1

Microlith

National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service

Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

**NO CHOICE IN THE MATTER:
THE EXPERIENCE OF INFERTILITY**

by

© **KIRSTEN KOZOLANKA, B.A., M.A.**

**A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfillment of
the requirements for the degree of
Master of Journalism
Department of Journalism**

Carleton University

Ottawa, Ontario

September 10, 1987

c copyright

1987, Kirsten Kozolanka

National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-51192-3

Canada

**The undersigned recommend to the Faculty of Graduate Studies
and Research acceptance of the thesis**

"NO CHOICE IN THE MATTER:

THE EXPERIENCE OF INFERTILITY"

submitted by Kirsten Kozolanka, B.A., M.A.

**in partial fulfillment of the requirements for
the degree of Master of Journalism**

Thesis Supervisor

Acting Director, Department of Journalism

Carleton University

October 2, 1987

LICENCE TO CARLETON UNIVERSITY

In the interests of facilitating research by others at this institution and elsewhere, I hereby grant a licence to:

CARLETON UNIVERSITY

to make copies of my thesis:

No Choice in the Matter: The Experience of Infertility

or substantial parts thereof, the copyright which is invested in me, provided that the licence is subject to the following conditions:

Only singled copies shall be made or authorized to be made at any one time, and only in response to a written request from the library of any university or similar institution on its own behalf or on behalf of one of its users.

This licence shall continue for the full term of the copyright, or for so long as may be legally permitted.

The Universal Copyright Notice shall appear on the title page of all copies made under the authority of this licence.

This licence does not permit the sale of authorized copies at a profit, but does permit the collection by the institution or institutions concerned of charges covering actual costs.

All copies under the authority of this licence shall bear a statement to the effect that the copy in question "is being made available in this form by the authority of the copyright owner solely for the purpose of private study and research and may not be copied or reproduced except as permitted by the copyright laws without written authority from the copyright owner."

The foregoing shall in no way preclude the granting by the author of a licence to the National Library of Canada to reproduce the thesis and to lend or to sell copies of the same. For this purpose it shall also be permissible for Carleton University to submit the abovementioned thesis to the National Library of Canada.

Signature of Witness

Signature of Student

Sept. 25, 1987 M.J.
Date Degree

Journalism
Department of Student

ABSTRACT

Infertility, the inability to conceive a child and carry it to term, affects 15 per cent of the population. Awareness of infertility is growing as the baby boom generation--better educated, more sexually active and at ease with technology--reaches its childbearing years. Although men and women share the "fault" for infertility, women bear the social, cultural and physiological brunt of the problem. A short history of reproduction points out how women in particular are expected to bear children at some point in their lives. When they are not able to fulfill these social expectations, they and their male partners face a life crisis. A diagnosis of infertility is a shock to couples pursuing parenthood in the 1980s because they have grown up believing they have a great deal of individual choice and control in structuring their lives. Infertility takes away that choice and control as they become caught up in tests and treatments that are emotionally and physically painful. Reproductive technology, which seems to offer them more choice, is in fact an option open to very few and has only minimal success rates. The bottom line for infertile couples is that, despite reproductive technology, pregnancy occurs just as often without treatment as with it. In the end, fewer than half of them will bring home the baby they so desperately want. Reproductive technology makes it more difficult for those who do not achieve a pregnancy to put an end to treatment and get on with their lives.

*The contribution to this thesis of
Dr. Eileen Saunders, thesis supervisor
until her sabbatical on August 15, 1987,
is hereby acknowledged.*

On Sterility

*The fruit tree that bears no fruit
Is called sterile. Who
Examines the soil?*

*The branch that breaks
Is called rotten, but
Wasn't there snow on it?*

Bertolt Brecht

TABLE OF CONTENTS

Chapter

I. 'I JUST WANT TO BE A MOTHER': SHIRLEY'S STORY	1
II. INTRODUCTION: CONCEPTION IN A NEW AGE AND NEW AGE CONCEPTION	13
III. WHY MOTHERHOOD?: REPRODUCTION AND THE MEANING OF CHOICE	30
IV. MEDICALLY SPEAKING: THE INFERTILITY WORK-UP	49
V. COPING WITH INFERTILITY: THE SOCIAL AND EMOTIONAL DIMENSION	78
VI. REMAKING BABY-MAKING: INFERTILITY AND REPRODUCTIVE TECHNOLOGIES	104
VII. CONCLUSION: RESOLVING INFERTILITY	133
APPENDIX: RESOURCE LIST ON INFERTILITY	154
BIBLIOGRAPHY	160
INTERVIEWS	171

ILLUSTRATIONS

Figure

I. Factors in Female Infertility	62
II. Reproductive Technologies	106

CHAPTER 1

"I JUST WANT TO BE A MOTHER":

SHIRLEY'S STORY

"I've got a story for you," she laughed into the telephone. "Are you sure you want to hear it? Come on over on Wednesday and I'll put the kettle on."

The story unfolded over countless pots of tea on a cool summer evening. From outside came the distant sound of children's voices, matching the casual litter of discarded bicycles and plastic sand toys that lined the street. Dave was outside at first, a slight figure alone in the grassy field beyond the patio at the back of the house. He was looking relaxed and rested as he flew his kite in the slight breeze. Inside, Shirley introduced their pet flop-eared rabbit and apologized for the mess. They'd just moved into the garden home at the end of a twisting row of similar houses, but the room looked cool and uncluttered. Endless carpet smothered the noise from the street and an aquarium of gently undulating fish provided the only movement.

It was a story that began in hope and expectation. By early 1985, Shirley and Dave had been trying for a year to have a child. Their lack of success didn't worry them, but they had reached their early 30s and thought maybe they should do something to help along the inevitable. The only clue they had that all might not go like clockwork was when they discovered quite casually that the drugs Dave took for his ileitis could lead to infertility.

"That was the only time I'd heard anything about infertility," says Shirley, a soft-featured woman with a warm voice. "Right after this, we went to our family doctor. I felt there were a lot of things I'd like to find out about our fertility problems, although at that time I thought it would be Dave's fertility problem."

A friend of Shirley's had undergone years of infertility testing and suggested to Shirley that she start keeping a temperature chart of her menstrual cycles, "so I went out and bought my first basal body thermometer. I've gone through two."

For most women, the fertile time of the month is easy to spot with the help of the thermometer. Until ovulation, which occurs mid-way through the menstrual cycle, the body temperature remains low. After ovulation, the temperature rises sharply. The best time to conceive is just before the rise.

Their family doctor thought the charts looked fine and ordered a semen analysis for Dave. A semen sample is produced by masturbation into a sterile container. The ejaculate must be kept at a steady temperature and brought to a laboratory within two hours.

"I didn't worry about it that much, because I figured there would be something wrong with Dave's semen count. I wasn't really concerned until Dave's count came back fine."

Shirley and Dave were referred to a specialist. They chose to see a specialist in private practice rather than go to one of the two Ottawa infertility clinics because there was a shorter waiting list. They were lucky-- they saw the doctor in October, 1985, just two months after being referred. The clinics caution there is a wait of from three to nine months for a first appointment.

"I was a bit apprehensive about seeing him because I didn't know what would happen if Dave didn't have the problem. Who had the problem? I more or less wanted to know whose fault it was--one person or the other. I just wanted to know.

"I didn't start to think of it as my problem until our first meeting with the doctor and he pinpointed it by looking at the temperature chart. He said it was a luteal phase defect and he could tell just by the way the temperature charts were read. And there my family doctor had looked at them and said everything was fine."

Shirley and Dave were reassured by the doctor's thorough explanation of the problem he had found. The luteal phase is the latter half of a woman's menstrual cycle. A defect means there is an inadequate supply of the hormone progesterone. Without progesterone, the uterus is not able to support a pregnancy. Just in case, the doctor ordered a set of tests to ensure that no other problem was present.

Shirley came away from the appointment feeling quite positive. Despite knowing that the luteal phase defect would take some sorting out with drugs, she felt they had pinpointed the problem and she and Dave would soon be parents.

"(But) I felt there was a lot ahead of us. Maybe if I'd really known what lay ahead, I'd have said no way..." She smiles ruefully.

After the blood tests, the first major test Shirley was given was the hysterosalpingogram (HSG), or x-ray of her internal reproductive organs. In it, an iodine-containing dye is injected into the uterus with slight force until the outline of the uterus and the fallopian tubes is clearly visible on the x-ray screen. It is one of the most painful of the infertility tests.

"My friend had warned me about the HSG and I knew there would be cramping, but I didn't think it would be that bad. For that one, they gave me muscle relaxant pills. They didn't do any good."

Despite the pain, Shirley was pleased that there were no blockages. She also learned a valuable lesson about coping with infertility tests: For her second HSG, she fortified herself with Bailey's Irish Cream.

The first series of tests was over very fast--it only took one and one half months. The "infertility work-up" can take up to a year. The tests confirmed that one of Shirley's hormones was down by one-third and the latter stage of the cycle--the luteal phase-- was inadequate. So much has happened to Shirley that she cannot even remember now which hormone was causing the original problem.

The doctor put her on one tablet daily of Clomiphene citrate, commonly known as Clomid. Clomid is one of the two best-known fertility drugs. Pergonal, the other, takes the credit for multiple births. Chances of twinning are increased with Clomid, although not significantly.

Clomid is taken as one tablet a day on each of days five to nine of the 28-day cycle. At mid-cycle, just before ovulation, Shirley would go to the doctor's office for an ultrasound to see if the follicles were ripening into eggs properly in the ovaries. An ultrasound machine produces a computerized image of internal organs through high-frequency sound waves. Since ultrasound gives the clearest images if an organ is surrounded by water, the test must be done on a full bladder. Shirley's abdomen would be coated in jelly and an external wand would be moved over the coated area until the desired organs--the ovaries--would appear on a screen.

It took Shirley only three months to get pregnant the first time.

"I remember I went in with the temperature charts showing a rise in temperature and it's like day 33 or 34 and I was pretty excited. The nurse and then the doctor said, 'Let me look at your hands' and I said, 'My hands?'. They said, 'Yeah, you look pregnant'. It's something about the colouring changing and there are bright red flushes in your hands when you get pregnant. This was before I even went in for a blood test.

"I went home and Dave already knew because he'd been involved all along. I always had this idea, this sort of fairy story, on how I was going to tell him, 'Oh, David, I'm pregnant'.

"We had no thought of anything going wrong. We had figured that we had gone through enough just to get pregnant. We had really no idea."

Dave has come in from his kite-flying. He's stretched out across the living room couch, silently watching and listening to Shirley tell the story. Now he speaks up: "We blabbed it all over." They laugh together and then fall silent.

Shirley says quietly: "I started bleeding at seven weeks.

"I started suddenly and that's when I went in for my first blood test. The test said that the hormone levels were starting to come down. That's when I first went on Progesterone suppositories to try and keep the pregnancy going. It's sort of like, well, you're bleeding, try this, but there's no guarantee that it's going to work."

Shirley went home and did as she was told--she lay down, she didn't do anything, she didn't get up. But the bleeding got worse and an ultrasound showed that the fetus hadn't survived.

Their doctor told them to come into the office for a suction procedure. After a miscarriage, a dilatation and curettage or a vacuum suction procedure under general anaesthetic is performed to ensure that the

uterus has emptied completely. It is the same procedure and principle as for an abortion--in fact, the medical parlance for miscarriage is "missed abortion".

If his patients are in the early stages of pregnancy when the miscarriage occurs, as Shirley was, this doctor often performs the suction procedure in his office without anesthetic.

"There were no painkillers at all. There was no one in the office when Dave and I went in. The doctor gave me the option of either having Dave in the examination room or in the waiting room. I said I'd rather have him in the waiting room, that the only time I wanted him in was for a delivery.

"I didn't do too well with the procedure. It reminded me too much of a friend of mine who went through two abortions."

As with most miscarriages, an analysis was done of the tissues removed from the uterus. The pathology report usually just indicates that "products of conception" were found without any further information. In most cases, the cause of the miscarriage is what is called a blighted ovum--basically, a fertilized egg that never develops properly.

Shirley was angry when she found out that the pathology report wouldn't give them any answers, that she was expected to go back on the drugs again without really understanding what had happened. Despite their anger and confusion, they took a short break and got back into the infertility regimen in June 1986.

By now, after two years of trying to conceive, infertility had become a strain. Dave was facing employment problems in addition to the strain that couples undergoing infertility usually feel. "We thought, 'why are we going through this when we have other problems?'" says Shirley "I really

don't understand why you keep on going, but we figured that everything else would work out. It almost seemed like, well, if you got pregnant, then no matter what happened in your life, at least you'd be pregnant."

Getting pregnant became Shirley's first priority, but Dave was starting to lose interest.

"I got tired of the whole thing," he says now. He is still lying on the couch across the room. "Having to perform at certain time periods, bringing in (semen) samples..." His voice trails away.

Under the new regimen, Shirley was taking the Clomid and going in to the doctor's office daily for six days at mid-cycle for ultrasounds. She would be given a shot of the hormone HCG--not to be confused with an HSG test--to boost her hormone levels. Dave would produce a semen sample about once in every four visits and the doctor would artificially inseminate Shirley and freeze the rest of the sample for use on other visits. The artificial insemination was an insurance that a large number of the sperm would survive the trip through the vagina, a hostile environment for them, and make it into the uterus.

The regimen began to get them down.

"At first, you think, we're making a baby, this is the right time," said Shirley. "Then, as the months go by, it's like, oh, is it that time again? It takes all the intimacy out of a relationship that was really good to begin with.

"One of the things that surprised me was Dave's reaction to the artificial insemination. It was that we were not making love to have a baby, but I'm giving a sample and you're making love with a test-tube. That was hard to take at first, that we needed help to make a baby."

In December, 1986, it finally happened. Shirley could read her chart so well that she knew even before she missed her period that she was pregnant again. A blood test confirmed the pregnancy, but with a low hormone level. The doctor put her on progesterone shots to boost the hormones and began biweekly blood tests. The test results weren't showing the expected increases. An ultrasound in the sixth week of pregnancy showed a smaller embryonic sac than normal, but no one was worried because they could see fetal movement.

Then the laboratory in Toronto botched two blood tests in a row and gave widely differing reports of Shirley's hormone levels. The second test reported a level so low that it looked like a miscarriage and she had to get another test done fast.

To that point, despite the emotional strain, all seemed to be progressing normally. But then Shirley started having extreme cramping. She and Dave went to the emergency room at Ottawa Civic Hospital.

"Well, it was six hours waiting. Six hours came and went and the only answer I got was that maybe it was ligament pain. I had two separate hours that were solid pain. They gave me something after five hours to relax me, but it didn't help." She sips her tea, her hands as steady as her voice, but her eyes are far away, lost in the remembering. The bubbling hum from the aquarium seems suddenly louder in the wait for her to continue.

"One of the doctors that came in more or less said, 'You're fairly anxious about this pregnancy because you've lost one'. She was implying that maybe it was emotional. I knew it was real pain and I knew something was going wrong."

Their own doctor obtained the results of the re-done blood test from Toronto and telephoned to say that the blood levels had doubled, a good sign.

"After six hours, we walked out. We figured it couldn't be ectopic. They wouldn't be ignoring me if it were ectopic." An ectopic pregnancy is one which lodges within a fallopian tube instead of continuing down into the uterus and implanting. Its major symptom is severe abdominal pain as the growing embryo ruptures the tube. Since Shirley had already had two ultrasounds, it seemed a foregone conclusion that her pregnancy was not ectopic.

"They said that there were two other ladies that were being seen and they were bleeding, so you take low priority because you're not bleeding. And they came and checked to see that I wasn't bleeding."

Shirley went home, doubled over with pain. Despite a continued rise in hormone levels and despite the progesterone shots, she started to bleed. Another ultrasound showed that the lower section of her uterus had elongated and the pregnancy was being pushed down, but no one could figure out why. A week later, still bleeding, still in pain, she had yet another ultrasound. This time, their doctor confirmed a missed abortion and said he would do another vacuum suction. Against her judgement, remembering the pain of the other suction, Shirley agreed.

"I went through the procedure without painkillers. Again. Your mind just sort of blocks it out. I was more or less thinking--it seems crazy--but if I shout out, people in the waiting room are going to hear me. I let out one yell. And I apologized for that yell." She is angry at herself, but she laughs. "For the first suction, I was coached on how to breathe through it, the same sort of breathing that you use for labour. I thought, at least I'll have practice. When the day comes, I'll know how to breathe."

Shirley went home and she and Dave tried to forget. Oddly enough, her last blood test before the miscarriage showed her blood levels still going up, but it didn't seem important at the time. Normally after a miscarriage or childbirth, hormone levels drop sharply.

Despite the setback, they were still hopeful and felt they wanted to continue to try for a pregnancy. Three weeks passed. In February, 1987, Shirley saw a gastroenterologist for the chronic flu and diarrhea she'd had for weeks. Before she could begin any tests, she started to feel more abdominal pain. After a sleepless night, she called her infertility doctor, who told her to go to the hospital for tests. He asked if she had gone in for her blood test that week and Shirley said he hadn't asked her to.

"That would have clinched it. Within an hour of having the test done at the General Hospital, they knew I was still pregnant."

What had happened to Shirley was a one in 33,000 chance of having both a uterine and an ectopic pregnancy--at the same time. The vacuum suction had removed only the fetus in the uterus. The elongating of the uterus shown on the ultrasound that no one could understand was caused by the pressure of the ectopic pregnancy. The diarrhea and flu-like symptoms are also symptoms of ectopic pregnancy.

"It was a shock. I was scared, I was really scared, because I didn't know what was going on. I knew I was getting very, very weak and very sick. I couldn't take the pain any more."

Because Shirley was admitted to the hospital on the weekend, an ultrasound wasn't scheduled until the following Monday. She wasn't given any painkillers, she was told, because she was pregnant.

When she finally had the ultrasound, Shirley hadn't slept in three days. No one would tell her what the ultrasound showed.

"It was very upsetting. I had reached my emotional limit... I was a total wreck. There are no words to describe how bad I was."

Five hours later, she was told that she had to have emergency surgery. A team of specialists would be there. One would do a laparoscopy, an exploratory procedure that basically allows a doctor to see what is happening in the abdomen. A second would do the dilatation and curettage to clean out the uterus. The third doctor was a cancer specialist who would be there in case he was needed.

In fact, the doctors still didn't know what they were dealing with. They could see a mass, but the bleeding and infection were so widespread that they didn't know what they were going to find.

Shirley woke up to find they had removed her left fallopian tube and the ectopic pregnancy that had ruptured it.

"I was just glad to be alive and out of pain. It didn't really hit me until four days after the surgery. I had a bad time, thinking that my chances of having children were somewhere close to nil. I spent a very emotional night thinking and being very angry that this had happened to me.

"The hard part was being up on the maternity ward..."

As soon as Shirley got out of hospital, Dave hid all her books and every scrap of information they had in the house on infertility. This time, they didn't want infertility to be a part of their lives.

It stayed that way while Shirley recovered. It took several months, during which time she was back in the hospital with an infection and still had to battle the colitis she had been plagued with all winter. In April, 1987, Shirley had a long talk with Mary, a fellow member of the Infertility Self-Help Support Group in Ottawa. Mary had had an ectopic pregnancy and had two successful pregnancies after that. Shirley met her for coffee and to

question her. Why had Mary gone back on Clomid after all she'd been through?

"She really didn't have an answer, except that she tends to think that the human mind blocks out the bad experiences. If you really have determination, you can forget about a lot of it. It's almost like brainwashing yourself.

"At first I didn't believe her. But once you get well, then you think maybe there's a chance again. Maybe you can get pregnant again. And there will always be that question in my mind: Can I get pregnant? Until I find some reason why I cannot get pregnant or I should not get pregnant... It won't come down to a life or death situation again."

There are, not for the first time on this summer evening, tears in Shirley's eyes. She sounds weary, but matter of fact.

"I just want to be a mother."

