the health authority funded cycle, which often appeared unexpectedly after a long period of waiting:

> *Sarah: Because we had a letter saying, you know, we've got some spare, end-of-season IVF's [both laughing] [...]*

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[103] In this study, the most expensive single cycle of treatment totalled approximately £5000, although this was unusual, and the total cost included money that the participant reported to have been demanded in unethical circumstances mid-cycle. £2-3000 is more usual for a cycle of treatment in the private sector.

The use of the language of the supermarket sale in the context of the discovery of cheap or free IVF treatment was deliberately and humorously incongruous, often provoking laughter. However, this incongruity points to a more general discomfort surround the introduction of money into the IVF context and the identification of the purchase as a bargain, and therefore not to be turned down, is an important strategy in resolving that tension. Where the intention was to carry on with treatment in any case, even if it meant paying privately, taking up the bargain treatments simply becomes a matter of economics – why pay more when you can pay less?

> *Martin: Just to clarify though, er…it wasn't that we couldn't afford to carry on with the [private clinic], it's just that here was a hospital giving us the same treatment for…a quarter of the price. And it was as simple as that. Would you go and buy a pair of shoes for £50 or £10? It was as simple as that.*

Martin values his role as the breadwinner and provider and is careful to assert that they didn't **need** the cheap treatment, and nor is he being mean in choosing to pay less rather than more. His illustrative rhetorical question about the more mundane shopping task of buying shoes makes it clear that the choice about IVF is "as simple as that" – the basic rules of careful shopping apply, and the cheaper option is the only logical choice when the treatment is fundamentally the same. This is interesting from the perspective of comparison with other consumer experiences where you might expect suspicion about a bargain. The experienced shopper, after all, always looks for the catch and reads the small print. However, this is not to suggest that the participants had not done their research, but rather, reflects their judgement that the core product remains the same in the bargain offers as in the more expensive versions. This willingness to accept cheaper treatment at face value partly reflects the concerns mentioned earlier about the contaminating effects of financial exchange in the reproductive process. From this perspective, cheaper IVF is less not more risky. However, another important aspect is the fact that the vast majority of irresistible bargains came out of the NHS hospitals, whose reputation was based on the provision of free (and therefore, uncontaminated) treatment. Bowlby also notes that getting a bargain, even where money is no object, is a "great social leveller" (Bowlby 2000: 122), thereby alleviating some of the tension around the privilege of being able to access private treatment.

However, from the perspective of the decision to end treatment, these offers proved to be something of a double-edged sword, since although they provide the means of pursuing treatment which may otherwise have not been affordable, cheap or free treatment also constitutes a strong incentive to pursue further treatment, even where tentative decisions to stop had already been made:

> *Cathy: The first one was the one that we got for £500, that we went through, three embryos were implanted and it was a failure. And then we decided then, that was it, no more, give up, didn't we. And the very night we talked about it...this one night, we were both sitting here. The next day, I get a letter through the door – it was literally the next day – "you have got a free cycle from [health authority]." They put the health authority's name in a hat – we got a free cycle. We paid for our own drugs, but the cycle was free, and so, we looked at it, because you don't look a gift horse in the mouth after all these years.*

One of the key problems identified in this study with health authority funded treatment cycles was the sudden and unexpected announcement of treatment provision often two or three years after first applying. In many cases, this was a welcome surprise – an unexpected financial saving on treatment that was due to be undertaken regardless of health authority funding – but for others, this necessitated a return to treatment that would otherwise not have taken place, since the patients cannot run the risk of unsettling regrets in later life, wondering if whether that cycle might have been their lucky one, if only they'd tried. Therefore, it can be seen that where health authority funding is unpredictable, it can protract the process of learning to live with involuntary childlessness. Even predictable funding can create its own problems however, and in one of the US case studies described by Yakov Epstein and Helane Rosenberg, the female partner wanted to carry on with treatment until all three of the cycles that were allowed by their insurer had been used up (Epstein and Rosenberg 1997: 141; see also, Britt 2001).

Living within your means

The second strategy by which the participants identified themselves as sensible shoppers became apparent in the frequent assertion that they had not spent more money

than they had available, or could manageably borrow. The assertion that they had used what was essentially disposable income, even where that disposability resulted from rationing expenditure elsewhere, shores up the representation of the self as rational and controlled with regards to the treatment. This representation was achieved in the first instance by contrasting their own financial management of IVF with that of the caricatured unwise, compulsive consumer of IVF, whose inability to limit treatment to within their financial capacity has led to financial ruin:

> *Alice: And I've heard of people who've second mortgaged their homes and get into debt over it, and I thought, I don't want to get onto that slippery slope.*

> *Jane: [private hospital] was a good one.*
> *Brian: And so was their price...and that was something that's got to be considered as well. I mean, people remortgage their houses.*

The unwise, compulsive shopper is an incarnation of desperation who has much in common with the desperate, infertile woman who emerged in the previous chapter as the irrational Other, and her purpose in the accounts is to serve as a foil to the rationality and moderation of those being interviewed. The compulsive shopper is always female in the accounts (as in popular culture), with the rationality of the male partners taken as given. The female participants, then, have to actively demonstrate their own control over their IVF consumption by defining themselves against the desperate Other[104].

This rationality is further confirmed by the assertion that the money that was spent was essentially going spare and did not impinge on necessary household expenditure:

> *Claire: I mean, we knew it was going to be expensive, but we knew that we were in the fortunate position that we had the money to spend, and you know, that was a choice we were able to make... we didn't have exotic holidays that year, but you know, fair enough.*

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[104] An irrational, uncontrolled male counterpart to rationality did emerge in the accounts, but in relation to violence and child abuse, rather than money.

Liz: And, you know, at Christmas time or something, if someone gave us some money, we would say, well, we'll put that in the baby fund. You know, it seemed a positive thing to do with it rather than say...well, go off to Marks and Sparks and buy some new curtains.

Melissa: [...] we probably didn't have as big a holiday, or as many holidays as we would have done, but I mean, I hardly see that as a sacrifice. You know, I mean, we were quite fortunate [...]

The financial sacrifices that are cited are deliberately frivolous – holidays and soft furnishings – suggesting not only that the money was disposable, but that the decision to spend that money on IVF marks a shift away from the dangerous self-indulgence of a life without children, confirming the commitment to the socially sanctioned institution of parenthood. They are literally investing in parenthood. The demonstration of that commitment is particularly important when that parenthood has never been realised, since it confirms the distinction between voluntary and involuntary childlessness that the participants are eager to maintain – a distinction which easily becomes blurred by the decision to stop treatment.

Cathy and John did get slightly into debt in the course of their IVF treatment, but Cathy made it clear that that borrowing was for living expenses, rather than for the IVF itself:

John: I think there were sums that got borrowed.
Cathy: What we borrowed was borrowing because of living [...] Not for IVF. The IVF was paid for, but then the living went down the tubes, so borrowing came from that [...]. And we didn't spend as much on IVF as people do. We were fortunate in so far as the GP paid for my drugs [...]

Even though it is clear from their account that Cathy and John had to borrow money **because** they had spent money on IVF, Cathy makes a clear distinction between borrowing for IVF and borrowing to live which distances them from the suggestion of immoderation in their spending on IVF. This also confirms the priority claim that IVF had on their funds, affirming their commitment to parenthood. This is further affirmed

by the comparison with the spending of others, and the reminder that what they had spent had been subsidised, and therefore constituted a good deal.

It is important to note, however, that it is getting into *unmanageable* debt that is the stigmatised position, rather than borrowing *per se*. In fact, the acceptability of borrowing to fund IVF is demonstrated by the provision of lines of credit by many of the private clinics. Naomi Pfeffer describes this as " a marketing ploy that [puts] IVF on a par with consumer durables such as videos and stereo equipment" (Pfeffer 1993: 174)[105]. The alliance of IVF with other forms of consumption normalises the purchasing of treatment (and by implication, the treatment itself), although this also normalises the expectation of borrowing to fund treatment, further blurring the end point of treatment.

Another important justificatory strategy in defence of IVF expenditure is the comparison with their imagined expenditure if they had been able to have children:

> *Michelle: I mean, it is expensive, but the way I looked at it was...children are*
> *expensive, and if we had children, I would probably have given up work anyway,*
> *so in the mean time, I'm working. You know, I'm earning a salary, so if I want to*
> *spend that money on trying to have a child, or we decided that's how we're going*
> *to spend it, so...that's what we did.*

By allying the expenditure of trying for a child with that of having a child, Michelle demonstrates not only her awareness of the expense of children, but also that she would have left work to care for those children, establishing herself as conforming to the values of the institution of motherhood. She also sets out the money they are spending on treatment as doubly available, since it is not only money that they are not spending on children, but it is also money that she would not be earning, were they to become parents. Her right to spend the money as she pleases is asserted through the fact that it is her salary – a rather half-hearted individualistic stance which is quickly then moderated

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[105] The Harley Medical Group now offers gift vouchers which can be redeemed against cosmetic surgery procedures, and were marketed as Christmas gifts (*Metro*, 17 December, 2001). It is not inconceivable that the same scheme could be applied to fertility treatment in the private sector in the future. Indeed, many of the participants received monetary gifts from relatives at Christmas and birthdays to put towards treatment, indicating this as an acceptable site for gifts.

by the transition from the first person to the collective "we" to highlight their joint decision-making.

Interestingly, while in general terms, and particularly in the context of starting treatment, the participants reported their expenditure as essentially disposable income, in the context of *stopping* treatment, expense was frequently cited as a factor. Of course, in many cases, expense is an *absolute* constraint, although this was only true of a small number of the participants in this study. However, even for those who could, in theory, have afforded more treatment, it became clear that it became less and less possible to manage the necessary financial and lifestyle sacrifices alongside repeated treatment failure:

> *Sharon: Well, we just saved, and didn't go on holiday. Everything was our IVF, wasn't it. We couldn't have that – it's IVF. Like, if we wanted a three piece suite…that was IVF money. I mean, everything revolved, for those few years, it all IVF. It was all we ever did really. That was our whole life.*

> *Jane: We just didn't…we lived in a house for years and it was in quite a state, and we just had to leave it in a state, because we couldn't afford it. […] And you used to do extra work, didn't you, getting part time in…a bit of decorating on the side to get enough money.*

The discursive contradiction between the assertion of the disposability of income and the claiming of financial strain reflects the fact that while those funds were technically disposable, this was frequently at the expense of all other extraneous expenditure. Consequently, many found the strain of not being able to go on holiday, or treat themselves to new clothes or furniture becoming increasingly wearing. In the case of Sharon, she also cited concern about her son from her previous marriage, who she felt was being unfairly denied family holidays and other treats as a result of their commitment to IVF, and in Jane's case, the IVF expenditure was affecting their ability to maintain their house, as well as placing a substantial burden on her husband, Brian, in terms of maintaining two jobs. What is apparent here is that the availability of the money is less significant than the relative value attached to it, particularly as treatment progresses through a number of unsuccessful cycles:

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Nancy: As it went on, we did get the value of the money a bit more, and you weren't very happy with the job that you were doing. And we were thinking, well, it's a lot of money.

Matthew: Well, our money was going on the IVF, so we couldn't afford to go on holiday. They were having holidays, and they were coming back and saying, "Oh, look, she's pregnant!" And that hurts, because it was like…they're getting the best of both worlds!

For several of the participants in this study, the value for money in continuing treatment began to fall away as the necessary financial sacrifices became harder to bear, as did the successive treatment failures, gradually shifting the cost-benefit analysis less favourably away from continuing treatment.

It is interesting to note at this point that while people were very willing to talk about the costs of treatment, particularly when they had got a bargain, they were much less willing to talk about money more generally. Only just over half of the participants were prepared to include their income on an initial questionnaire, and questions about the organisation of household finances were generally evaded. I initially put this down to a facet of Englishness – of it being perceived as rude to talk about money. However, as the interviews progressed, it became clear that this reluctance said far more about their fears of being judged as having spent too much or too little on treatment relative to income.

While IVF is clearly located within consumer culture, it is, in many ways, not a regular consumer experience and the "sensible shopper" discourse becomes increasingly unsustainable as the treatment failures mount up. While the pointing up of similarities with other shopping experiences is useful as a strategy for normalising the decision to spend money on IVF, the incongruities in the analogy become increasingly difficult to suppress, as the next section will demonstrate.

Disrupting Consumer Identities

The treatment of infertility in the UK is curiously positioned in relation to health care, with health authorities and private health insurers willing to conduct tests to establish the causes of infertility without necessarily being willing to fund fertility treatments such as IVF. Consequently, regardless of who eventually funds a particular treatment, most patients seeking treatment begin with a visit to their GP, who usually organises preliminary tests to assess sperm quality, the presence of particular hormones at different stages of the cycle, and perhaps an ultrasound scan to check for conditions such as polycystic ovaries or uterine fibroids. As the tests become increasingly invasive and treatment is entered into, the NHS is less and less accommodating, with long waiting lists for investigative laparoscopic surgeries and limited funding for treatment. Consequently, for those who can afford to pay, private treatment increasingly becomes an appealing option. Particularly in their early engagement with IVF, this transition in their own status from patient to consumer was obscured, often undergoing tests privately, for example, but on referral from their GP. Consequently, it is apparent from the interviews that far from being sensible shoppers from the outset, several of the participants were initially completely unaware of their potential status as consumers, and therefore, of the possibility of shopping around:

> *Jane: So there were so many hospitals involved [in providing IVF], but we didn't, we were so naïve really.*
> *Brian: Well, we got wrapped up in [hospital] and that was it.*
> *Jane: What was the be all and end all, and we just went with that. But now, perhaps looking back, we might have looked into it a bit more, and financially. But as each treatment came along, we just...*
> *Brian: We just went for it.*
> *Jane: We just went for it.*
> *Brian: Blindly.*

Accustomed to health care provision which has little opportunity for patient initiative and where there is a clear process to follow, Jane and Brian, along with many other of the participants, found themselves on a well-trodden path that ended up at IVF, which their health authority would not pay for. Consequently, their GP referred them to [hospital], and throughout their treatment, they remained only faintly aware of the thriving private sector IVF industry – something which was a cause of considerable

regret to them having stopped treatment, since they were left wondering whether they could have done more. This stands in contrast to the surveying of brochures and the bargain hunting of other participants, and can be explained in part by the extent to which their treatment had been conducted entirely in an NHS context (although funded by themselves at cost). As in many NHS hospitals, patients who are considered to have an extremely small chance of success will often not be allowed to undergo further cycles if one or two cycles show very poor results, particularly in terms of egg collection or fertilisation. However, Brian and Jane achieved very positive results[106] on each cycle, conceiving their son on their fourth cycle. It was only when Jane's egg quality began to decline with age that the consultant suggested that they might want to consider going elsewhere – a suggestion that Brian continued to feel angry about:

> *Brian: Then, after all that, they tell us that, well, "Go to the place down the road, and they might be able to do something different for you." So why didn't they tell us that before?*

Because many of the participants were unfamiliar both with IVF and with purchasing health care, shopping for treatment is a skill that had to be acquired. Some were fortunate to be instructed as to the necessity of shopping around by the GPs or gynaecologists:

> *Nancy: And he said, "You can find out about different clinics, in different areas of [city]." [Private clinic] were doing some, weren't they – that was private. There was a string of different clinics that were doing it privately. And he said, you know, "The prices do vary considerably. Ask for all that information and go from there [...]"*

However, for the most proficient shoppers, the skills were developed as their involvement with treatment progressed, gradually developing networks of friends and family who would spot articles in newspapers and magazines about new or cheap treatments, researching new techniques in medical journals, and subscribing to support

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[106] It was common among the participants to categorise cycles of treatment as having gone well or badly, even where those cycles had failed. This related to the number of eggs produced, the quality of the eggs, and the number and quality of the embryos following fertilisation.

organisations and networks such as ISSUE. Katy and Tim - both highly proficient and rigorous IVF shoppers - drew up a short-list of clinics where they were considering seeking treatment, and then test drove to each clinic both to gain a visual impression of them, but also to gauge their accessibility, in anticipation of the stress of repeated visits by car. Others shopped for clinics which could perform specific techniques or which were willing to treat older women.

The second way in which purchasing IVF differs from more conventional consumer experiences is that, particularly for the participants in this study, there is frequently nothing to show for the money:

> *Sharon: And it's the fact that you're paying out, and you've got nothing at the end of it. It's like if you're paying a couple of thousand pounds out for a car, you've got a car, or a holiday or whatever. You've got nothing to show for this couple of thousand pounds you've just spent, you know. Just nothing.*

Getting nothing for your money is very threatening to the constructed identity of the sensible shopper, since having nothing to show for the expenditure is suggestive of wastefulness rather than caution. Martin was particularly exercised by this, almost wishing that his daughter, conceived spontaneously after stopping IVF, had been the product of IVF:

> *Martin: I still feel a bit cheated that we didn't get pregnant. It's my personal feeling that...why did we have to spend so much money for it to happen naturally? At the end of the day, [...], I would rather have got [her] by IVF in the end [all laughing]*

It is important to note here that when his daughter was born, he made it very clear to everybody that she was not an IVF baby. This apparent contradiction reflects two aspects of masculine identity – that of being a good provider who doesn't waste money; and that of being virile and fertile, and not needing technology to become a father. This latter aspect of masculinity will be considered in more detail in the following chapter.

Another way in which the IVF consumer experience can be seen to differ is in the absence of any correlation between expenditure and the quality of the object of consumption. In the purchase of a car, for example, the more money spent, generally speaking, the better the car. However, in the case of IVF, it is not the quality of the treatment itself, or the better chance of a positive outcome, that was described as being paid for in the purchasing of private treatment, but rather, a better treatment environment:

> *Claire: [treatment at an NHS hospital] was quite nice, yeah. Erm, but I mean, the main difference was just what you'd expect – the difference between a privately and publicly funded hospital. You know, the plush carpet and the nice decorations as opposed to clanky linoleum floors and a more basic set-up. But the underlying care – I wouldn't say there were any dramatic differences.*

> *Liz: [...] but I think, you know, the actual treatment was the same as what you would get in any other clinic. It's just not such salubrious surroundings.*

The belief that the treatment in an NHS context is equal in the opportunities it provides for achieving pregnancy, if not in personal comfort, to that in the private sector is crucial to the participants' understanding of having done everything possible to achieve pregnancy, as well as being central in the construction of "bargain" treatments as sensible shopping rather than selfish unwillingness to pay. Furthermore, it dispels the potential feelings of guilt among those who were able to seek treatment in the private sector, suggesting that they did not achieve any advantage over those in the public sector in terms of the chances of becoming pregnant. In fact, the decision to seek private treatment could be presented as an act of sacrifice rather than advantage, stepping out of the NHS to give someone else a chance, and paying so that someone else didn't have to.

The treatment provision within NHS clinics was frequently described as a "conveyor belt" – "Get her out, there's another one coming in" (Len) - and the accounts were littered with references to the cramped conditions, the corridor which doubled as a waiting area, and the lack of recovery time allotted to patients after procedures. Interestingly, the vast majority of these stories were told as humorous anecdotes rather than serious complaints, and tales of having to hold up the leg of a broken bed (Susan

and Matthew) or clear books and files off a bed before an examination (Rebecca and Jeff) were told as shared jokes, drawing on a well-established social understanding of the NHS as resource-starved. Within this discourse, the doctors were victims too, uniting the patients and the doctors in a joint struggle:

> *Charlotte: It's not their fault. It's nobody's fault. It's just the state of our health*
> *service, if you like.*

In contrast, the experience of private treatment was characterised in the accounts by a succession of small luxuries: "tea and biscuits" (Katy), "posh settees" (Sharon), "tea on a little tray with a serviette" (Philip), and "the most expensive cucumber sandwiches" (Graham). Just as the participants made it clear that the quality of the NHS treatment should not be judged by the environment in which it was provided, the same applies to the private treatment, and in their accounts, this parade of little luxuries is presented as nothing more than window dressing, with little bearing on the product itself.

However, the differences are not entirely cosmetic, and aside from the more luxurious experience, being able to undergo treatment privately provides significant advantages. Firstly, those who can afford private treatment do not have to endure the long waiting lists that characterise NHS treatment, particularly when that treatment is health authority funded; and secondly, patients at private clinics can arrange appointment times at their own convenience, including outside of office hours, meaning that the treatment itself is easier to keep secret if they wish to do so. It is also significant in terms of making their schedules manageable, and avoiding the loss of working hours, particularly for those in casual employment, or not using up valuable paid holiday.

These differences aside, the belief that treatment in an NHS context is essentially the same as private treatment had a number of dissenters among the participants. Beth compared her health authority funded treatment protocol to that of her sister-in-law who had had treatment at a private clinic, and realised that the drug regimen was different:

> *Beth: And all her drugs were different to mine as well, and somebody said to me*
> *that, "Oh, yeah, you get the old shit that they used to use 10 years ago. They don't*

use those drugs now. They give it free just because it's the old stock that they've got in the cupboard."

Differing drugs protocols between clinics is common, but the cash-strapped reputation of the NHS allowed the seed that had been planted in Beth's mind to cause her to question the whole cycle of treatment she had received at the hospital. Katy and Tim's doubts were less specific, but focused primarily on Tim's concerns that the conveyer belt style delivery of treatment, followed by a long walk to the car because there was no parking provided, and a long drive home simply wasn't "the best start for an embryo in Katy's body." This continuing doubt resulted partly from the fact that Katy's sister had had twins by IVF in a private clinic, where she had been made to lie down for several hours after the embryo transfer. These lingering doubts point to the difficulties those seeking treatment face in achieving closure around treatment – a task that is made even more difficult by the burgeoning IVF industry, which seems to offer endless treatment possibilities in infinite combinations.

So far, this chapter has focused primarily on the problems faced by those who seek treatment in the private sector. However, the section that follows will look in more detail at receiving treatment within the NHS, which, ironically, even where it is free, does not release the patients from the problems of introducing financial exchange into the reproductive process.

