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IN VITRO-FERTILISATION: DEBATE AND ACTIVITY AT THE LOCAL LEVEL

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Synopsis—This study is an analysis of attempts at the local level to raise issues of concern surrounding the development and introduction of IVF in Britain. The main areas of concern and resulting activity are given, and possible reasons for lack of debate are considered. The effect these debates have had is also outlined. The activity around the issues raised by IVF is used as an illustration of the differences that exist between the national and local debates and the difficulties which groups and individuals face when attempting to participate in shaping health care policies.

INTRODUCTION

As a technology, in-vitro fertilisation (IVF) calls into question a vast number of issues. The debate that has existed at the national level, and was stimulated by the publication of the Warnock Report in 1984 (Warnock, 1985), has had a high profile. But, as many people have pointed out (see for example Spallone, 1987), the prioritisation of issues has been selective, the main focus of national attention has been on the ethical, social, and legal implications of IVF and has concentrated on the latest developments and medical successes in this field.

Apart from some criticism of the provision of services and lack of available information on the incidence of infertility (Mathieson, 1986; Warnock, 1985, p. 13) there has been very little attention directed towards infertility itself. In fact no alternative approach to infertility has been considered and it would seem that the development of IVF has been equated with a rational response to infertility.

Infertility has been described as an "invisible problem" (Pfeffer & Quick, 1988, p. 9) and, as it is not considered a life threatening disease, it has been given very low priority in health service plans. as the District Medical Officer from East Dorset has said:

> given all other demands upon the Health Service locally, it is difficult to see how the arrangements in regard to infertility clinics can have a very high priority (East Dorset CHC, 1986).

Recently though, a lot of attention has been directed towards IVF, which, as a technique used to enable some women to have children, has inevitably brought with it more awareness of the existence of infertility. However, it is not obvious that its development has done anything for the majority of the infertile. As Doyal says, "the debate about IVF may be largely a red herring" (Doyal, 1987, p. 189). The provision of services for general infertility treatment bears witness to the lack of attention directed towards infertile people. It is still the experience of an overwhelming number of infertile patients that they are treated with indifference. Many patients can relate stories of long waiting lists; years of tests and treatments, not all of which are any use at all; seeing a different doctor on every visit, many of whom do not really know what they are doing; and then, discovering that there was some test that should have been done years ago which would have shown the futility of the others.

It is ironic that, although there exists apparent concern with infertility at present,

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and consequently more opportunities to raise questions about the quality of services and treatment, the attention is still focused on the latest medical achievements, the 'success' of high technology, and not on the experience of infertility itself or the effects of these developments on the infertile. This lack of attention to the routine services has been mentioned by many, (see for example Doyal, 1987), and a number of local groups are critical of the lack of attention being given to the infertility services besides those involving the 'new' reproductive technologies. The Women's Reproductive Rights Campaign (WRRC), for example, is a network of groups throughout Britain who are concerned with looking at reproductive rights as a whole, not solely focusing on IVF but on all reproductive technologies and how they affect women. In their latest newsletter (WRRC, 1989) they printed a letter from Naomi Pfeffer in which she encourages women to "look at the quality of routine, low technology treatments of infertility."

There is clearly some discussion about issues raised by the development of IVF apart from those considered at a national level. Considering public opinion solely at a national level ignores the possibility of significantly different opinions and concern at the local level. However, not much is known about the extent or focus of concern at the local level and it is therefore instructive to look locally to see what is happening there.

The material for this article comes from research carried out which looked at the extent of debate and activity at a local level surrounding the development and introduction of IVF into Britain. Its purpose was to consider the similarities and differences between this and the national debate, and to see whether the same priorities were repeated at the local level. To investigate the extent of debate in this field at the local level it was necessary to contact those involved directly. I contacted the consumer representatives in the National Health Service (NHS), Community Health Councils (CHCs)[1]. There are 216 CHCs in England and Wales and 45 Local Health Councils (LHCs) in Scotland and for practical reasons I chose to focus on those CHCs with IVF services in their area. However, IVF is a technology that will enable only a very small percentage of childless women to have children and, focusing attention solely on debate around IVF services may have lead to more emphasis being placed on IVF than is justified by its value as a "treatment" for infertility. It is also clearly important not to assume that it is only in the areas of Britain where IVF services are already developed that there is debate around infertility services, for, as this article shows, local debate exists elsewhere and focuses on more than solely the provision of IVF. The CHCs I contacted gave me details of meetings they have held, consultation that has occurred, complaints, correspondence, and local newspaper articles. I also contacted those involved in the provision of services, including doctors and counsellors; members of campaigning groups such as the National Association for the Childless (NAC) and Child, and many women involved in women's health groups and national campaigns such as the Maternity Alliance, the National Childbirth Trust, the WRRC, and the Women's Health, and Reproductive Rights Information Centre in London. They were all willing to answer my questions and many provided me with further contacts with people working in the field and with women undergoing or awaiting infertility treatments.[2]