CHAPTER 2

INTRODUCTION:

CONCEPTION IN A NEW AGE AND NEW AGE CONCEPTION

Most of us never question our fertility. In fact, we spend a lot of time as young adults desperately avoiding conception.

But Shirley is one of about 8,000 women in Ottawa¹ who are unable to have children. With one in six couples of childbearing age, or 15 per cent of couples, having similar difficulties², it is estimated that a staggering one million Canadians and 10 million Americans are infertile.³

Infertility is the inability of a couple to conceive and carry a conception to a viable state.⁴ A couple is considered to be infertile if the woman is not pregnant after one year of regular intercourse without contraception.⁵

The public's knowledge of infertility is limited to individual cases that have caught the interest of the media, like the birth of the first "test-

¹Statistics Canada, 1981 figure. This represents 10 per cent of the married women of childbearing age in Ottawa-Carleton.

²Barbara Eck Menning, Infertility: A Guide for the Childless Couple (New Jersey: Prentice-Hall, 1977), p. 4; John J. Stangel, Fertility and Conception: An Essential Guide for Childless Couples (New York: New American Library, 1980), p. 11.

³Stephen Corson, Conquering Infertility (Norwalk, Conn.: Appleton-Century-Crofts, 1983) p.1.

⁴Dr. Norman Barwin, Infertility, pamphlet, (Ottawa, undated) p. 1

⁵Menning, p. 4.

tube" baby in 1978 or the court case in Spring 1987 to decide who would be the guardian of a baby ("Baby M") born to a surrogate mother.

The knowledge of those confronted with a fertility problem is no better. They are no better equipped than other members of the public to understand the vagaries of the body.

This lack of information and awareness should be puzzling when the sheer numbers of those affected are considered. But the words "sterile" and "barren" have stigmatized people for generations and infertility is not a subject for discussion on the party circuit.

There are myths and misconceptions concerning infertility that are behind these words. Infertility, it is said, is the woman's fault. It's a psychological problem--or a sexual disorder. Or it's plain irresponsible to work at having children⁶ when the world's population is five billion and counting.⁷

All this is changing. The Baby M case might give the public a lopsided view of what infertility is all about, but the seed of awareness is growing.

Just in time, judging by the increasing difficulties faced by couples interested in taking the plunge into parenthood. In 1965, the rate of infertility was six per cent. Today, it is commonly believed to be 15 per cent.⁸ If unmarried women were included in the statistics or those women

⁶Menning, p. 5.

⁷The Ottawa Citizen, "...And baby makes five billion," July 13, 1987

⁸Dr. Norman Barwin, gynecologist, interview in Ottawa, June 5, 1987; Lori B. Andrews, New Conceptions: A Consumer's Guide to the Newest Fertility Treatments (New York: St. Martin's Press, 1984), p. 2.

who don't know they are infertile because they've never tried to conceive, the figure might even be higher.⁹

Because of the lack of statistics on infertility, comparisons of rates of infertility are difficult. Some statisticians and sociologists contend that the rate per se is rising only marginally. But everyone agrees that the awareness of the problem continues to multiply, putting increased demand on infertility services.¹⁰

The reasons for the increase in awareness, if not the increase in infertility itself, are many and varied. The odd thing is that the new reasons for infertility--chemicals, air pollution, lifestyle--are inexorably linked: "The bulk of them have this in common: an advance in some other area of our lives or society has hampered fertility. Changes occurred and nobody asked about their effect on fertility."¹¹ Something as simple as a drug to ease ulcer pain or lower blood pressure can make the difference between conceiving and remaining childless.

One important factor that does affect the rising rate of infertility directly is age. Women are delaying marriage and childbearing until after their careers are established. Because fertility declines with age, and quite dramatically after age 35,¹² these women risk not being able to conceive when they are ready to parent. The number of women in their early 30s

⁹Rona Achilles, "New Age Procreation", Healthsharing, 6 (September 1985) : 13.

¹⁰Sevgi O. Aral and Willard Cates, Jr., "The Increasing Concern with Infertility: Why Now?", JAMA (Journal of the American Medical Association), 250 (Nov. 4, 1983) : 2328.

¹¹Andrews, p. 19.

¹²Jane Menken, James Trussell and Ulla Larsen, "Age and Infertility", Science, 233 (Sept. 26, 1986) : 1389.

having their first child tripled between 1970 and 1982,¹³ while peak fertility for men and women occurs between the ages of 20 and 25.¹⁴

The social revolution that began in the 1960s has meant a very different kind of life for many women. The new career-consciousness means later childbearing or, at least, later attempts to bear children. Late childbearing in itself is risky due to lowered fertility rates and higher incidences of fetal abnormalities, but a condition called endometriosis is also playing havoc with a woman's reproductive system as she ages.

Not all women get endometriosis, the career-woman's disease, as it is called, but those who do find the symptoms begin just as they turn from their established careers to begin childbearing. With endometriosis, small pieces of the lining of the uterus implant in different parts of the reproductive system. Painful menstrual periods and intercourse are two of the symptoms of the disease, which increases in intensity over time. Some women never experience any symptoms, but even mild cases impair fertility. Ironically, pregnancy is one of the few cures for endometriosis.

At the age of maximum fertility between 20 and 25, a couple has a one in four chance of conceiving in any menstrual cycle. By the time the same man and woman have turned 40, they have only an eight per cent chance of conceiving in one cycle¹⁵

With their fertility declining with every year they delay childbearing, this is unpleasant enough news for couples. But few infertile couples are made aware of the statistics early enough to take evasive

¹³Omni, December 1985, p. 94.

¹⁴Sherman Silber, How to get Pregnant (New York: Warner Books, 1980) p. 60.

¹⁵*Ibid.*

action. And other elements come in to play that have a serious effect on fertility totally apart from age.

One element is the force of numbers, as the baby-boom generation enters into the childbearing years. Although the boom began directly after World War II, the largest number of births actually occurred between 1956 and 1961.¹⁶ This would put the largest number of North American women ever currently in their reproductive-conscious years (the late 20s and early 30s). Thus, a larger number of couples are discovering their infertility as they turn to childbearing.

Fertility control is another element. Birth control methods to control fertility are highly effective. One consequence of being able to "turn off" fertility is a belief that it can also be turned on at will. When it can't, that is, when a child is not conceived when conception is intended, couples are more likely to believe something is wrong and seek help.¹⁷

Some contraceptives have been blamed for causing conditions that make women infertile. The intrauterine device (IUD) was thought to be the answer to the sexual permissiveness of the '60s and '70s. But women becoming pregnant after using an IUD increase their chances that the pregnancy is ectopic, lodged in a fallopian tube instead of the uterus. This is a serious condition that can result in maternal death if the pregnancy is not detected and the embryo removed early enough. Loss of a tube is the end result of an ectopic pregnancy--and with it, half a woman's chances of conceiving.

In addition, IUDs have been linked to pelvic inflammatory disease (PID), infections that are more prevalent with IUD use because the IUD

¹⁶Aral and Cates, p. 2329.

¹⁷Menken, Trussell and Larsen, p. 1393.

works by irritating the lining of the uterus. PID leaves adhesions on the ovaries and blocks fallopian tubes.

Statistics on IUD use and infertility are chilling. Women using IUDs are 70 per cent more likely to develop severe PID than women using other contraceptives.¹⁸ Each additional bout with PID poses an increased risk of infertility, rising to 90 per cent after the third time.¹⁹

The oral contraceptive pill is another contraceptive that freed women to participate in the sexual revolution. Again, the news after a generation of widespread use is depressing. In addition to a legion of other major health threats, prolonged use of the pill can inhibit ovulation and menstruation in women.²⁰ This is called post-pill syndrome.²¹ Although 95 to 98 per cent of women will resume ovulating and menstruating within one year, that year can seem endless if a woman's biological clock is ticking.²² Also, after one year 20 per cent of former pill users do not conceive,²³ compared to from six to 15 per cent of the rest of the female population.²⁴

More sexual activity beginning at a younger age also takes its toll. Two out of three single American women are sexually active by the age of

¹⁸Andrews, p. 26.

¹⁹Murray Thorpe, "Infertility and Reproductive Technologies", unpublished paper, Department of Psychology, Carleton University, Ottawa, 1986, p. 4.

²⁰Aral and Cates, p. 2329.

²¹Menning, p. 27.

²²Sherman J. Silber, How to get Pregnant (New York: Scribners, 1980), p. 214.

²³Karol White, What to do when you think you can't have a Baby (New York: Holt, Rinehart and Winston, 1981), p. 9.

²⁴Pfeffer and Woollett, p. 26; Lynda Rutledge Stephenson, Give us a Child: Coping with the Personal Crisis of Infertility (San Francisco: Harper and Row, 1987), p. 80.

19.²⁵ A recent survey in an Ottawa high school indicates that 52 per cent of young men and women are sexually active at the age of 16.²⁶ The risk of sexually transmitted diseases (STDs) like gonorrhea and syphilis increases with sexual activity. These diseases often have no overt symptoms in women. Women do not know they have become infected, they do not seek treatment, the diseases scar their fallopian tubes--and they become infertile.

Contraceptive successes as well as failures can affect fertility. Voluntary sterilizations, like vasectomies and tubal ligations, are widespread as the ultimate method of birth control. Millions of North American men and women have been sterilized successfully by these methods. One per cent of them, however, change their minds and want the operation reversed.²⁷ They, too, may join the ranks of the infertile.

Contraceptive failure which ends in abortion can affect fertility. Although legalized abortions mean sanitary conditions for the procedure, infections still occur which can disrupt or end a woman's reproductive capacity.

The list of actual and suspected hazards goes on and on.

Chemical pollutants are thought to be the cause of a dramatic decrease in average sperm count in men--a 30 per cent drop over 30 years.²⁸ Workplace hazards such as lead, pesticides, solvents, mercury and radioactive materials can be responsible for low sperm counts and irregular menstruation. Even stress, a psychological hazard of the workplace, can throw off ovulation.

²⁵Andrews, p. 29.

²⁶CBC Radio, "CBO Morning", June 4, 1987.

²⁷Andrews, p. 29.

²⁸Thorpe, p. 4.

One of the ironies of infertility is that it can be medically induced, or "iatrogenic". The most well-known of these medically-caused conditions is a legacy from the 1950s. Millions of pregnant women were routinely prescribed diethylstilbestrol (DES) to prevent miscarriage. Although there were no visible or immediate problems with the drug, a significant number of the daughters and sons of the women who took DES have genital abnormalities that render them infertile.²⁹

There are suspicions that misuse of drugs and alcohol has impaired fertility. Diet and lifestyle are now considered part of the problem. W. Gifford-Jones, M.D. recently reported in his Globe and Mail column³⁰ that prolonged bicycle riding by men can inhibit sperm production.

That's the medical side of the problem, the cold, hard facts that leave couples wondering: "Where do we go for help? How do we get a baby?"

It isn't that easy. Of all couples who walk through the doors of an infertility clinic, fewer than half will get the baby they so desperately want.³¹ Regardless of the type of infertility problem, regardless of the hype surrounding new reproductive technologies, regardless of the quality of the clinic, this is the commonly-acknowledged success rate

It's not a simple matter of pinpointing the problem and applying the correct solution. The fact is that one in two people will not be helped, with or without the much-vaunted reproductive technologies.

The new technologies challenge our perceptions of conception and parenthood, but they offer little real hope for infertile couples. Very few

²⁹ Andrews, p. 23.

³⁰ W. Gifford-Jones, M.D., "The Doctor Game", The Globe and Mail, May 12, 1987, p. 2.

³¹ Menning, p. xii and p. 5.

are eligible for such intriguing processes as in vitro fertilization, artificial insemination by donor, egg transfers, artificial embryonation and surrogate motherhood. Despite the excitement and wonder of reproductive technology, even the clinic which claims the highest success rate with the in vitro process, the Eastern Virginia Medical School in Norfolk, Virginia, reports a success rate of only 23 per cent.³² In Canada, Toronto East General Hospital has the highest success rate--and it is only 20 per cent.³³ As we will see, even these low rates are disputed by those who believe the actual rate to be far lower.

Even if the success rates were not so low, for some couples the cost of reproductive technology is prohibitive. Until recently, OHIP did not cover in vitro costs, which run \$1,200 for each fertilization treatment and \$600 for drugs.³⁴ There is also the cost involved in leaving one's work for weeks at a time, often to travel to a clinic in another city.

In addition, the new technologies with their bypassing of the traditional prerequisites of conception--a man, a woman and sexual intercourse--have raised ethical, moral and legal considerations that are not lessened by the comparatively small number of successes that result.

Adoption, once accepted as the usual solution to the problem of infertility, is no longer the ticket to parenthood it once was. Increased access to abortions and better social services for single mothers keeping their babies mean fewer babies are available for adoption. If couples are willing to parent an older child, or one that is disabled or non-white, the

³²Sandra Levine Slover, infertility counselor, Ottawa General Hospital, interview in Ottawa, May 28, 1987; More recently doctors at the clinic claim a success rate of 31 per cent, although the figure is not adjusted to include the high rate of miscarriage. Life, June 1987, p. 25

³³Barwin interview, June 5, 1987

³⁴The Ottawa Citizen, June 11, 1987, p. 2.

chances increase--but the figures are still low. One U.S. private adoption agency estimates that three million couples are looking to adopt and only 50,000 healthy white infants are available.³⁵ In Canada, it is not unusual to wait four years or more before receiving a child through the Children's Aid Society.³⁶

For the baby-boom generation raised to expect instant gratification, this is a serious setback to the perceived right to personally choose and control one's life. So much of life in the '80s is available on demand, from manipulation of weather patterns to instant take-out gourmet dinners. The advances in medicine are a particular and tangible source of pride. We are confident that cures have been either discovered--vaccine for polio or artificial heart transplants--or will soon be found--a cure for AIDS or cancer--for the diseases that plague us. Reproductive control, in particular, is a symbol of how far we have come both medically and socially in the relatively short post-World War II period.

Infertility strikes at the heart of how we see ourselves and the world around us. Suddenly infertile couples find they are unable to control this most basic part of life. Sandra Levine Slover, an infertility counselor at the Ottawa General Hospital, explains:

This particular generation, the Yuppie generation, they've had so much control over their lives that if they have control over their reproduction, that's the biggie. They've had control over their education and their careers and their major purchases and whatever and everything has been by design. Then when they

³⁵Life, p. 25.

³⁶CBC "Sunday Morning", July 5, 1987. ("Hot in the Pursuit of Parenthood".)

want the perfect baby by design, that just doesn't happen and they are as angry as hell. I mean *angry*.³⁷

With the diagnosis of infertility, couples lose more than the right to choose when to reproduce. Infertility is one of life's major crises,³⁸ one which sends the infertile into a tailspin from which they sometimes do not recover, either individually or as a couple: "It shakes to the core our most basic concepts of sexuality, self-image, and self-esteem."³⁹

Women, in particular, have been socialized into seeing themselves primarily as mothers. The feminist movement freed them to believe they could have both career and family instead of one or the other. The idea of not having children at all is not a frequent theme in feminist writing.⁴⁰ It seems that women have progressed from having only their family role to having both career and family roles, but a childfree option is still suspect even for many feminists.

In these circumstances, women finding out they are infertile is like having the ground pulled out from underneath them. They are jolted from their comfortable, ever-so-normal lives and must question what most people take for granted--the ability to choose when to have children. The anger described by Slover is one of the many emotions that they and their partners must sift through before they resolve their infertility, either by conceiving, adopting or remaining childfree.

³⁷Slover interview, May 28, 1987.

³⁸Menning, p. xii; Slover interview, May 28; Naomi Pfeffer and Anne Woollett, The Experience of Infertility (London: Virago, 1983), p. 2

³⁹Menning, p. xii.

⁴⁰Martha E. Gimenez, "Feminism, Pronatalism, and Motherhood", International Journal of Women's Studies, 3 (1979): 224.

Before they reach a state of resolution, they must submit to medical tests and treatments that intrude on their bodies, their relationship and the way they structure their lives. It is a journey that takes years and, although the destination is clear, it is not certain if they will ever arrive where they want to go.

Infertility is not a simple medical diagnosis. Infertile couples are under seige socially and emotionally as they go through the testing and treatment known as the "infertility work-up". They must question as never before in their lives how they, as infertile people, fit into a pronatalist society, that is, a society where motherhood is seen as a woman's major role in life.

Infertility is a life crisis that cannot be summed up medically, a rising social problem whose high-tech solutions bring ever more social questions, above all, heartbreak for thousands of couples who once took having children for granted.

The pursuit of parenthood, when one has to work at it, is arduous. The medical intrusiveness of the infertility work-up soon destroys a couple's physical relationship. "Making love" goes by the boards and "making babies" is tackled scientifically. Much of the work-up takes place on specific days of a woman's cycle, so there is always an awareness of the problem at the back of the mind. (Ask any woman where she is in her cycle. Unless she is having her period, she likely will have only a vague idea. Ask an infertile woman--she'll be able to tell you the exact day.)

It can become a narrowing, inward-looking experience. Life is on hiatus, planning is at a standstill until the great event happens. Infertility tends to block out the world, to individualize its prisoners by forcing them

to constantly think of themselves and their bodies which are not doing their jobs.

Much of the literature on infertility inadvertently reinforces those feelings by concentrating on individual solutions. One handbook on infertility is called How to get Pregnant.⁴¹ another, billed as "a consumer's guide", claims it can show "how to pick the right technology for you".⁴²

But it gets lonely when there are just two people sharing a world where they define themselves solely by their childlessness. Naomi Pfeffer and Anne Woollett, the authors of The Experience of Infertility who have first-hand knowledge of the subject, remember how it felt: "One of the things we shared was a sense of isolation, the feeling that we alone were having this experience."⁴³

Barbara Eck Menning agrees. Menning is the founder of the American-based counseling and referral service for the infertile called Resolve: "One of the most common feelings of the infertile couple is the isolation of 'being all alone'. I felt the same way myself when I was going through the worst of my problems...[Menning is infertile herself.] I longed to confirm my feelings with other infertile people."⁴⁴

Sandra Levine Slover says the patients she counsels feel a great sense of relief when they discover that she, too, was infertile: "They say to me, You know, Sandra, the doctors don't understand, the nurses don't understand, *you understand*".⁴⁵

⁴¹Sherman S. Silber, How to get Pregnant (Scribner's: New York, 1980).

⁴²Lori C. Andrews, New Conceptions: A Consumer's Guide to the Newest Infertility Treatments (St. Martin's Press: New York, 1984), p. xviii.

⁴³Pfeffer and Woollett, p. 1.

⁴⁴Menning, p. xii.

⁴⁵Slover interview, May 28, 1987

Pfeffer and Woollett, Menning and Slover realized that sharing the experience of infertility relieved much of the anxiety and burden. They successfully took infertility out of the realm of individual experience, out of that narrow world shared only by the couple, and broadened it.

In linking their own experiences with that of others, they were able to create for themselves and, not incidentally, for others a reassuring whole that is more than the sum total of its parts. Pfeffer and Woollett's book, for instance, is a sensitive and unusual look at infertility from a feminist point of view. Menning's Resolve has 40 affiliated chapters across the United States. Slover is a full-time infertility counselor in Ottawa. In effect, they "collectivized" their experience.

The Infertility Self-Help Support Group in Ottawa started in 1983 to give infertile men and women the same opportunity to share their experiences. One of the founding coordinators, Marie Morrissey, explained in its first newsletter why the group exists:

[It] was established with one goal in mind--to reach out to other infertile individuals and help them through the hurt, the pain, and the soul searching that infertility engenders. By meeting and sharing with others, infertile couples find comfort and feel less alone. Personal insight and the support of peers, we hope, will enable them to focus their energies on moving forward with life.⁴⁶

"Collectivizing" through sharing the experience of infertility is one of the goals of this work. The other is "contextualizing" the experience

One of the tragedies of infertility is the effect it has on self-esteem and self-image. Where before, a personality, a lifestyle or a relationship

⁴⁶Marie Morrissey, "Emotional Support through the I S H S G , Infertility Self-Help Support Group, 1 (June 1985) 1.

would have remained comparatively unquestioned, all are suspect under the burden of infertility. Infertility is equated with failure. Why would the fertile partner want to stay in such a relationship? What could the infertile partner have done wrong, how could she or he have been a better person and avoided this stigma?