NHS Provision

There are a number of fairly self-explanatory reasons why, from the patients' perspective, treatment in an NHS context, either health authority funded, or provided at a significantly reduced cost, is preferable to having to seek treatment in the private sector. Firstly, and most obviously, there is a strong financial incentive. Secondly, as has already been described, treatment on the NHS is perceived as relatively innocent of the risk of treatment providers being "in it for the money", thereby avoiding the contamination of the reproductive endeavour by financial ambition. And thirdly, treatment within the NHS not only legitimises infertility as an illness to be treated, but also normalises IVF itself as a mainstream medical technology, relieving the patients to some degree of the stigma discussed in the previous chapter of introducing technology into the reproductive process. However, treatment with the NHS is not unproblematic,

particularly with regards to the use of public resources which are currently subject to significant rationing:

> *Tracy: But people are dying from cancer and they can't fund that. It is very difficult, and to be honest, I'm quite glad I'm out of it. You know, in a way, you think, "Well, I'm off that cycle now." You know, when you say...people will... "Well, can I save someone dying, or bring a new life into the world?" I'm glad it's not my dilemma.*

> *Sarah: [...] if it's at the expense of a person getting cancer treatment, [funding IVF is] probably not [justified], but if it's something that the NHS can handle and it is handled efficiently...it's difficult. Erm...sometimes I think, yes, because we benefited from it. I don't know.*

For both Tracy and Sarah, having had NHS-funded IVF is problematic, and both are relieved that they no longer have to confront that dilemma in the pursuit of treatment. Cancer treatment is used here as the deserving "Other" against which IVF is to be judged – a regular feature of the accounts, reflecting the both the status of cancer as a social health priority, and the perceived failure of the NHS to manage essential services. As has already been described, those experiencing infertility, and women in particular, readily find themselves accused of selfishness, whether they have treatment or not. Consequently, many of the women interviewed were extremely sensitive to the issue of the legitimacy of their claim on NHS resources, particularly since their treatment had failed, and readily agreed that the case for providing IVF at the expense of treatments for cancer or heart disease was relatively weak. However, many were also quick to point out that a considerable number of other non-essential treatments were offered with respect to which it could be argued that IVF had an equal or superior claim to funding:

> *Melanie: [...] you can have a bunion done on the NHS – so why not such a serious thing as infertility?*

> *Angela: [...] You know, you can terminate a life on the NHS, but to create one, you can't. Well, how does that work?*

The issue of abortion services was a particularly sensitive one for the participants, for obvious reasons, although no-one actually opposed the provision of terminations *per se*. Instead, what was difficult to tolerate was that IVF did not rank at least equally with a termination in NHS priorities.

Whilst acknowledging the limitations to the claims for IVF as an NHS service, given the very real threat against even the limited provision that currently exists, the participants offered a substantial catalogue of reasons why continued, and even expanded, provision was justified. Firstly, it was argued that the NHS is a resource to which they had contributed and to which they therefore should have access:

> *Stephanie: I think I've paid into the NHS since I was 17. I very rarely have had to use doctors, hospital – why shouldn't I be able to? You know, neighbours of mine are probably up the doctors every day with nothing wrong with them, so I think there should have been something for me.*

For Stephanie, there is a terrible injustice in the failure to provide her with IVF on the NHS after her years of contributions and careful and responsible use of services, conceptualising national insurance contributions in terms of an individual savings plan on which you were entitled to draw, rather than as a system of welfare. For Cathy, the injustice lay not in being unable to draw on her financial investment in the NHS, but in being unable to draw on her physical investment as an employee of the NHS:

> *Cathy: I work for the NHS – why can't I get something done on the NHS? If I've got to have something done, why can't I get that done?*

Cathy also felt very strongly that the cause of her infertility – endometriosis – had been repeatedly misdiagnosed, extending the period over which the reproductive organs were being damaged by the disease before its effects were finally treated. Consequently, she felt that her GP, who she held responsible for this delay, should at least provide her drugs for the treatment, as he eventually did.

Perhaps the most common justification for the provision of treatment on the NHS was an economic one, in that failure to treat infertility has a series of knock-on effects that could bring significant future costs:

> *Melanie: [...] If they're not treating infertility, they're going to be treating the depression that's caused.*

> *Susan: But I don't know – in the scheme of things, if you added up all the anti-depressants people get, I mean, what is the bigger cost – funding a couple for IVF, or funding, you know, funding the rest of it? If it's all coming out of the pot – the marriage splitting up, then having to have counselling, losing your job...I don't know.*

The vision of the experience of infertility as destructive which we have already seen in a number of guises – the desperate woman, the compulsive IVF consumer – is used this time as an expression of affinity between infertility sufferers, rather than as a foil to reflect the normality of the participant and their parenthood aspirations. Indeed, investment in IVF is understood not only as valuable to those experiencing infertility, but also to the rest of society who must otherwise bear the costs. The engagement with IVF in this context is posited as productive, even when it fails, functioning as a sort of stepping stone towards achieving some form of resolution around involuntary childlessness. There is some evidence to support this in the interviews, with women in particular speaking very highly of IVF, and of having to have tried in order to achieve any form of closure around the experience of infertility. However, the financial argument offered by Susan is less convincing, since none of the negative outcomes that she envisages, with the exception of depression, are medical, which weakens the argument that it will save the NHS money to offer treatment.

Over and above the more general case for blanket NHS provision of IVF, given the reality of rationing of resources within the NHS, the participants were careful to legitimise their own claim to what resources were available. The one point upon which all the participants were agreed was the injustice of discriminatory access to treatment on the basis of postcode:

Nancy: I mean, we were there with people – we were paying, some were getting it through their…because they lived sort of 30 miles away, they were getting it on the NHS. I pay exactly the same taxes and all that, and that's wrong, without a doubt.

The issue of equal contributions but unequal access was a regular feature of the interviews, and particularly those whose health authority did not fund treatment nursed a strong sense of injustice on this issue. However, and perhaps not unsurprisingly, locational criteria aside, when asked to suggest possible criteria for treatment, given the limits on funding, most were careful to centralise their own circumstances as most deserving, thereby legitimising the claims they had made on public resources:

Nancy: it's probably a biased one, but I would say that you'd got to start looking for people who were in the position we were.

Katy: I think everybody should have their chance, but I don't think people should sell eggs, or there's all that publicity about – what is it? – the, erm, in America, isn't it, choosing your own sperm and stuff, to get the best baby.
Tim: Designer babies.
Katy: I think it should be constrained to people that are in, you know, our situation.

In the case of both Nancy and her husband, Martin, and Katy and Tim, "our situation" refers to their conformity to the normative reproductive standards in terms of age, sexuality, material circumstances and desire to parent. Furthermore, they see their age at the time of seeking treatment as placing them within a range where conception by IVF is still statistically feasible, making them a good investment from an NHS perspective. This situating of the self as the ideal candidate against other less deserving candidates was also identified by Kathy Davis in her study of state-funded cosmetic surgery in the Netherlands, where prospective patients perceived themselves as suffering intolerably, against the self-indulgent whimsicality that led others to seek surgery unnecessarily (Davis 1995: 76).

However, in the case of Alice, the justification of her claim to funding is made slightly more complicated by the fact that, as a woman in her mid-forties at the time she was receiving treatment (and still seeking treatment at the time of the interview, at 47), she actually fell well outside of health authority age criteria, and also beyond what most of the participants in this study considered to be a reasonable age at which to be pursuing further treatment. Alice began by addressing this issue of the provision of treatment for older women:

> *Alice: But sometimes I've read of women who – I don't know say 27, 28 – who've had IVF because they've been trying to conceive for 3 years and haven't managed it. They had IVF on the NHS....well, they've probably got another 15 years that they could have....Okay, I'm not saying that they should have to wait 15 years for a baby, but technically, medically and naturally, there's more chance that they will conceive naturally when time's running out for people of my age.*

Alice's case turns on its head the argument that those with the best chance of success should receive treatment, arguing for a different set of priorities – that those who are running out of time should take precedence. However, she then goes on to strengthen her relative claim to treatment by arguing that personal investment, effort and commitment should also play a role. She told a story of seeing a young pregnant woman in the street just after one of her cycles had failed. The woman had a baby in a pushchair, and another child by her side, and she was smoking:

> *Alice: [...] it would be nice to think that women that tried to look after themselves were perhaps given a bit better treatment...well, not better treatment, but given more of a chance, and I mean, for I know, that woman could get married again. There she is with three kids by three men[107], but couldn't have one with the next one, probably smoked all her life, and gets funding just because she happens to be 33 or whatever.*

Alice had taken considerable measures to maximise her chances of conception, such as losing weight, taking supplements, and avoiding the consumption of any food or drink

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[107] Alice did not know whether or not this assumption was true, and she is projecting the characteristics of a stereotyped "welfare mother" onto the woman in order to make her point.

that could possibly damage a foetus, and she felt very strongly that these efforts should have been acknowledged in the weighing up of her case for treatment

Conclusion

The analysis presented here has significant implications for the provision of the provision of health authority funding for IVF. The uncertainty which currently surrounds the funding of treatment means that those seeking treatment are unable to plan alternative futures. There were several cases in this study where participants (in every case, these were female) postponed retraining or a return to education, or turned down job opportunities "just in case" the health authority funding appeared. In other cases, the unexpected arrival of funding caused a reversal of the decision to stop. I would argue that a great deal of this uncertainty could be forestalled by establishing prompt, reliable, predictable funding. However, this is not without costs, particularly in terms of the compulsion which is then generated for patients to use up the full allocation of cycles, suggesting some value in offering only a very limited number of cycles. This is clearly an area where more research is needed, and a focus on those who would qualify for funded treatment but who have chosen not to pursue it would be particularly illuminating in this regard.

The identification of the IVF patient also as a consumer raises interesting questions about what is being consumed in the engagement with IVF. Of course, accessing IVF constitutes access to a range of practices and procedures which may, or may not, facilitate conception. However, when treatment fails, the participants are also marked by that engagement in ways that require careful management. In this context, patients can be seen not only to have purchased the product – access to the IVF procedure – but also a particular identity. The fact of having engaged with IVF, even when it has failed, serves to validate the participants' claims to normative reproductive values, establishing a distinction between their own childlessness and that of those who have either chosen to live without children, or who would like children but are not prepared to make the necessary sacrifices to achieve that. In this context, the consumption of IVF creates a particular form of infertility, where infertility is understood as the active desire for a child. However, as the end of the line in terms of available treatment, this may also function as a means of achieving closure around treatment, and retains its utility once treatment has ended, as a validating discourse and an affirmation of the thwarted

intention and desire to reproduce. Paradoxically, then, the consumption of IVF can also, potentially at least, facilitate the end of the identification as infertile.

The meanings conferred by the consumption of IVF are inflected by the specific context within which that engagement takes place, the amount of treatment undergone, and the individual circumstances of those seeking treatment. The accounts reveal an astute awareness of the risk of being perceived as having consumed to excess, or too parsimoniously; as having selfishly used scarce public resources wastefully, or as having reduced reproduction to a commodity. The management of these negative implications in the accounts reflects not only the extent to which reproduction is normatively determined, but also the degree to which the engagement with IVF is subject to disciplinary surveillance by others and by the participants themselves.

One of the effects of this is to locate reproduction firmly in the public domain, in defiance of its conventional construction as located within the private. This marks a curious reversal of the public and private along gendered lines, with women – conventionally inhabiting the private domain – located firmly in the public as both the patient and the consumer of IVF. It is *her* consumption that is subject to surveillance, in expectation of her slipping over into excess. Conversely, as neither the patient nor the consumer, the male partner's engagement with IVF remains largely invisible from scrutiny and out of the public domain. This finding reflects wider feminist theorising on reproduction, which has highlighted the extent to which its constructed location in the private domain disguises the surveillance and regulation to which reproduction is subject. What this analysis shows is that even when IVF fails and treatment is ended, this surveillance continues, and the accounts reflect the ongoing need to manage the perceptions of others of both their engagement with treatment and of their ongoing childlessness. Consequently, while IVF failure can be seen to be virtually invisible in the dominant representations of the technology and from the perspective of the providers of treatment, those for whom treatment fails remain highly visible at the level of social relations.

Chapter 6: Taking Responsibility

When IVF treatment succeeds, the achievement is constructed as belonging to medical science and its practitioners, as this excerpt from the final entry of Leah Wild's IVF diary in *The Guardian* demonstrates:

> *It took 10 people to make my babies. The Professor of the Assisted Conception Unit, the Pre-implantation Genetic Diagnosis (PGD) co-ordinator, the embryologist, two cytogeneticists, the team of four doctors who specialised in reproductive medicine, the consultant obstetrician, and my boyfriend who provided the basic material*[108].

The most striking aspect of this account is that she has written herself out of the process, not even acknowledging her share of the "basic material". Everyone, it seems, can take the credit except her.[109] This construction ignores not only the significant intervention into women's bodies that the procedure involves, but also the extensive emotional and practical labour which IVF entails, most of which takes place outside of the medical environment. In spite of the fact that a significant portion of this work is not necessarily gender specific, in this study it was the women who took on responsibility for this labour. Responsibility here refers not only to the taking on of particular duties, such as information gathering or giving injections, but also to the moral accountability for those actions and their outcome, and in this study it was women who took on responsibility for treatment and its failure. More importantly, while the dominant discourse obscures this burden of responsibility on women and does not credit them with achievement when treatment is successful, women are written back into the IVF narratives when treatment fails and are constructed, implicitly or explicitly, as culpable for that failure, absolving both the technology and its practitioners, and also the male partners, of that responsibility.

The construction of reproduction (and the failure to reproduce) as women's responsibility has a long history, particularly when things go wrong. Women have been

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[108] *The Guardian*, 18 April, 2001

[109] I owe this point to Maureen McNeil, who used this material in her presentation *Auto and Techno: Telling Tales* at the "Cyborg Lives? Women's Technobiographies" conference at the University of East London, 15 June, 2001

constructed historically as passive reproductive vessels, carrying the man's child (Bordo 1993: 90; Stonehouse 1994). As Emily Martin's analysis of contemporary discourses of conception demonstrates (and as discussed in Chapter 2), the modern medical understanding of the reproductive process still continues to be viewed through this lens, with eggs passively waiting for the masculine, active sperm. Conversely, the birth of children with disabilities, the failure to conceive, or the conception of too many girls, for example, has traditionally been laid at women's door (Stonehouse 1994: 35), and it can still be seen that although women continue to be constructed as passive receptacles in the reproductive process, they are also subject to a significant burden of care and responsibility for the welfare of a foetus. This is evidenced by the growing number of foetal protection cases in the US, where women have been accused of deliberately harming their foetus, for example, by drinking alcohol or taking drugs (Bertin 1995; Gallagher 1995). In order to achieve the successful outcome of a healthy, "normal" baby, women are increasingly pressed not only to avoid actions which are potentially harmful to the foetus, but also to take positive action in the form of scans and genetic testing, as well as changes in diet and lifestyle which are deemed to maximise the chances of a healthy baby. By not taking available measures, the women themselves become at fault for the birth of a child with an illness or disability (Lupton 1994: 154).

The contemporary health discourse of individual responsibility is fundamental to this new dimension to an old story. Apparent in both alternative and conventional medical contexts, this discourse argues for the capacity and responsibility of the individual to achieve positive health through monitoring, prevention, self-awareness and self-treatment (Sontag 1978; Coward 1989; Lupton 1994; Stacey 1997). This trend is inextricably linked with funding issues, and when Liz Kendall of the Institute of Public Policy Research urged people to admit that they have "not only rights to good quality health care but responsibilities to the health service", this was with the stated goal of cutting GP waiting lists without having to make further substantial financial investment[110]. The discourse of responsibilities points to the *moral* imperative to be healthy, and the implicit suggestion that ill health is to some extent deserved. It is in this context that it becomes possible to debate whether or not to offer heart surgery to people who have not demonstrated a commitment to stopping smoking, and candidates

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[110] www.netdoctor.co.uk/news , 17 June, 2001

for Orlistat, a recently approved drug to tackle obesity, have to prove their commitment to weight loss by demonstrating a weight loss of 2.5kg, and increased physical activity for a period of at least one month before being able to receive the drug[111].

Lupton describes self-control and self-discipline with regards to the body as "the new work ethic" (Lupton 1994: 31), and public censure awaits those who lack the self-control to live up to the moral imperative to strive for health. For example, Cooper describes the way that overweight people are constantly subject to the disapproving attentions of the "plate watchers" who police their eating with verbal and non-verbal comments. This, in turn, leads overweight people to police their own behaviour when shopping for food or eating in public (Cooper 1998: 24). Those experiencing infertility are equally closely disciplined, finding themselves subject to constant unsolicited advice about how to get pregnant, or criticism at having left it too long, not trying hard enough, being too fat, or too thin, or simply just not managing to achieve an appropriate level of relaxation.

One of the key features of the discourse of individual responsibility for health is that it is profoundly gendered, and while individuals may be responsible, this responsibility is not necessarily uniformly distributed. While men can be seen to take increasing responsibility for their own well-being in terms of exercise and diet (Watson 2000), it is also the case that the expression of emotional or physical weakness still constitutes a transgression of conventional constructions of masculinity (Moyhihan 1998). One of the results of this is that women, in their roles as carers, are still considered to have a primary role in male health care, resulting in book titles such as *When The Man You Love Won't Take Care of His Health* (subtitled, *Practical Ways To Help Your Bullet-Proof Man to Live Longer*) (Goldberg 1999). This also suggests why it might be that more women than men contact the Macmillan Cancer Relief prostate cancer helpline[112], for example.

This chapter will consider the distribution of both moral and practical responsibility within the couple undergoing IVF, and the ways in which conventional interpretations of the gendered body, social roles and emotional scripts provide a framework for the

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[111] www.nice.org.uk
[112] *The Guardian*, 10 April, 2001

lived experience of IVF that is disproportionately disadvantageous to women. This is not to argue that there is a deliberate or malicious intent on the part of the men to offload the responsibility onto their female partners. Instead, this should be seen as the consequence of dominant constructions of gender identity, offering a limited range of repertoires through which the experience of IVF and its failure can be made sense of. The chapter will focus on the ways in which women's responsibility is constructed and experienced, from the perspective of: (1) the IVF process; (2) past behaviour; (3) letting people down; and (4) IVF as woman's work. The final section will consider the ways in which this burden of responsibility impacts upon women's self esteem, and how this can inhibit the process of withdrawing from treatment and creating a positive future without (biological) children or the desired number of children.

The IVF Process

While the IVF process is hailed when treatment succeeds, it can also be seen to shift responsibility onto women over the course of the treatment process, and when treatment fails, it is the woman who is left feeling responsible. This occurs at two key points in the process: firstly, egg collection; and secondly, once the embryos have been transferred.

"Poor performer"

When treatment fails, the presumed inherent instability of the female body, coupled with the fact that it is the female body which is the focus of intervention, makes women a prime suspect in the inevitable search for explanations. Consequently, the apportioning of blame on to women, by doctors, partners and the women themselves, for the failure of particular aspects of the treatment process, if only implicitly, was a regular feature of the interviews. This was particularly true in the context of the process of collecting eggs. As suggested earlier, Liz was horrified to see that "Poor performer" had been written across the top of her medical file when she went for her third cycle of treatment:

> *Liz: I thought, well...I was just sitting there thinking...gosh, they can't...I feel labelled! You sort of...like a school report – could do better, you know.*

Many of the women for whom the hormonal treatment had not produced the desired results expressed the failure as belonging to them. Jane commented that she never "did

that well with the eggs", and others described themselves as producing "crap eggs" (Stephanie), or being "rubbish at producing eggs" (Jenny). The medical technology itself remains unblemished in these accounts, and the participants drew instead on the discourse of failed productivity within themselves – a discourse that has also been identified in accounts of menstruation and the menopause (Martin 1989; Martin 1990).

The Long Wait[113]

There is a two week wait between embryo transfer and the confirmation of whether or not the woman is pregnant. During this period, except for the use of self-administered hormone pessaries to maximise the chances of implantation, there is no further medical intervention. This period marks the fact that there is a temporal distinction between the conclusion of the IVF *procedure*, which ends with embryo transfer, and the IVF *process*, which extends well beyond the embryo transfer, whether the treatment is successful or not. The embryo transfer process is more commonly described by the participants as putting the embryos *back*. This is an important element in the construction of IVF as fundamentally natural, with the embryos portrayed as back where they belong, allowing the natural process to pick up where the temporary medical intervention left off. However, this not only exonerates the medical procedure, which is seen as having done its part, but it places the responsibility entirely onto the woman:

> *Karen: [...] When the treatment failed [...] where did you see the failure lying?*
> *Anne: [pause] ...well, in me, really [...] you know, we had three goes. We'd had three good embryos put back each time, and the chances were, you know, they were saying at that time, about 30%. So, rationally, I thought it should have worked. And so I thought the failure was something to do with me [...]*

Anne's case is particularly striking because following sperm tests and failed fertilisations, both Anne and her husband believed that the fertility problem lay with him, and yet she was still subject to profound feelings of guilt and responsibility. It is also interesting to observe that her sense of responsibility grew during her engagement with IVF, as the natural age-related decline in fertility began to be reflected in her egg quality.

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[113] Leah Wild uses this phrase in her IVF diary in *The Guardian* (30 August, 2001), which she in turn took from the clinic handbook.

For many women, the sense of responsibility once the embryos had been transferred was enormous, causing constant concern once the cycle had failed that something they had done, or not done, during that two week period could have somehow dislodged the embryos. It was not uncommon for women to be afraid to go to the toilet after the embryo transfer in case the embryos were washed away, and many took the two weeks after the transfer off work to rest. This was accompanied by the careful policing of diet and attempts to manage stress, which was perceived as inhibiting implantation, although paradoxically, several women found that the self-imposed rest period left them with time to dwell on the fate of the embryos creating the very stress that the rest period was intended to limit. Others kept working simply to provide an alternative focus and source of self-esteem, which was perceived as more valuable in the long term than the precaution of resting at home.

These precautionary measures (or disciplinary techniques) aim to maximise the chances of pregnancy, but in doing so, they also served to pre-empt future feelings of guilt with regards to treatment failure. This reveals a degree of scepticism towards medical assurances that it is impossible to influence the outcome of treatment either negatively or positively once the embryos have been transferred, drawing instead on common-sense knowledges of the importance of rest and relaxation in achieving pregnancy. One of the doctors I spoke to routinely told patients laughingly that they could go bungee jumping and it wouldn't make any difference, but the majority of the participants disregarded these assurances and focused instead on the measures that they perceived as potentially effective in maximising their chances of conception. This can be seen as a strategy for naturalising the engagement with IVF by creating a distance between themselves and the medical context. It can also be understood as an attempt to assert predictability over the seeming randomness of implantation, as well as offering welcome activity and a sense of purpose. However, this scepticism towards the assurances was also fuelled by the knowledge that while women being treated in NHS clinics were sent home immediately after the embryo transfer, in private clinics, women were made to lie down for several hours before leaving. Furthermore, women are bombarded with messages from both the alternative and conventional medical fields about the importance of pre-conceptual nutrition, environmental hazards and so on with

regards to early pregnancy[114]. In this context, the decision to err on the side of caution is hardly surprising, since the failure to take all possible steps would leave open the possibility of future regret that more had not been done.