DEBATE AT THE LOCAL LEVEL

The main area of debate occurring at a local level focuses on the level and standard of services that are provided for the majority of the infertile and the lack of thought over the introduction of the new developments. Both CHCs and groups such as NAC are involved in this, emphasising the necessity of planning

services to meet patients' needs and stressing the importance of looking beyond the 'high-tech,' 'magical' solutions, such as IVF and Gift, to those that will be the only available or suitable options for most of the involuntarily infertile in Britain. However it is clear that this is not easy.

The National Association for the Childless (NAC) is a self-help group which aims to represent, inform, and support infertile couples. The Scottish branch of this organisation has been "stressing the need for a review of infertility services in Scotland since 1984," as they say,

> Planning is essential in order to make economic use of resources, to ensure fair access to services, and to provide adequate services to meet the demand. (NAC, 1988, p. 1)

In 1987, "faced with the Scottish Office's refusal to undertake a review" (NAC, 1988, p. 1) they carried it out themselves, with the help of Charles Kennedy MR They found that the quality of services varies throughout Scotland and that the treatments available and the length of waiting time depends on where patients live. None of the Health Authorities were free from criticism and NAC concluded their report recommending that:

- Each mainland Health Authority set up a specialist Infertility centre which would be financed directly by the Health Authority.
- All infertility patients should be referred to these centres.
- High technology treatments should be located in four centres, and the cost should be shared by all Health Authorities.
- Nurses should be trained to carry out some of the work currently undertaken by doctors.
- Counsellors should be located in each Infertility Centre.
- Each Infertility Centre should be staffed so as to enable the efficient recording of data on infertility (NAC, 1988).

Within Scotland the local branches of NAC have pushed their Local Health Councils (LHC) to make representations to the Health Authority to ask for these recommendations to be considered and for infertility treatment to be provided as a service in its own right. Edinburgh LHC has taken this up with Lothian Health Board. The responses they have received have stressed that the financial situation of the Board means that no new developments are possible, but they will do their best to try to 'iron out' the problems of coordination of the services.

In Dorset the local branch of NAC contacted East Dorset CHC to:

- express concern at the inadequacy of infertility clinic facilities in East Dorset,
- request improvements in these facilities,
- enquire whether improved facilities would be available in the new Bournemouth General Hospital (East Dorset CHC, 1986, p. 1).

In response to this pressure by NAC the CHC decided to pursue these areas further and carried out their own inquiries, both about treatment people had received and the services available. As a result, in 1986 they produced a review of infertility services. The report outlines the main areas of dissatisfaction with the services, including: long waiting times; no specialist consultants or facilities; infertility patients being seen along with patients having abortions, or pregnant women; and lack of information or follow-up about further possibilities such as other treatments or adoption (East Dorset CHC, 1986, p. 1). They made a number of recommendations to the District Health Authority of ways in which the services could be improved and have had some success with regard to some of them. The appointment of a new consultant in the region with a particular interest in infertility has clearly helped as it has lead to opportunities for some of the recommendations to be implemented. However, their report has also played a role. Both its contents and the fact the survey

had been carried out and recommendations made meant that the CHC had a document from which to work and which could be used to pressurise the Health Authority into action. Dorset is not a district with IVF facilities and this activity illustrates the fact that it is not just in the areas with IVF services in which local groups such as NAC and the CHC are involved in these debates.