The questions inevitably lead into the past, with their anguish that past transgressions could have caused the infertility--be they promiscuity or use of the wrong contraceptive. The questions turn also to their upbringing and education, which always carried the assumption that they would one day be parents.

As the time of their treatment for infertility lengthens, they begin to question the future. If treatment is not successful, can they imagine a childfree life? Will they attempt one of the new reproductive technologies?

Once they begin to ask these questions, they are implicitly recognizing that infertility, like life itself, does not exist in a void, but is part of a structured past and a future. Infertility, they find, is socially-situated and they must understand what lies around it before they understand the experience of infertility itself.

In "collectivizing" and "contextualizing" their experience, it is hoped that they will be better able to cope with the medical, social and emotional aspects of infertility and reach that elusive stage of resolution.

In the next chapter, a short history of reproduction puts infertility into the context of the changing social and economic situations of the times in which birth control was developed and practised.

The pre-eminence of motherhood, woman's central function both socially and culturally, is the thread which runs through a history of

reproduction. Birth control is the sphere of woman; the onus for providing the accepted number of children falls on her.

When this breaks down, as when infertility changes the commonly-accepted prescription for having children, it is the woman who bears the burden. Common mythology faults a woman for her barrenness, in the form of warnings that she "will be saved through bearing children" in The Bible, in the reverence for fertility in ancient Rome and Greece and in Sigmund Freud's teaching that she is only fulfilled through childbearing.⁴⁷

This is despite the fact that men and woman share the "fault" for infertility equally. Reports vary, but it is commonly accepted that in 40 per cent of infertility cases, the problem lies with the man. In a further 40 per cent of cases, the problem is with the woman. In the remaining 20 per cent of cases, the problem is either unknown or both the man and woman share a problem.⁴⁸

But socially and culturally, the woman is identified as being at fault. In addition, once infertility has been diagnosed, most of the tests and treatments centre on the woman, who has a more complex (more can go wrong) and more treatable reproductive anatomy

Woman thus emerges as the more visible category in the process. This will become evident in the next chapters, as the focus becomes centered on the woman, rather than on the couple, facing infertility. In the chapter on the medical management of infertility (Chapter 4), for instance, most of the treatments centre on the woman. The same is true for

⁴⁷Menning, pp. 87 - 94.

⁴⁸See Figure 1 in Chapter 4; Menning, p. 5; Stangel, p. 17; Pletter and Woollett, p. 29; Dr. Peter Garner, Infertility and Reproductive Endocrinology Clinic, Ottawa Civic Hospital, conversation in Ottawa, April 7, 1987.

reproductive technologies (Chapter 6). In the chapter on the emotional aspects of infertility (Chapter 5), it becomes clear that the woman is more adversely affected than the man because of social expectations and socialization.

The last step for those confronted with an infertility problem, as discussed in Chapter 7, is resolving it. This resolution is very personal; each must write his or her own "success story", depending on what ending he or she chooses for the story. But infertility must also be resolved on the social stage. That stage is far from stable. The growing awareness of infertility, the mushrooming of clinics across North America and the almost daily pronouncements of new breakthroughs in reproductive technologies challenge our traditional understanding of how a family is created. In the end, infertile couples risk being forgotten as technology, rather than the family, takes over reproduction.

CHAPTER 3

WHY MOTHERHOOD?

REPRODUCTION AND THE MEANING OF CHOICE

I was born of a generation who are doing such liberal things as choosing to cohabit instead of marry, choosing to form open marriages and choosing not to have children at all. The key word here is CHOICE. I had *chosen* to marry; I had *chosen* a traditional relationship, and I had *chosen* to have children. Infertility robbed me of my right to choose to have my own genetic children.¹

Infertility is really about choice and the lack of choice.

Most people get to choose how they will structure their lives. The popular choice, the most-accepted choice, is to get an education, get a good job, marry and produce children.

Even when the pattern deviates--the order of career and marriage is reversed or a couple lives together before legal marriage--society has certain expectations that are commonly fulfilled by most people.

One is expected not only to marry, but also to follow certain other guidelines afterward. A steady job is prerequisite to social respect, material acquisitions are an announcement of normality, as are certain lifestyle hallmarks: the station wagon and the house in the suburbs, the two-week vacation in the camper with the children, membership in the PTA and token appearances at church on Christmas and Easter and more.²

¹ Menning, p. xi

² Ellen Peck and Judith Senderowitz, Pronatalism: The Myth of Mom and Apple Pie (New York: Thomas Crowell and Co., 1974), p. 5.

In the last couple of generations, the choices have widened considerably. Couples do choose, for example, not to have children. But it is not a popular choice and anyone choosing it should be prepared to defend it constantly.³

For most of us, choice in reproduction usually means choosing not to have children until we are ready. The feminist movement is responsible for our definition of the "right to choose" as the right to choose to control our fertility.⁴

The "our" here refers, of course, to women. Throughout history, reproduction has been the sphere of women--logically, since their bodies carry the capability of conception, pregnancy and birth within them.

But, until recently, women have not had the *choice* of using that capability, that is, they have not had the right and the control to make decisions on reproduction themselves.

"[R]eproduction generally, and fertility control in particular, must be understood as a historically-determined, socially-organized activity," writes political science professor Rosalind Petchesky in Abortion and Woman's Choice: The State, Sexuality and Reproductive Freedom. The relations that are encompassed in reproduction--which include economic and technical

³The American census of 1976 indicated that nearly three times as many (4.6 per cent) married women under 30 were expecting to remain childless as in 1964, when the figure was 1.7 per cent. Helen R. Kearney, "Feminist Challenges to the Social Structure and Sex Roles", Psychology of Women Quarterly, 4 (Fall 1979): 23.

⁴Barbara Katz Rothman, The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood (New York: Penguin, 1986), p. 12

conditions and social and sexual relations--are "dynamic and historically changing," she says.⁵

How woman's awareness of reproduction develops depends very much on these dynamic and changing conditions. The woman of 100 years ago making reproductive choices is very different and is making very different decisions than the woman of 50 years ago or the woman of today--inevitably so, because society has changed so much.

Warren Miller, an American researcher on issues of population, says that human reproduction has been characterized historically by the increasing importance of individual choice.

In his article, "Chance, Choice and the Future of Reproduction", he discusses what he sees as the most important trend in human reproduction, "the progressive dominance of choice over chance".⁶

Chance figures highly in the reproduction of other species. Miller uses as an example the oyster, which releases millions of sperm into ocean water and depends on chance union with an egg for successful reproduction.

In higher animals, different mechanisms are used to take away the dependence on chance. Mutual attraction, for instance, of male and female animals leads to sexual behaviour:

The mechanisms that bring this chain of events about are powerful and complex. They include anatomical, physiological, behavioral, and social factors. Especially in the higher vertebrates, all four of these

⁵Rosalind Pollack Petchesky, Abortion and Woman's Choice: The State, Sexuality and Reproductive Freedom (New York and London: Longman, 1981), p. ix.

⁶Warren Miller, "Chance, Choice and the Future of Reproduction", American Psychologist, November 1983, p. 1198.

factors are woven together in an intricate sequence that acts to overcome chance.⁷

Another adaptive mechanism emerged in the evolution from apes to humans:

[W]hat emerged in humans ultimately represented a qualitative leap to a new level of evolution, one in which the original organism, and the local group of which it was a member, no longer simply adapted passively to the environment, but rather began to actively control and regulate that environment to satisfy its own needs.⁸

As evolution proceeded, so progressed basic adaptive strategy--living in groups and the use of tools and language. Increased brain development improved memory, learning and decision-making skills. At this stage, it became understood that there was a direct causal relationship between sexual activity and childbearing.

The importance of this development to an understanding of the history of reproduction is that childbearing could now be regulated by individual choice and by social custom. Social custom--living arrangements, opportunities for intercourse, marital status--regulated sexual activity, which, in turn, regulated reproduction.

According to Miller and other theorists on population control,⁹ this began to change at the time of the industrial revolution. People relied less

⁷Ibid., p. 1199.

⁸Ibid.

⁹Linda Gordon, Woman's Body, Woman's Right: A Social History of Birth Control in America (New York: Grossman Publishers), 1976); Thomas M. Shapiro, Population Control Politics (Philadelphia: Temple University Press, 1985)

heavily on social custom for guidance and more on the new concept of individualism:

Initially, this affected reproduction primarily as a result of individuals' exerting greater choice over spouse selection and the timing of marriage. Gradually, however, individual choice began to exert itself in the area of conception control as the application of human rationality and technology was turned increasingly to the development of ways to enjoy sex without incurring a major risk of conception.¹⁰

Self-regulation of reproduction became the norm in the early 20th century. Today, individual choice, not chance "modulated by biological imperatives and social customs, serves as the primary regulator of reproduction".¹¹

Individual choice--the major tenet of reproductive control--is examined and discarded by infertile women because it is to them so patently false. They have no choice in the matter. Their inability to conceive, to choose to have children, automatically cancels out any perceived "individual choice". They have no right to control their bodies, yet they are faced with a society that has made personal choice in all aspects of life part of a daily way of operating.

At the same time, the struggle for reproductive control for women is ongoing and cannot be ignored because one is infertile: "The struggle for reproductive self-determination is one of the oldest projects of humanity, one of our earliest collective attempts to alter the biological limits of our existence."¹² (The New Right, with its biological determinist ideas, has laid siege to the right to choose, but its appeal is limiting to infertile women who

¹⁰Miller, p. 1199.

¹¹Ibid., p. 1200.

¹²Gordon, p. 403.

do not seek to curtail the rights of other women while trying to expand their own range of options.)

Infertile women find it difficult to relate to the concept of individual choice. On the other hand, they sanction in large numbers¹³ the new reproductive technologies, which have developed from individual choice.

The belief is that reproductive technology gives them more options, that it increases their right to choose. What this belief does, in effect, is encapsulate how the meaning of choice has changed throughout the history of reproduction.

Choice during the time of the industrial revolution meant the individual could have the freedom to choose a marital partner or when marriage itself would take place.¹⁴ Control over conception gradually became part of this.

Choice after the industrial revolution was more complex. Industrialization quelled the need for large families that was so vital for economic survival in agrarian or pre-industrial societies. The look of the family changed as the smaller, "nuclear" family evolved (although that term is applied much later). Child labour laws meant children were now an economic drain, rather than a resource.¹⁵

Birth control, which can be called the first reproductive technology, became more important and was practised privately. Although couples were choosing to limit the number of children, they were still choosing

¹³Omni, pp. 94-97 passim.

¹⁴Miller, p. 1199.

¹⁵Elkie Newman, "Who Controls Birth Control?" in Smothered by Invention: Technology in Women's Lives, Wendy Faulkner, and Erik Arnold eds. (London and Sydney: Pluto Press, 1985).

parenthood. This choice started as an economic imperative and swiftly moved to become the social norm.

By the 1870s, the early American feminists were openly talking about birth control. Curiously, early statements on birth control were not about contraceptive devices. Rather, they concerned the right of a wife to refuse to have sex with her husband and therefore to practise "voluntary motherhood".¹⁶ By the turn of the century, feminists were saying that women had a right to choose when to be pregnant. It was clear, though, that they would become mothers at some point:

As voluntary motherhood was an ideology intended to encourage sexual purity, so it was also a pro-motherhood ideology. Far from debunking motherhood, the voluntary-motherhood advocates consistently continued the traditional Victorian mystification and sentimentalization of the mother.¹⁷

The right to choose at this time, then, was understood in a very limited sense. The goal was to make motherhood better, not replace it as woman's primary function.¹⁸

The different elements that made up the American birth control movement came together into one united movement around 1915, the peak of American radicalism. Although avoiding motherhood was still considered abnormal and unhealthy, birth control became widespread as post-World

¹⁶ At the time, women were legally bound to submit to sex with their husbands. Gordon, p. 103.

¹⁷ Ibid., p. 111.

¹⁸ Ibid., p. 130.

War I women tasted relative sexual freedom for the first time.¹⁹ It became widely understood that making reproductive choices with the aid of birth control would extend the limits of people's control over their lives.

The fledgling social movement concentrated its efforts on opening birth control clinics and lobbying for pro-birth control legislation. Birth control became less "revolutionary" and more "reformist" as it began to gain acceptance and it became a fashionable cause. The hard fought-for clinics lost their self-help feminist image and became more like charities run by professionals and the rich. The lobbying efforts, now backed by the professionals, lost their emphasis on women's rights, as birth control was presented as a question of public policy, rather than as a right.²⁰

It is at this point that the eugenicists moved in, with their view of women as breeders and their fear of "race suicide", the belief that "inferior" races were overpopulating the world.

Choice in the United States between the two world wars had a distinct bias based on class and race. The right to reproductive control, which once united feminists and radicals of all classes into a social movement, meant by the end of the 1930s that the well-to-do practised birth control privately while advocating that other populations--the working class and non-whites--had birth control solutions imposed on them as public policy (a clear contradiction in the right to choose).

(Although, in Canada, the birth control movement developed somewhat later than in the U.S.--legislation passed as late as 1892 made it

¹⁹Women born between 1890 and 1899, thus coming to adulthood around World War I, had double the rate of sex before marriage (26 per cent) than those born in the previous decade. The rate doubled again, to 49 per cent for those born between 1900 and 1909 and continued to increase at a slower rate after that. Ibid., p. 193.

²⁰Ibid., p. 290.

illegal to sell, advertise or have for disposal contraceptive devices--by the 1930s we had all but caught up. A sensational trial in 1936 acquitted a woman accused under the 1892 legislation because she proved her acts were "in the public good".²¹)

Even with the social sanctioning of birth control, very little individual choice lay in the hands of women. Even if it had, her role as reproducer was still paramount to woman:

Her destiny was still motherhood even if she were allowed more control over it. Most [women] still put severe restrictions on birth control--no unmarried women, or *women with no children* were to have it, and it was only permissible for women with children if health or economic reasons dictated a small family.²² (Italics mine.)

The lack of access of childless women to birth control is a reminder that it was at this time (the 1930s) that the birth control clinics began to offer infertility therapy to couples.²³

Revelations after World War II of how the Nazis had implemented eugenist policies weakened that aspect of the birth control movement, but was replaced by another eugenist theory called population control.

Population control was later popularized as the ZPG (Zero Population Growth) movement. At its beginning, it was a belief "that for the good of society, in light of overpopulation, certain groups (usually the least powerful

²¹it was not until 1969 that the criminal code was amended to remove any mention of birth control. Dianne Dodd, "Birth Control and the Politics of Reproduction", unpublished honours essay, Department of History, Carleton University, 1981, p. 6 and p. 115.

²²Ibid., p. 7.

²³Gordon, p. 339.

and poor) should reduce their birth rates".²⁴ An understanding of population control is important to a review of reproductive choice because it is one of the three schools of thought--the women's movement, eugenics and population control--that shapes birth control.²⁵

The family planning organization Planned Parenthood was the bridge between the old birth control movement and the new population control.

Planned Parenthood's acknowledged sphere of interest was stabilizing the family through control of reproduction. In its emphasis on *family* planning, it implied that a woman alone should not herself have control of reproduction: "Planned Parenthood took the family, not the woman within it as the unit for the application of reproductive control."²⁶ The emphasis on planning actually strengthened the population control and eugenicist slant to the movement.²⁷

A history of reproduction that emphasizes choice and lack of choice cannot leave out these more recent trends in birth control. The fact that population control advocacy included eugenicist elements is important to understanding the reproductive choices that women must make. As population theorist Thomas Shapiro points out,

use of contraceptive devices often varies according to class, gender, and race, indicating that broad social conditions, cultural traditions, and structural inequalities play a large part in shaping a woman's birth control experience. Middle-class women are encouraged to use methods, such as the diaphragm and the pill, that allow individual control. Poor women are encouraged to use methods, such as the

²⁴Shapiro, p. 9

²⁵Ibid., p. 12.

²⁶Gordon, p. 341.

²⁷Ibid., p. 348

intrauterine device and sterilization, that are controlled by physicians.²⁸

The point is that choice, and the lack of choice, is only relative. Why, for instance, are most sterilizations--one of the most permanent forms of birth control--performed on poor women?²⁹ What kind of individual choice does a woman with such a profile really have in making this important reproductive decision?

When we come to a discussion of reproductive technology and the social aspects of infertility, it will be significant that middle-class women are the women most likely to attend infertility clinics. Their background, their reproductive histories, have led them to believe they can make an individual reproductive choice. When that choice is denied middle-class women through a diagnosis of infertility, they, unlike poor women, turn to whatever means will return that individual choice to them.

Once individual choice became incorporated into the value system during and after the industrial revolution, birth control developed according to the social and economic concerns appropriate to the times.

The common thread throughout the history of birth control is two-fold.

First, the choice for eventual motherhood was taken for granted. Whether it is in the voluntary motherhood stage, the heyday of the birth control movement or the planned parenting era, motherhood was considered

²⁸Shapiro, p. 9.

²⁹Socioeconomic status is the major determinant in sterilization, although there is also a larger number of black and minority women than white women who have been sterilized. Women of all races whose incomes are below the poverty line are 50 per cent more likely to be sterilized than those above that level. Shapiro, p. 99.

sacred and noble and, above all, woman's biological destiny. Reproductive choice might delay or space that process, but it was presumed that motherhood would eventually occur.

Second, the meaning of choice at every stage is narrowly defined. The brief history of reproduction above gives an idea of how limiting definitions of reproductive choice were--from the first statements on birth control that really weren't, practically speaking, about birth control at all to population control advocacy which, in effect, removed choice from those who might abuse it--particularly the poor and the developing nations already perceived to be overpopulated. Reproductive choice until the 1960s was concerned above all with quantity, that is, the self-imposed limitation of fertility. In the last 20 years, technological advances in reproductive technology have made quality, not quantity, the focus of reproductive choice.

These two threads--motherhood and the changing meaning of choice--flow through the the history of reproduction and are the major issues of discussion for women facing reproductive choices today. Infertile women in particular are forced to reevaluate reproductive decisions which others might consider "natural".

The questions infertile women ask themselves begin with questioning their desire for motherhood--the hitherto unquestionable! Once the first question--why motherhood?--is asked, a veritable floodgate is opened: Why not forget motherhood--and why does that feel so strange? If not motherhood, then what? The questions penetrate to the roots of their self-identity.

The questions end in the world of reproductive technology, which changes the limits of their reproductive options, but, as we shall find, may not expand their choices.

2

MicroD

I don't know why we do it. It's just a compelling force.
I just want to be a mother.

When Shirley says she doesn't understand why she wants to be a mother, she is not alone. Very few women question what is still to most people a "natural" function--reproductive labour or, more colloquially, having children.

Rosalind Petchesky writes that material conditions and social relations both contribute to a woman's decision to have children:

A woman does not simply "get pregnant" and "give birth" like the flowing of tides and seasons. She does so under the constraint of *material conditions* that set limits on "natural" reproductive processes--for example, existing birth control methods and technology and access to them; class divisions and the distribution/financing of health care; nutrition; employment, particularly of women; and the state of the economy generally. And she does so within a specific network of *social relations* and social arrangements involving herself, her sexual partner(s), her children and kin, neighbors, doctors, family planners, birth control providers and manufacturers, employers, the church and the state ³⁰

But this doesn't change the fact that women's choice to have children takes place within a framework that has always included reproduction and motherhood as their biological destiny. The history of reproduction above, with its assumption of eventual motherhood, shows us that all too clearly.

³⁰Petchesky, p. 9.

