PREGNANT COUPLES: MEDICAL AND SOCIAL CONSTRUCTIONS AROUND FERTILITY AND REPRODUCTION

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Synopsis – This article is devoted to the analysis of the mutual relationship between the development of new constructions of gender in the sphere of procreation and the nature of the new reproductive technologies, in particular in vitro fertilization and embryo transfer (IVF/ET). We pay attention to the contributions of this technology to the deconstruction of the continuity in female reproduction and its reconstruction as a technological process. This is accompanied by the shift in the conceptualization of infertility as a medical condition of a heterosexual couple. This conceptualization of a heterosexual couple as an infertile patient makes possible a redefinition of IVF/ET as a therapy for male infertility. In the sphere of policy making, the construction of the "infertile couple" legitimizes the exclusion of lesbian and single women from the application of this technology. In the debate around the issues of informed consent and parenthood, the attention given to "the couple" serves to cover up the fact that the securing of men's interests above those of women is at stake.

Synopsis – In dit artikel staat de wederzijdse relatie centraal tussen de nieuwe gender constructies rond vruchtbaarheid en voortplanting en het karakter van de nieuwe voortplantingstechnologieën, i.h.b. de in vitro fertilisatie en embryo transfer (IVF/ET). We analyseren de bijdragen van deze technologie tot de deconstructie van de continuïteit in de vrouwelijke voortplanting en de reconstructie ervan als een technologisch proces en aan de daarmee verbonden verschuiving in de conceptualisering van onvruchtbaarheid in termen van een relationele aandoening van een heterosexueel paar. De constructie van een heterosexueel paar als een onvruchtbare patiënt maakt de herdefiniëring van IVF als een therapie voor mannelijke onvruchtbaarheid mogelijk. In de steer van beleid legitimeert deze constructie de uitsluiting van lesbische en alleenstaande vrouwen van de toepassing van IVF. De aandacht voor "het paar" bij kwesties van toestemming en ouderschap verbergt het feit dat het veilig stellen van de belangen van mannen bij de voortplanting ten koste van vrouwen de inzet van het debat is.

The medicalization of reproduction is a source of continuous discomfort for the women's movement. The 1970s showed a flurry of measures to restrict fertility (struggle for abortion, increased supply and use of hormonal contraceptives), but the 1980s are characterized–at least in the West–by an obvious shift towards the development and rapid diffusion of fertility-enhancing and prenatal diagnostic techniques. Although in the

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Netherlands only 1 in 20 firstborns is conceived accidentally and the decision to have no children is socially accepted, unwanted childlessness is increasingly becoming a problem for which a solution is being sought in medical technology

The definition of involuntary childlessness as primarily a medical problem, for which a controversial medical technique (in vitro fertilization and embryo transfer (IVF/ET) and, earlier, artificial insemination by donor AID)) is being offered, takes (in)fertility and reproduction out of the intimate realm of individual relationship and brings it into the public sphere. Various professional and interest groups, including government agencies, state their opinion in public on the desirability and admissability of reproductive technologies. In the process of position-finding at different levels, shifts are taking place in the conceptualization of such phenomena as (in)fertility, patient, medical indication, social indication, and so on. Without being noticed, new concepts are being developed and implemented. On a closer look they may lead to practices detrimental for women.

We argue that a mutual relationship exists between the development of these new concepts and the nature of these reproductive technologies–in particular IVF/ET and the many variations thereof. In the first part of this article we therefore pay attention to the ways in which IVF/ET contributes to the deconstruction of the continuity in female reproduction and its reconstruction as a technological process. One of the results of this process of deconstruction/reconstruction is the decreasing relevance of the individual female body as the primary site of reproduction.

Because IVF technology decontextualizes the female body, it allows for the spreading of IVF to originally unintended applications. In order to tacitly reach a redefinition of IVF–an ethically questionable process to say the least–as a therapy for male infertility, a significant shift in the conceptualization of "patient" is indispensable. The construction of a heterosexual couple as an "infertile patient" is unreservedly borrowed from the medical profession and polished up in the sphere of healthcare policy. The second part of this article is devoted to the analysis of these constructions.

IVF AND TEDE DECONSTOUCTION OF THE CONTINUITY OF FEMALE REPRODUCTION

In vitro fertilization, a blessing for infertile women?