This rigorous self-policing implies that a successful outcome may be within the remit of the individual woman, however. Frank describes this assertion of control, as characteristic of the disciplined body – that is, where the body is perceived as dissociated from the self, and as something to be managed and controlled in order to assert predictability (Frank 1995: 41). This was reinforced by the women's partners and other relatives, who chastised them for "doing too much", or for failing to be positive. Interestingly, Frank describes disciplined bodies as making good patients (Frank 1995: 42), although in this case it is clear that the patients disregarded medical assurances in some cases and that bodily discipline was determined not only by medical discourses but also other common-sense discourses. However, this deviation from medical advice could only take place because none of the measures taken were perceived by the doctors as actually *endangering* a successful outcome. Instead, they were simply regarded as having no positive value, and therefore, the participants saw themselves as having nothing to lose, and everything to gain. In this sense, they are still being good patients, even by disregarding medical advice, since they are doing *more* than is required.

The importance of positive thinking and relaxation played an important role in the accounts of the two week waiting period, drawing on the long tradition of assuming that women can influence the outcome of pregnancy by the force of their imagination or mood. Women's dreams or imaginings were traditionally believed to be the cause of deformity or "monstrosity" in babies (Stonehouse 1994: 35; Braidotti 1996)[115], just as the mental excitement of studying was argued by the Victorians to inhibit reproduction (Rowold 1996). The contemporary parallel to these discourses is that of stress:

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[114] A recent news article reported a study that concluded that electro-magnetic fields could cause early miscarriage, and that pregnant women should avoid "microwaves, hairdryers and public transport operated by electricity" (www.netdoctor.co.uk/news, 17 June, 2001).
[115] In 1726, the satirical artist, William Hogarth, portrayed a woman giving birth to a litter of rabbits in response to the story of Mary Tofts, who, it was claimed, had seen two rabbits while out in a field, which she had tried to catch. It was said that the failure to catch the rabbits caused her to miscarry, and afterwards, she could only think about rabbits. She began to produce animal body parts, including a rabbit's liver, cats' legs, and then a litter of nine rabbits. Hailed initially as proof positive of the influence of the imagination during pregnancy, it was later shown that (unsurprisingly) the whole story was a fraud,

Martin: [...] because all the way through it, you get the people who do know
[about their infertility], like your friends, your boss...by boss − "Take her on
holiday", "Get her drunk", "Make her relax".
Nancy: And you think, I've been there, done that.
Martin: "Tell her to stop work" was a big one.
Karen: Really?
Nancy: And we did consider that, but I didn't.
Martin: But I did. I told you to pack up work, because...she wasn't in a
management position of any description, but she seemed to be somewhat stressed.
And er...I just felt, well, let's find out. Let's give it a year and find out. But
Nancy's answer to that was, "What's the bloody point?" Because we could end
up without a job, without a year's salary, and without a baby.

Martin recounts the pressures from others with resignation, finding himself trapped
between the competing discourses of his friends and of Nancy, particularly about
continuing to work. Even though conventional values of masculinity converge to place
responsibility onto Martin for resolving the "relaxation" issue, by getting her drunk, or
taking her on holiday, it is Nancy's decision to keep working that closes the discussion.
Martin remains torn between his suspicion that his workmates may be right about the
need for Nancy to stop working and his need to respect Nancy's reasoning for
continuing, thereby distancing himself from the responsibility for the decision. The
freedom with which others give "advice", and the store set by the importance credited to
stress in infertility, reveal the extent to which the self-discipline to which women
subject themselves in the two week waiting period is also produced by the surveillance
and judgement of others. When working is widely perceived as creating stress which
would inhibit pregnancy, Nancy's refusal to stop work in the face of pressure from
Martin constitutes something of a risk for her, although it is a calculated risk, since
stopping work also has significant costs. However, the retrospective telling of the story

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and the animals and body parts had been inserted into her vagina ready for eminent doctors to "deliver"!
(Uglow 1997: 118-119)

is risk free because they did go on to conceive spontaneously – a success that Martin attributes to her having relaxed after deciding to stop treatment.[116]

Significantly, although some of the male partners accepted responsibility with regards to overcoming what were seen as female problems of stress, even where male factor infertility was implicated, there were few cases where the connection between behaviour and fertility was made and acted upon by men, even though sperm quality is related to behaviours several months prior to the treatment. Several of the men were recommended to take simple steps to improve their sperm count and quality, such as not taking hot baths, wearing loose underwear, abstaining from alcohol and smoking, and taking supplements. However, the compliance rate was low[117], which contrasted sharply with the women who policed their own behaviour (and were policed by others) rigorously even where there was doubt as to whether it made any difference to the outcome:

> *Alice: And [they said] don't have hot baths, which he loves, so he still has hot baths. And erm...they talked about sort of putting a bag of frozen peas on appropriate areas [both laugh]. And he did try a dash of cold water once, and he said, "Never again!" I won't show him this transcript! But he does...Still, I think...sometimes he'll come out of the bath and say, "Cor, boiling hot, that was!" And I say, "Don't tell me!" Because to me, that's like saying, "You won't get pregnant in 6 weeks' time" [...] And I said to him a couple of times, and he was going, "No, no, no. the doctor doesn't know what he's talking about."*
> *Karen: Was he just disregarding the advice? He just didn't believe the advice?*
> *Alice: no, and he didn't see why he should change, just on the doctor's say-so. Even though it's come up in programmes since, but he just doesn't change anything, so I just think, "Well, it's down to me then." You know, "I'm the one that's got to do everything – you just carry on as you were before."*

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[116] The jury is still out over whether the alleviation of stress can increase the chances of conception. However, Domar argues that behavioural therapy to assist in the management of stress should be considered of value in its own right in helping women to cope with the stress of infertility and treatment (Domar 1997).

[117] This finding is supported by Lee, who notes the low compliance among his patients with sperm improvement regimes, although he does not speculate as to why this might be (Lee 1996: 20)

Firstly, this marks the extent to which sperm quality continues to be judged both by doctors and patients by the capacity to fertilise an egg, and little remains known about the role of sperm quality in embryo development and implantation. Consequently, with the development of micro-manipulation techniques such as ICSI, where fertilisation is facilitated through the injection of an individual sperm into the egg, male culpability is further reduced, while female responsibility continues unabated. Of the few men who did make dietary and lifestyle changes with the goal of maximising sperm quality, all but one did so at the instigation of their female partners, with the women gathering information as to what could be done and supplying the supplements for the men. However, this should not be understood in terms of the male partners not caring about the outcome of the treatment. Instead, it reflects the fact the belief, both in the medical and the wider social context, that fertility is a static absolute for men, whereas women are subject to constant change. This presumption is exemplified by Sandra Leiblum and Dorothy Greenfeld, who describe one of their case studies as involving "an infertile couple where the *wife* is diagnosed with "unexplained infertility" (my emphasis) (Leiblum & Greenfeld 1997: 91).

Only one man actively sought out alternative therapeutic treatments for sperm count and quality on his own initiative. Interestingly, in this case, while the fact that the fertility problem was assumed by both the male and female partners as predominantly male factor played a part in this initiative, it also became clear during the interview that the couple – Anne and her husband (who was not interviewed) – did not have a traditional division of labour in the household, and both were working part-time in order to share equally the care of their baby daughter whom they had adopted from China following failed IVF. They were both committed to counselling and therapy, both as a couple and individually, as a valuable personal development resource, and Anne stated a clear commitment to equity within the relationship as a fundamental principle. Tellingly, in spite of this commitment and his willingness to accept responsibility for the infertility which they both believed lay in his low sperm count, Anne still found herself subject to profound feelings of guilt and responsibility, revealing the potency of the association of women with reproduction, and the powerful effect of IVF in shifting responsibility onto women.

Secondly, this points to the continuing association of fertility and virility in men, and where virility is seen as central to masculine identity, undertaking a sperm improvement regimen constitutes a direct challenge to the masculine sense of identity. This threat to masculine identity was taken very seriously by the participants, and with some good reason, since while female infertility was generally met with sympathy (and less desirably, pity) and while surveillance constitutes a normal part of femininity, male infertility, or the suspicion of it, exposed men to considerable cruelty and ridicule:

> *Beth: I sent [partner] a card on Valentine's Day last year, saying "To the world's greatest lover" and there's a friend of mine in here, who actually has 4 children [...] and her boyfriend said, "Oh, how come I didn't get a card saying, "Greatest lover"?" and she said, "You've got children to prove you are."*

> *Matthew: I was actually at a meeting, conference kind of thing [...] and it was sort of said, "I could come round and see your wife".*

The questioning of male potency or virility came primarily (although as Beth's story illustrates, not exclusively) from men, and occurred most commonly in the work place, providing a powerful incentive to keep the treatment secret where possible. Offers to stand in, unsolicited advice on sexual technique or getting their wives drunk to relax them, and jokes such as presenting men suspected of being infertile with Jaffa (seedless) oranges or pots of seedless jam were commonplace, and this "humour" was generally perceived as unwelcome and humiliating. Where it was not experienced directly, the awareness of the possibility encouraged men to be circumspect about confiding in others. In response to this risk, Woollett notes that in the treatment context, men experiencing fertility problems are repeatedly assured by doctors and their partners that their infertility does not reflect on their masculinity, although no such assurances are offered to women who are infertile (Woollett 1992: 169).

Jeff was a notable exception to the way in which these comments were perceived, accepting the constant jokes of his work mates as evidence that he remained one of the lads.

Karen: [...] You also said that your mates, your workmates [...] you were taking a bit of stick...

Jeff: Just a bit!

Karen: How did you feel about that?

Jeff: Great!

Karen: Why do you say that?

Jeff: Because that's what the lads are like at work...on site...because I would have done exactly the same to them. It's all accepted. It's understood. [...] It wasn't a secret, it wasn't hushed up. That's a way to deal with it.

However, in Jeff's case, the joke depends precisely on the assumption of his colleagues that his fertility is not in doubt, drawing on the tacit assumption that it is the female and not the male body that is liable to fertility failure. Even where the treatment was known about by friends and family, if not by colleagues, male silence allowed this assumption of female factor infertility to go unchallenged:

Anne: No, he didn't talk about it anything like as much as me, and he wouldn't say, you know, he wouldn't tell people about the cause. He'd just let people's assumptions go... I think he just couldn't bear to talk about it.

This was particularly frustrating for Anne since in private they both accepted that the fertility was a male factor problem, yet she was torn between not wanting to pander to values of masculinity that she did not support and wanting to protect her husband. This complicity was common among the female partners of men whose fertility was in doubt – a finding also described by Russell Webb and Judith Daniluk (Webb & Daniluk 1999: 13). Angela, for example, described her and her husband as "a pair of old duffers", even though the fertility problem appeared to lie with her husband's low sperm count. Where the opposite case was true and female factor infertility was diagnosed, there was only one case in this study where the male partner insisted on sharing the blame in the way that the women did when the situation was reversed, and even then this was only between the two of them in private.

Where female factor fertility was implicated, several of the male partners actively promoted this information in order to avoid their own fertility being called into question:

> *John: [...] Now, it's like, "Do you have any children?" I say, "Well, no, unfortunately, my wife couldn't have any. We've tried. We couldn't."*

John expressed this unselfconsciously, until challenged by his wife, Cathy, later in the interview. Martin, on the other hand, adopted a more reflexive approach:

> *Martin: But one of the funniest aspects about telling people, especially from a male point, is that you let people know that, without really realising, the next bit a male person throws in is, "There ain't nothing wrong with me." [...] Because...you don't want people to think, "Oh, he can't have a baby. There's something wrong with him. He's not up to it." So it becomes a very male ego sort of situation...that you're prepared to tell people that you've got a problem, but you want to quickly make sure that they're aware that it ain't you.*

The eagerness of both John and Martin to establish clearly to friends and family where the fertility problem lies does not occur in the context of blame or resentment towards their partners. Instead, this should be seen as reflecting the importance of emerging from the encounter with their sense of masculinity intact, where masculinity is dependent on its association with virility.

Given these concerns, it is not surprising that the provision of sperm proved to be an extremely sensitive topic in the interviews, and very few of the male participants were prepared to discuss it in anything other than the most cursory terms. Where it was discussed, this was generally done using humour:

> *Jeff: The bloke actually has quite a good time through the IVF!*

Jeff uses humour to downplay any embarrassment, effectively closing off the discussion. One of the functions of this is clearly to change the topic of conversation, but it also reflects his desire, common to many of the men, not to detract from the

considerably greater intervention endured by his partner. However, the use of humour masks the pressure which the male partners are under to "perform", not only in terms of masculine identity, but also because the failure to produce a usable sample at the right time can lead to the cycle being abandoned. It is important to note, however, that this latter anxiety can be relieved by freezing a sperm sample in advance as a "safety net" (although this does have a slightly lower success rate (Winston 1999: 10)), suggesting that the anxiety related more closely to the "performance" itself, rather than its implications.

In spite of the "performance" anxieties and the embarrassment of the male participants, their sense of responsibility for the treatment outcome remains minimal, and once a usable sample has been produced, their responsibilities are considered by all the actors to have been met, with subsequent failures attributed to egg rather than sperm quality. This is particularly relevant when it is noted that for the last two years, the number of cycles using ICSI has grown disproportionately in relation to "standard" IVF. With ICSI, even a very poor sperm sample may be capable of fertilising an egg, which suggests a lessening of male responsibility with the female burden of responsibility left unchanged.

Past Behaviour

While the previous section focused on the possibility of blame in the context of the treatment process itself, many of the women also felt that the blame for their continuing infertility was the result not only of something that they may have done, or not done, in the course of the treatment, but also of past behaviours. Andrea Braverman observes that "many [therapy] patients feel that they are being punished through their infertility, which adds to their sense of being bad or defective" (Braverman 1997: 223), and the interpretation of illness and infertility as moral punishments has a long cultural history[118]. Treatment failure caused several of the participants to resurrect prior events in seeking an explanation for that failure. Many years prior to her experience of infertility, Sarah had terminated a pregnancy that had resulted from a brief and

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[118] See for example: Davis on the beliefs of physical deformity as a corporeal manifestation of the relationship between God and man (Davis 1995: 15); or Stonehouse on beliefs of the origins of infertility (Stonehouse 1994: 35).

unsuccessful relationship, and she speculated that her subsequent infertility could be "divine retribution":

> *Sarah: I'm not even sure I thought it was anything physical. I just thought it was kind of my just desserts in a way.*

Others perceived themselves as having waited too long to try to conceive, or as having not been proactive enough during the often protracted period of tests and referrals which precedes IVF. There is a strong moral aspect to the assessment of past events. Anne described this poignantly: "It's almost like you've done something wrong. You don't deserve a child." Interestingly, although Anne blamed herself for not trying to conceive earlier, it later became clear that it was her husband that had postponed trying, not her.

A common strategy to counter these feelings of guilt was comparison with others by drawing explicitly on the idea of the unfit mother, comparing themselves favourably with others who were judged far less deserving yet were still able to have an apparently unlimited number of children. For the male participants, the figure of the violent and abusive father took the position of unworthy Other. In the case of the female participants, the tabloid figure of the hyper-fertile teenage welfare mother featured regularly in the accounts. This was frequently accompanied by assertions of what they as a couple have to offer a child, both materially and emotionally. However, as a coping strategy, this could be seen as something of a phyrric victory, since it preserves intact the normative standards of deserving and undeserving motherhood that are so problematic for women for whom treatment is unsuccessful.

Letting people down

The fact that many of the women felt responsible for the failure of the treatment prompted another significant source of guilt – the feeling of having let people down. This reflects women's social role as the maintainers of social relationships, and manifested itself most frequently in concern about being unable to bestow fatherhood on the male partner:

> *Denise: I felt so tremendously guilty that I'd deprived him of having children.*

This sense of personal failure at not being able to give a child to the partner is also reflected in male accounts of infertility (Webb & Daniluk 1999), although as described above, this burden of guilt is more likely to be shared by the female partner, particularly where IVF is involved, than when the infertility is perceived as lying with the female partner.

The dominant representations of IVF are of treatment as a discrete event involving just the couple. However, as discussed in the previous chapter, this ignores the fact that reproduction takes place in a much wider social context, and the repercussions of IVF, particularly when it fails, affect a wide range of people. The role of the prospective grandparents is particularly pertinent here:

> *Mary: [...] It's quite difficult [for my mother] because, you know, it kind of challenged her ideas of where she would be in terms of one day having grandchildren.*

Many of the interviewees were keenly aware of their own parents' desires to be grandparents and felt responsible and ashamed for denying them that pleasure. Indeed, this was frequently cited as a reason for continuing treatment. Just as many of the female participants described being unable to participate in conversations among female friends and relative because of their child focus, this was also reflected in the experience of several of the participants' mothers who were unable to share proud stories and excitement about grandchildren with their friends. There were also several cases where not only the prospective grandparents, but also other relatives or friends had paid for treatment cycles, and while this contribution was perceived as supportive and generous, it could also add to the perception of having let them down when the cycles failed.

The women undergoing treatment were not the only ones to feel guilty:

> *Tracy: [...] I think the worst person, the person who took it worst, was my Mum. She was very much like, "Did I do this to you?", which is very strange. And I didn't, I hadn't realised it was playing on her mind [...] So she was very much like, "Is it something I did?" and having her youngest two daughters have*

problems, I think she sort of somehow thought that she'd eaten something wrong!!
[laughing]

Tracy's mother was unable to accept as coincidence the fact that two of her daughters had (unrelated) fertility problems, and looked to herself as the possible source of blame, revealing the potency of the construction of female responsibility for the outcomes of reproduction. The experience of infertility also generated guilt in relationships between women of the same generation. Melissa's sister, to whom she is very close, suffered from post-natal depression after the birth of her daughter:

> *Melissa: But I think it was a little to do with the fact that she just felt so guilty. So I felt guilty! So we all felt guilty!*

The discomfort felt by other women when they became pregnant placed further responsibility onto the female participants to put other people at ease and allow them to not feel uncomfortable about their own pregnancies. For many of the women, there were times when this task was too difficult to cope with, which could cause problems within relationships. In the middle of Susan's treatment, her sister-in-law became pregnant, and wrote to tell them the news:

> *Susan: And I just thought, "I can't face picking up the phone", because I knew her well, and I knew I wouldn't be able to not cry. I thought, "I've got to wait till I feel... "Congratulations! I'm so pleased for you! When's it due?" You know, without sort of blubbering, because I didn't want to make her feel worse. And then we had that message [from her mother-in-law] on the answering machine, saying, "Oh, [sister-in-law] is really upset because you haven't been in contact with her, and she feels dreadful, and I don't think it would have hurt if you picked up the phone and said congratulations."*

It is women (and not men) who are expected to be excited by the announcement of a pregnancy or to coo adoringly over a new baby, and the failure to put others at their ease by performing that role is a potential source of relationship friction for which the woman experiencing infertility can be made to feel responsible. Consequently, difficulties in coping with other people's pregnancies and babies can be experienced as

a personal failing, and a number of the female participants expressed their surprise and shame at their negative feelings towards other people's pregnancies and babies:

> *Jenny: [...] I remember when she [her friend] had her child, and I could not believe it. This was not like me at all – I'm not that way inclined. And I couldn't believe it, and I had to tell her, "I'm sorry, I can't come and see you."*

Many women also felt that they had let the doctors down:

> *Melissa: You contact [the hospital] to tell them whether you need a blood test or not [to see if you are pregnant]. You know...so I kept putting that off, 'cause it seemed really daft to actually phone and say, "Actually, no, it's not worked." You sort of feel a bit, not quite a failure, but, you know, like you've let them down.*

As has already been described, IVF is constructed by the patients as a team effort where all the parties are constructed as equally and altruistically committed to a positive outcome[119]. This leads women to feel responsible to the doctors when treatment fails. Furthermore, particularly in an NHS context, the fact that limited resources had been used on them when someone else could have used them successfully compounds the sense of guilt.

Many of the women experienced a profound sense of abandonment when treatment ended unsuccessfully, and the empty space that was left was very difficult for many to cope with after the intense activity of the treatment:

> *Susan: But you felt as though you were doing something. That was the...that wasn't too bad because you felt as thought you were doing something. But it was the waiting...but when all of a sudden...You'd had all this input and people scanning you and people injecting you, and then there was this, like, stop...and then it was the...when it didn't work, you're just left [...] It's like when someone*

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[119] In her IVF diary, Leah Wild describes her disappointment when, during her pregnancy, she sent Christmas cards to the staff of the clinic, but did not receive one in return (*The Guardian*, 24 January, 2001).

dies, that's the worst bit, isn't it, when you sort of like, well, when nothing
happens. It all just sort of stops.

Precisely because the IVF process is period of intense activity, particularly for the women, it gave many of the participants a sense of positive action often after years of tests and waiting lists. While most clinics offered follow-up appointments or counselling, none of the participants received any acknowledgement of their grief from the hospital – for example, a card or a telephone call - which conflicted sharply with the construction of treatment as a benevolent, joint venture[120]. This led several of the women to suspect that the clinics no longer had any interest in them because they did not offer any prospect of contributing positively to their success rates, compounding their sense of failure.

IVF as woman's work

One of the less acknowledged aspects of IVF is the extent to which it involves a considerable amount of work on the part of the patient, who has to attend appointments, gather information, make decisions, and organise work schedules around hormone injections and scan appointments. As Susan protested, "...it's not like a picnic, where you take a couple of tablets". As the patient, and therefore the focus of much of this activity, the woman is inevitably heavily involved. However, it also became clear in the course of this study that even those aspects of the work associated with treatment which men could take on still fell predominantly to the women. IVF, it seems, is woman's work. Four key areas of non-gender-specific work performed predominantly by women were identified in the course of this study: information gathering; the use of alternative therapies; decision-making; and the giving of injections.

Information gathering

In every case in this study, it was the woman who first visited the GP to discuss the fact that conception had not occurred:

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[120] I witnessed this disjuncture at the clinic one afternoon, while I was sitting in the area reserved for the clinic staff, folding letters to be mailed out to potential participants. The receptionist came down to announce that one of the former patients had brought her IVF baby in to show the staff, and the doctors began to debate amongst themselves who should go, with each arguing that they were too busy until one eventually went out to see the baby. This is not to suggest that the doctors are uncaring, but that the emotional involvement of the doctors in individual cases is inevitably limited, and a positive (or negative) treatment outcome will inevitably be experienced differently between doctors and patients.