Is it natural for women to want children? Is motherhood "a biological 'urge'"--or "a social response"?³¹ Betty Rollin writes:

"Motherhood--instinctive?" shouts distinguished sociologist/author Dr. Jessie Barnard. "Biological destiny? Forget biology! If it were biology, people would die from not doing it."³²

Warren Miller says there is no reproductive drive as such in humans, only a sexual drive, and reproduction follows as a result of sexual behaviour. "Clearly the imprinting of newborn babies and the natural responsiveness of adults to infants have biological components. But these operate after the baby's arrival."³³ Rather, he says, human reproductive motivation "seems to spring from a very complex set of personal, family, and cultural experiences".³⁴

There is no denying the power of this motivation. The sheer fact that Shirley and other infertile women cannot understand why they go to such lengths to satisfy the motherhood urge shows us how powerful it is.

It is ideas about sex roles that lay the groundwork for the motherhood mystique. Girls are socialized from infancy into accepting motherhood as their primary role: "Through sex-role socialization, women as well as men develop expectations about what women can or cannot do, and expectations get built into the operating principles of society's institutions."³⁵

³¹Jalna Hanmer, "A Womb of One's Own" in Test-Tube Women: What Future for Motherhood?, Rita Arditti, Renate Duelli Klein and Shelley Minden, eds. (London: Pandora Press, 1984), p. 445.

³²Betty Rollin, "Motherhood: Need or Myth?" in Peck and Senderowitz, p. 147.

³³Miller, p. 1199.

³⁴Ibid., p. 1201.

³⁵Nancy Felipe Russo, "The Motherhood Mandate", Journal of Social Issues, 32 (1976): 145.

Young women are shaped through these expectations into mothers-in-waiting. Sex-typed personalities, lack of access to role models, sex-role socialization all serve to limit their options.³⁶ When a choice other than motherhood is exercised, such as career, it is in tandem with, not in exclusion of, motherhood.

But motherhood is not simply a sex role for women: "Motherhood is on a qualitatively different plane than other sex roles for women in our society. It is a mandate that pervades our social institutions as well as our psyches."³⁷ Just how pervasive can be illustrated by the National Organization for Women's Bill of Rights, which was adopted at its first national conference in 1967. Here was North America's largest feminist organization--and four of its eight priorities dealt explicitly and implicitly with childbearing issues. Even to feminists, motherhood was central to womanhood.³⁸

The power of motherhood can be recognized again in the New Right's attempts to remove reproductive choice from women. Its attempts to limit abortions, birth control and sex education, amongst other things, reveal the pronatalist underpinnings of our society.

And who can doubt that we live in a pronatalist society?

Pronatalism has been defined as:

any attitude or policy that is 'pro-birth', that encourages reproduction, that exalts the role of parenthood. ...A key element in pronatalist thought is the age-old idea that woman's role must involve

³⁶Ibid., p. 145-146.

³⁷Idem, "Overview: Sex Roles, Fertility and the Motherhood Mandate", Psychology of Women Quarterly, 4 (Fall 1979), 7.

³⁸Kearney, p. 19.

maternity--that woman's destiny and fulfillment are closely wedded to the natal or birth, experience."³⁹

The long quest for reproductive control itself speaks to the desire to improve family life: "Women have long sought control over their own reproduction as a means of protecting their health and the quality of their parenting."⁴⁰

Linda Gordon calls motherhood "a series of pronatalist cultural pressures" and explains why it is so desirable:

Childless women often feel like failures, whereas childless men are not likely to. Girls are socialized from their own infancies to anticipate motherhood. Women learn to like themselves in mothering roles, which allow them experiences of love and power not easily found in other situations. These maternal attitudes do not emanate merely from learned ideas and ideologies, but from a fundamental female character structure formed through earliest experiences and reinforced in daily life throughout youth and adulthood. Few women escape it entirely; few women can reject or change all of it once they reach adolescence.⁴¹

Infertile women not only do not escape it, but it becomes a central force in their lives, all the more necessary for not achieving it. They have no choice, really, than to have the pursuit of motherhood take over their lives because so much--self-identity, self-esteem, self-image--depends on it.

Barbara Carroll, a Peterborough woman who is infertile, has attempted to come to grips with the "why motherhood" dilemma:

³⁹Peck and Senderowitz, p. 1.

⁴⁰Ibid.

⁴¹Gordon, p. 403.

What I've been hearing recently is "it's conditioning" and in part it obviously is. But I think the idea of self-identity goes beyond that. If you say it's just conditioning, you're saying, o.k., you can change it. But I think it's more essential than that. If you look at it from the point of view of self-identity, it's that you can't change it easily, that you can't just decide that this is not working, therefore I'll take my conditioning and do something else.

Infertility is a threat to self-identity. The alternative is to say "I quit and I change". Self-identity in any situation is something we hold on to as hard as we can. There's a real reluctance to face that change.⁴²

In an article she wrote for the newsletter of the Infertility Self-Help Support Group, Carroll looks at how self-identity evolves:

From the time we are born our parents and others behave towards us as males or females. ...[A] large part of our identity stems from the fact that we are women. Threats to our womanhood are therefore important threats to our identity.

Challenges that attack the social aspects of being a woman may be very upsetting but they can usually be overcome without damaging the central notion of ourselves as women.

Threats to our identity as women that are biologically based tend to be more serious because they are non-negotiable. We have little control over them...

The ability to bear children is the most basic biological expression of our femaleness... For this reason we infertile women come face to face with the very cornerstone of a major portion of our self-identity. We see it threatened, we watch it crumble, we feel it shatter. We can no longer take for granted that we are truly women. We feel we have failed. And we cannot rationalize that failure away because we are at our core; there are no more powerful definitions of womanhood.⁴³

As Carroll says, "there are no more powerful definitions of womanhood."

⁴²Barbara Carroll, interview in Ottawa, June 7, 1987

⁴³Idem, "The Question", Infertility Self-Help Support Group, newsletter, 1 (1985): 2, p.1.

Pronatalism is limiting in terms of the options it offers to all women; it is also callous in regard to those women who, apart from their infertility, might otherwise have been happy to fulfill the expected role.

But choice, even when we are starting from a set of limited options, is no longer simple. The history of reproduction shows how choice within a limited framework changed in meaning over the past century, from vague to increasingly specific statements on bettering family life.

Early statements on individual reproductive choice really concerned what sociology professor Barbara Katz Rothman has called the oldest and most basic reproductive technology--quantity control: "Self-imposed limits on fertility, through contraception or abortion, are the sine qua non of the reproductive rights movement."⁴⁴

Quantity control is now old hat to modern society. We accept fertility limitation: spacing of children, a small family, waiting to begin a family. Socially, this has become the norm--the popular reproductive choice.

The technology of quality control, which is the next level of reproductive technology, changes the range of choices available. Technology is supposed to expand an infertile woman's options. But it is very possible that it is really narrowing them by taking away the choice to give up gracefully:

If there is always one more doctor to try, one more treatment around, then the social role of infertility will always be seen in some sense as chosen: they chose to give up. Did taking away the sense of inevitability of their infertility and substituting the 'choice' of giving up truly increase their choice and their control?⁴⁵

⁴⁴Rothman, p. 11.

⁴⁵Barbara Katz Rothman, "The Meanings of Choice in Reproductive Technology" in Arditti et al., p. 32.

An infertile woman will find it difficult to come to terms with her infertility if new technology means there is never any specific "end of the road", but always new choices to make.

The history of reproduction, views on motherhood and the changing meaning of choice all inform the choices an infertile woman makes as she and her partner proceed through the maze of infertility tests and treatments and the end of the road gets ever closer.

CHAPTER 4

MEDICALLY SPEAKING:

THE INFERTILITY WORK-UP

It takes two to make a baby. Unless you are infertile, in which case it takes three or four, or even more. After a couple has been trying for a few months or a year, or longer, to conceive on their own, slowly the realization comes that something is wrong. To fit into the commonly-used definition of the medical profession, they must wait at least one year before officially being declared infertile.

Some couples are willing to try for long periods of time to conceive without medical help--as long as three or five years in some cases--but most become frustrated after about six months.

Doctors at one time might have treated the more impatient couples with kind words of advice and sent them home to wait patiently. Now they are paying closer attention, especially if the couple is in their 30s. They have learned that it is reassuring to the couple to schedule a few basic painless tests, such as a semen analysis or a blood test.¹

As Dr. Sherman Silber points out in his book, How to get Pregnant, "Getting pregnant is usually a game of odds. Some couples are simply likely to get pregnant sooner than others."² Many couples, even those who have

¹Menning, p. 18.

²Silber, p. 55.

waited a year or longer, might not be infertile, "but merely victims of statistical chance".³

Of course, there are those for whom a few extra months do not make much difference. They are truly the infertile, victims of a disease that has no symptoms: "[T]he problem for which we seek a cure is the absence of a child."⁴ Infertility has been called "the invisible handicap" and its sufferers "one of the most neglected minority groups in America".⁵

Infertility is medically unique, in that it involves the systems of two people, not one.⁶ Both partners must seek help, both must have their fertility evaluated, if pregnancy is to be achieved. In the past, doctors themselves were known to fall victims to society's belief that the woman was at fault in cases of infertility. Only the woman's reproductive system would be checked. She would be subjected to expensive, time-consuming and often painful tests, yet the simple step of examining her partner or doing a semen analysis would not be taken.⁷

For the most part, this is not the case today, although horror stories do still circulate among infertile couples. Susi is a day care worker in her mid-30s who is now pregnant after years of infertility treatments. She recalls an infertile friend going through the whole series of infertility tests without getting a diagnosis. The woman and her husband eventually had two children. When the husband went for a vasectomy, he was told his

³Ibid., p. 56.

⁴Pfeffer and Woollett, p. 41.

⁵Harriet F. Simons, "Infertility: Implications for Policy Formulation" in Miriam D. Mazor and Harriet F. Simons, eds., Infertility: Medical, Emotional and Social Considerations (New York: Human Sciences Press, 1984), p. 63.

⁶Dr. Peter Garner, conversation in Ottawa, April 7, 1987.

⁷Pfeffer and Woollett, p. 30.

sperm count was too low to bother with the procedure. The wife had gone through all the tests, but he had never been asked for a semen sample. Today, the pamphlet distributed by Ottawa General Hospital's Fertility Centre states bluntly: "The husband's factor is at fault in approximately 40 per cent of cases, far more often than is realized. Therefore, it must be considered early in the investigation of the infertile couple."⁸

A couple seeking help usually starts with their family doctor. Often, the general practitioner will carry out the first tests, but referrals are made as well to infertility specialists. Eventually, most couples will end up in a specialist's office.

In Canada, the infertility specialist is rare--almost as rare as the infertility clinic. In a country where there are fewer than 1,400 obstetricians and gynecologists to begin with, less than 50 work only in the areas of infertility and endocrinology (the science of the hormone glands).⁹ Naomi Pfeffer and Anne Woollett, who note the same lack of specialists in England in their book, The Experience of Infertility, suggest that the gap "reflects the lack of importance and prestige attached to infertility by medical practitioners and by government bodies which sanction developments in the medical profession".¹⁰

Only 24 major infertility clinics exist in Canada. They are recognized university teaching centres associated with hospitals. In infertility treatment, as in most other areas of Canadian life, there are regional

⁸Ottawa General Hospital, "Fertility Centre", pamphlet, 1981, p.1.

⁹Dr. John A. Collins, chair of Obstetrics and Gynecology, McMaster University Medical Centre, interview in Hamilton, July 16, 1987. By comparison, Collins says there are close to 32,000 obstetricians/gynecologists in the United States. The Canadian Fertility and Andrology Society lists as members 210 doctors who include infertility as part of their practices.

¹⁰Pfeffer and Woollett, p. 44.

disparities. Only one clinic in Nova Scotia serves the entire Maritimes, yet Ontario has four clinics, two of which are in Ottawa.¹¹

The Canadian Fertility and Andrology Society in Montreal is currently compiling data on infertility clinics and specialists. It hopes to present the information at its annual general meeting in Fall 1987.¹²

The number of infertility clinics in the U.S. is twice what one might expect, given the "10 per cent" rule of thumb. (For every clinic that Canada has, it is expected that the United States would have 10, because the U.S. is 10 times as populous as Canada. In fact, the U.S. has 20 clinics for every one clinic in Canada.)¹³ It's a long way from the first publicly-funded infertility clinic in the U.S. just 13 years ago.¹⁴

The infertility specialist has had training in his or her area of interest, such as endocrinology (the study of hormones), urology (the study of urinary tract disorders) or reproductive physiology (the study of the reproductive system). Because specialists are mostly working in clinics and the clinics are almost always associated with hospitals, there is a support network of specialists and services to treat the couple, whatever their particular problems.

Barbara Eck Menning sees the infertility "team" at a clinic eventually consisting of an endocrinologist, a urologist, a bacteriologist, a genetic counselor, a pathologist, a psychiatrist and a sexual therapist, in addition to specially-trained nurses, social workers and counselors. Menning admits this

¹¹Collins interview, July 16, 1987.

¹²Janine Gauthier, research coordinator, Canadian Committee for Fertility Research, interview in Montreal, July 15, 1987.

¹³Collins interview, July 16, 1987.

¹⁴Simons, p. 62.

is "the wave of the future"¹⁵ and not usually available at clinics today. The Reproductive Endocrinology and Infertility Clinic at Ottawa Civic Hospital consists of three specialists and their personal staffs, although all the hospital's facilities provide back-up, including such indispensable support as a state-of-the-art ultrasound department. A psychologist has just been hired to work part-time with infertile couples and two scientists are on staff in anticipation of the in vitro fertilization clinic to open next year.

The couple seeking help might already have several years of trying to conceive behind them, with all the accompanying stress and anxiety, but their arrival at a doctor or specialist's office still signals the beginning of the medical management of their infertility. It is a process that is physically painful, expensive for some and intrusive into their bodies and their lives. In effect, they are throwing open their bedroom door to the scrutiny of the medical profession. The two that it takes to make a baby becomes three with the arrival on the scene of the first doctor. Depending on the couple's particular problem, other participants will be added along the way.

An infertility investigation, the so-called infertility work-up, begins with a complete medical history of the couple. Often the questionnaire is completed by the couple before the first appointment. It includes questions on reproductive history (have you ever been pregnant before?), birth control (have you ever used an IUD?) and sexual relations (how often do you and your partner have sexual intercourse?). Other questions concern any surgery the couple might have had, occurrences of venereal disease and use of drugs or medication.¹⁶

¹⁵Menning, p. 20.

¹⁶Stangel, pp. 90 - 93; Serono Laboratories, Inc., "Female Patient History", medical form, undated.

In addition, because they must wait months before seeing the specialist, the couple might be asked to complete a few cycles of temperature charts before their first appointment with the specialist. If the woman's menstrual cycles are normal, ovulation can easily be pinpointed. Whenever intercourse takes place, it is also marked on the chart, so the doctor will be able to see if the couple are having sexual relations at a time most conducive to conception.

The next step is a complete physical examination of both partners.¹⁷ The doctor will check for obvious abnormalities or problems in the female reproductive anatomy that would prevent conception. For instance, a cyst on an ovary or a retroverted uterus, where the uterus is tipped backwards, might show up at this point. A cyst might prevent ovulation and a retroverted uterus might hinder passage of sperm through it on its way to meet the egg. In the male, the testes are checked to see if an obvious varicocele (enlarged vein) is present. A varicocele inhibits sperm production.

To complete this first round of basic tests, the woman is sent for blood tests to evaluate hormone levels and the man must produce a semen sample for analysis.

These tests are the most routine in the infertility work-up and are taken by everyone undergoing investigations. The temperature chart forms the basis for the work-up, giving instant knowledge of ovulation, hormone levels and timing of sexual intercourse. The most current temperature chart will be scrutinized at every appointment. The woman will have internal physical examinations with almost every appointment, especially if she is taking ovulation-inducing drugs (to see if cysts develop as a side-effect).

¹⁷Ibid., p. 94.

The woman is likely as well to have many more blood tests before testing is finished and the man will be asked to produce semen samples at intervals throughout.

Although much of this basic testing is likely to be completed at the first and second appointments with the specialist, giving the couple a sense that something finally is being done about their problem, time is both the infertile couple's greatest ally and their greatest enemy.

They might have an inkling already of how slowly an infertility work-up progresses if they have had to wait the standard six months to a year for their first appointment with the specialist. The brief flurry of activity at the first several appointments thus comes as a welcome relief. But they soon find that the bulk of the work-up follows at a snail's pace.

The clinics, with their long waiting lists, take on new patients as space permits. Ottawa Civic Hospital's Clinic will see about 35 new couples per month. The clinic at Ottawa General Hospital sees about 48 new couples per month. About 750 new couples will have a first appointment at the Civic and the General this year.¹⁸

Once the initial tests are completed, appointments follow on a more or less monthly basis. At this rate, it takes at least several months to progress through the specialized tests in the work-up. Often the specialist will go over some of the same ground as the general practitioner, which adds to the time taken.

For some couples, the regular office hours of the clinics mean that if they are due for an artificial insemination, a post-coital test or a hormone

¹⁸Dr. J. E. H. Spence, Ottawa Civic Hospital, interview in Ottawa, July 24, 1987; Dr. Elaine Jolly, Ottawa General Hospital, interview in Ottawa, July 29, 1987.

shot on a specific day of the cycle and the optimum day falls on a weekend, they must wait until next time.¹⁹

In England, this is a recognized part of the frustrations of infertility investigations. Often clinic days for infertility testing are on two set days a week (such as Tuesdays and Thursdays). Anyone ovulating regularly on a Saturday will be unable to schedule the appropriate test without difficulty.²⁰

The other side of the coin--seeing the passage of time as an ally, not as an enemy--reflects the anxiety and stress that infertile couples undergo. This will be discussed in detail in the next chapter. The spacing of the appointments gives the couple time to reflect on the direction their infertility investigation is taking. They also have the chance to recover from the extreme pressure of an appointment, in which they might be given unpleasant test results or must provide explanations as to why they did not manage intercourse at the right time the previous month.

In addition, time plays one important role for those who have come to the specialist early in the quest for parenthood. There is a high incidence of what is called "spontaneous pregnancy" after a first or early visit to a doctor or specialist concerning infertility: "[A]bout 20 per cent of couples with infertility achieve pregnancy before the doctor has a chance to initiate treatment."²¹ This advantage is viewed a little more cautiously by Pfeffer and Woollett, who are concerned that doctors might be offering the usually useless advice to "relax" and spinning out the time before they actually have

¹⁹In Ottawa, Dr. Norman Barwin, who operates as an infertility specialist outside the two local clinics, is available on weekends for these kinds of time-related tests. Barwin interview, June 5, 1987.

²⁰Pfeffer and Woollett, p. 42.

²¹Silber, p. 113.

to treat the patients. Be that as it may, Pfeffer and Woollett also report a spontaneous pregnancy rate of 13 per cent.²²

The high spontaneous pregnancy rate (as high as 50 per cent in one report²³) reflects the lack of knowledge that couples have about the details of how conception actually takes place. Once they are given tips on timing of intercourse, position and techniques, pregnancy follows quickly. According to Dr. Norman Barwin, a gynecologist in Ottawa, it is the reassurance--the feeling that "it's out of my hands and someone else is taking care of the problem"--that sometimes can have therapeutic effects. It's what Dr. William Masters of the famous Masters and Johnson sexual therapist team calls "basic sexual know-how and know-when".²⁴ Masters says one in eight infertile couples (about 13 per cent) conceives after being given the needed information and three months of "practice".

What is the basic know-how and know-when of conception? The man provides healthy sperm in bountiful numbers. The woman provides an ovum, or egg. The sperm are deposited near the opening of the uterus, from where they swim up to the fallopian tubes. In the meantime, the ovum leaves the ovary and is waiting in the tube for the sperm. Timing is crucial, as the ovum may live for as little as one-half a day and the sperm only for a day or two. If fertilized, the ovum moves down into the uterus, where it implants in the lining.²⁵ All this must therefore take place around the time of ovulation (when the egg ripens and leaves the ovary), which happens around day 14 of an average 28-day cycle.