In the early development of in vitro fertilization it was said that the dominant motivation for the development of this technique was compassion for the tragic fate of women who cannot bear children-because of deficient fallopian tubes (Edwards & Steptoe, 1980; Wood & Westmore, 1983). The birth of the first children conceived by means of in vitro fertilization has been celebrated by physicians and the media as a triumph of medical technology over women's physical impotence to have children. Since then the public was told that women with deficient–or no–fallopian tubes no longer had to suffer from infertility. By means of IVF they would have a reasonable chance to have their own child. The press, medical practitioners, and health-care officials mentioned regularly success rates of 30% and more. It was even suggested that these figures were higher than in the case of "normal" fertilization. However, more than 10 years after the birth of the first "IVF baby," the intended goal of relieving the pain of infertile women has not been reached. Statistically only 1 in 10 IVF-treated women is giving birth to a live baby. The medical risks to which IVF treated women are exposed are not of little importance: hyperstimulation and cancer of the ovary, cysts, stroke, heart attack, complicated and multiple pregnancies, higher incidence of caesarian deliveries, and so on

(Klein & Rowland, 1988; Wagner & St. Clair, 1989). For the remaining 90% of treated women, IVF results in a physical and mental burden and in protraction of the process of coping with childlessness (Klein, 1989a). These rather disappointing results for "IVF"-women are even more painful when one takes into account that 7 to 28% of women who are selected for IVF treatment get pregnant either before or after the treatment without external artificial intervention (Wagner & St. Clair, 1989). In fact, the incidence of natural pregnancies is higher than the percentage of healthy children born per IVF cycle!

IVF: Success of scientific reductionism?

At first, IVF appears to have been developed to solve childlessness that resulted from a particular kind of female infertility, blocked ovarian tubes. Such tubal occlusion makes the passage of a mature egg cell impossible. Because the sperm cannot meet the egg, there is no transport of a fertilized egg to the womb. IVF is employed as a "bypass" procedure for improperly functioning tubes. Fertilization in the tubes and the transport of the fertilized eggs to the womb are substituted by laboratory manipulations of the gametes outside the woman's body.

The development of this bypass procedure, however, would not be possible without the previous conceptual reduction of reproduction to a mere physiological process and its conceptualization as a process consisting of causally related stages/units. In principle, each stage may be viewed and researched as an independent part. Subsequently, stages of the process may independently be influenced/manipulated on the basis of partial knowledge. The conceptual reduction of procreation to bodily functions only and the dissection of the whole process into a sequence of relatively self-contained stages is well rooted in current scientific thought. The development of the traditional fertility treatments for women, such as hormonal stimulation to induce ovulation or tubal surgery, would not be possible without this type of thinking.

But, whereas all the pre-IVF fertility treatments aimed at the *restoration* of the deficient bodily functions, the arrival of IVF introduces a new "paradigm" into the treatment of infertility. IVF provides a *technological replacement* of some bodily functions. In addition, IVF brings into practice the conceptual dissection of the continuity in the female process of procreation (see also Braidotti, 1989; Klein, l989b).

To illustrate these ideas it is necessary to have a closer look at the procedure. The very name of the technology implies that it applies to the moment of fertilization only. In reality, IVF includes considerably more medical manipulations than the removal of egg cells from a woman's ovary, fertilization, and the subsequent placement of fertilized egg cells in the womb. Rather, the entire process of female procreation is being affected and subordinated to the laboratory standards of a "successful" fertilization.

Let us start with what seems to be the beginning of the procedure: the extraction of the mature egg cell from the woman's body. During the monthly cycle of a fertile woman, usually only one egg cell matures, which, after ovulation, eventually is fertilized. In order to achieve fertilization outside the body, the egg has to be extracted from the ovaries before ovulation takes place. Otherwise, it will be impossible to localize the egg cell in the woman's body. It means that it is practically impossible to remove fully matured egg cells from the body and that, consequently, maturation has to be artificially produced under laboratory conditions. Not every attempt to extract an egg cell from the body and fertilize it in a laboratory is successful. To increase the chances, women are given hormonal drugs to stimulate the growth of more egg cells per cycle. Moreover, the stimulated growth of maturing eggs is easier to

control. Once the eggs are removed from the woman's body and matured in the laboratory, they are exposed to a limited number of specially treated sperm cells. The sperm-capacitating activity of the female reproductive organs is replaced in the laboratory by washing, centrifuging, and placing the sperm in artificial culture media. If fertilization occurs, the fertilized eggs are allowed to grow for 2 to 3 days in the laboratory and are then placed in the woman's womb. Because of the time involved in these manipulations the uterus is not always in the right condition for the implantation of the embryo. So again, hormonal medication is prescribed in order to increase the chance of implantation. The extracorporal manipulation of procreation comes to an end with the transfer of one or more embryos. Not, however, does the technical interference and supervision. The crucial question for the woman *and* the doctors is whether she will become pregnant. This is no longer a matter of simply yes or no. Depending on the type and the timing of the test, different stages of pregnancy are distinguished. So, a woman may "experience" a biochemical, a commencing, a clinical, or a continuing pregnancy. Her chance to deliver a live baby is, however, at most 10% (Haan, van Steen, & Rutten, 1989).