> *Michelle: I think men generally don't like to sort of go and discuss their own, like, ailments and problems. You know, they're not very good at going to the doctor and having check-ups. They'd much rather not think about it and hope it will go away, whereas I think women are much more the opposite, so it was definitely me that instigated going and finding out about it, you know, what we could do[121].*

The initial GP visit was generally made along by the women at the "finding out" stage. This is a reflection, firstly, of the assumption that it is the woman's body that is at fault, and both male and female participants expressed the expectation that the female partners would simply be given fertility drugs which would sort the problem out with no further intervention. However, this also marks the beginning of a pattern that is repeated throughout treatment where women recall themselves as the instigators and organisers, and the men appear to have tagged along compliantly:

> *Paula: I would get the information and I'd leave books..."Have you read this? Just read this, this page, this paragraph!"*
> *Robert: But I did.*
> *Paula: Yeah, you did, but it tended to be as it got close to treatment rather than ...As each step of the process came up, then you would sort of find out what the process was. Sometimes, you know, "We're going to the hospital tomorrow. This is what's going to happen." No, it wasn't quite that bad, but...yeah. But you didn't sort of, like, if I'd brought information home, you didn't sort of jump to find out what it was.*

Paula developed strategies to entice Robert to read the information she had collected, boiling it down to key pages and paragraphs in order to minimise the effort it would take for him to read it, thereby maximising the chances that he would. Robert was taken aback by her suggestion that he was unwilling to participate in the information gathering task, arguing that he did read what he was asked to. The key point here is that it was material that was collected and condensed for him by Paula, and he never *actively sought out* information. Alice's husband refused to look at any information relating to

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[121] See, for example, Moynihan 1998.

specific clinic visits until they were on the train going to the clinic, and this last-minute reviewing of the pending procedure always increased Alice's nervousness. She recalled a brewery sign reading "Take Courage" that was visible from the train that she would look to for inspiration as she answered his questions. For other women, the information gathering task was a reflection of their own research skills, and they took pride in their ability to collect and distil information. Both Jeff and Rebecca accepted Rebecca's ability as a "great chaser of things" – a skill that was confirmed when she found out about a new tubal surgery technique, which she subsequently underwent, conceiving spontaneously the following month.

Susan and Matthew were one of the only couples where this division of labour did not apply. Instead, it was Matthew who took responsibility for seeking out information which they both read together – a division of labour that enabled Susan to take a break from the organisational labour involved in her job:

> Susan: If I was here on my own, I'd be fairly organised, but I don't have to because you're quite a scurrier, and you'll go to the library and you'll find stuff out…And you're "I've been on the Internet, I've rung up, I've done this, I've found out this, this and this," and you're quite…And then I'll come home and I'll read it all.

Matthew was also very involved in the setting up of the research interviews, and in providing feedback on the transcripts – more so than any of the other men. It is also important to note that this arrangement for gathering information is not an exact reversal of Paula and Robert's situation, since Susan would readily sit and read all the information that he had gathered. This reflects their wider commitment to a non-conventional division of labour within the household, where they rejected what they described as "pink jobs and blue jobs" in favour of a more flexible arrangement.

Alternative and complementary therapies

Although most of the women had at some point in their experience of infertility experimented with supplements and dietary changes, only a few pursued a wider range of alternative therapies more seriously. However, with the exception of Anne's husband, as described earlier, the dietary and lifestyle changes were always instigated

by the female partners. Sarah and her husband followed a preconceptual nutrition programme, which she sought out and her husband "went along with" and "stopped drinking alcohol and all those things". She accounted for her role as the instigator in terms of the wider division of labour in their household:

> *Sarah: But that's only because I do [take responsibility] when it comes to matters of health anyway. That's my job in this marriage. Not my job, but that's the way I am. There are certain things, you know, that we will do. One of the things I will do...I make sure that our health is as good as possible.*

Sarah takes a slightly defensive tone, recognised a conflict between her own construction of their relationship as based on equality and the disproportionate burden of responsibility which she took on in the engagement with IVF. This is a strategy which Carolyn Dryden, writing in the context of the household division of labour within marriage, describes as an attempt to "balance the books of fairness" (Dryden 1999: ch.3) in order to retain the integrity of the construction of the relationship as based on principles of equality.

Decision-making

Since it was primarily the women seeking out information and instigating the treatment process, it is not surprising that the responsibility for decision-making with regards to treatment fell predominantly to the women:

> *Melissa: To be honest, in the end, I feel I did make the decision [to stop], but I feel that he was behind me 100%, so there's not...I haven't got that to worry about, and don't worry about that.*

> *Alice: Well, [husband] left it up to me really. He said he'd do whatever made me happy, so if I wanted to go for it again, I could. You know, he wouldn't stop me.*

In reality, the freedom to determine whether the treatment would continue or not proved to be something of a mixed blessing, since it is a decision that affects not only their own future, but also that of their partners, families and friends. A few of the women expressed concern that in years to come the decision would be thrown back at them by

their partners in anger, but more generally, they found themselves torn between wanting control over the situation, but feeling burdened by the responsibility:

> *Claire: I think he never got as sort of embroiled in it emotionally as I did. I mean, he's a fairly typical male in that sense [...] And I think he was very much prepared to go with what I decided, which was nice in some ways, although on other occasions, I think it would have been nice to share the responsibility of the decision more. I mean, he probably thought he was being helpful by saying, "Look, you know, I won't cloud the issue. You ...whatever you want, I'll do it." But of course, that dumped the whole responsibility on my shoulders.*

However, what is also clear is that the women's decision-making power is not as absolute as it appears, with several of the men wielding an unspoken (and occasionally explicit) veto over the decisions of their female partners. As in the case of Alice above, her husband's agreement not to "stop" her clearly expresses his capacity to do just that. The male veto (although used very rarely in this study) is represented as the assertion of rationality over the uncontrolled female engagement with IVF:

> *Melanie: I think Paul set the boundaries [to treatment]*
> *Paul: well, I mean, to be honest, you would have carried on for ever and a day wouldn't you, so I suppose somebody's got to sort of set the boundaries. It's just not realistic to carry on for ever is it...with fertility treatment.*

The reality of IVF is that although the responsibility for the treatment and its outcome falls predominantly onto the women, the treatment cannot proceed without at least the co-operation of the male partner, most obviously in the provision of sperm and perhaps in the use of shared funds. Particularly in those cases where the woman desired to continue with treatment for significantly longer than the man, the potential of the male partner to veto further treatment by withdrawing co-operation hung over the decisions that the women made:

> *Rachel: So I was half thinking in my mind that he just...he wasn't going to participate then. And if he doesn't participate, then you can't actually go through with it.*

A few of the women perceived the threat of the veto very strongly and actively implemented strategies to minimise their partners' grounds for refusal, such as attending appointments alone unless a sperm sample was needed[122], taking responsibility for information gathering and arranging appointments, and in one case, paying for treatment out of her own savings. Others were careful not to become upset in front of their partners, or force them into long discussions about it, for fear of appearing overly emotional.

While an absolute veto over further treatment was relatively unusual, a veto of the *kinds* of treatment involved was more common, and this emerged particularly in the context of the use of both donor eggs and sperm:

> *Alice: No, I think he was quite happy to leave it up to me. If I thought something was going to be worth going for, because he hadn't read up on it or anything, if I thought it was going to be good, then he was quite happy to go along with that. The only thing we have had is this thing about donor eggs, and also surrogacy. He wouldn't entertain that.*

At the age of 47 and entering the menopause, Alice had already been told that the use of donor eggs was now her only option. Consequently, her husband's rejection of the use of a donor is tantamount to a refusal to continue with treatment. However, although Alice is unwilling to tackle him directly for fear of alienating him, she was encouraging him to consider a new technique which would use the donor egg as a container for her own genetic material. The treatment was being carried out experimentally in Italy and she was ostensibly considering recruiting a donor in order to be accepted onto the Italian programme. However, it soon became clear that Alice did not actually expect to be accepted to try the treatment. Instead, she was hoping that once the egg donor had been recruited, he could be persuaded to relent and agree to conventional treatment using the donor egg directly:

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[122] It is important to note, however, that not attending appointments should not always be read as male disinterest. For some, this was a means of playing down the significance of appointments, and for others,

Alice: [...] We might be able to talk him round if we get to the hospital appointment and they come up with all the reasons why it's better to try that [a donor egg] than to try with my own eggs and fail a third time. Erm...he might be persuaded to do it, and of course, knowing that this thing [the Italian treatment] is in the offing, there is a possibility that might make him feel happier about going on the waiting list [for a donor].

Alice allies herself with the clinic staff in her plans to further her cause, hoping that the case for donor eggs would be more persuasive coming from them. In this study, however, there were no cases where the female partner attempted to persuade a partner who was refusing to use donor sperm, reflecting the sensitivity around masculinity and fertility.

Other forms of discrete, and not so discrete, persuasion emerged in the course of the interviews:

Karen: When did you make the decision to move on to adoption?
Katy: Erm...it was ...well, it was something that we've talked about for a ...when I say we've talked about it, I've kept throwing it into the pot.

Denise: And I could manipulate him. I could cry.

Perhaps the most extreme act of resistance in this study was the decision of one of the women to take fertility drugs without her partner's knowledge and timing sex to coincide with the period of enhanced maximum fertility[123]. However, this was exceptional, and most opted for a "soft sell" approach, such as becoming upset, or not allowing an issue to be put aside.

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the male partner would have lost pay to attend – money that they would need to cover the cost of treatment

[123] The participant phoned to tell me this the day after the second interview with her and her husband, during which her husband had repeatedly told me how he considered his family to be complete. She ascribed her decision to pursue further treatment secretly to our first interview, during which she had realised how much she wanted another child. This raises significant ethical issues both in terms of the complexity of the interviewer / interviewee relationship, but also in the writing up of the research, and the decision to include this material was not an easy one because of my concerns about protecting her confidentiality.

While it is possible to interpret the male veto as an expression of authoritarian male power (and a few of the women did perceive it as such), an alternative interpretation is that it allows men to make a decision for the couple that is both more difficult and less socially acceptable for the women to make. By drawing on the traditional model of gender relations where men are defined as rational and women as emotional, the male partner is able to defend his assertion of the veto in terms of protecting the female partner from the physical and emotional effects of treatment on her, thereby facilitating the withdrawal from treatment without either partner breaching conventional gender roles. However, while this strategy can successfully extricate the couple from the IVF treadmill, it is ultimately dependent on construction of gender that is highly conventional – a construction which offers little space for the woman to imagine a positive future for herself without children.

Giving injections

One of the most obvious aspects of the treatment process (other than the provision of sperm) where the male partner can take an active role in IVF is the injections. The injections have to be given according to a strict timetable, and although some private clinics still encourage patients to visit the clinic daily to receive them, this is an option which is highly inconvenient for the woman, particularly if the clinic is not nearby. NHS clinics generally do not administer the injections, and patients have to either self-administer them or find someone else to do it for them. The most convenient and discrete option is to self-administer the drugs. In this study, approximately half of the women were injected by their partner. Of the remainder, a small handful preferred to inject themselves, and the rest had to seek out friends, relatives, GP practice nurses or, for those working in medical environments, colleagues. For several of the men, the giving of injections was simply out of the question, citing their squeamishness about needles:

> *Cathy: I can't give myself an intra-muscular injection. No, I can't do it myself.*
> *John is…can't even talk about it [...]*
> *Karen: So you never did them yourselves?*
> *Cathy. He did, actually. He did eventually. He did give me one. And he had to*
> *have a cup of tea afterwards and a lie down.*
> *John: I have a hatred of needles.*

The squeamish hatred of needles was accepted by the women, and there were no cases where they had tried to persuade their partners to give the injections. In counselling couples in conflict over the male partner's "needle-phobia", Epstein and Rosenberg advise: "Your job is not to cure his phobia, but to find someone to give you injections" (Epstein & Rosenberg 1997: 136-7). At one level, this acceptance is understandable in that few people would want to be injected by someone who was reluctant or unsure, and the priority is to get the job done. However, it also reveals a more fundamental assumption that the arrangement of the injections is the woman's job, and where the man can't or won't do it, the role for finding an alternative person to do it falls to the female and not to the male partner:

> *Alice: [husband] wasn't keen, but he said if I couldn't do it – because I had to go sort of right round the back – then he'd have a go, but he didn't want to unless it was absolutely necessary.*

Alice did not press her husband into doing the injections, and because of her concern about doing them herself, she was forced to ask GPs, the doctor at her workplace and finally her neighbour, a nurse, for help. This forced her to breach the secrecy which she wished to preserve around the treatment.

Self-esteem

One the key reasons why the issue of responsibility is important in the context of stopping treatment is that the subsequent feelings of guilt and failure impact negatively on self-esteem. This, in turn, can limit the choices women perceive as open to them. This erosion of self-esteem begins long before the experience of IVF, with the repeated "failures" to conceive challenging women's self-confidence. In this study, this was particularly apparent in ways in which some of the women felt (or were made to feel) incompetent when trying to keep temperature charts[124]:

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[124] Early on in infertility testing, women are often advised to keep temperature charts in order to see whether they are ovulating. The temperature has to be taken first thing every morning, and if the woman is ovulating normally, the chart should show a spike in the middle of the month.

Susan: I used to feel a complete failure because I was taking my temperature and it wasn't going up and down. I was thinking, "I'm obviously doing it wrong," and I tried and tried. I went back [to the doctor] and I thought, "I'm not stupid. I'm an intelligent woman. I can't get it to..." And then, after all that time, I went to the hospital and had the blood test and he said, "Oh, it's as we thought, you know, you're not ovulating."

Sarah: [...] my GP, when I told him we'd been trying for ages, and he gave me one of those temperature charts. We'd been doing that for a year, and he said, "Oh, rubbish, you're doing it on the wrong days!" – in a very unsympathetic manner, and as if I was an idiot.

In Sarah's case, in common with many women, she had tried using the temperature charts for some time before approaching her GP, although she found her medically unsupervised efforts summarily dismissed as incompetent. Unsurprisingly, the subsequent, supervised charts showed the same results. In Susan's case, she was following her doctor's instructions, although he had clearly not explained fully what she should expect – that is, that he suspected that she may not be ovulating and therefore that the temperature would not go up and down. Consequently, Susan's confidence was undermined in the earliest stages of the testing process in spite of her own self-belief.

The treatment itself also affected women's self-image:

Susan: But it wasn't even just the fact that you felt dreadful. It was the fact that your body's been pumped full of all this stuff, and suddenly the drugs just stopped and you're just left. My hair was all – it's not much better now [laughing] – my hair was all like, sort of, horrible, my legs were sort of blotched and horrible. And I just thought, "Oh, god, I look a right old wreck."

Several of the women found that a combination of stress and the drugs had led them to gain weight during and immediately after the treatment, and others, like Susan, found that the drugs had affected her hair and skin condition, in addition to the scarring caused by repeated injections. This highlights the fact that IVF is a physical, corporeal experience which literally (particularly in the short term) as well as discursively marks

the body. In a culture which values physical appearance as an essential expression of femininity, this creates an additional burden for women whose feminine identity is already under threat as a result of not having conceived.

For some of the women, their confidence was undermined to the point where it impacted on the choices that they made after stopping IVF, particularly in terms of employment. Susan made a conscious decision to pursue a more ambitious career path following the decision to withdraw from IVF, since she had remained in her old job only because it would have been well-suited to part-time work when she became a mother. However, her reaction to not getting the first job she was interviewed for after stopping demonstrates the extent to which her confidence had been undermined:

> *Susan: And I remember sitting in the office getting feedback from this guy and I was just sobbing, and I thought, "Oh, my god, no wonder he doesn't want to give me the job!" [mimics hysterical sobbing] It's just the thought of it...this is what I'd decided to do. This was the direction my life was going to go, and at the first attempt, you know, at 20, 30 something...33, I'd failed an interview. I'd never failed an interview in my life! I mean, that sort of knocked by confidence. I thought, "That's it. Nobody will want me. I can't do that. I can't be employed anywhere."*

Fortunately, Susan was able to recover from this further blow to her confidence and to secure a new and challenging job, but it also demonstrates the potential of infertility and IVF to impinge on women's self-belief. However, it is also important to note that it is not only self-confidence that limits women's career prospects. Many women undergoing fertility treatment stay in unchallenging and unsatisfying careers for many years in the expectation of either leaving to have a baby, or of having a baby and returning part-time. Furthermore, many stay in order to qualify for enhanced maternity and other benefits from which they would be excluded if they were to change jobs and then become pregnant. Consequently, many women for whom IVF fails can find themselves without the qualifications and experience to take on a more challenging job, and lacking the material resources to undertake retraining. As increasing numbers of women take up IVF as an option, this might be a factor which will need to be taken into account in studies of gendered work patterns.

One area where the erosion of women's self-esteem consistently manifested itself is in the need for reassurance from their partners – a need which was not always met, leading to tension:

> *Jeff: Oh, you get all that, "Why don't you go and find another woman?" – all that sort of thing [both laugh]*
> *Karen: Did you have that kind of ...?*
> *Jeff: A couple of times, when you were really blue, didn't you. That's just pure emotion, more...*
> *Rebecca: I suppose you think...I knew he could have children, er...with somebody whose bits were all in working order, so I suppose, you know, you think, you want to make sure they want to be with you for you.*

> *Denise: I did have very emotional days.*
> *Graham: Little things blew up into big things.*
> *Denise: But it wouldn't come out directly, like I said, about not being able to have children. [...] But I think I would really push you to the limits sometimes, wouldn't I? In terms of needing to know that he loved me and it didn't matter.*
> *Graham: Yeah, that it didn't matter.*
> *Denise: That he loved me anyway. I think I did push you – in arguments, I'd be quite cruel.*
> *Graham: I think the divorce rate for IVF is quite high. If you can survive that, you can survive anything.*
> *[...]*
> *Denise: So I'd test him. And when I talk about [his] integrity with you now – you stuck through it all.*

Jeff described the male role in IVF as being a "handholder", suggesting that "all you can do is try to be emotionally strong". Within this discourse, the desire of the women for reassurance from their male partners is something to be "stuck through", placing the responsibility for the discord onto the women for feeling insecure unnecessarily.

One framework through which this relationship discord was explained was that of the well-established discourse of women as emotionally vulnerable to their hormones. Hormones are conventionally assumed to make women unpredictable, moody and aggressive, particularly in the context of menstruation and pre-menstrual syndrome, (Laws 1990), post-natal depression (Nicolson 1998) and the menopause (Ussher 1992). Consequently, many women fear that they will be unable to control their behaviour whilst on the hormonal drug treatments for IVF, and perceptible mood changes were readily ascribed to the hormones by both the male and the female participants. Cathy described being on the hormones as "like having PMT permanently", and she and her husband, John, argued fiercely at the time, even to the point of separating for short periods of time, and later considering divorce. However, John's account also inadvertently problematises the hormonal explanation:

> *John: Totally irrational rages. I mean, erm... but totally, totally irrational rages. And, you know, I've either...I've had to walk out of the house, or as I said, punch various objects, rather than punch her. Erm...to be honest, the less time I spent with her, the better it was.*

As he was explaining, John pointed to a large dent in one wall where he had punched it, and he also told me that he had punched through all the doors upstairs, yet he saw no irony in the portrayal of her rages as "totally irrational" and of his as rational and even restrained. He assured me that "friends have said that they don't know how I put up with some of the mood swings", and this was supported by Liz, who described herself as having been an "irrational cow".

In her study of post-natal depression, Nicolson argues that hormonal explanations ignore the physical trauma, uncertainty and stress of becoming a mother, and instead, they locate the problem within the individual woman rather than in the social context in which the experience of new motherhood takes place (Nicolson 1998). It would be equally possible to formulate a similar explanation for the "mood swings" that accompany fertility treatment, which is painful, intrusive and profoundly stressful, and yet female (but not male) stress and anger continue to be interpreted as hormonal responses, reflecting the persistence of the representation of women as martyrs to their raging hormones. This offers a means of bracketing off the relationship tension to

within the period of engagement with IVF, but this is achieved by placing the responsibility for those tensions onto the idiosyncratic female body – a discursive move which is both woman-blaming, and also which denigrates the physical and emotional stresses of IVF for the female partner.

Consequently, while the majority of the men indisputably had nothing but the best intentions in their commitment to being supportive, the male supportive role was not always experienced as such by the women:

Cathy: I mean, I think I found it very hard, because he's not a talker, and I think the reason that I did want to talk about it every night was that at least I'd get something out of him, whereas maybe I'd tried to talk about it one night and he didn't want to talk, so I tried again another night, so it did always feel as if I was talking about it, but at the end of the day, I wasn't getting the conversation I wanted, so I would keep on. I'm like that. I'm like that in my job. The reason I do well in my job is that I keep on at people, and I think that's, you know, the way it went, because he's not a talker. I am. So I wasn't getting satisfaction, so I was constantly looking for satisfaction, which is probably driving him bananas, but also driving me bananas.

For many of the women, "satisfaction" simply meant no more than seeing that their partners were equally upset and disappointed by the failure of treatment, but with men pursuing a "supportive" role of being strong and therefore not showing their emotions, there was a constant dissonance between the two strategies. Cathy's husband, John, agreed in retrospect that he had not been as communicative as he could have been:

John: But really, I just saw [my role] as being there when I was needed, but the one thing I probably should have done while we were doing it was maybe sat down and listened a little bit more to Cathy. But I was in a position where I didn't want to sit there and discuss it every night, and that's what it was becoming. You know, and so it's like everything else. You don't mind discussing it when the subject comes up occasionally, but when it was every day, every week, for what, the best part of a couple of years or more, I think, from that point of view, I probably …well, I did, I switched off from it, because I was, "Let's get on with it.

If we do it, we're doing it." I think I probably said to Cathy on more than one occasion, "We're going through this. Let's get it done. But I don't see the point of sitting here talking about it every night." So I don't know — maybe I wasn't as supportive in the way that I might have been. [...] You do what you can.

The male partners in the study were routinely described as "not being talkers", and Graham, who is discussed above, was even jokily known as "the Ice Man" in his family because of his reluctance to express his emotions. Carolyn Dryden describes male silence or withdrawal as a strategy for controlling and delimiting change (Dryden 1999: Ch.6), and therefore, this silence should not necessarily be interpreted as disengagement from the IVF process. However, the potentially relationship-damaging implications of this silence are diffused in the accounts by constructing the silence as a characteristic, rather than a strategy. "Not being a talker", then, acknowledges the man as *unable* to be more communicative and expressive of emotion as a facet of normal masculinity (see, Moynihan 1998), rather than *unwilling* – an important distinction which means that the relationship can be kept intact (Seymour 1999: 91). However, implicit in this is a division of labour where women *talk*, and men *do* without the recognition that for the women, talking *is* a form of doing. Once decisions had been made, few of the men were prepared to engage in "just" talking, and as a consequence, few of the women were able to receive the emotional support that they desired from their partners.

This emphasis on male activity is interesting in the light of the analysis earlier in this chapter, since it is clear that it is the *women* who perform the work of IVF, even in those areas where the responsibility could reasonably be taken over by the men. Seymour suggests that this problem-focused approach, although generally seen as male, can be gender-appropriate for women when it is framed within a legitimately emotional context (Seymour 1999) – the desire for a child in this case. Where female positive, problem-focused action is limited to the context of reproduction, it can be seen that the responsibility borne by the women in the engagement with IVF continually orients them towards achieving parenthood and is in danger of placing women in a catch-22 from which they cannot extricate themselves.