²²Ibid., p. 41.

²³Barwin pamphlet, p. 1.

²⁴White, p. 9.

²⁵Pfeffer and Woollett, p. 55; Menning, p. 14; Stangel, pp. 30 - 32.

It is breathtakingly complicated, when you consider that so much can go wrong. What if it all happens like clockwork, but the lining of the uterus is not ready for the fertilized egg? Or what if the ovum releases too late and the sperm have already died? As Barbara Eck Menning puts it: "Considering the precision with which both male and female reproductive systems must function to result in a live birth, it seems miraculous that human beings are conceived and born at all!"²⁶

It comes down to four basic questions, according to the American Fertility Society: Is there an egg? Are there enough sperm? Can egg and sperm meet? Can implantation occur?²⁷ The society's four questions address the most common causes of infertility: inadequate or no ovulation, not enough sperm and no transport of either egg or sperm.²⁸

Finding answers to these questions is what the specialized infertility testing is all about. The problem is that human reproduction is a long list of question marks for the medical profession.

"Ninety-five per cent of success, of reasons for pregnancy, is attributable to unknown factors, that is, not to medical treatment," says Dr. John A. Collins, a prominent infertility specialist and head of the Department of Obstetrics and Gynecology at McMaster University Medical Centre. "It's hardly surprising when you consider that all we are able to do is count sperm, check on progesterone levels and look at the surfaces of the female reproductive anatomy."²⁹

²⁶Menning, p. 15.

²⁷Stephenson, pp. 97 -98.

²⁸Planned Parenthood of Ottawa, "Infertility: Concepts and Controversies", handbook from public forum, Nov. 5, 1987, p. 2.

²⁹Collins interview, July 16, 1987

Dr. Albert Yuzpe of University Hospital in London, Ontario, says only three of 10 basic steps in the reproductive process can be measured (sperm production, clear fallopian tubes and ovulation).³⁰ As for the rest of it,

[D]octors cannot measure transport of the sperm, its capacity to penetrate the egg, pick-up of the egg by the tube, transport of the egg, fertilization or implantation of the embryo in the uterus.³¹

If nothing of importance shows up in the basic tests of the infertility work-up, the specialized tests try to pinpoint the problem. Even if one probable factor is found for the infertility, tests usually continue to ensure that nothing else is overlooked.³² It is possible that a combination of factors exists--for instance, a woman might have blocked fallopian tubes and her partner might have a marginal sperm count.

Male infertility is much more straight-forward than female infertility, if only because there is so little that can be done. Either there are enough sperm, or there are not. Although it's not quite as cut-and-dried as that--men with low sperm counts have become fathers--the fact is that sperm are necessary for conception and when there aren't any, there is little treatment available.

The most common test for male infertility is the semen analysis. The specimen, which requires four days of abstinence from sexual intercourse, is collected by masturbation into a clean, wide-mouthed bottle. It must be

³⁰Planned Parenthood of Ottawa, "Infertility: Concepts and Controversies", public forum, Nov. 5, 1985, oral presentation by Dr. Albert Yuzpe.

³¹Thorpe, p. 5.

³²Stangel, p. 95.

kept warm and brought to a medical laboratory for analysis within two hours.³³

Quite a lot can be analysed in a sperm sample. The two most important aspects are the concentration of sperm per cubic centimeter and the motility of the sperm.³⁴ The motility is the speed and quality of the sperm's movement. There must be enough sperm (a minimum of 20 million per cubic centimeter) and they must wiggle determinedly forward at a rapid speed.³⁵ Also tested are the amount and appearance of the semen, the sugar and chemicals present and the morphology (shape) of the sperm.³⁶

There are two treatments for a poor sperm count: improving the quality of the sperm and artificial insemination by donor.

Sperm enhancing drugs--the same drugs used to induce ovulation in infertile women--do not work very well and other methods are being developed to provide "medical muscle for sluggish sperm", as one recent magazine article put it.³⁷ "Electric ejaculation" is one new method that "jump-starts" the nerves responsible for ejaculation by passing a gentle electric current through a probe in the man's rectum, according to this magazine.

³³Civic Parkdale Clinic, [Ottawa Civic Hospital], "Reproductive Endocrinology and Infertility Unit", pamphlet, 1984.

³⁴Silber, p. 66.

³⁵Pfeffer and Woollett, p. 60.

³⁶*Semen* is the fluid ejaculated at orgasm. It may or may not contain *sperm*.

³⁷Mary Garner, "'Impossible' Pregnancies, Miracle Babies: Breakthroughs that are turning Infertile Couples into Families", Self, June 1987, p. 133.

The alternative to sperm enhancement is artificial insemination by donor, which has an extremely high success rate--65 to 75 per cent, usually within four or five cycles.³⁸

Twenty to 30 per cent of male infertility is caused by an enlarged vein on the testes called a varicocele.³⁹ The treatment is tying off the left internal spermatic vein through an incision in the groin. Although it is not clear how a varicocele affects fertility, the procedure results in an immediate increase in both sperm count and motility 80 per cent of the time.⁴⁰ Only 30 per cent of operations for varicoceles return the sperm count to normal.⁴¹

There is very little else that can be said about male infertility. Sometimes a man will have a hormone imbalance and drugs are prescribed--without much benefit.⁴² In other cases of male infertility, a testicular biopsy performed on both testicles can determine if there is an obstruction which is making the man sterile. But these do not happen regularly.

The focus of the infertility work-up very quickly turns to the woman. Because she has the childbearing capacity within her body, hers is the more complex anatomy. More can go wrong, to be sure, but more can potentially be fixed as well. In addition, more is known about a woman's reproductive system because of research on contraception.⁴³

Factors involved in female infertility can be divided into three basic areas (see figure 1). Ovulatory and hormonal factors account for 35 per cent

³⁸Planned Parenthood forum, handbook, p. 6. The artificial insemination by donor procedure is described in Chapter 6.

³⁹Silber, p. 81.

⁴⁰Menning, p. 47 and p. 57.

⁴¹CTV, "Lifetime", July 2, 1987.

⁴²Planned Parenthood forum, oral presentation by Dr. Peter Garner, Reproductive Endocrinology and Infertility Unit, Ottawa Civic Hospital.

⁴³Pfeffer and Woollett, p. 40.

FIGURE 1

FACTORS IN FEMALE INFERTILITY

[known factors only]

Female Reproductive Anatomy

of overall infertility problems, tubal factors for 18 per cent and uterine factors for five per cent. The remainder of problems are made up of the male factor at 35 per cent and the combined male-female factor, at six per cent⁴⁴

One-half of infertile women have ovulatory problems, 30 per cent have tubal problems and 10 per cent have uterine problems. (The male-female combined factor then rises to 10 per cent.)

The timetable for the testing and treatment of female infertility is based on the menstrual cycle. One of the first tasks a woman must undertake in the infertility work-up is keeping a basal body temperature chart. The chart will show when or if ovulation occurs. The length of the cycle will be an indicator of how prepared the uterus is to accept a fertilized egg. When the days of sexual intercourse are added to the chart, a picture of the readiness of egg and sperm comes into focus.

There are tests that cannot take place until ovulation occurs and there are treatments that must take place at the time of ovulation; the chart will show the optimum time for these tests and treatments.

An infertility specialist is much better at interpreting the chart than a general practitioner who sees only a few infertility cases. Several women have commented that their gynecologist or general practitioner said their charts looked fine. Later, their specialists discovered a major problem that was glaringly obvious to them from looking at the chart.

The chart is the first true indication that there might be an *ovulatory* or *hormonal* problem. A medical history, although important, can only give

⁴⁴This is after removing the 13 per cent overall of cases that are idiopathic, or unexplained. John A. Collins, William Wrixon, Lynn B. Janes and Elaine H. Wilson, "Treatment-Independent Pregnancy among Infertile Couples", The New England Journal of Medicine, 309 (Nov. 17, 1983): 1201.

clues to such a problem.⁴⁵ A history of irregular menstrual cycles might mean the uterus is not building up a lining of sufficient quality to support a pregnancy, but the chart will be able to pinpoint if this is significant by counting the specific number of days the temperature stays high after ovulation. The difference in temperature between the first and second half of the cycle might vary by only one-half a Centigrade degree.

Most ovulatory and hormonal problems concern lack of ovulation, irregular ovulation or the quality of ovulation. The medical history and the temperature chart are the first ways of determining if ovulation is occurring. The other tests are a blood test and an endometrial biopsy. These two tests determine which, if any, of the various hormones usually present during the cycle are either lacking or too abundant.

The blood test is one of the tests that the infertility specialist might repeat, following initial tests by the general practitioner. Sometimes the GP who first ordered a blood test does not ask for a complete breakdown of all the hormones vital to a diagnosis. Or the test results might not be considered recent enough if there has been a long wait to see the specialist. Also, hormone levels change daily and several blood tests performed at different times in the cycle might be needed in order to obtain an overall hormone evaluation.⁴⁶

Luckily, the essential hormones to be tested--estrogen and progesterone--can usually be detected on temperature charts or by inspecting the cervical mucous, so constant blood tests are not necessary. Estrogen is the primary female hormone and is produced mainly in the

⁴⁵Silber, p. 86.

⁴⁶Ibid., p. 101.

ovaries. Progesterone is produced in the second half of the cycle and must be present to prepare the lining of the uterus for pregnancy.

Two other hormones are also tested. Luteinizing hormone (LH) should peak just before ovulation. Follicular Stimulating Hormone (FSH) stimulates the ovary to ripen the egg. Both these hormones are controlled by the pituitary, a gland at the base of the brain.⁴⁷

The endometrial biopsy is the testing of a sample of the uterine lining (the endometrium, hence endometrial biopsy) taken any time after ovulation, but usually around day 20 of the cycle. In this procedure, performed in the doctor's office, a thin tube is inserted into the uterus. When it is removed, a small piece of the lining of the uterus comes away with it. If ovulation has occurred properly, the tissue taken in the sample will show the influence of progesterone.

Doctors tend to downplay the pain involved in this test, prompting one infertile woman to protest: "An endometrial biopsy? Won't hurt a bit? It's not 'hurting a bit' that bothers me, Doctor, it's 'hurting a lot' that has me concerned..."⁴⁸

An ovulatory problem can be a relatively simple diagnosis of lack of ovulation or a more complex luteal phase defect, where the second half of the cycle produces an inadequate supply of progesterone.

Other diagnoses considered to be ovulatory problems are polycystic ovaries and hormone imbalances due to high prolactin levels. With polycystic ovaries, the ovaries develop cysts and can become enlarged. It is thought that this is caused by an imbalance of FSH and LH. The eggs do not develop properly, forming cysts instead. Prolactin, detected by a blood test,

⁴⁷Menning, pp. 12, 166 - 167.

⁴⁸Stephenson, p. 75.

is a hormone produced by the pituitary gland. High levels of prolactin cause failure to ovulate.

Whatever the diagnosis, ovulatory and hormonal problems in infertile women are treated with the same drugs in different combinations.

The two drugs used the most frequently are Clomiphene Citrate, known as Clomid, and Human Menopausal Gonadotropin, or HMG, marketed as Pergonal. Clomid and Pergonal have the public reputation of "fertility drugs". Pergonal is known to be responsible for multiple births, but Clomid has only a slightly increased chance of twinning.⁴⁹

Clomid is given in tablet form on days five to nine of the cycle. It stimulates the production of FSH and LH, which in turn stimulate the ovaries to ripen and produce an egg at the right time. When not ovulating is the problem, Clomid will assist in getting a woman pregnant about 35 per cent of the time.⁵⁰

Ironically, Clomid was first developed as a contraceptive, but it was found that it stimulated ovulation in humans, rather than suppressed it.⁵¹

If Clomid does not have the desired result, the dose can be increased. Sometimes a shot of a drug called human chorionic gonadotropin (HCG) on day 14 helps ovulation to occur.

For those women who do not respond to Clomid, the more powerful Pergonal is tried. Like Clomid, Pergonal stimulates the follicles to ripen the eggs. The difference is that Pergonal is itself made up of FSH. Basically, the doctor is injecting FSH, rather than triggering the body's store of it.

⁴⁹Stangel, p. 134; About 20 per cent of births after taking Pergonal are multiple. Menning, p. 41; Stangel, p. 140.

⁵⁰Planned Parenthood forum, handbook, p. 5.

⁵¹Silber, p. 124.

Pergonal must be monitored carefully and is therefore a much more onerous regimen than Clomid for the woman and her doctor to follow. It is given by injection for seven to 10 days before ovulation should occur. Its effect on the body's estrogen production is measured by daily testing of a 24-hour urine sample. The woman must collect every drop of urine she passes each day that an injection is given and bring it to be analysed. When the estrogen has reached the right level, a booster shot of the hormone HCG is given. This is the optimum time for ovulation and conception.⁵²

Sometimes the ovaries become overstimulated on Pergonal, so the HCG injection must not be given and the next cycle should be considered a rest period.

Pergonal has a good rate of success. Most women will ovulate and more than 50 per cent will become pregnant.

Different combinations of Clomid, Pergonal and the booster shot of HCG are given in more stubborn cases. It is thought that the cases that do not respond to Pergonal have some other factor at the root of the infertility.⁵³

Other drugs are used besides Clomid and Pergonal to deal with ovulatory problems. Bromocriptine is used in cases where the body's prolactin level is too high. Prednisone is used to lower a woman's supply of the male hormone testosterone (only a slight increase in testosterone can suppress or delay ovulation).⁵⁴

These drugs are not without their unpleasant side-effects. For Clomid, these include hot flashes, breast tenderness, nausea, blurred vision,

⁵²Pfeffer and Woollett, p. 84.

⁵³Stangel, p. 141.

⁵⁴Silber, p. 122.

headaches and insomnia.⁵⁵ If the ovaries are overstimulated on Pergonal, a woman can feel low abdominal pain, swelling and weight gain.⁵⁶ Multiple pregnancy should also be considered a side-effect. Bromocriptine is known to cause nausea, headaches and constipation.⁵⁷ Side-effects from progesterone may include water retention, weight gain and gastrointestinal disturbances.⁵⁸ Yet women seem to take the drugs without much comment or complaint, despite the daily hardship involved.

The outlook for the 30 per cent of infertile women with *tubal* problems is much less optimistic. Not only are the tests themselves more painful, but the treatment has the lowest success rates (about 25 per cent after three years of treatment)⁵⁹ of any factor in female infertility.

The tests for tubal factors are looking for abnormalities that might prevent the transport of the egg and the sperm, such as damaged or blocked fallopian tubes. Tubes can be damaged very easily by pelvic inflammatory disease or venereal disease. Sometimes infection caused by an abortion or the use of an IUD can lead to damage. Even after the infection has cleared up, scar tissue or adhesions can remain to block the tubes.⁶⁰

After a physical examination, which can examine only the surfaces of the reproductive organs, two major tests are used to reach a diagnosis.

⁵⁵Resolve, "Clomid", pamphlet, 1981, p.1.

⁵⁶Idem, "H.M.G. (Pergonal)", pamphlet, p. 2.

⁵⁷Idem, "Bromocriptine and Elevated Prolactin Levels", pamphlet, p. 1.

⁵⁸Idem, "Luteal Phase Defect", pamphlet, p. 2.

⁵⁹Collins et al., p. 1204; Reproductive Endocrinology and Infertility Unit, Ottawa Civic Hospital, "Cumulative pregnancy rates among 1297 couples grouped according to primary clinical diagnosis", graph, date unknown.

⁶⁰Pfeffer and Woollett, p. 96.

The first test is an x-ray of the uterus called a hysterosalpingogram (hystero meaning uterus in Greek, salpingo meaning tubes and gram meaning picture)⁶¹ It's commonly known as an HSG. Dye is injected into the uterus and through the tubes. An x-ray is then taken. The outline of the tubes and uterus should be clearly seen on the x-ray if there is no blockage or problem. If the dye does not flow freely through the organs, scarring and adhesions are suspected.

Women agree that the HSG is the most painful of all the tests in the infertility work-up, the more so because the pain is usually unexpected. The most common complaint of infertile women about their medical treatment is that they were told that the HSG was a relatively pain-free procedure. Susi was 30 and new to infertility testing when she went for her HSG. She was faint with pain when she asked her doctor during the procedure, "Is this what having a baby is like?" "No", he replied, "this is worse." This was the same doctor, she says, who had assured her in his office that the HSG was a "regular procedure with no pain".

The second test used to diagnose a tubal problem is the laparoscopy, performed under general anesthetic. Carbon dioxide is pumped into the abdomen through an incision in the navel. This separates the organs for easier viewing. Then a small telescope with a light is inserted into the abdomen so the the tubes, uterus and ovaries can be inspected.

Most of the discomfort with this test lies in the gas, which is absorbed gradually into the body but is felt as pain in the shoulders for several days afterwards.

Success rates vary with tubal problems. The more difficult problems, such as closed tubes, do not respond well to surgery, which is the usual

⁶¹Ibid., p. 88.

treatment. Adhesions are often easily removed by surgery and success rates are higher. As a rule, if the problem occurs outside and around the tube, there is a better chance that surgery can help.⁶²

The alternative to tubal surgery is in vitro fertilization. If the couple's only fertility problem is blocked fallopian tubes, they are suitable candidates for in vitro as the procedure bypasses the tube by fertilizing the egg with the male partner's sperm in a laboratory dish before returning it to the woman's uterus.⁶³

For the 10 per cent of women whose infertility problem is *uterine*-related, surgery is often both test and treatment. The two tests described for tubal problems--the hysterosalpingogram and the laparoscopy--usually are necessary to make the diagnosis.

Uterine problems are varied. The most common are: fibroids, benign tumours that grow on the uterus; endometriosis, in which pieces of the uterine lining are growing in other areas of the abdomen; a septum, an anatomical abnormality that divides the uterus; and a retroverted or tilted uterus, which can be a problem in tandem with another infertility factor.

Surgery is the treatment for these conditions. In recent years, fibroids and endometriosis have generated interest in the medical community because of experimental therapies being attempted.

Fibroids are the most common benign tumour of a woman's reproductive organs. They usually grow until they cause discomfort and then are removed by hysterectomy, taking with it a woman's chances to ever have biological children. But a new drug called Buserelin is changing that. The drug suppresses the flow of estrogen to the fibroids. Without

⁶²White, p. 88.

⁶³In vitro fertilization is described in detail in Chapter 6.

estrogen, the fibroids shrink to the point that they, rather than the uterus, can be removed. Then the woman can attempt a pregnancy.⁶⁴

In Canada, the centre for this therapy is at Saint-Francois d'Assise de Quebec Hospital in Quebec City. Sylvie, a 31-year-old nurse from Ottawa who underwent the therapy, reports that the operation was a complete success. She is now attempting to conceive. The specialist pioneering the surgery, Dr. Rodolphe Maheux, has had considerable success with removing the shrunken fibroids.

With endometriosis, the interest arises more because the disease seems to be diagnosed with increasing frequency. Called the "career-woman's disease", endometriosis is found in women who have delayed childbearing until their 30s. Many women have mild cases of the disease unknowingly, but 40 per cent of patients with endometriosis will have some trouble with infertility.⁶⁵

The most frequently-prescribed drug, Danazol, is used cautiously, but with good results. The problem seems to be more in the decision to use Danazol, still somewhat experimental in nature, or not to use drugs at all. In mild cases of endometriosis, significantly more pregnancies are achieved without Danazol than with the drug.⁶⁶

⁶⁴Marie Morrissey, "New Breakthrough", Infertility Self-Help Support Group newsletter, October 1986, p. 4; Rodolphe Maheux, "Le leiomyome utérin: une nouvelle approche médicale", L'actualité médecine, 12 aout 1985, p. 22.