Dividing up pregnancy into so many different stages fulfills an important role in proving the effectiveness of IVF. The most obvious means of measuring effectiveness of IVF is the number of *healthy babies* per started cycle of treatment. This success rate is assessed at 4-5% according to recent data (Wagner & St. Clair, 1989). But, from a purely technological point of view, effectiveness may likewise be measured as the probability that transferring an embryo into the woman's womb will result in one of the different types of pregnancy mentioned above. In this way, the success rate can be inflated to 20% or higher depending on the stage of pregnancy, which serves as the yardstick. In their effort to "prove" that IVF technology produces results as good as nature, some doctors compare these inflated rates of success with the chances of fertile young women to get pregnant during a sole cycle (approximately 25%).

IVF and the alienation of the body

In daily practice, IVF results in an almost entire dissection of the continuity of female reproduction. New hazards and uncertainties are inextricably bound up with the manipulation of the separate stages of the dissected process of procreation. Although it is now possible (but still difficult) to gain an understanding of the kind and the seriousness of the physical risks involved for women, the psychological effects of the IVF programme are still largely being overlooked and underplayed in policy documents. However, serious psychological stress has been mentioned in a few studies (e.g., Klein, 1989a, 1989b).

The division of the reproductive process into smaller parts and the conscious identification of women with each separate part also appears to result in an intensive perception of the uncertainties of the separate parts of this technological process. The uncertainty of reaching the next stage and the related stress is great, for women realize that the whole treatment can fail them at any moment. Thus, women are constantly torn emotionally between hope and disillusionment. When they face the final attempt, tensions become almost unbearable. At each stage the decision of (dis)continuing the treatment rests with the IVF team. In such a situation, according to Schenk, Deurloo-Sluyter, and van Leeuwen (1989, p. 612), "one [who? the woman?, M.K. & I.v.d.P.] is and feels very dependent and vulnerable," which is not surprising. After half a year or more of life in total chaos, most women have to face the failure of-the IVF treatment. The process of coping with the sorrow is painful and longlasting. Even after a year or more

some women are still having problems returning to normal life (Hermans, 1987; Klein, 1989a).

Apart from this psychological swing with a deep fall in the end, a number of women experience a temporary emotional separation between body and mind. As a Dutch woman put it (quoted by Schenk et al., 1989, p. 612, our emphasis):

> Everytime I enter [the IVF clinic, M.K. & I.v.d.P.] I am absent-minded, I am not aware of many things. I hardly can remember something, *it is if someone else is undergoing all examinations.* I think it is a way to protect myself frenetically against all kinds of emotions.

Women in other countries recount similar reactions to IVF. For some women the treatment is such a serious breach of their personal integrity that the temporary alienation between mind and body is experienced as a means to pull through for the baby's sake. An Australian woman said (Burton, 1985, quoted by Corea, 1988, p. 86, our emphasis):

> It (the IVF treatment) is embarrassing. You leave your pride on the hospital door when you walk in and pick up when you leave. *You feel like a piece of meat in a meat-works.* But if you want a baby badly enough you'll do it.

Authors such as Gena Corea and Renate Klein stress that a repeatedly experienced alienation can not remain without consequences for these women (an IVF programme may be repeated up to 10 or 15 times). We will come back to the question of which mechanisms operate so that the psychological burden of the IVF programme for women largely remains undiscussed in the medical and healthcare policy literature.

THE RECONSTRUCTION OF REPRODUCTION AS A MEDICOTECHNOLOGICAL PROCESS

Together with the division of the reproductive process into a series of consecutive stages, women almost entirely disappear from the medical literature as the subjects of medical practice. They are being exchanged for organs and their functions, for stages of physiological processes and for medicotechnological interventions by attending specialists. And even when human beings and not organs are mentioned, the apparently neutral term "patient" is used. It is, however, not certain that in the IVF programme this term applies to a woman.

Medical control of organs

The replacement of women with organs is an important step in the reconstruction of reproduction as a medicotechnological process, since these substitutes become assigned specific autonomous capacities that are independent of women. Hormones, egg cells, and embryos are now the active participants in the reproductive process. Egg cells and not women are capable of being fertilized, and embryos may or may not be successful in the pursuit of settling in the womb. To quote an example (Fischer, Boukloh, & Bohnet, 1986, p. 56, our emphasis): "A well-timed *interaction of hormones* is essential for the maturation of an *oocyte capable of being fertilized,* as well for *implantation success of the early embryo* and the first critical phase following conception."

The technological intervention seems necessary to start off the interaction between the various actors in the reproductive process and to check its development in order to reach the desired result (i.e., the pregnancy). What is more, it is clear that the attending specialists prefer a technologically controlled process to a natural one. Measured by technological standards, control leads to an increased efficacy of IVF.

Variability in the temporal relationships between the oestradiol peak of the

> periovulatory interval and the detection of the onset of the LH [luteinizing hormone] surge caused problems related to timing aspiration of the dominant follicle. This made the *natural cycle inferior to the treated cycle* from the standpoint of efficient management. . . . Methods to promote multiple follicular development have proven *superior* to the natural cycle not only in terms of *increased oocyte yield,* but also by allowing more *controlled* protocols for ovarian stimulation. This control, achieved by administration of exogenous agents that *override the natural cycle,* has resulted in *increased pregnancy rates* in in vitro fertilisation programs worldwide. (Hodgen & Van Uem, 1986, p. 36, our emphasis)

In this technologically controlled and depersonalized process of procreation even the attending doctors seem to fade away. Nevertheless, as members of the clinics, they are indirectly credited for obtaining the desired results.