Conclusion

From a feminist perspective, the repeated recurrence in the accounts of female insufficiency as an explanatory framework for IVF and its failure is a very sobering finding. Equally shocking is the insight into masculine culture that this analysis offers, particularly in terms of the strong and enduring association between fertility, virility and masculinity. These two related findings have important implications for the feminist theorising of masculinity, gender relations and the body.

The predominance of the association of virility, fertility and masculinity as the discourse through which the male experience of IVF failure was mediated highlights the profoundly limited discursive resources available to men to discuss these issues – limitations that undoubtedly work to deleterious effect for both the male and the female partners. It is possible the interview context brought this aspect of the male experience out disproportionately, particularly since the male and female partners were interviewed together. This may have inhibited the men in talking about their own grief at their frustrated fatherhood ambitions for fear of compounding the guilt that their partners already felt. In addition, the gender dynamic between myself and the male participants may have acted as a constraint. There is very little research that has been done on the male experience of fertility treatment outside of the context of male factor infertility, and the analysis presented here suggests the need for further research in this area.

The concept of "hegemonic masculinity" (Connell 1995) offers one means of making sense of the apparent dominance of this discourse. Hegemonic masculinity is the normative masculine standard, and is defined by the repudiation of the feminine other. Where virility and fertility are so closely associated with masculinity, then even the suspicion of infertility is threatening to the masculine identity. Just as the women in the accounts laid claim to normatively feminine attributes in order to demonstrate their conformity, the male response can be understood in the same context. It is important to note in this context that the absence of a discourse on father*hood* (as opposed to father*ing*) from the accounts does not necessarily reflect the absence of that desire. Instead, this reflects the fact that these accounts are not about the *desire* to parent, but rather, are about managing the status of *not being* a parent in the context of normative social and cultural standards within which parenthood constitutes "normality". Therefore, this analysis constitutes an important contribution in terms of understanding

the nature of "normal" masculinity in relation to those normative standards. Nevertheless, what is clear from the analysis in this study is that it is *women* who are disproportionately disadvantaged by the protection and maintenance of a particular version of this masculinity in the accounts, with material and emotional consequences. This highlights the importance of locating the study of masculinity firmly in the context of inequalities of gender relations.

For the majority of participants in this study, gender relations in the context of the engagement with IVF emerged as highly traditional, particularly in terms of the emotional division of labour. This created a mutually unsatisfactory situation whereby the women experienced isolation and felt unsupported, and the male partners were unable to express support beyond a show of emotional strength. The apparent intractability of these emotional scripts after decades of feminism makes for sombre reading. The enduring nature of these traditional gender relations highlights the continued relevance of feminism to social analysis, and the pernicious nature of "post-feminism", or "new feminism" in Natasha Walter's terms (Walter 1998). The fly leaf of Walter's book, The New Feminism, declares that "it's time to break the link between the personal and the political". However, the analysis presented here suggests that gender relations, as expressed at the personal, intimate, emotional level, remain of fundamental significance to feminist theory and politics, and that the work of feminism is far from done[125].

Finally, this analysis reveals an enduring construction of the female body as unpredictable and liable to failure. This construction results not only in the female body being rendered as an object of medical surveillance and intervention, but it also means that that body can be held responsible for the failure of those interventions. The analysis of discourse in this context functions as a means of recognising and understanding the materiality of people's lives, whilst acknowledging discourse as both reproduced by and productive of that materiality. The dominant discourse emerges from this analysis as entrenched, but not inevitable, and this analysis points to the fundamental importance of finding alternative ways of understanding the female body which move away from

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[125] This is a finding that is not confined to the analysis in this chapter, and the seemingly intractable construction of women as naturally reproductive, as discussed in Chapter 4, for example, also points to a similar conclusion.

insufficiency and blame. Emily Martin's work on discourses of the immune system and the use of military metaphors is particularly instructive in this regard (Martin 1994: Part III, ch. 1), and there is an urgent need for a new vocabulary which facilitates the development of different ways of thinking about (and visualising) both male and female bodies.

Chapter 7: Seeking Resolution

This final analysis chapter focuses on how the participants constructed their experiences *after* stopping treatment. It is important to note that the failure of what eventually turns out to be the final cycle of treatment does not necessarily coincide with the *decision* to end treatment, which may come several months or even years later, if at all. Furthermore, the *recognition* of the end of treatment, whether voluntarily or involuntarily arrived at, does not necessarily coincide with (or inevitably lead to) the transition from identifying as child*less* to child*free* – that is, a life that has ceased to be defined by the lack of children. Consequently, the transition from being "not yet pregnant" (Daniluk 1996) to "not going to be pregnant" should be seen as a long, complex process rather than an identifiable transitional moment, and none of these transitions are assured. Furthermore, this should not be seen as a linear progression, and people move backwards and forwards between stages at different times of their lives.

The decision to stop IVF is highly problematic, and while those undergoing IVF emphatically report the need to have tried everything before being able to accept a life without their own biological children, it is not at all clear what doing "everything" actually consists of. Furthermore, while there are well trodden paths *into* IVF, the routes *out* of treatment are more obscure. This is particularly true for women, given the plethora of negative associations and the paucity of positive role models for women living without children, either voluntarily or involuntarily (Morell 1994; Daniluk 1996; Daniluk 1997; Campbell 1999; Morell 2000). Ironically, even when IVF is successful, the end of treatment is still not clearly marked, since the successful cycle may well provide the motivation to return to treatment to try for a second child to "complete" the family. There is, therefore, no self-evident, identifiable end to IVF treatment, but rather, the point at which treatment ends is subjectively determined according to a wide range of factors, events and personal circumstances.

However, the decision to stop treatment is just one step in the transition towards a life that is not defined by the absence of a child. In the engagement with IVF, the problem which is identified as in need of resolution is the absence of a child. The goal of IVF, then, is to resolve that problem through the birth of a baby. However, the decision to

stop treatment presents those for whom treatment has failed with a new problem, or at least an old problem with a new twist that was postponed by the engagement with IVF – that is, the problem of living without children in a social and cultural context where childlessness is considered abnormal. This is particularly the case for women, since normative femininity is closely bound up in motherhood. Therefore, the new problem which needs to be resolved is the discomforting visibility that the stigmatised difference of childlessness brings, although the extent of this visibility varies depending on age, race, class etc. The seeking of resolution, then, is not about diminishing or denying the desire for a child, but instead, is about the management of normativity to the point where they are able to enjoy the relative anonymity of "normality", or, in Elspeth Probyn's terms, of "belonging" (Probyn 1996).

This brings the analysis back to Probyn's concept of "outside belonging" that was introduced in Chapter 2. Those for whom treatment fails find themselves occupying an ambiguous third space, since they are unable to conceive, but have stopped treatment, and are therefore neither unambiguously voluntarily nor involuntarily childless. Similarly, the desire or intention to reproduce is ambiguously located in relation to normative reproductive standards when that desire is expressed (through having sought treatment, for example) but not fulfilled. This third space is a site of "ongoing inbetweenness" (Probyn 1996: 6), and in seeking resolution to the problem of the visibility of not belonging, the participants can be seen to be both productive of and located between contradictory categories. It will be argued in this chapter that in seeking resolution, the participants not only move strategically between those categories, but that those categories are reconfigured in the process, thereby effecting a reconfiguration of their own location in relation to those normative categories.

This chapter will explore the ways in which the participants manage reproductive normativity in order to establish themselves as normal without actually being able to meet those standards through biological parenthood, and will consider some of the political and theoretical implications of this seeking of resolution. The first section in the chapter will consider the ways in which the participants make use of the complementary discourses of "doing everything possible" and of the strategic role of discourses of fate in limiting the definition of what can productively be done; the second section explores three discourses which allow the participants to situate

themselves within the normative reproductive standards by claiming the conventionally maternal attributes of benevolence, fertility and the fitness to parent; and the final section consider the ways in which the participants laid claim to (and resisted) a childfree identity.

Doing everything possible

Doing what you can

The need to have tried every possible means of achieving pregnancy before accepting childlessness is frequently cited by those undergoing treatment. However, for as long as people are embroiled in the treatment process, what actually constitutes doing everything is frustratingly unclear. Although the participants recalled this confusion over how and when to end treatment, for those who had definitely stopped treatment or who were edging towards closure around IVF, the argument that they had done everything possible regained currency in the context of the positive construction of the end of treatment:

> Karen: Are you glad you did it [IVF]?
>
> Katy: Yes.
>
> Tim: I am, yeah.
>
> Karen: Why would you say that?
>
> Tim: Because if we hadn't had, we would never have known.
>
> Katy: I mean, it wasn't an option not to have a go.
>
> Tim: Because we had to do all we thought we could do to try and have a family, so if we'd not tried IVF, we would just have thought, "Oh well, we haven't done everything we could have done." So at least our consciences are clear of that sort of …alright, we've tried our best. That's it, we can't have a family. That's life.

Katy and Tim had originally decided to undergo 6 cycles of treatment, although eventually stopped after 5 following Katy's emergency hospitalisation relating to ovarian hyperstimulation in response to the drug treatments. Even though they fell short of their original limit of 6 before stopping, they asserted with confidence that they could have done no more. Tim's insistence that their "consciences are clear" demonstrates the way in which IVF has a public, confessional (Foucault 1978: 62) dimension through which the intention and desire to parent is made clear in spite of the absence of a child.

The exoneration attained through IVF reveals the extent to which those living outside the normative reproductive standards are subject to the evaluation of others.

Katy and Tim had recently been made especially aware of the ease with which their actions could be misunderstood, highlighting the need for this "confession". Even though they had not told anybody they were having treatment, Tim was appalled to discover that his closest friend had always assumed they did not want children:

> *Tim: We had to tell my close friend I've known since I was 14. He was my best man – and he thought, last week, when we told him because we put him down as a sort of adoption referee, they all thought we didn't have children because we didn't want them. Which is quite astounding really, when it's a person we see every week and it's obvious…he must have picked up a few bits and pieces, mustn't he?*

Tim is shocked that IVF and infertility do not speak for themselves – that they are not "obvious" – and that it requires active confession in order to confirm the parenting intention, and in order not to be confused with someone who has chosen to live without children. This communication failure between Tim and his friend reflects, to some degree, masculine relations, as described in the previous chapter, and this assumption that people must know that they couldn't have (rather than didn't want) children was rarely replicated by the female participants, who were frequently questioned about their childlessness by others, and were therefore very aware of the need to manage the assumptions of others.

There are three key aspects to the assertion that everything possible has been done. Firstly, it refers to having done everything that is *reasonably*, rather than *literally*, possible. Moderation in the engagement with IVF is socially sanctioned, and even required[126]. Therefore, the assertion of moderation gives legitimacy to the decision to stop, which could otherwise be interpreted negatively as "giving up" or not being sufficiently committed. Therefore, even though Katy and Tim failed to reach the limit which they had set for themselves as "doing everything", the perceived risks of further

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[126] As discussed in Chapter 4.

treatment to Katy's health made it unreasonable to pursue that goal. It is also interesting to note that throughout the interviews, Tim continually expressed concern that the long drive to the clinic may have impacted negatively on the outcome of treatment, and he wondered whether treatment more locally might have been more effective. This continuing doubt co-existed paradoxically with the assertion that everything possible had been done, emphasising the strategic role of the discourse in achieving closure around IVF, or at least demonstrating closure to others.

The discursive use of the possible health risks associated with treatment is also worth noting here. Risk is used here as a future possibility, presenting the decision to stop as an act of reason and moderation. This provides a useful counterbalance to the need to prevent future regrets, but resists the possibility of harm already having been done, with Katy's health scare serving only as a warning of future dangers. Very few of the participants expressed concern about the potential health risks of IVF during the interviews, and it is unclear whether this was due to a lack of awareness of the ongoing debates about safety, or whether it was simply too disruptive to the claim of moderation. The risk of ovarian cancer is roundly disregarded by the doctors as unproven, and Winston attempts to set the record straight by asserting that "I would have no hesitation about giving them to my own family if needed" (Winston 1999: 21)[127].

Secondly, implicit in the assertion that everything possible has been done is the acknowledgement and acceptance of a degree of responsibility as a patient in the IVF process. Therefore, where those responsibilities or duties are accepted, "doing everything" requires that those responsibilities be met fully and capably:

> *Denise: Yeah, there was lots of information. I had lots of sort of information and leaflets. And I suppose I became a bit of a veteran really.*
> *Graham: You got – after the first three attempts – you end up knowing more sometimes than some of the nurses.*
> *Denise: And I used to be better at drawing up the Perganol with no bubbles in it than my sister as a nurse. I got sort of quite good at the technique.*

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[127] Winston's assertion recalls the widely publicised gesture by Douglas Hogg, agriculture minister at the beginning of the BSE crisis in the UK, of feeding a hamburger to his young daughter in order to prove that beef posed no risk to humans –an assertion which later proved false.

As "veterans" of IVF after 12 cycles of treatment, Denise and Graham take pride in their acquired expertise, even exceeding that of the medical professionals in some aspects. For others, it was not acquired skills, but innate characteristics that made them good candidates for IVF:

Claire: [...] obviously, you had to, there was this drug that you had to inhale – I'm trying to remember it all now – you had to inhale for a while, and that was done on a sort of every four hours. But, you know, I'm quite good at doing that, like, like, I'm the sort of person who never forgot to take the pill when I was on the pill, and yet you get some people who can't remember from one day to the next. So I'm, you know, I'm sufficiently organised for that not to have been a problem.

Katy: Yeah, I'm very, very focused in that I'm disciplined but I have to have everything just so. So, as long as everything's just so. So the fact that, you know, as Tim said, sort of, as soon as the, getting the ampoule out and making sure there's no air in the needle, if a little spurt spurted out I'd be horrified. Whereas, subsequently, you know, they'd sort of you know, spurt out the end and I said, "Oh!" [horrified] and they said, "It's alright, they allow factors of, you know, lost." And I'd been doing everything sort of [all laughing] – mustn't lose anything. It might make all the difference.

Both Claire and Katy define themselves as good, responsible IVF candidates because of their good organisational skills and their ability to exercise discipline over themselves. Katy's self-deprecating story about the injections draws upon her lack of medical knowledge about the built-in excess, but it also highlights the seriousness with which she approached her responsibilities in the treatment process, and particularly her attention to precision and detail – a precision which actually exceeds that of the medical professionals. Of course, as the previous chapter described, this need for absolute precision reflects the responsibility she feels – "it might make all the difference" – and while the claiming of expert or veteran status demonstrates the meeting of those responsibilities, it leaves that burden of responsibility unchallenged.

The third aspect of having "done everything possible" is that of having persevered and overcome obstacles, demonstrating that they did not "give up" easily. The previous chapter described the role of persuasion, particularly on the part of the women towards their male partners, in overcoming obstacles to treatment. However, many of the participants also took more deceptive measures. The decision by one of the participants to take fertility drugs behind her husband's back is an extreme example, but small acts of dishonesty in order to work the system were widespread. These included: lying to GPs about the length of time they had been trying to conceive in order to get the ball rolling quickly; lying to social workers in the adoption process about contraceptive use[128] or about having stopped fertility treatment[129]; lying about smoking in the (mistaken) belief that smoking would exclude them from treatment; inventing small recurrent health problems such as dental problems in order to justify regular absences from work to colleagues; and, in collusion with doctors, presenting fertility investigations as investigations for menstrual problems in order to secure insurance coverage for procedures[130]. The participants demonstrated no shame or embarrassment about these deceptions, which were understood as necessary responses to an unfair or prejudiced system which otherwise had the potential to thwart their endeavours.

By arguing that they have done everything possible, the participants were actively embracing patient responsibility in IVF in order to demonstrate their own commitment to the socially sanctioned goal of parenthood, as well as using it to demonstrate their own status as good candidates for IVF because of their proficiency and perseverance. Furthermore, implicit in this discourse is the acceptance of the normative standards which define parenthood, and particularly motherhood, as the natural, inevitable and morally preferred life course. However, where individual agency is given such a prominent role in the treatment process, the failure of treatment is easily laid at the door of the patients themselves, as described in the previous chapter. Consequently, a discourse of fate emerged to highlight the extent to which that individual agency was

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[128] Candidates for adoption are supposed to use contraception to avoid becoming pregnant in the early stages of adoption, which might be disruptive for the adopted child. However, as discussed later in this chapter, several of the women found that using contraception was actually disruptive to the resolution they had achieved around biological childlessness, and therefore, they preferred not to use it.
[129] Candidates for adoption are expected to have ended fertility treatment when applying for adoption.
[130] Most health insurers will not offer any coverage for either the diagnosis or treatment of fertility problems. This exemption is also used by insurance companies to refuse treatment for conditions such as endometriosis, where one consequence of treatment might be enhanced fertility, even though primary purpose of the treatment was pain relief, for example.

inevitably limited, thereby relieving the participants to some extent of the charge of not having done enough.

Fate

The concept of fate was a regular feature of the accounts, and is used here to refer to the "inevitable destiny or necessity"[131]. Variously named as fate, god[132] or nature, this inevitable destiny was understood in a non-religious context, and was credited with varying degrees of interaction and responsiveness. One of the key features of fate in the accounts was its readability - that is, the existence of signs to be followed:

Lisa: So I had a laparoscopy and we decided that we didn't want to go ahead with IVF because I was okay. [We] kept trying, then I had a miscarriage. Then, lo and behold, through the post a month after the miscarriage, a letter from [hospital] saying, "We've got local authority funding for your first cycle of IVF".
Simon: We thought that was sort of fate, really.

Cathy: It was fate that did it for us. We didn't go searching for it, to be honest. The first time we did, but not for the last two.

Alice: But he [the doctor] just sort of stopped [during the egg collection] and it sounded like he threw down his tools, and the nurse had to actually beg him to...she said, "There's another follicle, do that one". And he's going, "It's not worth it." And I...I'd burst into tears by this time. And she said, "Look, just do it. Do that one." And there was one in it. And again, I thought "Well, it's...that's a sign as well. This is the one." But it wasn't.

The narrative use of fate enables the participants to justify choices such as proceeding with treatment. This is particularly true of Lisa and Simon, who had postponed entering into IVF because of their reservations about "interfering with nature". Consequently, the arrival of the letter from the hospital gave them the impetus to proceed. Interestingly, Lisa realised later in the interview that there was actually a space of more than a year

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[131] Chambers Maxi Paperback Dictionary (1992)

between the miscarriage and the letter from the health authority. This compression of the chronology in the narrative enforces the relationship between those events which they have identified as central to the decisions that they made.

Cathy also uses a fatalistic discourse to explain the two unplanned cycles which they underwent. However, she is unable to sustain her passive role in this narrative, acknowledging that "a dog could have crossed the road and I would have gone, 'Oh, that dog's telling me something'". Ultimately, she accepts that the "signs" were simply a reflection of her own desires for further treatment, and she speculates that if she had not had to have a hysterectomy due to her severe endometriosis, she might still be pursuing it.[133]

For Alice, however, the signs that she perceived took on a different aspect as her treatment failed and as her hopes of future treatment became increasingly frustrated by her age and gynaecological problems, interpreting them as evidence of fate (or perhaps, more accurately, Fate) as malevolent, cruel and deliberately misleading:

> *Alice: I've still got folic acid in the bathroom. One of these mornings I'll think, "Oh, perhaps I will [take it]" and I'll start up again. [...] I don't like giving up on things too soon, but there comes a time when you think, "Perhaps I'm just being daft". You know – fate's having a good laugh at me – "oh, there she goes, taking it again".*

Alice's interviews were littered with stories of fate laughing at her by offering promising but ultimately unproductive "signs", or persecuting her by surrounding her with other people's babies. She told a story about how, shortly after one of the cycles had failed, she had gone to her local supermarket – part of a large chain – which had just launched a "Baby Club". In the store, enormous cut-out baby heads had been suspended from the ceiling, literally surrounding her with babies. The banners read: "Have you joined our baby club yet?". "No, I blinking well haven't", she observed,

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[132] Only one of the participants was actively religious (Christian), and infertility had caused another to lose her Christian faith. The remainder did not practise any religion. Where God is mentioned in a specifically religious context, it has been capitalised.

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wryly. Fate here is cruelly vicissitudinous, and the signs that she earlier perceived as leading her towards a positive outcome are now reinterpreted as taunting her[134]. It is important to note, however, that Alice's narrative is, in many ways, quite unique in this study in her persistence in the face of extremely unfavourable odds, and her inability to imagine a positive future without children. In particular, the malevolence which she perceived in the workings of fate was not evident in any of the other accounts.

For others, however, the attribution of the failure of treatment to a higher purpose offered means of making sense of continued infertility. Beth, like Alice, remained unable to accept that she might not become pregnant, but instead speculated whether her treatment failure was preparation for a future life as an older mother of a child with disabilities:

> *Beth: It's another...time's ticking away. I'm 35 next month, and I keep thinking, "Have I got a job in special needs...did I suddenly have a career change to prepare me for this later baby that I'm having in life, which is going to be Down's Syndrome?" All these things I've gone through – it's a preparation thing. It's preparing me for the worst. But your mind gets carried away with yourself, doesn't it?*

Beth is not entirely convinced herself of this, acknowledging that her mind "gets carried away", but she retained a strong conviction in readable pre-destination and that everything happened according to a wider positive purpose that was not necessarily immediately clear. Like several of the participants, Beth had consulted clairvoyants, and tarot card readings had repeatedly predicted her future fertility. In fact, it was the prediction that someone would be contacting her about her fertility that motivated her to participate in this research project[135].

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[133] Another of the participants, Anne, used the I-Ching (a Chinese method of prediction using dice) to help her to identify what she wanted. If the I-Ching came up with a prediction that she disliked, she would then have established what she really wanted and could act accordingly!

[134] Several of the women remarked that they had felt overwhelmed by babies during their treatment, and that they would see them everywhere, in real life and in advertising.

[135] Beth had visited a clairvoyant who had told her that in four months' time, someone would contact her about her fertility, and this would be a starting point for her to take action with regards to her infertility. She received my letter inviting her to participate in the project four months later, prompting her to agree to my request. I personally do not share her belief in prediction, but I am not including this story in order to deride her beliefs in any way. However, from a position of scepticism, I would argue that this demonstrates not only the vulnerability of those experiencing infertility, but also that it highlights

While Beth only had suspicions as to the reasons for her infertility, for Stephanie, this was already clear:

> *Stephanie: [husband] can't have children. I've had a child. [Son's] on this earth to give [husband] the...because I'm sure my ex-husband has fathered umpteen children probably.*
> *Karen: Does he have contact with [son]?*
> *Stephanie: No, but not through my fault. It's his choice. But erm...so if you take that and work it through, me getting pregnant under the awful pressures I had has enabled [husband] to have a child, which is spooky.*

Stephanie became pregnant whilst on the pill early on in an abusive marriage that she left shortly after the birth of the baby. She attributed the fertility problems that she and her second husband subsequently experienced to his low sperm count, and her tubes, which had become blocked following an IUD-related infection. Her narrative brings these two situations together as complementary, offering a neat resolution to the problem of their infertility. This "spooky" set of circumstances is reinforced by her conviction that their infertility is pre-destined as a form of protection against disability. Her husband's family had a relatively high incidence of infertility, and this made her "suspicious that god, nature is saying that that line of people is not to be carried on."