⁶⁵Resolve, "Endometriosis", pamphlet, p. 1.

⁶⁶Machelle M. Seibel, Merle J. Berger, Frederick G. Weinstein and Melvin L. Taymor, "The Effectiveness of Danazol on Subsequent Fertility in Minimal Endometriosis", Fertility and Sterility, 38 (November 1982): 534. In this study, 50 per cent of subjects conceived without Danazol and 30 per cent conceived with the drug.

Although there are many unpleasant side-effects with the use of Danazol--such as hot flashes, weight gain and excessive hair growth--women take the drug without complaint.⁶⁷ Pregnancy is not attempted until after the six month or so drug regimen. Nikkie, a journalist who lives near Kemptville, Ont., endured some of these side-effects when she took the drug for three months at age 27. Now 34, she feels the end result--a daughter born several years after treatment--was worth the dizziness and vomiting. At the time of treatment, she was a student and finding the \$100 per month for the drug was more of a concern than the treatment itself. Now, she worries about the long-term effects of Danazol on both her and her daughter. "The doctor said there were none documented, but you know how these things are. Fifty years later they find out..."

Linda's treatment with Danazol helped her mild case of endometriosis, but she didn't conceive until three years later, which is not considered a Danazol-aided pregnancy. (In fact, the high school teacher, now 36 and the mother of two, feels a series of back adjustments undertaken by her chiropractor was what really helped her!) She experienced some side-effects, but shrugged them off.

The other solution for endometriosis is a surgical one. Conservative surgery, where as much as possible of the endometriosis is removed, has excellent success rates in terms of pregnancy, depending on the severity of the case.⁶⁸ For severe endometriosis, "a total abdominal hysterectomy... is the only curative and definitive procedure".⁶⁹

⁶⁷Pfeffer and Woollett, p. 95.

⁶⁸Michael M. Alper, B. Norman Barwin, Elaine E. Jolly, "Endometriosis: a therapeutic dilemma", Modern Medicine of Canada, 39 (April 1984) : 457.

⁶⁹Ibid., p. 5.

given birth, but cannot seem to conceive again. Couples with secondary infertility have the same range of problems as those with primary infertility and the same rate of success after treatment.

All in all, 50 per cent of couples who are infertile will conceive after three years of treatment.⁷⁵ But conception is not the only problem. Some expectant couples barely get over celebrating their good news when disaster strikes.

Miscarriage ends one in every six pregnancies. Some of these pregnancies end in the first two weeks and no one is the wiser. The only sign is a heavier than usual menstrual period. Other miscarriages happen after the woman misses her first period, but still in the first 13 weeks of pregnancy. At this time, miscarriage is physically and emotionally painful for all who undergo it.

The rate of miscarriage for couples who undergo infertility investigations is thought by some to be no higher than for the general fertile population.⁷⁶ Others, however, believe that the rate of miscarriage for those who have trouble conceiving is as high as 40 per cent overall and their pregnancies should be considered "high-risk".⁷⁷

Dr. Pierre Huard is an obstetrician who specializes in high-risk pregnancies. Many of his patients were infertile before conceiving. Of the high rate of miscarriage for these women, he says wryly: "Infertile women make lousy reproducers." When the factor for the infertility is controlled by

⁷⁵Planned Parenthood forum, handbook, p. 2.

⁷⁶Women who conceive after using Clomid are told that there is only a very slight increase in the incidence of miscarriage. Garner conversation, April 7, 1987.

⁷⁷Menning, p. 76.

virtually impossible to perform in tune with a doctor's appointment book. Timing is crucial for this test, not only because of the clinic appointment. The intercourse must take place precisely at the time of ovulation and the woman must arrive at the clinic shortly thereafter. Bozica, a public affairs specialist and now the mother of a daughter, remembers having intercourse as scheduled on the morning of the appointment, only to discover while on the doctor's examining table that it was the wrong day: "We screwed up our post-coital test," she laughs--but it was an embarrassing moment.

For five to 10 per cent of infertile men and women, no reason can be found for their infertility. Although both reproductive systems appear to be in working order, no pregnancy occurs. This is frustrating for both the couple and specialists who cannot help them. There is no course of treatment, no beginning or end to the infertility. Years pass and they must live with the fact that pregnancy could happen in any given month: "In theory at least, with a new partner, I could get pregnant," says one woman who has put her infertility behind her and would not welcome a pregnancy now.⁷³

Fortunately, time seems to be on the side of these couples. Idiopathic, or unexplained, infertility has a relatively high rate of pregnancy over time--up to 55 per cent over three years.⁷⁴

Secondary infertility is possibly more frustrating than unexplained infertility. This is when a couple is unable to achieve a pregnancy after having conceived previously. Some couples classed as secondary infertile have problems maintaining pregnancies to birth, others have successfully

⁷³Barbara Carroll, "After Infertility--The Child-Free Option", Infertility Self-Help Support Group, newsletter, 2 (April 1987): 8.

⁷⁴Reproductive Endocrinology and Infertility unit graph.

given birth, but cannot seem to conceive again. Couples with secondary infertility have the same range of problems as those with primary infertility and the same rate of success after treatment.

All in all, 50 per cent of couples who are infertile will conceive after three years of treatment.⁷⁵ But conception is not the only problem. Some expectant couples barely get over celebrating their good news when disaster strikes.

Miscarriage ends one in every six pregnancies. Some of these pregnancies end in the first two weeks and no one is the wiser. The only sign is a heavier than usual menstrual period. Other miscarriages happen after the woman misses her first period, but still in the first 13 weeks of pregnancy. At this time, miscarriage is physically and emotionally painful for all who undergo it.

The rate of miscarriage for couples who undergo infertility investigations is thought by some to be no higher than for the general fertile population.⁷⁶ Others, however, believe that the rate of miscarriage for those who have trouble conceiving is as high as 40 per cent overall and their pregnancies should be considered "high-risk".⁷⁷

Dr. Pierre Huard is an obstetrician who specializes in high-risk pregnancies. Many of his patients were infertile before conceiving. Of the high rate of miscarriage for these women, he says wryly: "Infertile women make lousy reproducers." When the factor for the infertility is controlled by

⁷⁵Planned Parenthood forum, handbook, p. 2.

⁷⁶Women who conceive after using Clomid are told that there is only a very slight increase in the incidence of miscarriage. Garner conversation, April 7, 1987.

⁷⁷Menning, p. 76.

treatment, some other aspect of the reproductive system still might not be conducive to maintaining pregnancy.

Whatever the statistics, the difference is that for infertile couples, miscarriage is a crippling blow compounded by the frustrations of years of tests and treatment.

Most miscarriages are caused by blighted eggs. Although fertilized, the egg cells never divide or develop properly. This kind of blighted pregnancy will never reach a viable state. If an egg is blighted, nothing will help it.

Other causes of miscarriage include hormonal deficiencies, genetic abnormalities and anatomical problems. These problems may cause repeated miscarriages until they are sorted out.⁷⁸

The medical management of infertility may take two or five or eight years--or more. Once a cause has been established through the testing, the treatment can go on as long as the couple and their doctor feel there is hope.

Infertility is unusual in a medical sense because treatments are directed not at curing a disease, but at attaining a social goal.⁷⁹ At some point, though, the couple must ask themselves how long they are willing to endure the often daily medical intrusion into their personal lives. A lot is at stake--self-esteem, approval of peers, a sense of belonging, a deep-rooted desire to become a mother (or father)--and it is not easy to call a halt to the struggle.

⁷⁸Ibid., pp. 73 - 77.

⁷⁹E. V. Van Hall, "The Infertile Couple and the Gynaecologist: Psychosocial and Emotional Aspects" in Fertility and Sterility: The Proceedings of the XIth World Congress on Fertility and Sterility, Dublin, June 1983, held under the Auspices of the International Federation of Fertility Societies, R. F. Harrison and J. Bonnar W. Thompson, eds. (MTP Press Limited: Boston, 1983), p. 359.

The next chapter discusses the feelings of the infertile couple as they attempt to reach that goal.

CHAPTER 5

COPING WITH INFERTILITY: THE SOCIAL AND EMOTIONAL DIMENSION

Every morning for the last 36 months, Shirley has opened her eyes and reached for her basal body thermometer. It used to be that she would remain lying down for five minutes, squinting periodically at her bedside clock, until the thermometer registered her body's temperature. Then she would note the result on the chart she updates daily. Now, with her new digital thermometer, it takes one minute for her temperature to register and a small beep lets her know when the minute is up.

Then she gets up and gets on with her day. Depending on the rise or fall of her temperature, she will tell her husband that today they must have sexual intercourse. Or she will start drinking the first of eight glasses of water to fill her bladder for an ultrasound later in the morning. Or, instead of going to the ultrasound unit, she will dash to her doctor's office for a shot of Pergonal before work.

Nothing is more important to Shirley than the rise and fall of her temperature. It schedules her day, her husband's day, her work-day, her leisure time. It is always in her thoughts. It means that infertility is with her literally from the moment she opens her eyes in the morning.

Under these circumstances, is it any wonder that infertility is a personal life crisis? Shirley and others like her must deal on a day-to-day basis with complex feelings of failure, guilt, anger and frustration that arise from their ongoing struggle to become parents

But infertility is not simply a personal crisis to be resolved within one's self, although that is in itself a major achievement. Infertile people must sort out not only "portraits of their future selves"¹ that may never be realized, but they have to understand how these portraits came to be--and how to change them.

Infertility is a personal problem, but also a sociocultural problem "and the virtually inevitable psychological stress is perhaps induced more strongly by current attitudes in our society than by the situation itself".²

The current attitudes that make parenting the accepted part of adult human activity also drive infertile people to panic and despair when they cannot achieve it. The extreme stress they inevitably feel comes from their inability to be the people they always thought they would be, both to themselves and to the rest of their world.

It was once thought that stress and other emotional factors were the reason for as much as 50 per cent of infertility.³ No wonder infertility has been hushed up or ignored--to admit to it was to admit to being abnormal. Today, even though a medical diagnosis tells them otherwise 95 per cent of the time, that is still how infertile people feel.

On both the personal and social levels, infertile people feel a sense of being out of control, of having their lives manipulated from beyond them.⁴

¹Stephenson, p. 19.

²E. V. Van Hall, p. 367.

³Machelle M. Seibel and Melvin L. Taymor, "Emotional Aspects of Infertility" in Fertility and Sterility, 37 (February 1982) : 137.

⁴Jerome J. Platt, Ilda Ficher and Maurice J. Silver, "Infertile Couples: Personality Traits and Self-Ideal Concept Discrepancies" in Fertility and Sterility, 24 (December 1973) : 976; David L. Rosenfeld and Eileen Mitchell, "Treating the Emotional Aspects of Infertility: Counseling Services in an Infertility Clinic" in American Journal of Obstetrics and Gynecology, 135 (1979) : 179.

This is not surprising, when it is remembered that the medical management of infertility structures their lives. To get back that control, they must resolve their own inner turmoil and learn to cope with being infertile in a fertile world.

Barbara Eck Menning, who has counseled the infertile extensively, has described the feelings that infertile couples go through as they work through the crisis: denial, anger, isolation, guilt and grief.⁵ These feelings follow a pattern very much like the one described by Dr. Elisabeth Kubler-Ross in her widely-known book, On Death and Dying.⁶

Surprise is the initial reaction to the news of infertility. To those who waited until the time was right and faithfully practised birth control for years, it is an unwelcome shock. Some even get married in preparation for the children to come. "I was one of those people who felt that marriage was for children," says Trish, who eventually adopted two children. "We were living together and when we decided to have children, we got married."

Often the news is so overwhelming that the next reaction is denial. As a short-term reaction, denial actually helps infertile people to adjust to their new status.

Then comes anger. Menning says anger is a reaction to the loss of control people feel over their bodies and their destiny, particularly as they undergo the medical treatment of their infertility. Anger can be either rational, focused on real insults and events, or irrational, such as when someone who appears to be in control over them is targeted. Marie, a nurse

⁵Barbara Eck Menning, "The Emotional Needs of Infertile Couples" in Fertility and Sterility, 34 (October 1980): 314 - 317.

⁶Kubler-Ross feels that people confronted with news of their impending death go through four stages before accepting their fate: denial and isolation, anger, bargaining, depression and acceptance. Elisabeth Kubler-Ross, On Death and Dying (New York: Macmillan, 1969).

who underwent eight years of infertility testing, remembers vividly her conversations with God, yelling at Him as she bargained with Him to help her accept her fate.

Isolation follows. As they go through the infertility work-up, couples withdraw into themselves. They try to avoid potentially-hurtful situations, such as family gatherings, where they will be asked to justify their childlessness through well-meaning, but probing, questions from relatives. At the same time, they focus on each other as the sole means of mutual support. This places them under even greater stress, as both partners are already trying to cope with their own complex feelings.

Wendy is a 34-year-old computer programmer. She noticed that it wasn't so much she and her husband Rob who isolated themselves from others, but that their family and friends seemed to withdraw from them. "No one wants to hear about an ache that never goes away or a situation that takes years to resolve. They hide, well-meaning and embarrassed, behind the stance that we will make the first move and come to them if we want support or encouragement."⁷

Guilt is the next feeling. Couples come to think that they are infertile because they are being punished for something. They search frantically for the reason they are so unworthy of being blessed with a pregnancy. Perhaps it was venereal disease or an abortion or premarital sex, they think.

When a couple reach the end of the road for infertility investigations without attaining the desired goal, there is a period of grief. Often grief is preceded by depression, as they realize the end is near. Menning says there are elaborate rituals to help the bereaved through death, but no rituals exist

⁷Wendy Williams, "Thoughts on Infertility", unpublished article, 1987, p. 1.

to comfort people for their *potential* losses. Wendy is carefully articulate as she discusses her feelings on grieving. She keeps a diary detailing her experiences with infertility and writes articles for the ISSG newsletter in Ottawa. She compares her grief at not being able to bear children to her grief at the death of her father:

When he died, no one would have considered coming to the funeral to say, 'well, just be glad you still have your mother'. Nor would they have dared to comfort my mother with 'you're a fine person--you can always remarry'. But the infertile couple hears the equivalent all the time: 'At least you have each other'... or 'well, you can always adopt'.⁸

According to Menning, resolution of the emotional crisis follows these feelings.

The grief model does have limitations when applied to the infertile. Emotional reactions to infertility may not follow a sequential pattern, but can be randomly mixed depending on specific external or internal events, such as pregnancies of other women, menstruation or insensitive comments from other people.⁹ Or the pattern may lead the infertile woman to believe she should be proceeding at a particular speed through emotional stages when that speed is not suited to her personal emotional state.

Infertility counselor Sandra Levine Slover cautions that the couples she sees go through all these emotions, but not necessarily in the order noted by Menning. "They slide in and out. They're just not angry for a week and then come back the next week and they're isolated, but the emotions exist

⁸Ibid.

⁹Anita M. Unruh and Patrick J. McGrath, "The Psychology of Female Infertility: Toward a New Perspective", Health Care for Women International, 6 (1985): 373.

simultaneously," she says. "It's very dependent on how long the couple has been going through infertility and on when the intervention [counseling] comes."¹⁰

In addition, the grief model tends to focus on individual pain, but does not explore why the pain exists: "By its individual focus, the grief model does not provide an avenue for resisting feelings of guilt and self-blame."¹¹

Where the model is useful, however, is when it describes the major emotions that infertile women feel. Although Dr. Pat Gervaise, a psychologist who works with infertile couples at Ottawa Civic Hospital, says she is not trying to move people through stages in her sessions, there are "characteristic patterns".

The characteristic patterns--denial, anger, isolation, guilt and grief--are really only the tip of the emotional iceberg.

Psychologist Patricia Mahlstedt discusses the "excessive losses and prolonged stresses created by infertility"¹² in her article, "The Psychological Component of Infertility".

She discusses losses in adulthood which are important to understanding depression. Such losses include: loss of a relationship, loss of health or an acceptable self or body image, loss of status or prestige, loss of self-esteem, loss of self-confidence or a sense of control, loss of security, loss of a fantasy or the hope of fulfilling an important fantasy, loss of something of great symbolic value.

¹⁰Slover interview, May 28, 1987

¹¹Unruh and McGrath, p. 373

¹²Patricia P. Mahlstedt, "The Psychological Component of Infertility" in Fertility and Sterility, 43 (March 1985): 336.

"Any *one* of these losses could precipitate a depressive reaction in an adult," she writes. "The experience of infertility involves them *all*."¹³

The "self" comes in for quite a beating in a diagnosis of infertility, according to both Menning and Mahlstedt.

On the personal level, self-esteem, or pride in oneself, suffers. Many women attach the experience of motherhood and pregnancy to feelings of femininity and self-worth.¹⁴ Menning, herself infertile, remembers how it felt:

I am an infertile woman. There was a time, some years ago, when I was not able to say those words at all, much less think of myself as an infertile *woman*. The words seemed mutually exclusive. I could be either infertile or a woman but not both.¹⁵

Of course, it is difficult to separate personal feelings on self-esteem from the social level:

Socialization creates a female personality structure for which motherhood becomes a need not easily rejected. To be childless becomes synonymous */sic/* with failure and those feelings are reinforced by cultural and social pressures which evaluate childlessness negatively.¹⁶

The operative word is "failure". For infertile women, every month that they menstruate tells them graphically that they have failed.¹⁷

¹³Ibid.

¹⁴Adrienne D. Kraft, Joseph Palombo, Dorena Mitchell, Catherine Dean, Steven Meyers and Anne Wright Schmidt, "The Psychological Dimensions of Infertility" in The American Journal of Orthopsychiatry, 50 (October 1980): 624.

¹⁵Menning, p. xi.

¹⁶Simenez, p. 624.

¹⁷Mahlstedt, p. 338.

Menning did not conclude by herself that there was something wrong with being both infertile and a woman:

Despite emancipation processes in most Western societies, the majority of couples have a fairly traditional sex-role distribution: the woman is supposed to become pregnant and to have, nurture, and bring up children while the man works... When the... infertility lies in the female partner, her... feeling of self-esteem will be reinforced by feelings of failure and guilt because she is unable to comply with the social expectancy and, moreover, the inability is her fault.¹⁸

Feelings about motherhood are deep-rooted, striking at the heart of a woman's sense of self. Yet, despite this, infertile women are no more articulate than their fertile sisters on the subject of why they want to be mothers. These are women who undergo painful and stressful tests and treatments, who have obviously thought a lot about what they are doing, yet they are unable to articulate *why* they are doing it. Often, they resent being asked--and they usually are asked--why they want to be mothers. No one would think of asking a member of the fertile population the same question. "As if it's unnatural to want to be parents," says Wendy. "It's like saying, 'Why do you want to breathe?'" Most shrug off the question. "It was always there," they say. For those who have thought about it, having children is often an eventual goal, after establishing a career or travelling: "When I was 28, my body started saying 'Make baby'," says Susi. "Before that, it was saying, 'Travel, do this, do that'."

Surely this is the segment of the population most likely to think carefully about why they are going through this experience. Yet their very

¹⁸Van Hall, p. 362.

inability to express it speaks very clearly to the deep-rootedness of their feelings.

"It's not that women walk in and blithely report, 'gee, I just don't feel I'm living up to my role as a woman,'" says Dr. Pat Gervaise of Ottawa Civic Hospital. "Instead, it's just at the deepest level that something is wrong, that they should be having babies.

"Socialization is so strong that we are to nurture, to reproduce, to create a family. We may be professionals and we may have that overlay, but the bottom line is most of us were brought up to be moms. People around us expect it, we expect it of ourselves and, for a lot of women, there's a sense of failure (in not doing it)."

Self-esteem is affected as well when infertile people notice how negative their emotions have become. A few infertile women report becoming so enraged and jealous at the sight of pregnant women that they want to push them down escalators or run over them with their cars. Then they are mortified and feel guilty for being so hateful, so "bad".¹⁹ Sylvie admits she, like many other infertile women, has an immediate, jealous gut reaction to the news of someone else's pregnancy: "Why not me?" she cries inside.