> The first pregnancy achieved by in vitro fertilisation in Australia occurs in 1979. Eight *units* [clinics, M.K. & I.v.d.P.] *with pregnancies completed* before the end of 1983. (Australian In Vitro Fertilisation Collaborative Group, 1985, p. 1160, our emphasis)

In this way the circle seems to be closed. The women have disappeared. Any pregnancies are presented as a product of a successful medical intervention: a "harvested egg cell," fertilized by "capacitated sperm cells" and successfully placed into a womb of good quality. The clinics (i.e., "units") appropriate the full-term pregnancies.

Substitutes for women's procreative capacities?

Up to the birth of Louise Brown in 1978 the idea of procreation outside a woman's body belonged to the domain of science fiction. Now, after more than 12 years, we are no longer so sure. Whereas millions of women experience pregnancy as an integral part of their personality, the medicalization of reproduction has largely led to the reduction of pregnancy to processes inside the womb. All the rest is becoming irrelevant. This fixation on the womb, combined with the availability of technical means to bring about fertilization outside a woman's body, is creating a wide range of new substitutes for women. Not only is the laboratory a good surrogate for the female body. Her egg cells may be replaced with those of other women and embryos developed from her egg cells may be placed in other "suitable" wombs. Still newer frameworks of pregnancy are suggested. To give some examples: An Italian research team at the University of Bologna announced a successful experiment to bring about a pregnancy (not only a fertilization) outside a woman's body. The experiment involved the placing of three embryos into a womb that had earlier been removed from a woman's body and kept functioning in the laboratory on a perfusion machine for 52 hours. During that period one embryo showed signs of development, but at the end the womb collapsed (Klein, 1989b, p. 279). In Australia a staff member of the University of Queensland proposed to use brain-dead women as "surrogate mothers." Analogous to keeping "alive" brain-dead organ donors he said: "There is no reason why a woman's womb should not be used as well" (Corea & de Wit, 1989, p. 161). New frameworks for reproduction are not restricted to surrogate motherhood. Prior to the first IVF pregnancy attempts had been made to develop human embryos in animal wombs (Wood & Westmore, 1983, p. 75). IVF technology permits the research of these and similar applications. In turn, such applications more and more undermine the meaning of the unique physical involvement of women in

procreation.

Woman/man symmetry?

As a way of conclusion, we would like to point to another aspect of IVF technology we believe is crucial for the reconstruction of reproduction as a technological process. It concerns the central place assigned to the fertilization of egg cells and to the development of embryos. The focus of medicoscientific research on the process of fertilization strongly suggests equality between the male and female contribution to reproduction. This mistaken suggestion is reflected in the construction of a heterosexual couple as a collective infertile patient. This construction is established not only in the medical world but also in other networks developed around technologized reproduction.

THE CONSTRUCTION OF THE COLLECTIVE PATIENT

Infertile individuals or infertile couples?

The medicotechnological deconstruction of the continuity of female reproduction and its reconstruction as a technological process is combined with a change in the meaning of the concepts of (in)fertility and patient. Medicotechnological interventions to stimulate fertilization are based on the presumption that it is a physiological problem of the woman or the man (i.e., of an individual) that lies at the root of infertility. This approach is reflected in the use of terms such as "female" and "male" infertility and in the development of various diagnostic and therapeutic methods aimed at the treatment of individual women or (to a considerably lesser extent) men.

However, this approach is gradually being abandoned. In 1975, university lecturer Professor J. Kremer labelled a couple a "biological unit":

> In this lecture the conventional classification of the subject matter treating male and female infertility in two separate sections, has been abandoned. The objection against the conventional classification is that it insufficiently takes into account that the physiology as well as the pathology of male and female reproduction are closely interlinked. As far as reproduction is concerned, a couple constitutes *a biological unit.* (Kremer, 1977, p. 1, emphasis in the original)

In the second half of the 1980s infertility is increasingly seen as a relational problem, as a physiological disorder of a heterosexual couple. This perception results in the conceptualization of the couple as an infertile patient: "Fertility is the product of interaction between two people [read a man and a woman!, M.K. & I.v.d.P] and so the infertile *patient* is in effect the infertile *couple*" (Office of Technology Assessment, 1988, p. 6, emphasis in the original).