For others, there was no point in even speculating what the reason might be, whilst accepting that there must be one and that it was for the best:

> *Sarah: I kind of felt that if god wasn't letting us get pregnant, there might be a reason for it [...] so I...maybe it wasn't religion, maybe it was fate, thinking, well, I'm not going to bash myself about the head doing something that fate isn't making...letting happen. There's a reason for it. I don't know what the reason is, but you know, let's trust in life.*

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fundamental ethical issues in interview-based research with regards to the different motivations of the researcher and the researched.

> *Rebecca: I believed in my mind anyway, you know, I think that if I was meant to*
> *have fallen pregnant, I'd have fallen pregnant.*

The assertion of an unknowable, but directed, greater purpose offers a framework within which to accept the ending of treatment without writing off that treatment as futile. Rebecca argues that she was "meant to have done all that [treatment]", since it was only by means of the treatment failure that it became clear that it wasn't meant to be.

While the understanding of the world as fatalistically and purposefully organised predominated, a small handful of the participants managed to resolve their infertility by interpreting it as a facet of an entirely random and unpredictable world:

> *Jenny: But it did shake me up a bit. But I don't sort of think, "Why me?" because*
> *I think, "Why not me?". You know, life is life, and you know, there's things*
> *happening for no particular reason. It just happens.*

That things "just happen" marks the recognition that the world is not necessarily organised on fair terms, where infertility is either warranted as punishment or is a part of a larger scheme for the greater good. As Michelle described it, "it's just one of those things," although for Jenny, the belief that "it just happens" was experienced with great sadness, since it reflected her loss of Christian faith as a result of her infertility and the loss of social support that her subsequent move away from the church resulted in. For Susan and Matthew, the acceptance of fate as random enabled them to dispel the suspicion that their infertility had been somehow earned, finally recognising that "the best people in the world aren't the ones that get, that have families".

Meeting the motherhood criteria

One strategy to remain within the normative reproductive standards without actually having a biological child that emerged in the accounts was to detach the socially valued attributes of motherhood from biological motherhood and then to lay claim to those attributes. There is no comparable discursive process in evidence in the accounts in relation to fatherhood, which suggests that this discursive strategy is not about the desire to parent, but the need to manage and negotiate reproductive normativity, the focus of which rests on motherhood. The strategy of laying claim to the attributes of

motherhood establishes the participants as conforming in all but actual parenthood, and three key attributes were identified: benevolence; fertility; and relating to children.

Benevolence

One of the key conventional attributes of motherhood and femininity is that of self-sacrifice and benevolence. This is precisely why the suggestion of selfishness is so potent when directed against women who live without children, or women who have children but fail to meet the normative reproductive standards, such as older women, single mothers, lesbian mothers, or even working mothers, who are judged (in some quarters) to be insufficiently willing to sacrifice their own personal interests for the sake of their children. In this context, one of the key problems faced by those for whom IVF fails is that there is nothing that marks them out from those who have chosen to live without children. Consequently, the accusation of selfishness sticks easily, particularly when the involuntarily childless couple are sufficiently affluent to be able to enjoy the freedom and increased mobility and flexibility that living without children can bring, or the female partner invests time and energy heavily into her career.

In response to these pressures, the construction of the ending of treatment as an act of giving affirms the participant as conforming to key criteria for motherhood, even while being unable to reproduce. This desire to be seen as benevolent is exploited by the treatment providers with regards to participation in egg sharing and research programmes, where women are told that their contributions will help other infertility women, or people with serious illnesses. The newsletter of the Cromwell IVF and Fertility Centre (Spring / Summer 1998) offers a good example of this. The issue focuses on egg sharing[136], which is described as a "dignified solution to the egg donor shortage in fertility treatments". The headline to the newsletter is a definition of sharing – "a very effective way of reducing risk without reducing supply" – that is cited as coming from a publication called *The Origins of Virtue* (my emphasis). The message is clear: the virtuous path for a woman lucky enough to have surplus eggs or embryos is to donate them to another woman. The same strategy is applied to the multiple cycle treatment packages, where women are told that if they conceive in the first cycle of

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[136] In egg sharing schemes, a woman receives IVF for free if she agrees to give up an agreed number of the eggs that she produces to be donated to other women.

treatment, although they would have paid over the odds for that cycle, they would effectively be subsidising women who need more cycles to achieve the same results.

This demonstration of benevolence is apparent in the accounts in two key areas: firstly, by giving someone else a chance to try IVF by ending your own treatment; and secondly, for those who already had children, by sacrificing the desire for more children in order to protect the interests of existing children.

Giving others a chance

IVF treatment that is performed in an NHS context, whether it is funded by the health authority or privately funded at cost by the patient, is widely recognised by those receiving treatment as making a claim on a limited resource[137]. While the vast majority of the participants in this study asserted that their claim on those resources was justified, this was frequently accompanied by considerable discomfort:

> *Melissa: [...] but I did worry that I was using up vital NHS resources over something that wasn't going to kill me. And there's, you know, people with cancer, people with heart trouble, you know. Cutting up the cake. But maybe that sort of infertility area really shouldn't get any money. That was really hard to cope with.*

In addition to the concern that the funding of IVF might detract from other more deserving treatments, the injustice of a distribution of health authority funding which was dependent on post-codes was a source of considerable discomfort to those who happened to live in an area where funding was available. However, the complex issues of "cutting up the cake" also offered the participants a means of translating the decision to end treatment as an act of benevolence to others who were also competing for those scarce resources. After a disappointing first cycle, where the embryos had fragmented soon after fertilisation, Paula and Robert were advised by the NHS hospital where they were being treated that if the second cycle had a similar outcome, they would not be offered any more treatment unless they agreed to the use of either donor eggs or sperm[138]:

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[137] As discussed in Chapter 5.

[138] This kind of last chance was marked in patient files with the letters "YC" – meaning "yellow card"!

Karen: And how did you feel about that?

Paula: Oh, I thought it was a very fair thing to do.

Robert: There are so many other people waiting for treatment.

By acknowledging the needs of other prospective patients, Paula and Robert successfully turn the potentially disempowering imposed end of treatment, at least at that hospital, into an act of generosity. For Liz, the end of treatment was imposed by repeated poor results from the hormonal drugs which are intended to stimulate the growth of egg follicles. Assigned the label "poor performer" on her medical records, she believed that treatment had been subsequently refused because she would not be able to make a positive contribution to the clinic's success rates:

Liz: [...] I felt very much like I am not going to make your figures look good at the end of the day, and another part of me thought, well, yeah...stand aside and let someone else have a go who would have a chance. [...] You do sometimes see women who, you know, had ten goes [...] so I thought that was a bit unfair. Someone else could have a go.

By interpreting the end of treatment as an act of benevolence rather than something imposed by the doctors, Liz firstly reasserts her control over the process in contrast to the excessive number of cycles she ascribes to others; but secondly, she also marks the end of treatment as a positive and generous act on her part. This stand in stark contrast to the commercial motivations which she suspects to be behind the clinic's decision to refuse her further treatment. This discursive distancing of herself from the doctors recalls the need described in Chapter 5 for the participants to locate their engagement with IVF within an altruistic moral framework, rather than one motivated by financial gain.

Protecting existing children

7 of the participants in this study already had one child prior to the final, unsuccessful IVF cycle. Two of these were conceived through earlier IVF attempts, and the remainder were either conceived within that relationship prior to the onset of fertility problems, or were the product of earlier relationships. While one of these children was

almost in adulthood by the time his mother and her partner were undergoing IVF, the remainder were relatively young at the time their parents were pursuing treatment, and the hope of producing a sibling for the existing child was frequently cited as an important motivation for pursuing treatment. However, concern about the possible loneliness or isolation of an only child was also balanced against concern that the engagement with IVF would impact negatively on that child, both in terms of the redirection of resources and the anxiety that repeated hospital visits might generate:

> *Courtney: Poking and prodding... operation after operation...ever since [daughter's] been born it's "My Mum's in hospital, my Mum's in hospital"...and I don't want that for her. [...] I don't want her to constantly keep worrying ... at school, "My Mum's in hospital again." I don't want that.*

> *Sharon: And the thing is, we could spent that [IVF money] on [son]. I mean, we was like forsaking holidays and things like that, to take him away on holiday, because...oh no, that's our IVF money. [...] And the thing is, like, really, we weren't neglecting [son], but he was sort of like pushed into the background because IVF was in the front.*

Consequently, while existing children were frequently cited as a reason for pursuing treatment, they featured equally prominently in the decision to stop, allowing those withdrawing from treatment to establish their credentials as appropriately caring parents, even while withdrawing from the possibility of the "complete" family that they desired. This was also apparent in discussions of adoption, where the potential disruption to existing children of introducing a child into the family who may have behavioural problems was commonly cited as a key reason for not proceeding.

Fertility

One of the most striking features of the interviews was the regularity with which the participants asserted the continued possibility of conception, even in those participants, like Sarah, who could be described as living a childfree life:

> *Sarah: We never really made the decision not to try on our own – in fact, we still have unprotected sex. [...] It's not that we decided not to have children. We just*

don't see something happening. And if it does, great. But we're not even expecting it to happen.

Throughout the experience of infertility, including IVF, many of the participants complained about being regaled with stories of women who tried for years and years and then suddenly and unexpectedly conceived. These stories were told by family members, friends and especially doctors, as well as being reported in the press. While these stories were generally approached with scepticism and annoyance, the fact remains that for some people, this does happen, and so even after stopping treatment, for as long there is no pharmaceutical or surgical prevention of pregnancy, the possibility technically remains. In fact, one of the women in this study was embarrassed to have become one of those stories by conceiving spontaneously after 12 cycles of treatment. However, very few women in the study were actively pursuing the possibility of spontaneous pregnancy in terms of counting days of the menstrual cycle and timing sex to coincide with ovulation. The most notable exception is Alice, who continued to count days using an ovulation predictor, although in a heartbreaking note added to the interview transcript, she had modified her goals, suggesting that "even a miscarriage would be something – if I'm not meant to have children at all, at least we'd have had some hope and joy at the beginning, even if it was to be lost later, but we'll probably never even have that now." The majority, like Sarah, were simply not taking any steps to prevent conception and had ceased the scrutiny of the menstrual cycle that is habitual to many women trying to conceive. In fact, conversely, several felt that the use of contraception was actually disruptive of their gradual acceptance of the fact that they were not able to conceive, since its very use suggests the "risk" of pregnancy.

For most of the participants, the label of infertility was extremely distasteful and suggestive of pejorative terms such as "barren". Therefore, rather than expressing a straightforward expectation of pregnancy, the assertion of the continued possibility, however slight, of pregnancy serves as a means of claiming the normality that fertility bestows. In particular, continued menstruation or ovulation were cited as indications of essential fertility, even where other reproductive health problems made conception impossible:

Karen: Would you identify yourselves as infertile?

Susan: Well, yes.

Matthew: Yeah. I don't think we've ever used the term as such.

Karen: Right. What does the term mean to you?

Susan: Well, you see, the thing is, people talk about sub-fertility, but having never had a child, and never actually being able to conceive, so I always consider that I was completely infertile, because I've never, ever...although that's not strictly true because I've produced eggs.

Susan draws initially on the medical understanding of infertility as the inability to conceive. However, this is also modified by observing that she has produced eggs, preferring instead the category of *sub*-fertility. Others, and particularly those whose infertility was caused by blocked tubes, rejected the category of infertility entirely, arguing that it was simply a technical problem that prevents them from conceiving – what Claire described as a "transport problem", continuing to view her fertility essentially intact.

This construction of a retained core fertility, in spite of the inability to become pregnant, constitutes a response to the way in which cultural and social values have constructed the (reproductive) body as integral to female identity. The fatalistic insistence that you can never say never enables women to conform to those ideals regardless of their actual capacity to reproduce, situating reproduction back firmly in the realm of unpredictable nature.

Relating to children

As has already been discussed, one of the key functions of the accounts of the end of IVF treatment is to assert the essential "normality" of the participants in terms of social and cultural values with regards to reproduction, even where they have been unable to achieve the most obvious display of that conformity – a biological child. Consequently, a key feature of the accounts in this study was the demonstration of the self as being fit to mother by highlighting other areas where those skills and attributes have manifested themselves in their lives post-IVF. This was particularly apparent with regards to relationships with other children:

Sarah: [...] but I've got my god-children, and [husband] has got a god-daughter.

Karen: Are they near? I mean, do you see them?

Sarah: Very near. I can borrow them. The two special ones,[god-daughters], used to live next door. In fact, we heard [god-daughter] being born! It was really weird. We heard all the awful language that was coming out of the house, and within hours we were round there. [...] so we borrow them for weekends, and I must say that a lot of my girlfriends at the same time as I had my miscarriage had a baby, so they are all around 7 years old, and younger, because those were all the first batch, and they went on to have a second...So I know a lot of children. And we kind of get the vicarious pleasure out of them [...]

It is important to note that these are not substitute children for Sarah, and she has managed to construct non-parental relationships with them, which she values very highly. For many of those undergoing IVF, other people's pregnancies and children are hugely problematic, and many of the women reported being appalled by their own feelings of jealousy towards friends and family. Consequently, the reintroduction of children into their lives served for many as confirmation of their recovery, and their successful transition towards acceptance that pregnancy was no longer a realistic possibility for them. Susan and Matthew spoke with delight about a recent weekend they had spent with friends, who have three young children:

Susan: They used to be our neighbours, and I mean, there was a time when I used to find it really, really hard, because she was sort of having her children – when she was living next door – she was having her children and sort of every time another treatment had failed, she was pregnant again. I mean, she's only got three, but, you know, it felt like that. You just go, "Every time! Oh, for goodness sake. She's having another one!" And this time, when we went down, you sort of said to me on the way back [...] and he said, "How did you find it?" and I said, "I enjoy it. It's nice." I go down...we go down, we really play with the children, but I don't have this awful...

Matthew: This gut-wrenching feeling.

Susan: This, "Oh, my god. Isn't it awful. I haven't got any of my own!" We just felt we could enjoy them, and play with them – because we haven't got children, they tend to think we can't be parents so we must be children like them. So we play with them, but then we wave goodbye! [laughing]

Susan identifies this playful relationship with the children as marking a definite and positive transition in her own attitude towards her inability to conceive, and something that had evolved out of the grieving process initiated by three failed cycles and the ending of treatment[139]. Contemporary social and cultural values dictate that for women, the unwillingness to be around children, for whatever reason, is dysfunctional. Indeed, one of the most difficult situations many of the women faced during treatment was the pressure to admire and fuss over other people's new babies, particularly in the workplace, where colleagues tended to be less aware of the treatment. Ironically, however, it is at the point when they were most determinedly pursuing parenthood that the participants were least able to conform to this normative assumption that women will (or at least should) always love being around children. Consequently, the restoration of the capacity to relate positively to children marks a return to normality.

However, the ease with which this constructed normality is achievable in practice should not be overstated, and many of the female participants reported the continuing, very literal social exclusion of not being a parent in a social world full of children:

> *Michelle: But even like the other week [husband's] brother and his wife had some cousins down to stay for the weekend, and they invited us all round there for the Sunday. And when we got there, all the men were in the lounge, watching the rugby on TV, and all the women were sitting in the dining room, and they were all talking about their children. You know, "Is yours doing this yet?" And I just think, "Where do I go?" You know. Erm...and that is difficult, because you feel like you haven't got anything to contribute.*

Michelle's story highlights the extent to which it is the women, rather than their male partners, who are continually exposed to reminders of their childlessness and the practical ways in which that continues to set them apart, no matter how accepting they are of their own lives without children. This demonstrates the way in which those women living without children can find themselves curiously bereft of gender,

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[139] She also marked her progress by the fact that she had just been on a shopping trip with a heavily pregnant friend for baby clothes, and it had not upset her at all. In fact, she remarked that she was simply

inhabiting an ill-defined third space. As Cathy observed of her husband's club, "I go over there and sit with them [the men]…because I'm odd. I'm one of the boys. Well, not one of the boys, but I mean…they wouldn't choose to ask me to go and play golf with them."

The demonstration of a general concern for the welfare of children also featured significantly in the accounts. This manifested itself over small issues such as concern about friends or acquaintances not reading to their children, not disciplining them properly, or smoking during pregnancy or around young children, but also over more serious child welfare issues:

> *Susan: [...] it's like the sort of paedophile business on the television. You know, I mean, that incenses me, you know, that if somebody was like anywhere near my godchildren, or our nephews, I'd be out there banging on the door, and yet, no, because I've got no children, therefore I should believe that everyone should live in harmony with everybody else. But I don't —I still have that ….I mean, I would kill somebody if they went anywhere near any of the children we knew. [...] And we don't know what it's like [to be a parent], but that doesn't mean to say that we don't have that same anger or nurturing or wanting to protect those children, even when they're not ours.*

Susan was interviewed at a time when paedophilia was in the news following the tabloid newspaper campaign which was publicly identifying sex offenders in response to the murder of the young girl, Sarah Payne. The subsequent protests and campaigns for a public register of known offenders was led by a group of *mothers*, and Susan resented the implication that only those who have children can care about children, asserting instead her own fiercely protective instincts towards the children in her life.

This desire to be seen as worthy of motherhood was influential for several of the participants in the decision not to enter into the adoption process, since it was perceived as carrying the risk of being professionally judged unfit to mother. Conversely, as Anne

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disgruntled because it was a beautiful day and she would have preferred to have been visiting garden centres!

found, approval for adoption was experienced as a positive affirmation of the suitability to parent – perhaps even more so than when parenthood is achieved naturally:

> *Anne: [...] having gone through the adoption assessment, I feel incredibly validated, and, you know, affirmed as a parent. You know, because it is hard being assessed to adopt, and it...you know, it feels like...that feels good. It feels good to be able to ...because when you give birth, you don't go through this assessment, so that feels validating.*

Not only adoption, but also god-parenting, or "special" relationships with the children of friends or siblings were perceived by many of the participants as offering this validation.

Another way in which the meeting of parenting criteria is demonstrated is through the assertion of creativity and nurturing in other areas of life not involving children:

> *Sarah: [...] I thought, I've got all this maternal energy that I've been saving up, because I wanted, I mean, I've...I'm not sure it's a broody thing, it's just that I've learned so much – and I want to pass it on to someone [...] And I kind of wanted that, and I'm quite good at teaching – I find myself in training situations quite a lot so this...I feel that I wanted to...I've learnt so many things since, you know, the age of 30 that I wish I'd known when I was 16, you know.*
> *Karen: Yeah! [both laughing]*
> *Sarah: So I just thought, this energy, I want to put it somewhere, but I'm not going to have kids. That's when I decided, I mean, it wasn't an overnight decision, but for a while I thought, "Well, you know, I've got all this energy. I'm going to start a business."*

The energy Sarah describes herself as drawing on is explicitly maternal, which she applied to her business, and particularly to the teaching / training aspects of her work as a management consultant. The energy that she feels would have made her a good mother is now directed towards her business, but by focusing on the giving aspects of her job, she is affirming her suitability to mother and rejecting the selfish stereotype of women living without children. When we met 6 months later, Sarah described this

energy as creative rather than maternal – she had just won a major jewellery-making competition and her work was being displayed in a nationally renowned museum. This separation of the capacity to conceive from the core qualities and skills that define the social institution of motherhood facilitates the creation of a positive future which is not defined by lack or absence whilst still demonstrating the essential conformity to the socially and culturally determined standards of womanhood in all but actually becoming a mother.

Living childfree (?)

Franklin identifies two conventional narrative categories for IVF stories: the happy and the hopeless (Franklin 1990: 212-214). The happy stories are those of success, encapsulated in the iconic image of the miracle baby in the arms of its grateful parents. The hopeless stories speak of treatment failure, where failure becomes a metaphor for the relationship itself (Franklin 1990: 213). Both these stories are committed to parenthood as the only possible satisfactory resolution to infertility, offering a salutary vision of life after IVF for those who are not successful, and a powerful incentive to return to treatment. The former IVF patients emerge from stories of hopelessness as tragic and pitiful, perpetually defined by their lack of a child, or the desired number of children. This status as sympathy figures was not welcomed by the participants in this study, who spoke exasperatedly of "little pats on the wrist" (John), and of being the last to hear about other people's pregnancies. Another of the participants was not asked back to babysit for a neighbour – a task that she greatly enjoyed – once the neighbour discovered that she was unable to have children, worrying that the babysitting would distress her.

For several of the participants, their life without children (or the desired number of children), caused them to reflect critically on the social construction of motherhood as essential to feminine identity:

> *Claire: [...] being a whole person, being a good person, [having] a meaningful life, does not mean being a parent. You know, there's lots of ways that you can have a perfectly valid existence.*

Charlotte: And I remember being very angry at the god-like person who I'd decided was responsible. I remember saying, "You've taken away from me the one thing that I'd be good at!" [...] Why did I think that? [...] When I actually had a child, I'm not that good at it [...] And I might well have been good at other things, had I allowed myself just to keep...get off this track of wanting a child [...] That's what's interesting – how you limit yourself by what you believe is important.

The resistant positions to the ideology of motherhood articulated by Claire and Charlotte are risky in their directness, and while the interviews constituted a safe space to explore these ideas, they were both more circumspect in interactions in other contexts, and also in other parts of their interviews, where more conventional discourses of the motivations for parenthood were marshalled to enable them to construct an account of the engagement with IVF which avoided portraying themselves as having been duped into it. This highlights the fact that the accounts can be seen to be performing several different tasks at once – in this case, constructing themselves as normal and rational both in the engagement with treatment, and in the decision to stop. It is also important to note that while Claire and Charlotte were unusual in expressing so directly their resistance to the normative construction of women as only of value as mothers, this was also expressed in other, less overtly resistant, ways by several of the participants.

The ability to find and express appreciation of the post-IVF life provides a useful means of rebutting the pitiful image in favour of a more positive and forward moving self-representation. However, this is a strategy of resistance that has to be used with care because of the pejorative association of a childfree life with selfishness:

Sarah: So, we were convinced we'd done all we could, within reason. So, that was good, because if we hadn't, we might have been, you know, sort of, we could have done something...Um, in a bit of a horrible sense, it also...for friends, who...might be tempted to think "They're a selfish pair. They've chosen not to have kids." This is a bit horrible, but you do get that sense from people. People see you, you have things, you've got money to spend on holidays and things, you've got more free time and they think that you're selfish. And if you say, if they

ask, "Have you got kids?" and you say, "We can't. We had IVF", and they leave you alone [...]