Central Manchester CHC has been involved in the issues raised over the IVF unit at St. Mary's Hospital. The members were concerned that individual cases were being discussed at the hospital Infertility Services Ethical Committee. If this were the case, then it could be argued that those patients should have the right to representation. They raised the matter with the District General Manager, and, as the Chair of the committee had already expressed her concern at this, a scheme was initiated whereby general principles could be discussed but not individual cases. The CHC subsequently had a talk by the Chair of the committee at which questions were raised, including one about the membership of this committee as it did not have a CHC member (Manchester CHC, 1986). This CHC had also received a complaint from a woman about the IVF unit. Her complaint was that despite being placed on the waiting list in January 1983 it was not until September 1985, after being refused treatment for a number of spurious reasons, that she was given the correct reason for her ineligibility for treatment. Mrs. Harriott applied for judicial review to get this decision reversed, but although the hospital was criticised for their handling of the case she was not restored to the list (Lexis, 1987).

This refusal leads to questions not only about why Mrs. Harriott had to wait so long before being told the correct reasons for the refusal but also to consider whether, in this case, a conviction for soliciting should be a relevant consideration. It is not the only case where doctors have exercised their own value judgements in deciding which women are fit to mother. Publicly many doctors express the view that they are not in a position to decide who should make good parents, as one doctor said: "What right have we got to decide?" However they *can* and *do* make such decisions. One doctor I talked to removed a woman from the list after it was discovered that she already had three children, two of whom had been battered and the other taken into care. He also refused to treat an Irish woman living in a squat, as he did not think she was in a situation in which to offer a reasonable home to a child. Another was in the process of considering whether a couple, where the male partner had a criminal record, should be given IVF and yet another was unsure if a single, twice divorced woman was emotionly stable and therefore if IVF should go ahead. These examples show the extent to which doctors' concerns for childless women are directed towards all women. They also illustrate the 'hidden agenda' behind these new developments which many feminist writers have brought to our attention by drawing links between, for example: the ideology of motherhood, which emphasises women's 'natural' wish to become mothers, and access policies that discriminate against fulfillment of that wish on the grounds of race, class, or sexuality (Steinberg, 1987).

Debate about infertility services has also occurred in London. In 1987 City and Hackney CHC (1985/6) held a meeting to discuss infertility and IVF services in the district. They would like to see changes along similar lines to those recommended by NAC Scotland and East Dorset CHC. As they say:

> What this CHC would like is an operating policy for the infertility service including a protocol for tests, a designated manager, a review of the accommodation in which procedures are carried out, and a funded counselling service for the whole infertility programme.

At the meeting it was reported that the District intended to carry out a review of all the infertility services, including the

counselling services. They also stated that they would produce an information package for general practitioners (GPs) to help them refer people to the appropriate clinics (City and Hackney CHC, 1987). The CHC also hoped that "the searchlight currently on IVF would bring improvements in the basic infertility services for the benefit of all patients" (City and Hackney CHC, 1985/6), for, as the secretary has said, their concerns are with:

> the low quality of care at primary and secondary level, and the lack of care for the 70% of patients who will fail.

The latest survey of infertility services was published in July 1988 when the Greater London Association of Community Health Councils (GLACHC) brought out a report *Infertility Services—A Desperate Case* (Pfef-fer and Quick, 1988) covering the services provided in London. Written, as the authors Pfeffer and Quick say, expressly to "enable Community Health Councils and others to contribute to an informed debate about infertility services and to evaluate the services in their own districts from the perspective of infertile men and women" (p. 9), it echoes the findings of the inadequacies of the present infertility services of those investigations conducted by other groups, and makes similar recommendations for change.

Although some CHCs and local groups are discussing the issues and trying to raise them with their Health Authorities, in most areas the level of activity is not very high. To conclude from this that people, whether individuals or in groups, have no reason to debate the introduction of IVF or to criticise infertility services is to make too many assumptions and would be wrong. It is clearly important to look behind the immediate findings and asking if there are any possible reasons for the lack of activity.

CHCs exist specifically to represent consumer interests in the NHS and yet the majority of them have had no involvement in debates about infertility services. Lack of resources means that many CHCs are not in a position to do proactive work or to look at every service provided by the NHS. Many are only able to react to developments as they occur and have to prioritise the areas they become involved in, as in Wandsworth CHC where, as the secretary said, they:

> are constrained at present in monitoring all the local health services by a lack of resources which has meant that we have to strictly prioritise our work.