This conceptualization is inconsistent with daily practice. The physiological causes of reduced fertility may still be traced back to individual women or men (perhaps with the exception of the immunological factor). Most of the fertility-stimulating medical activity concentrates on operations in connection with the woman's body. The man's physiological participation in, for example, the IVF treatment is merely to supply sperm cells. The mystifying belief that couples are being treated with IVF is, however, still dominant. Assessing IVF results in a number of clinics, a recent Dutch study explicitly speaks of couples as the patients under IVF treatment (Haan et al., 1989). Defects or medical treatment that hitherto were evidently connected with the woman's body are now being ascribed to couples. Tube pathology has now become a medical ground to treat *couples;* apparently it is no problem anymore to diagnose a "defect in the cavum uteri of 10 percent of the couples under treatment" (Haan et al, 1989, pp. 22, 25)! The authors of the study want us also to

believe that it is possible to perform surgery on couples these days!

> The results of IVF treatments for this category of *couples who underwent tube surgery,* as well adhaesiology or salpingotomy in particular, appeared to be identical to *couples without tube surgery* in the anamnesis. (Haan et al., 1989, p. 24, our emphasis)

The denial of a distinct physiological involvement of men and women in reproduction and in the treatment of infertility by means of the construction of the couple as the infertile patient reaches its (interim?) culmination in the replacement of pregnant women by *pregnant couples.* In one of the most recent recommendations on IVF it is said that: "on 1 September 1988 . . . *107 couples were still pregnant*" (Ziekenfondsraad, 1989, p. 16, our emphasis).

Treatment of a man through the help of the woman's body?

The conceptualization of a couple as an infertile patient with its own body ("IVF couples give the control over their body," Haan et al., 1989, p. 86), in connection with the availability of a technology that undermines the importance of the physiological framework, brings about a particular interpretation of the treatment of an infertile couple. In conceptual and technical respect, the conditions have been created to spread diagnosis and infertility treatment over two different bodies. In view of the medical tradition, this is an extremely bizarre development. But the spreading over the two bodies is in no way symmetrical. IVF creates the possibility to "treat" male infertility, caused by abnormal sperm or by an insufficient dose of sperm, via the woman's body and not the other way around. In other words, the woman's body still bears the brunt!

Extending medical grounds for IVF to male infertility was quietly introduced without any protest at all. In the Netherlands, male infertility is accepted as the sole medical grounds in 10% of all IVF programmes! (Haan et al., 1989). Technological developments, however, are not stagnating. On the basis of in vitro fertilization new fertility stimulating techniques are being developed that are particularly suitable to further realize a separation between the "infertile" body and the body "under treatment."

Gamete intrafallopian transfer (GIFT), intrauterine insemination (IUI), zygote intrafallopian transfer (ZIFT), and direct intra-peritoneal insemination (DIPI) all potentially permit "treatment" of male infertility via the female body. No moral questions are posed about the evident consequences of such innovations when physiologically fertile women have to endure burdensome treatment for the remedy of physiologically infertile men. One treats a couple as one infertile patient! "This, *for the patient burdensome,* technique [ZIFT, M.K. & I.v.d.P.] would be particularly advantageous in the case of a *couple of which the man has subfertile sperm*" (Velde, 1989, our emphasis).

It is interesting to mention that the phenomenon of "surrogate motherhood" (almost nonexistent in the Netherlands) indeed evoked many debates, but that this very phenomenon may likewise be considered as the treatment of a fertile woman to mend the infertility diagnosed in another woman!

INFERTILE HETEROSEXUAL COUPLE AND THE POLICY DEBATE ON REPRODUCTIVE TECHNOLOGIES

The construction of "the couple" as an infertile patient is not restricted to the medicoscientific world, but also occurs at policy levels. In recent years in the Netherlands, many advisory bodies (Health Council, National Health Service, Council for Juvenile Welfare), some political parties (Christian Democrats, Radical

Party), and the government have published a number of reports formulating proposals for the regulation of IVF and other reproductive technologies. Because of the expert and/or political status of the authors of these reports, it is of great importance for the course of the public and political debate on reproductive technologies to see how they identify and conceptualize policy problems on IVF.

When infertility becomes a medical problem?

Many policy studies emphasize that reproductive technologies should be considered as a solution for medical, and not for (psycho)-social problems. In addition, the medical approach and the psychosocial approach of unwanted childlessness are not presented as complementary but as mutually exclusive perspectives. Which type of childlessness is being considered in one or the other perspective is politically far from neutral. It is only the medical application of reproductive technology that is seen as legitimate. This technology is not to serve as "an alternative for natural procreation" (Minister van Justitie en Minister van Welzijn, Volksgezondheid en Cultuur [Dutch Ministry of Justice], 1988, pp. 3, 12), and fertile people are to be excluded.