For most of the participants who continued to live without children, the advantages of childlessness post-IVF included more frequent holidays, increased free time, a higher percentage of disposable income, greater professional mobility (particularly for women) and the freedom to act spontaneously without having to worry about childcare arrangements. It is important to note, however, that this financial freedom was not experienced by all the participants, and for a small number, this was simply an opportunity to not get into more debt, or to pay off loans.

However, as in the excerpt from Sarah above, those positive aspects to living without children from which the participants were able to benefit are strongly associated with the presumed selfishness of the voluntarily childless lifestyle – an association that runs contrary to the desire to demonstrate conformity to normative social and reproductive standards. The two discourses of having done everything possible and of fate are central to the resolution of this dilemma, justifying not only the decision to stop treatment, but effectively licensing the pursuit of a lifestyle that would otherwise be deemed selfish. The benefits of living without children are constructed here not as the first choice, but as making the best of a bad job – "Plan B", as Melissa described it:

Melissa: [...] I just thought, "Sod it!", you know. Life's what you make it. I haven't got what I wanted, so I'm going to find something I do want then go for that.

Some of the women threw themselves into "Plan B" with great determination, with two setting up thriving businesses, and several retraining within their current employment field in order to take on more challenging positions. Melissa initially returned to education to study horticulture with the goal of setting up a nursery – "plants, not children" – with her husband, although this plan had been shelved at the time of the second interview because they were still enjoying the freedom and financial benefits of not having treatment. Other participants carried on with their lives much as before, simply enjoying not having IVF, and being able to spend money on their house or on holidays, or by restocking savings depleted by IVF treatment. These attempts to create a

positive outcome out of the IVF failure were used directly to deflect sympathy and to gain affirmation from friends and relatives:

> *Susan: I think the nicest thing was when our friends stopped doing that, "Oh, poor Susan and Matthew", and did the, "You're blooming lucky, you two!!" And I thought, "Yes, we are very lucky". You know, we are lucky that we're...cause I mean, not everyone that can't have a family can afford to do other things, and although we haven't got pots of money, we are able... if we want to go and do something, we can.*

Significantly, Susan and Matthew recounted stories of having reacted angrily to being told how lucky they were to be leading their childfree life by people who were unaware of their history of infertility. However, from friends who knew that their childlessness was not chosen, this was received as acceptance and affirmation. Matthew even became confident enough in his childfree identity to use it as a put- down against a work colleague who, while they were having treatment, had crudely offered to "come round and see your wife". Matthew taunted him in a later encounter with his recent trip to the Caribbean to see the cricket and with their upcoming trip to the US.

This demonstration of a fulfilling life without children also proved useful in convincing others of the end of treatment:

> *Mary: In fact, my friends were a bit of a pain in the neck sometimes, because at the end of the third one, they were just like, "Oh, no, go for the donor sperm!" And I'd reached a stage where...I'd moved on to a stage where I was able to let go of it, but actually, they weren't. And they were actually still fired up around it, you know. It was quite difficult, actually, saying "I'm ready to let go of this. I actually don't need children around me any more. What I need you to do is come to terms with 'it won't happen'".*

Liz also encountered the same problem when a friend of hers who worked in adoption services kept telling her about the number of very young, white babies that were being handled by his service, and encouraging her to apply for adoption – an intervention that was not particularly welcome after years of "psyching yourself up to the benefits of not

having children" (Liz). Therefore, the demonstration of those benefits communicated the end of treatment firmly back to those offering encouragement and support. The main drawback of this strategy is that to be convincing, it offers no room to express the continuing sorrow and grief that emerges, often unpredictably, for many years after the experience of IVF has ended. This means that the responsibilities of the participants to put on a brave face during treatment – what Susan called "[doing] the response" – in order to protect others from awkwardness and embarrassment have to continue in order for the categorical end of treatment to be entirely convincing.

Age also emerged as a means of claiming the benefits of living without children whilst still conforming to normative reproductive standards. Firstly, for women (but not men) reproduction in the late thirties and early forties is considered risky both because of the increased risk of chromosomal disorders and because of the possibility of either not living to see the child into adulthood, or not having the energy to provide proper care for the child. Therefore, citing age as a reason for stopping proved a very effective strategy in demonstrating conformity in terms of concern for child welfare over self interest. However, age also enabled the participants to "pass" as parents, preventing their conformity ever coming into question with those who were unaware of their history of infertility:

> *Matthew: [...] it's the case now, at our age, that people...some of whom assume*
> *where I'm working, assume that the kids have gone off to university, you know,*
> *away from home.*

Approaching 40, both Matthew and Susan found that the constant questioning that they had experienced in their late twenties and early thirties had now dwindled to nothing, since nobody any longer expected her to become pregnant. This is not to say that they were inventing children they did not have, but rather, that this assumption enabled them to enjoy a decreased interest in their reproductive history.

Susan and Matthew also developed a new conception of "the family" which enabled them to take pride and pleasure in their family unit of two. This emerged in the interviews in the context of work, where particularly Susan found herself constantly

providing cover for others because she had no children and was therefore assumed to be constantly available:

> *Susan: It was "Oh, we've got children. We need the time off at Christmas. You haven't got children." - "But I've got a family" – "Oh, but it's not the same. You don't understand." And I thought, "Why should I not have time off at Christmas to be with my family, just because I haven't got children? Why is my family less important than your family? Why is Matthew and my elderly parents of less value to me than your children are to you?"*

The conventional "family" of two (heterosexual male and female) adults and two children emerged repeatedly in the interviews as the ideal. Susan and Matthew had planned for their "family", purchasing a house on an estate that was well served with good schools and other services. When they decided to stop treatment, they literally as well as emotionally moved on, buying a new house, and divesting themselves of their accumulated "baby stuff":

> *Susan: [...] I'd collected all these Beatrix Potter frames – pictures that were going to go up in the nursery. I kept all these bits and pieces, and I thought, you know…and we just got rid of it all, and we gave it to people's children, and we took it to the charity shop.*
> *Matthew: We totally got rid of it. It was a cleansing.*

They moved to a cottage in the country, deliberately selecting a house that would not have easily accommodated children. By establishing a lifestyle and environment where they did not so readily perceive "this gaping hole" (Susan), they were able to reinvest in their own relationship. As their confidence grew, they were able to celebrate their lifestyle, joking that they were able to indulge their passion for travelling by "spending their children's inheritance". It is important to note that living childfree and wanting children are not mutually exclusive, and whilst asserting their status as a complete family of two, Susan and Matthew remained extremely sad that they had been unable to have children. This highlights their liminal location in relation to the dominant discourse of reproductive normality, and points to the disruptive potential of their construction of themselves as a complete family of two. However, it is also important to

recognise that Susan and Matthew are aided in this construction by their access to material resources, both in terms of moving house, but also in the lifestyle they were able to lead once they had decided to stop.

Age also allowed the participants to account for the childfree aspects of their lifestyles as what would have happened anyway, and therefore perfectly within the normal course of events:

> *Sarah: I do these things – I make jewellery, and I go to Aikido, and I'm very grateful for being able to do those things. The other interesting thing about this as well is that because we leave it so late to have kids these days...Um, I was talking to my friend earlier, [saying] "do you realise that by the time [friend's two children] have left home, I'm going to be 60". And she said, "in the normal course of things, we would have had our kids in our 20's and by 40 we would be free to start living our own lives." I think that's true as well. So I think if I had had a child in my 20's, and that child was now...whatever...I'd be starting on what I'm doing now.*

Sarah is eager to emphasise the normality of her life in her 40's, and the extent to which her life path has now merged back with the more conventional life path of motherhood. For Cathy and John, too, the fact that they now have two holidays a year and weekends away was simply a more affluent version of the lifestyle they would have led had they had children. This diminishing of the divergence of the lifestyles of those with and without children normalises the life without children. However, particularly for women whose peers have small children, their own freedom to be spontaneous was not matched by their friends, meaning that they were still forced to plan social activities well in advance. Their male partners did not experience the same constraints on their social lives since their friends' female partners were primarily responsible for childcare. Furthermore, it is important to note that the advantages of the childfree life are not so easily available to those experiencing secondary infertility, and whose social lives continue to revolve very much around children.

It is also significant that the prospect of ageing was a cause of fear and sadness for several of the participants, and for some, the prospect of a lonely old age without

grandchildren was dreadful. For Alice, her long-term childless future was an appalling prospect for her:

> *Alice: And I think to myself, right, this is it. You know, this is it forever, until we get taken into a home and we die. That's what life is. It'll just be work and more work.*

With an imagined future of only work, institutionalisation and death to look forward to, the prospect of finally ending treatment was understandably fearful for Alice, and she continued to seek treatment. Consequently, while this chapter focuses largely on strategies that were used to achieve resolution around infertility, for some the inability to imagine a positive future without children remained an apparently intractable barrier to that. It is important, therefore, to appreciate that there is nothing that is easy or inevitable about the transition from being "not yet pregnant" to "never going to be pregnant".

Conclusion

This chapter has focused on the ways in which the participants sought to resolve the "abnormality" of their childlessness. The analysis began by exploring the ways in which an end to treatment was constructed as a pre-requisite to making the transition out of infertility, where infertility is understood as a state of *active* desire. This is an important point, since resolution around childlessness, or living childfree, is in no way exclusive of the desire to have a biological child (or more children). In fact, the resolution which is sought is precisely one which can accommodate both the desire to have a child, and also the possibility of a positive present and future that is not negatively defined by that desire.

The achievement of resolution is crucially dependent on the ability of the individual participants to construct themselves as having done everything that is reasonably possible in order to become biological parents. This is certainly a strategy for managing the responses of others to their childless future, but it also reflects their personal desires for children, and the need to postpone future regrets. As has already been described, there is no objective end point to IVF, and it is a technology of seemingly endless possibilities. The end point, then, is discursively determined and individually managed.

This is, of course, easier said than done, but there are aspects of the treatment process which could certainly facilitate this difficult task. The clinic environment is charged with the likelihood of success, not least because of the baby photographs which are conventionally on display in waiting rooms and offices, and the publishing of *success* rates. I will return to the implications of this analysis as a whole for treatment providers in the conclusion to the thesis. However, the important point here is the need for frank representations of IVF, both to prospective patients, and also in the wider social context within which treatment failure is experienced and given meaning.

Beyond establishing closure around the experience of IVF itself, those for whom treatment fails are confronted with the task of creating, or at least imagining, a different future from the one on which their engagement with IVF was predicated. As discussed in relation to the concept of masculinity in the previous chapter, the discursive work which the participants perform is crucially not about suppressing the desire for a child *per se*, but is about seeking ways to live with that desire without being negatively defined by it in a social context that prescribes parenthood as a facet of normality. This discursive agency exposes the constructed nature of the apparently static categories which constitute reproductive normativity, whilst both reproducing and reworking those categories. In laying claim to explicitly maternal feminine attributes, for example, the participants effected a separation of actual motherhood from femininity, reworking both categories as a result. Ironically, then, a strategy of conformity functions as a form of careful resistance to normative standards. Similar reworkings are evident in the analysis of the categories of "the family", and ultimately, of IVF itself, which is transformed from an "end of the line" attempt to become pregnant to a validating structure upon which to construct a positive future without children. It is precisely the "ongoing inbetweenness" of the experience of IVF failure which creates the circumstances for this reconfiguration of categories, and this can be seen as part of the "transformative" project explored in Linda Layne's edited collection (Layne 1999a), through which a close examination of the "fringes" of mothering creates a space from which the categories of reproduction are both produced and transformed. However, it is important not to overstate the transformative potential of the experience of IVF failure, which can be experienced as devastating and isolating.

The accounts demonstrate the extent to which the normativity of reproduction can be managed in order to accommodate a life without children (or the desired number of children) once IVF treatment has ended. Nevertheless, this is highly constrained, and the accommodations that are reached require constant maintenance through repetition. Furthermore, the capacity to imagine and create a positive future without children after unsuccessful IVF is shown in the accounts to be dependent on a wide variety of personal, educational, material and social resources, to which not everybody had access. More fundamentally, what the analysis makes visible is that the vast majority of the discursive work performed by the participants in the interviews is related directly to the task of *managing normativity*, in order to locate themselves within the domain of normality when treatment fails. This is distinct from (although related to) the grieving process which follows IVF failure, and from a feminist perspective, the necessity of this discursive labour points to a depressing lack of change in the narrow construction of femininity through reproduction, in spite of decades of feminism.

Chapter 8: Conclusions

In concluding this thesis, I would like to return to my assertion in the first chapter that this research does not aim simply to plug a gap in our knowledge about IVF. Instead, I have argued that the relative invisibility of IVF failure from the dominant representations cannot be explained simply in terms of biased oversight, but instead can be seen as actively produced by exclusion from those dominant representations. Where the dominant discourse of IVF is of technology giving nature a helping hand to produce miracle babies, there is simply no space for any representation of treatment failure other than ones of devastation following the failure to achieve restitution through biological parenthood. Furthermore, I have argued that those for whom treatment has failed occupy an extraordinary and liminal location among the dominant discourses of gender, technology and the body. Consequently, their accounts can be understood as constituting faithful, situated knowledges which produce new ways of seeing not only IVF, but also the power relations which produce and maintain the dominant representations, and which exclude others. In the remainder of this chapter, I will first set out some of the key findings of the analysis; the second section will discuss some of the implications of the analysis for IVF policy and treatment delivery; the third section will outline areas of future research which this analysis has opened up; and the chapter will conclude with some brief reflections on the research and the thesis.

Key findings

Perhaps the most significant finding of the analysis presented in this thesis is discursive orientation of the accounts to the task of *managing normativity*, as discussed in the previous chapter. This stands in stark contrast to the dominant representations of IVF failure as the catastrophic absence of restitution through motherhood, where the desire for a child dominates the narrative. In this research, it is not the desire for a child which dominates the narrative, but rather, the desire to locate the self as normal, where normal is always normatively determined. This marks a divergence from the seductively coherent narrative of restitution – a divergence which disrupts the coherence of the dominant discourses of gender, technology and the body which comprise that narrative, and which exposes them as contradictory, fluid and mutually imbricated. The task of managing normativity that emerges so strongly out of the analysis produces a burden of

work for the participants, and particularly the women, to reframe those discursive resources in order to locate themselves positively in relation to them.

The understanding of the interviews as rhetorically organised around the management of normative discourses in relation to which they are ambiguously and ambivalently located points to a number of important findings. While the strategies of normalisation are in essence oriented towards conformity to social and cultural norms, the very act of locating themselves as belonging from a position of non-belonging constitutes an act of resistance to those categories and a reframing of the boundaries through which normality is defined. These gentle, micro-level acts of resistance lack the spectacular gesture of Donna Haraway's embracing of the transgressive potential of nature-technology hybridity, or of the categorical rejection of the NRTs that the FINRRAGE position advocates. Instead, this reframing of the boundaries of social and cultural norms points to the inadequacy of theoretical or political paradigms based on conformity and transgression as opposing and irreconcilable categories. Instead, by conceptualising both conformity and transgression as actions rather than outcomes, it is possible to perceive both aspects at work simultaneously in the discursive labour being performed by the participants.

This fluidity of and between categories is particularly evident in the context of the management of discourses of nature and technology. As described in Chapter 4, the normative positioning of women and reproduction in the natural domain, and of men as rational and cultural, renders the discursive management of the unsuccessful engagement with technology for reproduction highly problematic for the participants. While the dominant discourse constructs the nature and technology as complementary in the (re)production of miracle babies, the analysis presented here demonstrates an alternative strategy which is oriented towards the *naturalisation*, and therefore, normalisation, of the technology. However, while it can be seen as an effective strategy for diffusing fears about "meddling with nature", the discursive rendering of natural and normal as synonymous also has the effect of shoring up the dominant representations of IVF as mainstream and unproblematic. This leads to technological "creep", where concerns around particular technologies are diffused by normalising them relative to newer, more controversial technologies. Those seeking fertility treatment can claim, for example, to have only had "normal" IVF, as opposed to ICSI, PGD or other less

mainstream procedures. Furthermore, the construction of the engagement with IVF as natural, and therefore normal, effectively renders those who do not engage with treatment unnatural and abnormal. This fortifies the imperative to engage with treatment that IVF produces, as well as reinforcing the normative construction of proper womanhood as synonymous with motherhood

This points to IVF the usefulness of thinking about IVF as a *disciplinary technology* through which new identities and norms are produced, and in their accounts, the participants identified those who do not seek treatment, or who had undertaken treatment less moderately or under less conventional circumstances, as the abnormal Others against which their own normality in having tried and been unsuccessful was defined. However, the fluidity of the boundaries between abnormality and normality means that the task of managing normativity is one that is constant, requiring the rigorous surveillance of the self. This can be seen, for example, in the concerns discussed in Chapter 5 about spending money on themselves once IVF has ended in case that is misunderstood in terms of being "too selfish" to have a child. The disciplinary surveillance of women by themselves and others highlights the process of meaning production as constantly ongoing, and one in which the women themselves are actively engaged. This provides a useful antidote to the strategies aiming at the closure of meaning around IVF, as in the radical feminist opposition to the NRTs.

However, to argue that the process of meaning production is ongoing, and therefore always contingent, is not to suggest an array of free-floating meanings waiting to be plucked by those engaged in that process. On the contrary, one of the most sobering findings of this analysis is the extent to which the dominant discourses are deeply entrenched and seemingly intractable. This emerged as particularly true in relation to gender, where narrow definitions of masculinity and femininity have been identified as impacting deleteriously (if asymmetrically) on both partners. In particular, the definition of normal femininity in terms of reproduction has been identified repeatedly in the analysis as a central focus of the task of managing normativity, generating a constant burden of discursive labour for women. From this perspective, agency and constraint can be seen as always simultaneously present and productive of each other. This points to the inadequacy of conceptualisations of the engagement with IVF as either the

exercise of choice or as violent imposition, and therefore, of the need for an approach which can accommodate the contradictory and ambivalent nature of that engagement.

The apparent intractability of gender norms that emerges from this analysis also serves as a reminder of what is at stake in the management of normativity in the accounts, pointing to the impossibility of a definitive conceptual split between the discursive and the material. What Donna Haraway condemns as the "mundane fiction of Man and Woman" (Haraway 1991: 180) is far from mundane for the participants, and both non-belonging and the strategies employed in order to belong can have tangible consequences in terms of feelings of guilt and responsibility, social exclusion, short and long term health, financial security, employment prospects and emotional well-being, to name but a few. Furthermore, it is important to note that it is women who bear the lion's share of these negative impacts. Therefore, in these accounts, the management of normativity and the reframing of the boundaries between discourses should not be understood in terms of blasphemous "play" (Haraway 1991: 149) which can rise above the risks of transgression, and the participants do not celebrate, or take pleasure in, their (potentially) disruptive boundary location. This points to the importance of retaining the lived realities of IVF failure in the foreground of any attempts to draw theoretical insights from those experiences. This blurring of the boundaries between feminist theory and practice is embodied in the methodological framework of this project as a means of both seeking out new and productive connections between categories and of redrawing the categories themselves.

Implications for IVF policy and treatment delivery

One of the strengths of the methodological approach taken here is that it is able to generate findings not only at the theoretical and conceptual level, but also at the level of IVF policy and practice. Many of these findings have already been discussed with the medical team at the clinic through which the participants were recruited, as described in Chapter 3. However, it is also anticipated that these findings will be of interest to policy makers, treatment providers, counsellors, patient support groups and organisations, and those experiencing or seeking treatment. The targeted dissemination of the research findings to as many potential users as possible is fundamental to the feminist orientation of this research.

At the policy level, this research raises important issues in relation to the health authority funding of treatment. At the current time, funding is not consistent across health authorities, and is generally subject to widely varying eligibility criteria and long waiting lists. This creates uncertainty for those seeking treatment, causing women in particular to place their lives on hold. Furthermore, the analysis presented here has demonstrated that IVF does offer, at least potentially, a means of achieving resolution around the experience of infertility, even when treatment fails. Therefore, I would argue that there is a strong case to be made for the prompt, predictable and nationally consistent provision of health authority funding for IVF treatment. However, it is also important to note that the provision of health authority funding may also create an imperative to engage with treatment, the refusal of which may expose women to the accusation that their desire for a child was somehow deficient. This is an area that requires considerable further research.

At the level of the delivery of treatment, three key sets of conclusions can be drawn. Firstly, the research findings point to important issues of informed consent. While the clinics provide technical information about the procedure of IVF, the wider process in which that procedure is embedded, and particularly the emotional aspects, are largely disregarded, with the exception of the mandatory mention of the availability of independent counselling – an option which the participants in this study were reluctant to make use of. Consequently, pre-emptive strategies for coping with treatment failure are rarely raised with patients before entering into treatment, such as setting limits, even if only provisionally, drawing up post-IVF contingency plans, and considering in advance of treatment some of the complex relational issues that IVF raises, such as who to tell about treatment. However, those participants who had been able to consider these issues in the early stages of treatment, either under their own initiative or on the advice of friends or relatives, felt that these had been extremely beneficial. Conversely, the benefit of hindsight led several of the participants to express regret that no-one had warned them of the problems which confiding (or not confiding) in others had subsequently created. Patients cannot be said to be fully informed if they have not been made aware of the implications of the treatment they are undertaking, not just medically, but socially and emotionally. I would argue, therefore, that it is incumbent on the clinics to develop accessible forms of information and advice that do not necessarily

carry the stigma of counselling, but which focus on the wider process in which the patients are engaged.

Secondly, the interviews revealed a number of occasions where the medical staff inadvertently made particularly the female participants feel responsible, sullied or stupid. These include, for example: informing women that they, rather than the doctors or the medication, had not produced good enough eggs; carrying out financial transactions in the corridor; or laughing off women's fears about standing up or going to the toilet after embryo transfer. These are not malicious acts, but they ignore the normative social and cultural context within which IVF operates which easily blames women for their own infertility, and which views the commodification of reproduction critically. Many of the women in this study, for example, read the silence from the clinics following the failure of treatment as proof that the doctors were only ever interested in boosting the clinic's success rates, thereby sullying the reproductive endeavour. Therefore, it might be useful for clinics to consider making a short phone call expressing sympathy, or sending a small card. This is an area where more research in the context of treatment delivery would be extremely useful, as would programmes to raise the awareness of treatment providers of the unintended, but potentially undermining, effects of their everyday talk and actions.