One's self-image also comes under attack. Self-image is developed through self-observation and, "by far the most powerful",²⁰ through the eyes of others. Discovery of a physical defect or a physical illness threatens the stability of the image people have of themselves.²¹

¹⁹Mahlstedt, p. 339.

²⁰Menning, p. 121.

²¹Kraft et al., p. 623.

Infertile people feel something is wrong with them, that their bodies are deficient and defective-- and surely the defect must be apparent to all.²² Their medical diagnosis has already told them that; often the medical treatments make them feel worse. Jane, a naturally-reserved woman, remembers how shattered she felt when the technician, after examining her cervical mucous in a post-coital test, commented that the mucous looked fine, "so why aren't you pregnant?" (She had the presence of mind to answer that she didn't know and that's why she was there.)

Part of one's self-image consists of feelings about sexuality. Infertility is an inherently sexual topic, dealing as it does with the reproductive organs. In addition, sex becomes regimented by medical necessity. The woman must ovulate, the man is expected to get an erection on schedule. Hurry up, the doctor is waiting.

Most couples say that good sex is the foremost casualty of infertility. "It took all the intimacy out of a relationship that was really good to begin with," laments Shirley. Dave, her husband, agrees. "I got tired of the whole thing--having to perform at certain times, bringing in (semen) samples..."

Couples report a loss of spontaneity, a loss of desire, a loss of a sense of themselves as sexual beings. Specifically, they become inorgasmic or impotent.²³ In effect, "making love becomes a mechanical chore and a painful reminder of the failure to conceive".²⁴

²²Seibel and Taymor, p. 138; Mahlstedt, p. 337.

²³David L. Rosenfeld and Eileen Mitchell, "Treating the Emotional Aspects of Infertility: Counseling Services in an Infertility Clinic", The American Journal of Obstetrics and Gynecology, 135 (Sept. 15, 1979): 178, Rose E. Boyarsky, "The Importance of Foreplay in Infertility", Resolve, newsletter, undated; Seibel and Taymor, p. 138.

²⁴Mahlstedt, p. 337.

For men who are infertile, sex becomes particularly difficult to handle: "In our culture, fertility, masculinity and potency are closely related."²⁵ For this reason, male infertility is still a taboo subject. (Women have been known to pretend that the fault for infertility lies with them, or say they wish that it did, so as to salvage their male partners' pride.²⁶) Even producing a semen sample is a major obstacle. Some men refuse to provide a sample or they avoid sex-on-schedule, which thwarts the medical treatment.²⁷

The shift in the sexual relationship from lovemaking to performance is particularly stressful for men. Anita McGrath Unruh is a social worker and researcher who is conducting a study on stress and infertility. Unruh says men feel the burden is on them to perform, "to get their part right".

"They tend to feel objectified and to feel that they have really lost their partner as a lover," she writes. "Some men feel this to the extent that they are unable at times to have intercourse."²⁸

For the woman, "sex is a step in the process", much like "submitting to frequent vaginal examinations".

Unruh says women are bitter about the change in their sex lives, but they grow more resigned to it. Men, on the other hand, protest and "become more passionately angry" about it.

Men and woman who are infertile thrash through these emotions and concepts, often for years, as they learn to cope with infertility. The inner

²⁵Van Hall, p. 362.

²⁶Ibid., p. 363; Pfeffer and Woollett, p. 30.

²⁷Pfeffer and Woollett, pp. 36 - 39.

²⁸Anita McGrath Unruh, personal communication from London, England, July 20, 1987.

crisis is substantial as they deal with a problem that has turned their well-ordered lives upside-down.

Although they typically withdraw into themselves as they work through this process, they must inevitably deal on a social level with the world around them. They must interrelate with their fertile partners, their family and friends and their infertility specialist. And they must do so with the dubious help of a concept of self that has already taken an emotional beating.

In their relationships with their partners, communication suffers the most. Each partner will be experiencing his or her own feelings, often not in synchronization with the other. Marie remembers how difficult it was when she and her husband Jim were trying for their second child. They had "been on the same wavelength" the first time through the infertility clinic, but the second time was different. She was impatient to get pregnant and he was prepared to wait. When they had not conceived after 18 months, the situation was reversed. Marie accepted that it might not happen for some time, but Jim became worried and impatient.

Or the couple might find that the level of interest they have in the infertility investigations fluctuates. Men seem to lose interest in the whole process more easily. They see their partners undergoing the stress and pain of the treatments and they feel helpless.

Anita McGrath Unruh says this helplessness is the second area of great stress for men, after the change in the sexual relationship. "Most men are quite aware of the stress that infertility arouses in their partners and are worried about the obsession and jealousy it creates for their wives," she writes. "However, they perceive that the support they offer has limited effect in easing their partner's pain."

Add sexual problems and you have a recipe for disaster in a relationship. A common reaction to the sexual stress is for both partners to tacitly ignore the fertile time of month. After all, if they don't try to conceive, they won't have failed: "We knew we had to have sex when I was ovulating," says Susi. "Sometimes we wouldn't and there would be bad feelings. We didn't try, so maybe we don't love each other anymore, maybe we don't want kids. We felt guilty and angry, like, why didn't you do it? What's wrong with you?" Michael, her husband, adds reasonably: "Sometimes I just didn't feel like it."

This leads to a tragicomic situation where the couple must face the specialist with the evidence that they did not perform as expected--the temperature chart without the needed circles to indicate intercourse. Even more farcical is when the guilty couple feel they must fake the chart and add the appropriate circles in order to protect their pride.

Men and women differ in their responses to pain and stress. Women traditionally express their emotions more openly than men.²⁹ While women communicate their feelings to their partners, men still internalize. This leads to conflict, as women react by verbalizing more and men retreat further:

[T]he woman feels abandoned when she needs her husband most, and he feels overwhelmed because she needs him so much. They begin to resent each other and become depressed not only by their failure to conceive but also by their loss of closeness and ability to understand.³⁰

²⁹Martha E. Griffin, "Resolving Infertility: An Emotional Crisis" *AORN Journal*, 38 (October 1983): 600.

³⁰Mahlstedt, p. 337.

3

2.8

3.2

5

4

Micro-D

In addition, "many women feel they are unable to talk to their partners for as often or as long as they need or want to about infertility," writes Anita McGrath Unruh. She draws an example from her own experience with infertility: "I know I once mentioned this to my husband (and I felt I coped with infertility quite well) and he said that I mentioned infertility at least once a day! I was quite astonished and disbelieving, but watched myself over the next week and found that indeed I felt the urge to discuss it in some way at least once a day.

"I don't think that women in general are aware of the considerable demands we make on our partners to be supportive."

Family and friends are often a source of stress to the infertile couple. Some couples try to avoid the unwanted advice and pity by not revealing they are infertile. But if they do not tell anyone they are infertile, the stress of keeping it to themselves can be unbearable for their relationship. "Infertility has a terrible power" when it is kept secret, according to Jane, who had to learn to overcome her reserve and confide in people.

The couple must also then put up with well-meaning questions, such as "so when are you two going to start a family?" and "how many children do you have?"

Marie Morrissey, the founder of the Infertility Self-Help Support Group in Ottawa, says she and her husband told the people they felt could help them the most through the crisis. "And the people we did tell were extremely supportive," she adds.

For others, it's not so simple. People one expects to be supportive turn out not to understand. Many infertile women have problems with their mothers. Trish Maynard is a group leader for the Infertility Self-Help Support Group. She believes mothers feel guilty about their daughters'

infertility: "They feel somehow it's connected to them, that it was something they did." At the same time, the mothers are more fatalistic and accepting than their infertile daughters, believing "if you're meant to have children, then you'll have them".

Some families try to pretend the infertility does not exist. They simply ignore it. "With my family, when we do bring the topic up, the conversation stops. That's it," says Rob. "If we waited for them to bring the subject up, it would never come up."

Even if no particular person in the family circle is unsupportive, it is still difficult for the infertile couple to relate to other family members who are juggling their children at the Christmas dinner table while trying to commiserate or converse.

Family and friends may be sympathetic, but not know what to say. Some try and minimize their own parenting experience. "You want kids? Take mine!" they say. Or, fearful of the reaction of the infertile couple, they don't let them know when someone in the family circle gets pregnant. "I didn't hear from my family about it," Susi recalls of her younger sister's first pregnancy. "I heard about it from a friend on the street."

Others are thoughtlessly cruel. Michael recalls one memorable family gathering: "My aunt asked me, 'Why don't you have any children?' I said we're having a few problems, but I didn't say what specifically. She said, 'Well, you can always marry another girl'."

Most just offer advice. Although infertile people usually can shrug off specific advice, like how wearing boxer shorts instead of briefs will get her pregnant in no time, they do resent being told to "relax".

"People used to say, 'If you relax, if you rest, take a holiday, change jobs, you'll get pregnant', implying that it was a psychological problem, that it was my nerves getting in the way of me making babies," says Susi.

For every infertile woman, there seems to be some family folklore as to why she can't conceive. For some, it's a weight problem. For others, it might be the lower back exercises they never do, or that they're too uptight or too high-strung.

The danger in telling too many people, as some couples have discovered too late, is the lack of privacy. If your best friend knows you're having a sperm invasion test, she's likely to call you up and ask how it went. But so will your mother, your co-worker, your sister-in-law and assorted others. And infertility takes over in yet another way. The identity of the infertile person becomes limited to the description of him or her as infertile.

The loss of privacy extends to the medical process and medical practitioners. As Wendy says with ironic humour, referring to conception through reproductive technologies: "How many people know the exact moment they got pregnant? And not only that, but they had six other people there? And, in fact, didn't even have to have sex that month?"

Even other infertile people sometimes say the wrong thing or cannot help. Although it is usually a relief to be able to commiserate with others sharing the same problem, infertile people can also react harshly to each other.

American writer Mark Jacobson and his wife have had the experience of infertility followed by pregnancy. Jacobson recently described the almost-hurt reaction of his and his wife's infertile friends to their happy news:

100

"It wasn't that they weren't happy for us. They were. You could sense that in their voices, see it during their visits. Their baby gifts were invariably the best, the ones reflecting the most thought and warmth. Yet, it was there, too, the growing hurt, as if our good fortune had added yet another small increment to their torture," Jacobson writes in Esquire.³¹

Although there might be a more tactful moment to announce a pregnancy to fellow infertiles than after their unsuccessful tubal surgery, the mixed feelings are usually there, regardless of timing.

Those who have secondary infertility know how it feels to be a part of the infertile crowd, but somehow not a part of it because they have a child already. They can be shunned by other infertile couples, although they need the same support.³² "Be grateful that you already have a child" is the response of both the infertile and fertile population (and sometimes the medical profession).

"I felt guilty," says Elizabeth, a day-care worker who already had a son when she resumed infertility treatment. "I felt really greedy. But then I thought, why shouldn't I have more? My feelings were just as strong this time as last time. I still went through everything--the testing, the frustration."

Relations between the infertile couple and their specialist swing with the ups and downs of the treatment. Because the specialist is seen as the person in control of their lives, resentment and anger can develop. In the traditional physician-patient relationship, the specialist is a man and the patient is a woman. His feelings toward women in general can subtly enter

³¹Mark Jacobson, "Baby Chase: Struggles with the Inconceivable" reprinted from Esquire, May 1987 in The Ottawa Citizen, June 6, 1987.

³²Andrea Shrednick, "Secondary Infertility", Infertility Self-Help Support Group, newsletter, 2 (February 1987): 6.

THE
JOURNAL OF THE
ROYAL ANTHROPOLOGICAL INSTITUTE

into a relationship where he is already her superior because of his professional knowledge and the traditional status of a doctor ³³ Sometimes it is not subtle at all: "One doctor called me 'kiddo' and smiled paternally and patronizingly at my questions. Then he told me I shouldn't worry my pretty little head over all of it, and suggested I just trust him to do what's best."³⁴

Quite apart from problems with paternalism, doctor-patient communication often suffers. Patients hear emotionally upsetting news of test results and tune out the rest of what is being told them. If a combined factor for infertility is involved, the woman may be told one thing by her doctor and the man told something different by his doctor.

After hearing conflicting stories from their different specialists, Susi insisted on accompanying her husband to his appointment. Once there, his urologist phoned her doctor and discussed the case in front of them. Her doctor, who had been telling her she had no problems, then told the urologist that maybe she wasn't ovulating. "That was the first time I'd ever heard about it. I was livid," she recalls. "Why would he tell someone else that I'm not ovulating [and not tell me]? How dare he?"

Such outright breakdowns in communication do not happen all the time. Not every infertile woman has a horror story about her specialist, although residents and gynaecologists--the non-specialists--do come under fire for their insensitivity or poor communicative skills fairly often. Susi walked out on infertility testing for a year after a confrontation with an insensitive resident who was substituting for her regular specialist.

³³E. V. Van Hall, "Androgyny: A Model for Improving Gynaecologist-Patient Relations", Journal of Psychosomatic Obstetrics and Gynaecology, 1 - 2 (1982) : 87.

³⁴Stephenson, p. 89.

1
 2
 3
 4
 5
 6
 7
 8
 9
 10
 11
 12
 13
 14
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25
 26
 27
 28
 29
 30
 31
 32
 33
 34
 35
 36
 37
 38
 39
 40
 41
 42
 43
 44
 45
 46
 47
 48
 49
 50
 51
 52
 53
 54
 55
 56
 57
 58
 59
 60
 61
 62
 63
 64
 65
 66
 67
 68
 69
 70
 71
 72
 73
 74
 75
 76
 77
 78
 79
 80
 81
 82
 83
 84
 85
 86
 87
 88
 89
 90
 91
 92
 93
 94
 95
 96
 97
 98
 99
 100
 101
 102
 103
 104
 105
 106
 107
 108
 109
 110
 111
 112
 113
 114
 115
 116
 117
 118
 119
 120
 121
 122
 123
 124
 125
 126
 127
 128
 129
 130
 131
 132
 133
 134
 135
 136
 137
 138
 139
 140
 141
 142
 143
 144
 145
 146
 147
 148
 149
 150
 151
 152
 153
 154
 155
 156
 157
 158
 159
 160
 161
 162
 163
 164
 165
 166
 167
 168
 169
 170
 171
 172
 173
 174
 175
 176
 177
 178
 179
 180
 181
 182
 183
 184
 185
 186
 187
 188
 189
 190
 191
 192
 193
 194
 195
 196
 197
 198
 199
 200
 201
 202
 203
 204
 205
 206
 207
 208
 209
 210
 211
 212
 213
 214
 215
 216
 217
 218
 219
 220
 221
 222
 223
 224
 225
 226
 227
 228
 229
 230
 231
 232
 233
 234
 235
 236
 237
 238
 239
 240
 241
 242
 243
 244
 245
 246
 247
 248
 249
 250
 251
 252
 253
 254
 255
 256
 257
 258
 259
 260
 261
 262
 263
 264
 265
 266
 267
 268
 269
 270
 271
 272
 273
 274
 275
 276
 277
 278
 279
 280
 281
 282
 283
 284
 285
 286
 287
 288
 289
 290
 291
 292
 293
 294
 295
 296
 297
 298
 299
 300
 301
 302
 303
 304
 305
 306
 307
 308
 309
 310
 311
 312
 313
 314
 315
 316
 317
 318
 319
 320
 321
 322
 323
 324
 325
 326
 327
 328
 329
 330
 331
 332
 333
 334
 335
 336
 337
 338
 339
 340
 341
 342
 343
 344
 345
 346
 347
 348
 349
 350
 351
 352
 353
 354
 355
 356
 357
 358
 359
 360
 361
 362
 363
 364
 365
 366
 367
 368
 369
 370
 371
 372
 373
 374
 375
 376
 377
 378
 379
 380
 381
 382
 383
 384
 385
 386
 387
 388
 389
 390
 391
 392
 393
 394
 395
 396
 397
 398
 399
 400
 401
 402
 403
 404
 405
 406
 407
 408
 409
 410
 411
 412
 413
 414
 415
 416
 417
 418
 419
 420
 421
 422
 423
 424
 425
 426
 427
 428
 429
 430
 431
 432
 433
 434
 435
 436
 437
 438
 439
 440
 441
 442
 443
 444
 445
 446
 447
 448
 449
 450
 451
 452
 453
 454
 455
 456
 457
 458
 459
 460
 461
 462
 463
 464
 465
 466
 467
 468
 469
 470
 471
 472
 473
 474
 475
 476
 477
 478
 479
 480
 481
 482
 483
 484
 485
 486
 487
 488
 489
 490
 491
 492
 493
 494
 495
 496
 497
 498
 499
 500
 501
 502
 503
 504
 505
 506
 507
 508
 509
 510
 511
 512
 513
 514
 515
 516
 517
 518
 519
 520
 521
 522
 523
 524
 525

Coping with partners, family, friends and the medical profession--not to mention co-workers and assorted others--becomes a daily emotional rollercoaster. The boss allowed you to take a half-day off to get that ultrasound with no questions asked? A definite feeling of relief. You get a menstrual cramp and can't pretend to yourself any longer that you might be pregnant? Down in the dumps again.

With such extremes in feelings, infertile people spend a lot of time agonizing over whether or not they are "normal". Family and friends may question their single-minded devotion to their pursuit of parenthood. They may see job opportunities evaporate because they are unwilling to make transfers to other locations and leave their infertility workup behind. And they are *so* touchy every time babies are mentioned in a conversation.

Are they normal or neurotic? Not only the infertile and those in their social circle ask the question. Infertile women have been labelled more neurotic, dependent and anxious than fertile women in psychological profiles.³⁵ They show significant emotional disturbance³⁶, it is reported, more anxiety and more neuroses than infertile men.³⁷

These studies come from psychoanalytic theory, the same Freudian school that believes women are only fulfilled in their mothering roles. The Freud-influenced literature depicts infertility as "as disguise for deep-seated psychosexual conflicts, particularly in women".³⁸ At one time, when it was

³⁵Seibel and Taymor, p.137.

³⁶J. Stephen Bell, "Psychological Problems among Patients attending an Infertility Clinic", Journal of Psychosomatic Research, 25 (1981) : 2.

³⁷Platt et al., p. 976.

³⁸Margarete Sandelowski, "Sophie's Choice: A Metaphor for Infertility", Health Care for Women International, 7 (1986) : 445.

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

thought that 50 per cent of all infertility was caused by psychological factors in women,³⁹ this school of thought was very powerful.

"There is no truth to the notion that women can't get pregnant because they're frigid or they're this or they're that," emphasizes Dr. Pat Gervaise. "As science progresses and they find out the physical problems, that group gets smaller and smaller. But women have been really raked over the coals because of psychoanalytic interpretation." It is now believed that only five per cent of infertility is caused by psychological factors.

These studies also do not take into account the stress that infertility itself places on infertile couples. Infertility provides them with "a frequently insoluble problem that taxes them physically, financially, and emotionally."⁴⁰

So the answer, if there is one, is yes--and no. Individually, they may exhibit some neurotic behaviour, but there is nothing to suggest that they are any more neurotic than the fertile population.⁴¹ They are more stressed, more emotionally upset, more anxious, but this is a result of, not a cause of, infertility. Above all, it is because of the situation in which they find themselves: "Only recently have there been efforts to view psychological dysfunction as *resulting from* the experience of being infertile in a treatment environment that is intrusive, painful, and embarrassing and in a social milieu in which childlessness is considered deviant."⁴²

The question of normalcy is one which infertile people must come to terms with as they learn to cope. Once they understand that their anger and

³⁹Seibel and Taymor, p. 137.

⁴⁰Ibid.

⁴¹Ibid.

⁴²Sandelowski, p. 446.

1970-1971

guilt are normal, given their situation, they are on their way to regaining the control they lost.

There is some speculation that typical personality traits mark those who are better able to cope. These traits might be related to the concept of androgyny, that is, having both male and female characteristics.