However, it is not just lack of resources that has meant few CHCs are involved in these debates; CHCs suffer greatly from lack of information about what is going on. Although there are IVF facilities for NHS patients in more than 20 places, Oxford CHC is the only one that reported having been consulted about them (Oxford CHC, 1988). Clearly consultation is not happening; the process does not work as well in practice as it does in theory. According to the secretary of Salford CHC consultation by the Health Service is "pretty shabby." Although it is meant to consult, there are ways around it. In cases of 'urgency' or if something is only 'temporary' then the Health Authority does not have to consult about the changes. They can, and do, use the fact that there is a financial crisis at present in the NHS and argue that, as things have to be carried out immediately, there is no time to consult. Or they can close something temporarily due to 'financial urgency' and then when they do consult CHCs about it, months or possibly years later, it is effectively too late to object.

CHC secretaries realise the ineffectiveness of their objecting to services like IVF when they are already being provided and they recognise that CHCs would clearly have more influence if they were allowed to be involved at the planning stage. However, as the secretary of Bristol CHC says, the Health Authority is "incredibly defensive." They are afraid that CHCs will not be able to distinguish between ideas and concrete proposals and

that there will be misunderstandings leaked to the press. Not only that, but also many Health Authorities do not welcome the presence of active 'watchdogs' who, if forewarned of their plans, may be able to alter them. Consequently, they are not prepared to let the CHCs take part in such discussion. Clearly a lot of the potential of CHCs is not realised through lack of cooperation and lack of information.

Sometimes the District Health Authority does take notice of what the CHCs say and, as a result of pressure from CHCs and other groups, some small changes have been made in the infertility services. However, this is rare. Although more Health Authorities are promising to see what they can do in the way of reorganisation of services, time and time again CHCs come up against the 'apparent' problem of lack of finances for the changes.

City and Hackney CHC has had some success over raising the question of IVF and how it came to be introduced in their area. As a result of their campaigning, the Research Ethical Committee has discussed the issues, but they were not allowed a lay representative on the committee when it was discussed, so do not know exactly what went on. In many other cases a lack of importance is given to their views. As the secretary of Dundee LHC said:

> Although Community Health Councils (Local Health Councils here in Scotland) are commonly included in consultation processes, their impact on clinical policy such as IVF is not generally thought to be significant, as they come mainly from lay members.

The surveys that have been carried out show that there is considerable dissatisfaction with the provision of infertility services. Groups like NAC and Child have all heard countless horror stories of people's experiences while undergoing infertility investigations. Despite this, only two CHCs had received formal complaints about the treatment received in their areas. It is important to consider possible reasons for this.

There is a lot of pressure on couples, and on women in particular, to have children. There is considerable feeling that until you have had children you have not fulfilled your role as a woman. As Adrienne Rich (1977, p. 252) says in her book *Of Woman Born:*

> Throughout recorded history the 'childless' woman has been regarded (with certain specific exceptions, such as the cloistered nun or the temple virgin) as a failed woman, unable to speak for the rest of her sex, and omitted from the hypocritical and palliative reverence accorded the mother. 'Childless' women have been burned as witches, persecuted as lesbians, have been refused the right to adopt children because they were unmarried. They have been seen as embodiments of the great threat to male hegemony: the woman who is not tied to the family, who is disloyal to the law of heterosexual pairing and bearing.

It is not surprising therefore that women are reluctant to talk about being childless. One woman I talked to explained her reticence by saying, "It's a very private matter." Similarly, another quoted by Pfeffer and Woollett (1983, p. 22) said, "It's such a personal thing, a secret I was harbouring." Dave Owens the director of NAC, has said that: "... for some, the desire for privacy is paramount," and a counsellor at a London Hospital has also said that, although:

> patients do feel unhappy with things they live with it as most are so grateful for any treatment that they won't do anything.

Although Dundee LHC has heard complaints and comments about the attitudes of those offering the infertility treatments they only know of one case in which a written complaint was made. This complainant suggested, as have others to whom I have talked, that unhappy patients: ". . . wanted the services too much to make any formal complaint while still being treated."

There is no doubt that such a situation arises particularly where services are in short supply and preceeded by long waiting lists: and is true of a treatment like IVF with its limited NHS provision. A lot of people feel that, if they voice any dissatisfaction with the service, they will jeopardise their chance of having IVF. Many are understandably reluctant to do that, especially if they have waited for years already and are reaching the age limit beyond which people are not accepted on to the lists. NHS patients, despite having a system through which complaints can be made, are often in a worse position than private patients as they have no choice of where and from whom they receive treatment.