And finally, the research points to the need to think carefully about the clinic environment itself. In an NHS context, in particular, this is clearly subject to the availability of resources. However, issues such as the importance of privacy in relation to the provision of sperm samples, the conducting of consultations and transactions in public spaces, and the use of baby pictures as decoration in the waiting areas repeatedly emerged as problematic for the participants, but subject to positive change at very little cost. One of the steps taken at the clinic through which the participants were recruited, for example, was to reduce the number of baby pictures down to a single panel, and to replace them with art work by former patients, including those whose treatment had failed. When we met to discuss the research findings, the possibility of including positive images or narratives from those whose treatment had not been successful in the patient literature was also under consideration. These are important areas of future research, both by the clinics themselves, and also by those external to those contexts.

Future research

The analysis presented here opens up a number of potentially productive areas of future research. In the context of this study, the interview transcripts constitute a rich data set, to which it is not possible to do justice in the relatively limited space of a thesis. In particular, there are several themes which are only touched upon in the analysis which warrant further explanation, including: the management of risk; issues of privacy; the impact of existing children on the experience of IVF failure; the use of statistics; and the construction of "the family". It is anticipated that a further analysis of the interview data along these thematic lines would enrich the existing analysis.

In addition to focusing on themes which run across the accounts, a narrative analysis of selected interviews would offer an alternative perspective which would bring out the contradictions within individual narratives. In writing up the analysis here, I have chosen to illustrate the different discursive strategies using the best examples possible, thereby moving freely between accounts. This has the effect of bringing out the contradictions *between* the accounts, but can also inadvertently obscure the contradictions *within* individual narratives. Therefore, a narrative analysis would complement the more thematic approach taken in this thesis to produce a more nuanced analysis of the interview data as a whole. This would be a particularly interesting approach to take to Alice's narrative. At 47 and still hoping to conceive through the engagement with increasingly high-tech procedures, Alice was, in many ways, a tragic figure, and of all the interviews I conducted, I found hers the most depressing and disturbing. However, she also emerges from the interviews as intelligent, creative, witty and excellent company – characteristics which I found difficult to reconcile with the despair which infused the interviews and with her bleak vision of her future without children. As a result, I had great difficulty in writing about Alice in a way which reflects this complexity and a narrative approach offers a potentially productive alternative perspective from which to think about her story.

The thesis also points to a number of interesting and important epistemological, methodological and ethical issues which warrant greater discussion than I have been able to give them here. In the process of conducting the research, I repeatedly encountered a conflict between my role as analyst and my ethical responsibilities towards the participants, particularly with regards to the risk of imposing meanings or

interpretations with which they would not agree. This dilemma is a product of the adoption of a discourse analytic approach to empirical data, and a more detailed discussion of this dilemma and the ways in which it was manifested in the research process would make an interesting contribution to the literature on feminist methodology and epistemology.

Beyond this particular research project, the analysis points to a number of other areas of research which would intersect productively with the findings presented here. Firstly, in the context of IVF, treatment failure is not the only experience which is marginalised by the dominant discourse, and the experiences of those who would qualify as candidates for treatment but who choose not to engage with it, and of those who want to engage with treatment but are unable to gain access to it, can also be understood as liminal, boundary perspectives which would constitute equally productive arenas from which to think about IVF and its context. In particular, these perspectives would offer interesting insights into the management of the normative pressures to engage with treatment; the ways in which pejorative constructions of childlessness, particularly in women, are resisted; the strategies by means of which resolution around involuntary childlessness is achieved or attempted; and the ways in which IVF impacts upon the experience of involuntary childlessness even when it is not experienced directly.

In addition, the mutual imbrication of discourses of gender, technology and the body that is apparent in the dominant discourses of IVF is not confined to that context. Therefore, the findings presented here could be usefully developed in the context of other medical interventions which are legitimised within a discourse of disease, but where the contravention of gendered bodily norms is clearly at play in the designation of that disease. These might include, for example, obesity surgery or breast reconstruction following mastectomy. In particular, an analysis of the way in which discourses of the gendered body, nature, technology, responsibility and agency play out in these contexts would further enrich the analysis presented here.

Concluding remarks

In Chapter 1 of this thesis I listed three questions which marked the starting point of this research project. At the end of this concluding chapter, it is clear to me that my analysis has moved some distance away from these questions, which I have not answered

directly in the analysis or in my conclusions. This is particularly true of my first research question – *what are the factors informing the decision to stop treatment?* – which was an extremely useful point from which to think about the drawing up of interview questions, but became virtually redundant once I had embarked upon the analysis. However, I retained the initial questions in the writing up of the thesis in order to demonstrate the ways in which the research, analysis, and ultimately, the thesis have evolved over the four and a half years I have been working on it – a process which I anticipate will continue through the areas of future research discussed in the previous section. This highlights the status of this thesis as a situated knowledge which would become *un*faithful precisely at the point at which I attempted to make any definitive claims for it. As such, my claims for this thesis are as a contribution to ongoing debates rather than a conclusion to them.

One of the regrets I have in concluding this thesis is the feeling that I have offered here a very sober reading of the participants' experiences that does not adequately capture the dynamic nature of the interviews, or the creativity and courage with which they were all, in different ways, seeking to find a way forwards. Therefore, while I stand by my analysis, the separating out of one particular aspect of someone's life for analytical purposes will always be a contrivance, and the participants should never be seen as defined solely by their experience of IVF failure and the challenging task of managing it. Instead, this should be understood as just one aspect of their identity among many, and while the participants inevitably feature in this analysis in terms of IVF failure, this says nothing about the proliferation of other talents, interests and desires which manifested themselves both within the interviews, and when the tape recorder had been switched off. Alice's beautiful garden, Rachel's skilfully restored house, Sarah's successful business built from scratch, and Claire's completion of her degree are all excellent examples of the participants as always much more than their experience of IVF failure.

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Appendix

Letter of Invitation

The [clinic] is currently co-operating in a research project being conducted by Karen Throsby, a PhD sociology student at the Gender Institute of the London School of Economics and we are writing to ask whether you would consider participating in this research. In summary, the project aims to identify the factors that lead people to withdraw from IVF programmes and to consider the impact of this decision over time on attitudes towards IVF and towards infertility. It is hoped that this research will not only contribute to a more complete picture of the range of experiences of IVF, but will also identify elements in the delivery of treatment and the more general experience of infertility that might make it easier for a couple who wish to withdraw from treatment to do so.

Karen would like to interview women and, where possible, their husbands or partners, who have had one or more unsuccessful cycles of IVF, with the most recent cycle having taken place at least two years ago. The records at the [clinic] show that you may meet these criteria and your contribution would be greatly appreciated. The attached Patient Information Sheet details what would be involved if you were to participate, but Karen would be happy to answer any further questions that you may have without any obligation. If you have sought treatment elsewhere since you attended the [clinic], or if you have since become parents by a means other than IVF (e.g. adoption, fostering, natural conception), your participation would still be greatly welcomed as long as your last IVF cycle was more than two years ago. Your participation in no way affects your right to seek treatment at [hospital] or elsewhere in the future.

Karen is bound by the same legal obligations as the staff at the [clinic] under the license issued to [hospital] by the Human Fertilisation and Embryology Authority (HFEA) and your confidentiality is guaranteed, whether or not you choose to participate. Your anonymity is assured in the final report.

If you are interested in participating, please contact Karen by telephone, e-mail or using the reply card supplied. If you do not wish to participate, you can either indicate this by not responding or by marking the appropriate box on the reply card provided. There will be no further attempts to contact you in this regard. If you have any further questions, the contact details are listed on the Patient Information Sheet.

Thank you for taking the time to read this letter.

Yours sincerely,

[clinic director – details deleted]   Karen Throsby

                                             Gender Institute, LSE

Patient Information Sheet

Calling It A Day: the decision to withdraw from IVF treatment and its impact over time

- You have been invited to participate in the research project named above. This project is being conducted by Karen Throsby, a post-graduate student at the Gender Institute of the London School of Economics under the academic supervision of Dr Rosalind Gill and in co-operation with the [clinic] at [hospital].

- The research will consider the experiences of women and their partners, where relevant, who have had one or more unsuccessful cycles of IVF and who have withdrawn from treatment programmes at least two years previously. The research aims to identify the factors which make it more, or less, difficult to withdraw from treatment and to consider what the implications are for the delivery of treatment. The final report will take the form of a PhD thesis, as well as a comprehensive report for practitioners, and a condensed report for publication in academic journals and those of advocacy and counselling organisations.

- If you decide to participate in this study, you will be asked to complete two questionnaires. The first covers basic biographical information, and the second covers your treatment history. You will then be asked to participate in two taped interviews, approximately six months apart, concerning the factors which led you to withdraw from treatment and your subsequent feelings concerning reproductive technologies and your own difficulties conceiving. These interviews will be transcribed and the transcripts will be sent to you to be reviewed. You are free to make any changes that you feel necessary to the transcript. You will receive a summary of the findings of the research when the project has been concluded.

- This project has been approved by the Research Ethics Committee of [hospital] and the researcher is under the same legal obligations as the staff of the [clinic]. The confidentiality of all participants is assured. Personal information will be stored in a locked filing cabinet to which only the researcher has access and only Karen Throsby and Dr Rosalind Gill will have access to the interview tapes. Pseudonyms will be used in the transcripts and all identifying information will be removed in the final report. Confidential information will not be retained beyond completion of the project, with the exception of your contact details. Both the researcher and the

[hospital] will retain a copy of this information in order to allow your name to be excluded from any future projects of a similar nature. You will be asked to sign a consent form agreeing to this arrangement.

- It is possible that you may find the interviews distressing and that it may raise issues which you would like to discuss further with a counsellor. Therefore, at the time of the interview you will be given the contact details of an independent counsellor who is aware of this research project who would be happy to talk with you.

- You will be free to withdraw from the project at any time, or to refrain from answering particular questions, and your participation will not have any effect on your right to seek treatment in the future.

- For further information, please contact the researcher, as given below. This will not place you under any obligation to participate.

Researcher: Karen Throsby

Address: Gender Institute, London School of Economics, Houghton Street, London WC2A 2AE

Home telephone: 0181 451 7692

E-mail: karen@throsby.freeserve.co.uk

Signature: ....

Questionnaire Letter

Karen Throsby

Flat 1, 133 Roundwood Road

London NW10 9UL

TEL: 0181 451 7692

e-mail: karen@throsby.freeserve.co.uk

Dear

Thank you very much for agreeing to participate in my research project.

I have enclosed two questionnaires which it would be very helpful if you would complete and then return to me in the envelope provided. If your husband / partner is also willing to participate, you should complete one copy of Questionnaire A each, and Questionnaire B can be completed together. The aim of the questionnaires is just to give me some background information before we meet, so if there are questions included that you would prefer not to answer, that is no problem.

I have also enclosed two copies each of the consent form. One signed copy each should be returned to me and the other copy is for you to keep. The purpose of the consent form is to clarify what you can expect from me and it does not place you under any obligation to continue should you change your mind about participating. I should also point out that Dr Rosalind Gill, my academic supervisor, is currently on leave and I am being supervised by Dr Clare Hemmings until she returns. I have therefore added Clare's name to the consent form as having access to the interview tapes. If you have any objections to this, please let me know.

Once all the papers have been returned to me, I will call you and we can arrange a time to meet for our first interview. I am very grateful for your participation in this project, and I am looking forward to meeting you. Please do not hesitate to contact me if anything is not clear or you have any questions.

Yours sincerely,

Karen Throsby

Questionnaire A

Biographical information

1. Name

    ....

2. Sex   (please circle) F / M

3. Address

    ....

4. Telephone: ....

5. Age ....

6. Date of birth ....

7. Marital status (please circle):

    -   married

    -   single

    -   living with partner

    -   divorced

    -   separated

    -   widowed

8. How long have you been married or living with your partner?

    ....

9. Do you have any dependants? (please include adopted children, step-children, foster children, or elderly relatives whose full-time care you are responsible for).

    ....

    ....

10. Which ethnic group would you describe yourself as belonging

    to?..

11. What is your religion, if any?

    ....

Education

12. Which of the following levels of qualification do you hold? Please specify the subject for degree level and upwards.

- O level / CSE / GCSE

- NVQ

- Access

- A level

- Degree

- Masters

- PhD

- Professional qualification

- Technical qualification

....

....

....

13. When did you complete your final qualification? ....

14. Are you currently studying for a qualification? Please specify

....

Employment

15. If you are in paid employment or self-employment, what job are you currently working in?

....

....

16. If you are not currently working, when were you last in paid employment? What kind of employment was it?

....

....

17. What is your current gross annual income?

- £0 – 10,000

- £10,001 – 20,000

- £20,001 – 40,000

- £40,001 – 60,000

- more than £60,000

18. What is your household income?...

Questionnaire B

Infertility treatment history

1. When did you first begin trying to conceive?

....

2. Did you have any reason to suspect that you may have trouble having a baby when you first decided to try?

....

....

3. When did you begin to think that you might have a fertility problem?

....

....

4. When did you first seek medical advice?

....

....

5. Where did you go for this advice?

....

....

6. When did you begin having tests?

....

7. What tests did you have? (Please give the month and year, and location, if possible)

....

....

....

....

....

8. When and where did you begin your first cycle of IVF?

....

....

....

9. Please detail the procedure used (e.g. GIFT, ZIFT, ICSI etc.)

....

....

....

10. Please list any subsequent treatments you have had, including dates, and the location, where possible.

....

....

....

....

....

....

....

11. Did you try any alternative therapies prior to, or during, these courses of treatment? If yes, please give details.

....

....

....

....

....

....

12. How much money do you estimate you have spent on fertility treatment?

....

13. What treatments, if any, have you received on the NHS?

....

....

....

....

....

....

Withdrawing from IVF programmes

14. Did you set a limit on the number of cycles before you began treatment? Did you stick to that limit?

....

....

....

....

....

15. When did you finally decide to cease treatment?

....

....

....

....

....

16. Would you say that your decision to have no further cycles of IVF is a permanent
    one?

....

....

....

Post-IVF

17. Following the decision to withdraw from IVF, did you stop trying for a child, or did
    you pursue other strategies, such as adoption, fostering or surrogacy?

....

....

....

....

....

Consent Form

Calling It a Day: the decision to withdraw from IVF treatment and its impact over time

I am conducting a research project into the experiences of women and couples who have had one or more unsuccessful cycles of IVF and who have made the decision to withdraw from treatment programmes. As a part of this study, you have volunteered to complete questionnaires covering biographical details and your treatment history, and to participate in two taped interviews, approximately six months apart, concerning the factors which led you to decide to withdraw from treatment and your subsequent feelings concerning reproductive technologies and your own difficulties in conceiving.

There is the possibility that these interviews could revive some distressing emotions for you and you may feel that it would be useful to speak to a counsellor in relation to these following the interview. Therefore, prior to the first interview, you will be given the contact details of an independent counsellor who is aware of this project. Your participation is entirely voluntary, and you are free to withdraw at any time or to decline to answer particular questions. Your participation will not prejudice any treatment you seek at a later date.

As the researcher, I undertake the following:
- Anonymity of all research participants is guaranteed and in transcripts and in the final report, all identifying information will be removed.
- All information will remain strictly confidential. Only I will have access to the questionnaires and other personal information, and myself and my academic supervisors, Dr Rosalind Gill and Dr Clare Hemmings will have access to the interview tapes. All information will be kept in a locked filing cabinet when not in use. Confidential information will not be retained beyond the completion of the project, with the exception of your contact details. Both the researcher and the [clinic] at [hospital] will retain a copy of this information in order to allow your name to be excluded from any future projects of a similar nature.
- You will receive a typed transcript of each of your interviews and you will have the opportunity to make any changes you feel are necessary.

- You will receive a summary of the findings of the research on its completion.

The final report will take the form of a PhD thesis and may be used for publication at a later date

If you have any questions, you can contact me on 0181 451 7692.

■■

I agree to participate in the research project entitled "Calling it a day: the decision to withdraw from IVF and its impact over time". I have been given a complete copy of this form and have had a chance to read it.

Name _____

Date _____

Signature of researcher _____

■■

First Interview Guide

1. Treatment:
- How did you choose your clinic?
    - Did you consult the HFEA literature?
    - How important were published success rates? Cost? Location? Particular practitioners? Clinic atmosphere? General appearance?
    - Did you visit more than one clinic in making your choice?
    - How useful was clinic literature in making your choice?
- Was IVF your first choice of treatment? (Did you have IVF in mind when you first sought treatment?)
- What steps did you take to educate yourself about IVF? Internet?
- Did you consider not having IVF?
- How did the treatment compare with your expectations?

2. Withdrawal from treatment:
- Can you describe how you came to the decision to withdraw from treatment?
    - Before starting treatment did you have a clear limit on how many cycles of treatment you would undertake? Did you stick to that limit?
    - Was it a definite decision or something you drifted into?
    - Who instigated the decision to withdraw?
    - Was the decision mutual?
    - Are you happy with your decision to withdraw when you did? Do you wish you had stopped earlier / later?
    - How absolute is that decision?
- To what extent did friends / relatives influence your decision?
    - How widely known was it that you were having fertility treatment?
    - What was the reaction of those who knew you were having treatment to your decision to stop?
    - Did you have a particular confidante (other than your partner) who helped you to make that choice?
    - Do you continue to talk to friends about the decision?
    - Did you use internet support groups?
- Were financial constraints a significant factor in your decision to withdraw from treatment?

- What kind lifestyle sacrifices were you making in order to pay for treatment?
- Do you feel that the money was well spent even though the treatment was not successful in your case?
- What role did your clinic play in your decision to withdraw from treatment?
  - Were you advised to stop treatment?
  - Were you satisfied with the treatment provided by the clinic?
  - Did you make use of counselling opportunities (inside / outside the clinic)?
  - Were you able to make use of support groups (inside / outside)?

3. Post-IVF:
- Did you have any clear plans for the future in terms of other strategies for becoming parents before you withdrew from treatment?
  - Did you consider adoption / surrogacy / fostering / alternative therapies?
  - Did you follow-up with those plans?
  - Did you make other plans, prior to ending treatment, not directly related to your infertility? (Career / travel / study)
- Did you continue any form of counselling / support groups after withdrawing from treatment?
- At the time you decided to withdraw from treatment, did you regret having tried IVF? Have those feelings changed since you first decided to end treatment?
- Do you consider yourself to be infertile?
- Did your experience of IVF change the way you thought/felt about your own infertility? Have these feelings changed over the years since you withdrew from treatment?
- At the time you decided to withdraw from treatment, how did you feel about IVF? (Disillusioned? Generally positive?) Have those feelings changed since you first decided to end treatment?
- To what extent are your feelings influenced by media coverage of reproductive technology, especially the high profile stories such as Mandy Allwood, or Diane Blood?

4. The future:

- Do you follow advances in reproductive technology (in the media)? If there were an advance in an area that could be beneficial to your case, would you consider returning for treatment?

- If financial constraints were removed, do you think you would return to treatment?

Second Interview Guide

1. Update:
   - changes in circumstances (careers / parenting / other people's babies etc.)
   - treatment started / planned

2. Clarifications from first interview:
   - factual details (number of cycles / location etc.)
     - money
     - whose money was used for treatment (joint / individual / family)?
     - Who is responsible for money in the household?

3. Approach to infertility:
   - Has your approach to your infertility changed since you finished treatment? Since the last interview? (How? Why?)
   - Have you considered using contraception?
   - Would you consider yourself as still hoping / expecting to conceive?
   - Do you count days in your cycle? (for ovulation / menstruation)

4. Negotiation
   - as a couple, how did you go about making the necessary decisions involved in having IVF?
     - organised / structured discussions?
     - Information gathering? (who?)
     - Planning ahead vs. taking it as it comes?
   - Would you say that one of you took the lead in the decision-making?

5. Confiding
   - Do you think that you would find confiding in people that you were having treatment easier now (because IVF is more common)?
   - Do you think you made the right decisions about confiding / or not confiding?
   - Were you ever given any advice by the hospital about telling people?
   - What would you advise others to do about telling people?
   - Were you in agreement as a couple over who to tell and when?

- If you'd conceived through IVF, would you have told people / the child?

6. Relationships
   - circle of friends
     - would you say that your social circle is changing? (e.g. fewer people with children / same people / new friends from new job etc.)

7. Children
   - why do you / did you want children?
     - had you considered why before you tried to conceive?
     - social inclusion?
     - had you always wanted children?
     - Had you ever imagined / considered living without children?
     - Would you say that you were both equally keen to have children?
   - how important is genetics? Physical similarity?
   - How important is the idea of continuity?
   - Are there any childless women (e.g. aunts / god-parents etc.) in your family? How about in your social / working life? (in terms of role models for living without children).
   - If you the IVF had been successful, would you have continued working?

8. Body
   - why do you think the treatment failed? Did you see the technology as having failed? The doctors?
   - Would you say the failure of the treatment affected your own self-esteem? Confidence? The way you saw yourself?
   - Do you think that positive thinking (from you, or the doctors) affects the outcome?
   - Do you think the failure of treatment affected you differently (as a couple) in terms of your sense of self?
   - Did you find that having had IVF gave you any answers / greater certainty / resolution?
   - When you say you had to try everything, was that for yourself or to show others?

9. Advice to others

- would you recommend other to have IVF (in a similar situation to yourself)?
- Are there any circumstances when you wouldn't recommend it?
- Is there anything you wish you had done prior to having IVF (e.g. more personal research / counselling / discussing particular issues with partner or family)?
- Is there anything you regret / wish you hadn't done?

10. Being interviewed:

- how did you find being interviewed (the first time)? (upsetting / thought provoking).
- Did you discuss it with your partner after the interviewer had left?
- Did you reconsider treatment after being interviewed?

Coding Framework

1. Nature

- reproduction as natural (for women)
- nature / fate
- nature as superior / good
- interfering with nature

2. Technology / Science

- progressive
- modern life
- regulation
- fear of technology (designer baby)
- limits
- alternative therapies

3. IVF consumer

- shopping around
- money
- resource distribution
- gifts from others (or spending as a gift to others)
- statistics
- NHS / private
- Other conventional treatments

4. Drugs

- injections
- long / short term effects
- hormones / stress
- privacy issues
- images of drug taking

5. Life path

- parenthood expectations / motivations
- identity
- old age
- employment
- ageing / public perception

6. Infertility

- disease
- causes (iatrogenic)
- continued hope
- male factor
- negative images
- confusion with childfree (outside perceptions)
- explanatory work
- subfertility
- female age factor
- counselling

7. Social relations

- communication
- support
- other people's babies
- privacy / telling others
- social exclusion
- reintroducing children
- cruelty of others
- (grand)parents

8. Agency / control

- information seeking
- decision making
- IVF as work / activity

- Weakness / strength
- Positive thinking
- Doing everything
- Being deserving
- Guilt / shame
- responsibility

9. Stopping treatment

- reasons
- decision / imposed
- contraception
- treatment of other conditions
- life plans
- adoption
- childfree / selfish
- regrets
- responses of others

10. Men

- sperm
- masculinity
- protection
- denial
- action (e.g. sperm quality)
- communication with others