> Counteracting indicative medicine and medicalization of reproduction results in two conditions. . . . In the first place there must be a biological reason for the unwanted childlessness. This implies that fertile people cannot be taken into consideration. (Wetenschappelijk Instituut voor het CDA, 1988, p. 65)

On the other hand, male infertility is at the same time accepted (and propagated) on medical grounds for treating healthy, fertile women. Only the conceptualization of a heterosexual couple as a collective patient permits that this is not regarded as inconsistent. Moreover, this conceptualization has a politicorhetorical function: In this way the heterosexual couple apparently becomes "a natural unit." Unwanted childlessness of fertile women with a male partner still comes under the medical definition of infertility, but the problems of childless single and lesbian women remain outside its scope. It is indeed the relationship with an infertile man that medically legitimizes the treatment of a fertile woman. The childlessness of single and lesbian women allegedly has a "social cause," and their demand for reproductive technology may be rejected as a dubious and objectionable kind of "indicative medicine":

> The basic assumption for medical grounds concerning IVF/AID should be infertility for which the medical technology can offer a remedy. This excludes AID attendance of fertile single women or of fertile women in a lesbian relationship. (Gezondheidsraad, 1986, minority opinion Galjaard, p. 3)

However, including the male partner in the medical definition conceals the fact that a (psycho)social motivation is the reason for "treating" male infertility with IVF. Strictly speaking, no *medical* grounds exist to medicate healthy and fertile women only because their partners are infertile–even less so to expose them to the burdensome and largely ineffective IVF procedure rather than, for example, use AID. The real reason in these cases is the desire for *genetical* fatherhood. As with single and lesbian women, this is a psychosocial desire for a genetically related child that is embedded in the wishes of the people concerned.

The construction of a heterosexual couple as the object of medical treatment has a politicorhetorical function: It endows the psycho-social motives of heterosexual couples with a medical legitimization and excludes the motives of lesbian and single women. Apart from an indirect preferential treatment of certain types of relationships, the use of the

term "couples" produces another important mystifying effect. The woman and her male partner are assigned *one subject* position that suggests both are, equally and to the same degree, involved in the programme. This blurs the structural asymmetry of their relationship in the medical treatment. Likewise, this has consequences for the way in which non-medical issues of IVF are dealt with.

Who runs the psychological risks?

In the Dutch policy making and (para)-medical literature some attention is usually paid to the psychosocial aspects and psycho-social risks of IVF (Gezondheidsraad, 1986; Haan et al., 1989; Schenk et al., 1989 Wetenschappelijk Instituut voor het CDA, 1988;). Generally, a distinction can be made between publications that predominantly centre on analyzing how IVF is experienced by the "patients" and how this influences the arrangement and effectivity of the programme, and publications which focus attention on the psychosocial hazards involved. It is striking that in both types of policy and medical publications there is hardly any recognition of the possibility that women may have experiences and problems with the IVF treatment that their male partners do not have.

Publications by IVF supporters based on research and/or practice briefly mention that women and men (may) experience infertility and IVF in different ways but then ignore this distinction (Haan et al., 1989; Schenk et al., 1989). The couple is put at the centre of professional interest: Couples should be well prepared in advance for the programme, couples should make their own conscious choice, the couple's psychological strength should be assessed, and so on (Schenk et al., 1989). The specific experiences of women are difficult to trace. In most cases the experienced reader is able to guess that, behind apparently neutral terms like "men," "people," and "patients," real women are hidden. In accordance with the focus on the couple, the few references to women and men suggest a symmetry in experiencing IVF: Both women and men are more fearful than the normal population, or during IVF both women and men express an increase of general complaints (Haan et al., 1989, p. 93). The problems women experience become vague or disappear from the text and are referred to in a footnote as illustrated in the following quote: "A significant increase has been recorded of somatic complaints from women who became pregnant; these women probably take this increase for granted" (Haan et al., 1989, p. 93). The general conclusions by these authors only concern couples: "The physiological and psycho-social stress of the IVF treatment is itself by and large negligible" (Haan et al., 1989, p. 95).

The minimal sympathy for women starkly contrasts with the very selective concern for parenthood resulting from IVF, despite the fact that a mere 5–10% of those undergoing IVF will have a baby. The experience of parenthood is considered to be the most substantial psychosocial IVF risk for the couple (often referred to as "the prospective parents" or, somewhat prematurely, "the parents"), "in particular when donors have been used" (Wetenschappelijk Instituut voor het CDA, 1988, pp. 57, 72): in other words, when parenthood is nongenetic. This is also connected with the fact that in the discussion of psycho-social aspects IVF and AID are often lumped together. The selective focus on nongenetic parenthood indicates that behind the constructed appearance of *symmetry* the real concern is about the position of the male partner. Gender-neutral formulations notwithstanding, nongenetic parenthood practically always concerns the male partner. For him, nongenetic parenthood excludes any biological bond with the future child. In the extremely rare (albeit rapidly increasing) cases of egg-cell donation in IVF the women also do not have a genetic link. They do have, however, a *biological* bond with their child as

they themselves carry the baby to term and deliver it. Cases of nongenetical parenthood therefore relate not so much to couples, but particularly to male partners. The relative attention paid to this aspect sharply contrasts with the total lack of attention to the specific stress of women involved in IVF.