Other patients have suggested another reason for the lack of formal complaints made by individuals, and their lack of involvement in other forms of participation in local debates. As the main contact for Child in Hampshire said:

> part of the problem of getting involved in anything except helping those who need help directly is that we are all undergoing treatment and are therefore subject to the time and emotional pressure involved in that.

A woman who was refused treatment at St. Mary's Hospital, Manchester, because she had fostered a child echoed these comments saying that, although she was really very angry about the consultant's attitude and the way in which she had been treated, she had not pursued it because she felt unable to spend lots of time and energy on doing so.

It is clear from the examples given that individuals do have a hard time bringing pressure to bear on the medical profession. However, one of the doctors I talked to seemed to think that pressure groups do have a lot of power. He said that they have the potential to destroy a doctor's credibility, but also went on to say that they had no effect on medical decisions and that doctors try to ". . . keep them all happy . . . to dissipate them." When talking about the effect of pressure groups another doctor said that he would respond to requests for changes in services if he considered there to be a valid case, but believed that, if doctors had not thought about the recommendations already, then there was probably not much to them. However they *are* keen to integrate those who support them and to get pressure groups on to their side as their bargaining power is clearly increased with consumer support. As one doctor said, "Pressure from patients is useful, doctors have more clout that way." It seems that although pressure groups have a lot of power over how doctors present themselves to the public they do not really have very much power to influence things. Although doctors are inclined to listen to their patients' concerns when they coincide with their own interests, it is not obvious that their solicitude over patients views occurs at all times!

Dundee Local Health Council, although it has a relatively comprehensive infertility service in its district, including IVF and Gift, has received complaints in relation to the services. They have been about the attitudes of personnel rather than about the medical treatments, and the consultant in charge has been described as being: "offhand, brief to the point of rudeness, and providing too little information." Patients from other clinics have similar complaints. As one woman said of her treatment at a private clinic in London: "I was disgusted with their attitude and the offhand way they turned us away." And another:

> My results were given in a corridor. I was told, "Your hormones are wrong, you can go home" in front of everyone in the waiting room. They could have shown some sympathy. (Pfeffer and Quick, 1988, p. 47)

The justification most often heard for the developments of new reproductive technologies is that they will enable involuntarily infertile women to have children, and, although no one knows exactly how many people are involuntarily

infertile, (for the most recent estimation see Hull, 1985), it is clear that IVF is not doing anything for the majority of those infertile women. The examination of the quality of general infertility services and the dissatisfaction with them shows, as Pfeffer says, that:

> the same doctors who are so enthusiastic about the new technologies are content to offer a substandard routine service to women seeking help for their infertility. Clearly it is their own interests (and bank accounts that they are serving, not childless women. (Pfeffer, 1989)

This is illustrated further by the situation at St. Bartholomew's Hospital, London, where the IVF clinic has started to operate on every day of the week so that women's menstrual cycles do not have to be adjusted to fit in with the clinic's opening times. However, women have been stressing the need for clinics to operate on every day for ages and, as Naomi Pfeffer asked at a meeting with the health authority, why is it only now that such necessary changes are occurring (City and Hackney CHC, 1987)?

The same is true over the provision of counseling services. Coming to terms with being infertile can take a long time and there is no doubt that there is a lot of grief and distress surrounding the experience of being infertile (although this is often more to do with the treatment received and the attitudes of others than something induced by infertility itself). However, it is only with the development of IVF and related techniques that gynaecologists have started to recognise this and thus the need for follow up services such as counseling. Although such services are being provided for those women undergoing IVF and Gift it is not clear that such provision is made for women attending routine infertility clinics. This illustrates that although there is an increase in interest in infertility, it is really only the new reproductive technologies, the areas of medicine which confer status and prestige upon doctors, that they are concerned with developing and improving.

Some CHCs are debating the effect of the introduction of IVF on infertility services. One of City and Hackney CHCs concerns about "the superimposition of IVF on top of an ill coordinated and poorly managed infertility service" is that "the service was developed without any discussions about the impact on the rest of the gynaecology/infertility services." As they go on to say:

> IVF highlights the problems caused when a technique that is media attractive is developed and unscrupulously marketed. It detracts attention from the routine parts of the service that will benefit the majority, concentrates on the few and detracts attention from the whole human experience that in turn generates desperate-ness. (City and Hackney CHC, 1985/6, p. 4).

The development of certain specialist areas of medicine within the private sector also 'detracts attention from the routine parts of the service.' In vitro fertilisation is one such technology whose provision is expanding mainly in the private sector. The effect of private services on the NHS has always been of questionable benefit to the NHS. Whether the real cost of private health care in the NHS is recouped is widely debated and it is evident that, as Doyal says:

> private practice in its present form could not exist without the NHS. It is dependent to a very considerable extent on the hospitals, the back-up services, the equipment and the highly trained staff of the state sector, as well as on the ability of consultants to work on a part-time contract and to use NHS facilities for their private patients. (Doyal, 1983, p. 189)

It is for these reasons that City and Hackney CHC have voiced criticism of the way that the IVF programme has been introduced at St. Bartholomew's Hospital, London. The CHC has asked the District Health Authority questions about "how

this seemingly unplanned development was being funded" as:

> although the Baits IVF programme, like others in the country, is not directly funded by the NHS, it depends on NHS facilities for its existence. (City and Hackney CHC, 1985/6, p. 4)

The gynaecologist providing the service is reported to have been "talking to private hospitals 'about sharing skills and facilities for the mutual benefit of the NHS and the private sector.'" The CHC asked for clarification of this and received the reply, "I cannot see how it is of any concern to the Community Health Council" (City and Hackney CHC, 1985/6).

In a more indirect way the development of the private sector also contributes to the deterioration of the NHS. As private services develop the government is able to use their existence as a justification for putting less money into the NHS. As Pfeffer and Quick say:

> in the case of infertility, it seems plausible that the existence of a substantial private sector to which patients are frequently referred, or seek themselves to avoid frustrating waits in the NHS, may allow inadequacies within the NHS to persist. (Pfeffer and Quick, 1988, p. 56)

There is only one unit that is fully funded by its Regional Health Authority, that at St. Mary's Hospital in Manchester, though here too the doctors involved also run a private practice. The other units that provide a service for NHS patients rely for their existence on research grants, the creation of self-financing schemes by diverting funds to NHS patients from private fees, or raising money through donations. Doctors, although criticising the lack of funds for NHS IVF services, have focused their activities mainly on issues which directly concern them. Many are concentrating their efforts on developing self-financing schemes or trying to obtain research grants in order to expand the provision of IVF services. This is not altogether surprising as there is no doubt that doctors gain enormous benefits from the private sector. Many are being increasingly drawn into the private sector as there are fewer resources for the NHS and the new branches of medicine are developed privately.

The NHS was established to provide a service on a basis of equal access free at the point of delivery, but this is changing. Clearly the development of IVF and its mode of provision is transformative. As Health Authorities are increasingly starved of resources they are looking to private enterprise to continue to develop new services. The 'example' set by the self-financing schemes to provide IVF and Gift is likely to be followed. One doctor who provides a self-financing Gift programme has said that schemes like his are becoming more and more common due to the financial crisis of the NHS. He has had doctors from other areas of medicine come to him to find out how the programme is being run in order to develop their own.

Although CHCs are concerned about the issues surrounding the provision of infertility services they are constrained by lack of resources and have to react to things as they occur. Being committed to the principles of the NHS much of their involvement around these issues stems from their opposition to private health care. Thus, it is criticism of the development of semiprivate schemes, and concern about the effects of such changes on the NHS, rather than concern about infertility services in general, that is drawing many of them into these debates. Lewisham and North Southwark CHC is concerned about the threat such proposals for raising money pose to the "principle of a free universal health service." and the secretary of Greater Glasgow East LHC has said:

> In general we support activity in this field so long as it is carried out within the NHS and without the field of commercial medicine.

Salford CHC is going to discuss the development of a self-financing scheme for Gift by the consultants of Hope Hospital (Salford Health Authority, 1988). Its members have reservations about such a scheme, as they are opposed to private treatment they are concerned about the precedent that this initiative creates. Members of Oxfordshire CHC's Women's Health Working Party are critical of the inadequacies of infertility services, of the effects of IVF on other services and the inequalities that exist in its distribution. They are also concerned that the unit set up at the John Radcliffe Hospital is a "private fee-paying clinic and not part of the NHS" (Oxford CHC, 1988).