The right to dispose of one's own body?

A similar mechanism is visible in the way the couple appears when legal and formal aspects of IVF are raised in various policy reports. To safeguard a "prospective mother" as well as a "prospective father," the signing of a declaration of consent is a prerequisite for acceptance into IVF. This means that prior to IVF the man as well as the woman has to sign a declaration stating that they are aware of the procedure, the risks, and so on, and agree with what is going to happen. Such a declaration of consent implies that not only the woman but also her male partner has the right to make decisions about the treatment the woman will undergo. This right to decide is justified by way of a controversial definition that it is in "the interest of the child," although this definition refers to activities in a situation where there is no child at all! The consent form has to do with a series of operations in the body of the woman.

> On the partner's side consent is required from the woman as well as *from her partner*. . . . Concluding an agreement for treatment with the aim to artificially establish a fertilization, this consensus ad idem refers to a complex consisting of medical examination, hormonal stimulation, egg cell puncture, laboratory work, replacing of fertilized eggs, and, in many cases also the supervision of a resulting pregnancy and delivery, etc. In case of donor insemination, the consent should explicity include also this aspect. (Minister van Justitie en Minister van Welzijn, Volksgezonheid en Cultuur, 1988. p. 7, our emphasis)

It is not very clear to whom the man is giving his consent: either to the physicians to perform the mentioned operations on the woman, or to the woman herself to do with her body as she wishes. But in both cases it presents an encroachment on the woman's autonomy. A similar declaration of consent for medical treatment from a third party was hitherto only required in the case of minors and mentally retarded people.

The most detailed elaboration of a statutory consent for all potential cases is to be found in the report of the influential Vereniging voor Familie-en Jeugdrecht [Society for Family- and Juvenile Law] (FJR), Werk-groep Studie Problematiek Rond Bevruchting en Afstamming (1985). The various drafts show how this consent boils down to a man's right to make decisions on behalf of the woman. Theoretically, a man wishing to do so, for whatever reason, could discontinue a treatment against the woman's will. In spite of the fact that it is *her body* that has already undergone some treatment, including various hormonal treatments, she is no more entitled to make decisions than her partner: "If only the man reconsiders his approval, then further inseminations as requested by the woman only, will in principle be discontinued" (FJR, Werkgroep Studie Problematiek Rond Bevruchting en Afstamming, 1985, p. 36). And:

> If both man and woman beforehand do not explicitly approve of this method of fertilization and of the embryo transfer, or if one of them reconsiders their consent *during* a series of treatments, then (. . .) this method of fertilization should not take place or should be discontinued; in principle, this should also be the case if the man would pull out and the woman would want to continue. (FJR, Werkgroep Studie Problematiek Rond Bevruchting en

Afstamming, 1985, p. 41 our emphasis)

The man's right to make such decisions is only justifiable in the case of married couples. A man is considered to be the legal father of the child his wife gives birth to. This implies statutory duties but also gives him the legal possibility to deny fatherhood. Also, when the egg cells are fertilized with his sperm, the male partner explicitly has to agree before his sperm is used. (We believe that the man's right to reconsider his consent during treatment should at the least be balanced by the woman's right to use donor sperm.) However, decision-making power is not restricted to spouses. Even when a woman and a man are not married (i.e., have no mutual legal bond), the draft law proposes that the man should have rights over the woman's body. This extends as far as the case when his sperm is not used and he therefore has no biological bond with the future child. It seems that the woman and her male partner are forced into an "extramarital wedlock."

> It is the opinion of the working group that the woman and her partner ought to decide jointly in case of an insemination with the sperm of another man. In practice this occurs also when a married woman will be inseminated with donor sperm. (FJR, Werkgroep Studie Problematiek Rond Bevruchting en Afstamming, 1985, p. 36)

The situation outlined above is confirmed by the many voices in various reports to link the male partner's written declaration of consent to juridical fatherhood. That the legal recognition of fatherhood is still not possible without the woman's permission is considered by the authors to be a difficult obstacle that should be removed by amending the law.

This mechanism is comparable with the earlier mentioned mystifying effect of the construction of "the couple." The asymmetrical relationship between women and men in respect to IVF treatment is hidden behind an artificially construed symmetry. The same importance is attached to the declaration of consent. The man's right is established over (the body of) the woman. This does not result in symmetry but in an even more unequal relationship.

CONCLUDING REMAINS

Drawing attention to these developments calls for an interpretation. What are the consequences of the processes of deconstruction and (re)construction for the relationships between men and women in the realm of reproduction? Is it possible to conceive of other developments, and if so, under which conditions?

Looking at the way in which the construction "the couple" is operating at different levels, a remarkable effect catches the eye: the inherent suggestion of equality and symmetry between woman and man. An "equality" expressed in the way in which they are assigned the same shared position as a couple. Not only do they merge to *one* infertile patient, but the same degree of involvement with respect to the treatment is suggested. It appears as if they undergo the IVF procedure as a couple, and as if the experience of the treatment were fully shared by woman and man. In analogy to this, an equal right of decision for both members of the couple develops on the formal-juridical level.