The proposal by the unit at the Women's Hospital in Liverpool to ask for a 'contribution' of £500 towards the cost of Gift has caused debate and criticism by both Liverpool Central and Southern and Liverpool Eastern CHCs. They are concerned about how patients will pay the proposed charge for each attempt at Gift, but are also keen to discuss the scheme with the Health Authority as they believe that there is a very important principle at stake. They were consulted about the introduction of Gift in their area, and although they have expressed their doubts to the health authority there have been delays in the discussions. By the time the matter is finally considered, the service will have been in operation for four months. It is unlikely that changes will be made.

CONCLUSION

There are very few CHCs who have debated issues raised by infertility and IVF and those that have are fairly atypical. Those that are involved in the debates about self-financing and private health care have become so because of the threat these changes pose to the NHS, rather than as a result of concern about the technology itself. Others have become involved for different reasons. Issues arise on a CHCs agenda in different ways, but often because of local pressure. This was the case in East Dorset, where there is a very active local NAC group who pressurised the CHC into taking the matter up with the Health Authority. Edinburgh LHC was also stirred into action by their local NAC group. The amount of activity a CHC is involved in depends very much upon the council members and its secretary. To this extent City and Hackney CHC is unusual in that Naomi Pfeffer, a woman who has written extensively about the experience of infertility and the provision of services, is involved with their work. Central Manchester CHC has the only fully NHS funded IVF unit in their area and perhaps for that reason have been more involved than CHCs in areas where there are only private services. In some districts where I contacted CHCs, IVF facilities are only just being developed and, as yet the CHC has not been active around the issues raised, but many are planning to get involved. Some, like Newham CHC, are doing so in response to the report produced by GLACHC (Pfeffer and Quick, 1988), and the secretary has said that they hope this will be an issue which they tackle in the next year.

There are still few people involved in these debates, but perhaps this will change as more interest is raised with further developments in this field. It is possible that the involvement of CHCs will change as semiprivate schemes, or possibly NHS services, expand. But, as this study has shown, this increasing interest has a double edge to it. There is a danger that as more and more attention is drawn towards high tech medicine and consequently to private services there will be less involvement and concern over the NHS and routine infertility services which will thus continue to be ignored and so continue to deteriorate.

It is important to note that these groups have been involved in the debates from a standpoint of accepting IVF as a technology to alleviate infertility. Their criticisms and concerns have been about the way this is provided and the effects on

other services. There is a clear difference here between these concerns and those voiced by groups like WRRC and FINRRAGE. Those involved in these debates are not challenging the structures within which these technologies are developed or the reasons for such developments. Again the danger is, that as more people get involved in these debates their attention will be drawn still further onto questions about the provision of services and away from other important issues such as the control of reproduction, safety of the techniques and the drugs used, and the eugenic aspect of these technologies. As has been said, it is more difficult to protest about services when they are already being provided and, as more and more are developed, it becomes even harder.

It is clear that major issues are being considered at the local level, although in a very discontinuous way. Although many concerns overlap with national ones there is a considerable difference in emphasis between them, and a marked lack of local debate about the political and ethical effects of the reproductive technologies on women. Given that it has proved difficult to raise a feminist dimension within the national debate, where the political and ethical concerns are at least raised, it could prove even more difficult to encourage a feminist consideration locally. The evidence assembled suggests that the ability of groups and individuals to get issues raised, even given the heightened interest in infertility at present, is an uphill struggle. Attempts have been made to raise these issues but these are repeatedly hijacked by the emphasis on high technology treatments such as IVF and Gift.

ENDNOTES

1. Community Health Councils (Local Health Councils in Scotland) were established during the reorganisation of the NHS in 1974. There is one CHC in every Health Authority and their members consist of nominated representatives from local voluntary organisations, the local authority, and the Regional Health Authority. They are statutory bodies and their legal duty is to represent patients interests in the NHS. In order to do this they have a number of rights: to information from the NHS; to visit Health Authority premises; and to be consulted in the event of any change of purpose of buildings. They also provide help and information for members of the public.

2. Much of the material for this article comes from personal conversations and correspondence with people involved in these debates. I have quoted from them directly in the text but kept their identities anonymous.

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