The couple is introduced as an apparently natural and harmonious unit, making it impossible to question relevant differences in position, not to mention conflicting interests of woman and man. Such an impression is of course an *abstraction,* ignoring the *specificity* of the woman's and man's position in the framework of reproduction and the practice of IVF. The couple is likewise an abstraction from the physical reality of the bodies. The involvement of the woman and the man may only be represented as equal by totally

neglecting the meaning of what is happening to the individual bodies. The structural asymmetry between the woman's position and the man's is completely blurred by denying that the couple as a unit does *not* have one sole body. Not a couple's body is being submitted to a series of operations but a *woman's* body. The man's body stands alone.

The medicotechnical language of IVF creates a disconnection between the female subjectivity and women's objectified bodies, which are visible only as disembodied organs and processes. Subsequently, the abstraction of "the couple" as subject replaces "the woman" in such a way that the "attachment" of the woman as subject to the body (which has been reduced to an object) is no longer evident. As part of the couple, the woman is detached from her own body. She seems to have the same connection with her body as the second half of the couple: the man. Again and again the meaning of the treatment is thought to be identical for the woman and for the man. The formal declaration of consent of both members of the couple may finally be interpreted as sealing the disconnection of (female) subjectivity and corporality. The woman should give up the autonomous right to decide over her own body and share it with her partner; the couple agrees to the treatment.

Despite the fact that (for the time being?) only a relatively small group of women has to deal with the construction of the couple and with the negative consequences of IVF technology, we want to end with some reflections on different approaches to the problems of involuntary childlessness.

It strikes us that in the dominant medical discourse the term "infertility" carries an important contortion of reality. In technological terms, infertility equals involuntary childlessness. This however is not a necessary precondition. A considerable number of women on IVF programmes are not childless. Moreover, infertility does not necessarily mean "no children," as there is adoption and foster parenthood. Thus infertility is artificially reduced to a medicophysiological problem of an individual heterosexual couple. It is not relevant that involuntary childlessness is as much a social problem as a medical one. Medical technology like IVF presents itself as an adequate solution to the problem of childlessness when it is narrowed down to medical/individual dimensions. Although it is questionable whether IVF, even from a medical point of view, may ever offer an adequate solution to the problem, infertile people have come to consider IVF a serious possibility.

The social adaptation of this new technological "solution" to childlessness paves the way for new problems. Socially, the definition of unwanted childlessness as a predominantly medical problem of a (heterosexual) couple is not brought up for discussion, and neither is there debate about adequacy of IVF as a medical/technological solution. On the other hand, problems in connection with the in and out of reproductive technology (despite its low chance of success) are indeed hotly debated: Who is eligible for IVF/ET? Under which condition? Which medical/technical operations are permitted and which are not? What is the status of an embryo? Is surrogate motherhood acceptable? In the debate, the voices of the involuntary childless women are hardly heard. Other groups (i.e., politicians, legal experts, ethicists, economists, medical insurers) participate actively in designing frameworks for incorporation of reproductive technologies into the healthcare and legal systems. On several levels the construction "the couple" encourages a solution to these problems that is detrimental to women.

The search for other solutions to the problems with reproduction could start with redefining the problem. As feminists have pointed out, assigning more significance to the social and cultural aspects of infertility and involuntary childlessness produces other than

purely medical/technological solutions. Involved women and men could consider such options as real alternatives. The medical approach would thus not occupy a central place, and within the medical model different approaches to women and men would be provided. These would acknowledge the differences and similarities in the ways women and men give meaning to parenthood, infertility, and childlessness, and pay attention to the difference between men and women in the physiological involvement of reproduction. Is it true that women tend to interpret motherhood in terms of upbringing and caring, while men attach relatively more significance to the genetic tie with the child? (See Crowe, 1985.) Why is it that some women experience infertility as a sign of failure and uselessness, while others do not? Why are some infertile men inclined to feel sexually less virile, and how generalized are such feelings? What is the meaning of statements by fertile women with an infertile partner that they would prefer to have the "defect" themselves? Why do some women who have been successfully treated for infertility consider their pregnancy a "doctor's" pregnancy (Hall, 1985)?

A possibly new approach to childlessness and infertility should do more justice to the complexity and diversity of problems for which IVF is now presented as the one and only solution. Such new approaches require a greater understanding of the combination of psychological, physiological, and social aspects of infertility. Medical treatments should aim at restoring fertility instead of by passing the causes of infertility in the hope of creating "one off" success. Medical treatment should persistently be aimed at the person who has been diagnosed as infertile. Unnecessary dependency relations with the medical/specialist staff are to be avoided. We hope that the development of new approaches to childlessness and infertility will help to avert the dangers hidden behind the current construction of "the couple."

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