Dr. John D. Adler, an Oregon doctor, conducted a study for the Skamania County Counseling Center in Stevenson, Washington, to determine if sex roles would predict the extent to which people experience problems in coping with infertility.

He checked out the self-esteem and body image of female and male infertility patients and found that those scoring higher in masculinity or androgyny reported fewer problems in coping. These were the patients with higher self-esteem and somewhat better body images: "[M]asculine characteristics such as assertiveness and goal directedness lead to more successful experiences (better self-esteem) in our society."⁴³

The "masculine" trait of being achievement-oriented is of particular interest to Barbara Eck Menning. She says the discovery of an infertility problem is felt "most keenly" by those who are achievement-oriented, because these people believe themselves capable of surmounting obstacles through enough effort and will.⁴⁴ After the initial discovery of the problem, these people might very well fall into the pattern studied by Dr. Adler, but no one has put the discovery of the problem together with ultimate ability to cope with it.

⁴³John D. Adler and Russell L. Boxley, "The Psychological Reactions to Infertility: Sex Roles and Coping Styles", Sex Roles, 12 (1985) ; 278.

⁴⁴Menning article, p. 315.

[Illegible vertical text]

It is interesting that one infertile woman who said she had an upbringing more or less free of traditional sex-role stereotyping is also the rare woman who chooses to resolve her infertility by remaining childless. Barbara Carroll is self-admittedly very goal directed: "As I pursued my career, I did so with the kind of singlemindedness that I had once applied to infertility."⁴⁵

Dr. Gervaise feels coping with infertility has less to do with achievement orientation or traditional values and more to do with the couple's relationship.

"I don't think that achievement-oriented women do any better than those who identify themselves as nurturant," she says. "From my clinical experience, I would say that what makes the difference is the communication pattern between the couple. The coping is really in a large part a function of the relationship. If the relationship is working... they get through it."

Any studies done in the area of coping and infertility have one glaring fault. The infertile subjects for the studies are all taken from the ranks of those who attend infertility clinics. A large element of self-selection is involved in choosing to attend clinics. Do these people, who become the subjects of the studies, have different character traits than those who do not make the decision to attend?⁴⁶ Are they more goal-oriented, more aggressive in the pursuit of parenthood? Do the very qualities that make them pursue infertility treatments also make it more difficult for them to cope?

⁴⁵Barbara Carroll, "After Infertility - The Child-Free Option", p. 7

⁴⁶Pauline Slade, "Sexual Attitudes and Social Role Orientations in Infertile Women", Journal of Psychosomatic Research, 25 (1981) - 185.

UNIVERSITY OF CALIFORNIA

Dr. Gervaise says little research is being done in this area. She personally feels that the group of women who do not pursue infertility "don't have, for whatever reason, that strong a desire to reproduce". She suspects these women might put children in their lives another way.

Personal character traits are undoubtedly an important part of different coping styles. Infertile couples have devised other coping mechanisms, some to deal with specific problems, others that speak to the situation of being infertile itself.

Jane dealt with the frustration of long waits at the clinic by phoning ahead to ask if the doctor was seeing patients on time that day. She also kept her own file of test results. On occasion, she was able to provide results when they were not readily available in her clinic file. Small steps at assertiveness, perhaps, but they made her feel in control.

A sense of humour proved valuable to Marie Morrissey. On the most auspicious day in the cycle for conception, her husband would call her at work, shout "tonight's the night!" and hang up. This would go on all day and would include message slips when she wasn't available to answer the call.

Sylvie had to laugh at the irony of finally being declared ready to conceive by her doctor, when fate seemed to decree otherwise: "They said, 'Go ahead, try'. The first month, I had a vaginal infection. The second month, he was away on a business trip. The third month, I was working in an area with toxic substances..."

Susi took comfort in her depiction of the nurse at her clinic who checks the temperature charts as "The Chart Police". Whenever there weren't enough circles (denoting intercourse) on the chart, thoughts of The Chart Police would spur her on, she says.

100

Some couples work hard at renewing their once-satisfying sex lives. They take care to "make love" at infertile times as well as "have intercourse" at the fertile times.⁴⁷ They work at putting romance back into what has become mechanical and stressful.

One way to cope is by taking a break from the infertility treadmill. Those who have tried it highly recommend it to put infertility back into perspective within a larger scheme of things. But it is very difficult to convince couples to try it when they are certain that this month is the month they will finally conceive.

Dr. Gervaise tells her patients they are involved in infertility regimens like keeping temperature charts in order to provide data for the doctors, not because they are going to get the reward of a baby for doing it. "If you want to take a break, take a break. They can live without their data for three to six months, however long it is."

Jane and her husband have taken breaks at two different times in their infertility treatments. The first time, they were exhausted after a drug regimen that was affecting Jane's whole system adversely, notably through constant vomiting. They decided after that break not to continue with the drugs. The second break came after a miscarriage. (She conceived without the drugs.) They planned a holiday for two of sailing and relaxing--and not taking along the thermometer.

Support groups are considered vital by those who attend them. Very few infertile people in Ottawa know of the existence of the Infertility Self-Help Support Group. Doctors do not routinely recommend the group to patients, because they fear they are anticipating an emotional problem

⁴⁷Stephenson, p. 72.

UNIVERSITY OF CALIFORNIA

which may not exist.⁴⁸ The only advertising the group does is by leaving pamphlets in the waiting-rooms of the two local clinics.

The support group provides a "safe arena" for infertile people to express their feelings and to receive information that helps allay their fears. Groups consist of about five to seven individuals or couples who meet weekly for several months.

Trish Maynard comes in contact with infertile people who have not attended the support group. A group leader for the Open Door Society, an organization for prospective adoptive patients, Maynard says many wish they had heard of the group.

"They're in a lot of pain," she says. "They fully expect they should have gotten over infertility because they've progressed on to adoption. But they have a lot of problems because they haven't resolved a lot of issues around their infertility because they haven't talked about it a lot."

Counseling also helps infertile couples cope. Infertility counseling is relatively new. In Ottawa, a social worker has been working in conjunction with the General's clinic for several years. A psychologist has recently been hired at the Civic Hospital's clinic to work part-time with infertility patients. "Counseling isn't going to solve infertility," says Sandra Levine Slover, the General's social worker, "but it's going to make it somewhat more bearable."

One advantage to couple counseling is that it allows the male partner to express his emotions, often for the first time. "Often it's he who benefits more, because no one has asked him how he feels and how he's coping," says Slover.

Resolving the crisis of infertility involves much soul-searching by the couple. They must each individually come to grips with infertility and then

⁴⁸Dr. J. E. H. Spence, interview in Ottawa, July 14, 1987.

Unlabeled

arrive together at a mutually agreed-upon course of action. Essentially, they must decide how far they will go in the pursuit of parenthood.

Many couples will go to the wall to become parents. They will undergo whatever treatments are necessary. Others draw the line early in the quest. One couple were told by their doctor that their very first test would be the post-coital test. After the doctor described the test to them, their response was immediate: "Are you out of your mind?" That's where they stopped. To them, the first test in their infertility work-up had too much medical intervention.⁴⁹

Even if a couple feel they know how far they will go, new reproductive technologies are blurring the lines for them. Where once they could emphatically draw the line, almost daily revelations of newer breakthroughs cause them to rethink their position. In effect, the new technologies may never allow them to close the door on infertility if there is always one more avenue to try.

The next chapter discusses the "one more avenue" world of reproductive technologies and their effect, emotionally and physically, on infertile couples.

⁴⁹Maynard interview, July 20, 1987.

C
10-2,
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50

CHAPTER 6

REMAKING BABY-MAKING:

INFERTILITY AND REPRODUCTIVE TECHNOLOGIES

It's the high-tech version of "boy meets girl". Sperm meets egg in petri dish. Happiness follows.

To the public, reproductive technologies are an intriguing but distant concept that comes to mind once in a while when another breakthrough is announced in the media.

For the infertile, however, they represent a very real dilemma. The option of using them comes to an infertile couple at the end of physically and emotionally draining medical treatments. The couple might be at the point of giving up when in vitro fertilization, where sperm and egg are fertilized in a laboratory dish, or other reproductive variations offer them one last try at parenting.

It's an easy decision--when it's abstract. Most people approve of the new technologies. In an American survey of women undertaken by Omni, a popular science magazine, 88 per cent of women said they would consider in vitro fertilization. Those surveyed said they were pleased that women have so many new childbearing options (68 per cent) and found none of the new options to be immoral (41 per cent).¹

¹Women polled came from the United States, England, Japan and South Africa. Kathy Keeton and Yvonne Baskin, Women of Tomorrow (New York: St. Martin's/Marek, 1985), pp. 287 - 88.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
84

Among the infertile, opinion is cautiously optimistic about the new technologies--again, in the abstract. "If it works for one, then it's a good thing," says Michael, who has undergone infertility testing. Yet he and his partner said an outright "no" when in vitro was recommended to them. At the time, they were exploring several different avenues of treatment. The next year, when it came down to in vitro being the only way they could conceive, they changed their minds and put their names on a waiting list.

Whereas the public does not distinguish among the different kinds of reproductive technologies, the infertile are by necessity better informed. They are better-educated and better-read than potential parents of yesteryear² and they have had the advantage of a decade of technological development since the first in vitro baby was born in 1978.

Most of the newer technologies are variations of in vitro fertilization (IVF), the so-called "test-tube baby" process. In this kind of procedure, the sperm and egg are transported at some point outside the body. Newer variations are GIFT (Gamete intrafallopian tube transfer) and in vivo fertilization³, or egg transfer.

Artificial insemination has been available for so long that it is hardly considered high-tech, but it is a starting point for several other procedures: AID (by donor), AIH (by husband), AIC (by combined husband and donor), artificial embryonation and surrogacy. In these procedures, the sperm and egg meet inside the body (see figure 2).

Popularized as the first modern reproductive technology, artificial insemination (AI) has been around for at least 100 years. The first

²Slover interview, May 28, 1987.

³In vitro is Latin for "in glass", in this case meaning in a laboratory or petri dish. In vivo is Latin for "in the body".

U. S. DEPARTMENT OF AGRICULTURE

FIGURE 2
REPRODUCTIVE TECHNOLOGIES

In Vitro Fertilization

woman infertile; man fertile; tubal factor

♀
genetic mother
is female
partner

♂
genetic father
is male
partner

- egg meets sperm in petri dish
- two days elapse
- fertilized egg inserted into female partner's uterus

GIFT (Gamete Intrafallopian Tube Transfer)

woman infertile; man infertile; cervical or (marginal) seminal factor

♀
genetic mother
is female
partner

♂
genetic father
is male
partner

- sperm meets egg in petri dish
- minutes elapse
- sperm and egg mixture is inserted into female partner's fallopian tube

AIH (Artificial Insemination by Husband)

woman fertile; man fertile; combined or cervical factor

♀
genetic mother
is female
partner

♂
genetic father
is male
partner

- male partner's sperm sample collected
- sperm inserted into female partner's vagina near cervix

AID (Artificial Insemination by Donor)

woman fertile; man infertile; seminal factor

♀
genetic mother
is female
partner

♂
genetic father
is sperm
donor

♂
social father
is male
partner

- donor sperm sample collected
- sperm inserted into female partner's vagina near cervix

Union County, N.C.

Surrogacy

woman infertile; man fertile; (probable) ovulatory or uterine factor

- male partner's sperm sample collected
- sperm inserted into host mother's vagina near cervix

In Vivo Fertilization (Egg or Embryo Transfer)

woman infertile; man fertile; ovulatory factor

- male partner's sperm sample collected
- sperm used to inseminate donor mother
- fertilized egg flushed from donor mother
- fertilized egg inserted into female

Host Uterus

woman infertile; man fertile; uterine factor

- egg and sperm meet in petri dish
- two days elapse
- fertilized egg inserted into donor woman's uterus

UNITED STATES DEPARTMENT OF THE INTERIOR

documented insemination was performed in 1884 on a woman using a medical student's sperm. The woman did not know the insemination was taking place.⁴ During World War II, soldiers could arrange to deposit their sperm in sperm banks before going to war assured of their reproductive future.⁵

Artificial insemination by donor (AID) is the most common AI procedure. It allows an infertile couple to share the experience of pregnancy when the man is infertile.⁶ It has been called "semi-adoption" because one-half of the genetic material used belongs to the couple.⁷

In AID, a donor's sperm is inserted into the woman's vagina near the opening to the uterus. This is timed to be as close to the woman's ovulation as possible. Conception then proceeds as usual, with the sperm travelling up to the tubes to meet the egg.

In effect, AI is a treatment for male infertility where the woman becomes the patient.⁸ One woman's partner wasn't even present at "their" first attempt at AID. In the examining room with her male doctor and a semen sample from an unknown man, she recalled, "[i]n this ultra clinical environment, two strange men were... trying to impregnate me!"⁹

⁴Gena Corea, The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs (New York: Harper and Row, 1986), p. 12.

⁵Bartha Maria Knoppers, "Women and the Reproductive Technologies" in Family Law in Canada: New Directions, Elizabeth Sloss, ed., (Ottawa: Canadian Advisory Council on the Status of Women, 1985), p. 212.

⁶Andrews, p. 161.

⁷Barwin interview, June 5, 1987.

⁸Van Hall, "The Infertile Couple...", p. 363.

⁹Pamela M. Bond, "Male Infertility and AID", Resolve, newsletter, April 1984, p. 5.

U
S
C
A
R
E
C
O
R
D

Success rates vary with AID. The overall rate is believed to be close to that of the fertile population¹⁰--about 80 per cent within a year of trying--but there is some variance. Dr. Norman Barwin in Ottawa reports a 72 per cent success rate over six months.¹¹ Doctors with large practices tend to have high success rates.¹² Different procedures are tried to improve the rate of success: removing impurities from the sperm, mixing fresh and frozen sperm¹³ or using "split ejaculate", where the first half of the ejaculate, which has more healthy and active sperm, is used.¹⁴

Donor selection is a vital part of AID. Traditionally, donors have been medical students who happen to be available when a woman is to be inseminated.¹⁵ Often donors are paid a nominal sum, about \$25 per ejaculate.¹⁶ This raises the question whether they should be called sperm donors or sperm vendors. Although this is not an issue for most participants in AI programs, it could have an effect on the quality of the sperm collected. Rona Achilles is writing a thesis on artificial insemination by donor for the Ontario Institute for Studies in Education. In an article she wrote for Healthsharing, she draws a parallel with blood donors:

The major argument for payment is that, without reimbursement, donors would not come forward. But there are countries like Sweden and France where donors are *not* paid, and their AID programs

¹⁰Philip Marchand, "How Infertile Couples become Parents", Chatelaine, November 1983, p. 109.

¹¹Barwin interview, June 5, 1987.

¹²Andrews, p. 181.

¹³B. Norman Barwin, "Artificial Insemination by Donor with Fresh Human Sperm", Male Reproduction and Infertility, 1983, p. 297.

¹⁴Menning, p. 57.

¹⁵Peter Garner, "Artificial Insemination", Infertility Self-Help Support Group, newsletter, 1 (December 1985): 2.

¹⁶Thorpe, p. 11.

SECRET

continue to operate. In contrast, blood donors in Canada are *not* paid, and there is strong evidence that in countries where they do get paid the quality of donated blood declines.¹⁷

Sperm banks now exist which screen the donors using a variety of criteria. They are screened for current or hereditary health problems and blood type. Donors are matched to physically resemble the male partner as closely as possible.¹⁸ If sperm is not available with the appropriate characteristics, one Ottawa doctor imports frozen sperm from a reputable bank in New York.¹⁹

Ironically, artificial insemination by donor is the easiest new technology, in terms of the procedure itself, but the one that causes the strongest negative reactions. The Omni survey reports that half of the women surveyed, when given a choice between AID or adoption, said they preferred to adopt.²⁰

Infertile couples also react strongly to AID. According to Dr. J. E. H. Spence at the Civic Hospital's infertility clinic, "The biggest refusal is for AID. Because in vitro fertilization involves both partners, they're going to have a baby together. With AID, it's 'you're going to have a baby, I'm going to be a bystander'".

Dr. Peter Garner reports that couples who do choose to go through AID have very stable marriages and seem to have already "pre-selected" themselves for the procedure. He says the divorce rate after AID is between

¹⁷Achilles, p. 13.

¹⁸Resolve, "Facts about Artificial Insemination", pamphlet, 1980, p. 1; Marchand, p. 107.

¹⁹Barwin interview, June 5, 1987.

²⁰Kathy Keeton with Yvonne Baskin, "Birthtech", Omni, December 1985, p. 97.

Wm. H. H. H. H. H.

one and five per cent, many times lower than the divorce rate for the general population, which approaches 50 per cent.²¹ Ninety-eight per cent of couples who do go ahead with AID believe they made the right decision.²²

Secrecy is also an important consideration in AID. Sperm donors expect anonymity. In return, they are not informed if a woman becomes pregnant with their sperm.²³ The couple who bring up an AID child usually also maintain their privacy by not explaining the circumstances of conception.

This not only has legal fall-out--with problems arising from determining legitimacy and inheritance rights--but is unsettling on a social level as well. After all, what the infertile couple is doing, as Rona Achilles phrases it, is "passing" for fertile.²⁴ Although they have a right to their privacy, it seems odd that adoption is discussed openly, but AID, which pinpoints the male as the infertile partner, is still very much a closed subject: "Maybe that is because biological fatherhood still means genetic parenthood, and social fatherhood is so ambiguous... What makes a man 'really' the father of a child in this society, if not genetics?"²⁵

AID is difficult for the male partner because he must accept his infertility, which is so tied in a man to his socialized feelings of potency and masculinity.²⁶ Secrecy over AID at least allows him to maintain a fictional paternity.

²¹Garner, p. 2.

²²Andrews, p. 186.

²³Resolve, "Facts about AI...", pamphlet, p. 1.

²⁴Achilles, p. 12.

²⁵Barbara Katz Rothman, "How Science is Redefining Parenthood", Ms., August 1982, p. 154.

²⁶Van Hall, "The Infertile Couple...", p. 362.

University of California

Some use of artificial insemination by husband (AIH) was developed in response to these feelings. The procedure is actually called AIC, because it combines the sperm of the male partner with that of a donor. The male partner can then feel that he could be the genetic father of the child.²⁷

Although AIH by itself is used rarely because it does not have a high success rate overall--about 18 per cent²⁸--it can be used when there is a cervical problem such as sperm antibodies. In this kind of case, the sperm is introduced into the uterus, bypassing the vagina and cervix where the problem occurs.

AIH is also used to help things along when factors other than sperm problems exist. If a woman has an ovulatory problem and is visiting the doctor at the time of ovulation, her partner can be asked to produce a semen sample. The doctor will then inseminate the woman. AIH in this case bypasses the vagina, giving the sperm an extra chance to fertilize the egg on schedule.

"It happened the very first time I went in for a [cervical] mucous test and I brought in my husband's sperm sample," says Shirley, 33, a cartographer. "I remember the doctor saying 'we'll give this a try' and I had no idea he was going to do artificial insemination. He said, 'Waste not, want not'".

Surrogacy is another new form of reproduction that has received a lot of publicity. It is usually known as surrogate motherhood, a misnomer,

²⁷Resolve pamphlet, p. 2.

²⁸B. N. Barwin, "Intrauterine Artificial Insemination by Husband-- A Neglected Field", Male Reproduction and Infertility, 1983, p. 307.

UNIVERSITY OF CALIFORNIA

as there is nothing surrogate about the role the host mother plays in the situation.²⁹

Surrogacy is a variation of artificial insemination wherein a donor egg and uterus are used along with the male partner's sperm. Sperm donation is a function a man can perform anonymously, but surrogacy, in using a donor uterus, is a much more visible technique. The child is in the custody of the host mother for nine important months as it develops. Unlike AID, the two parties involved are known to one another, as the infertile couple hopes to "share" the experience of the pregnancy with the host mother or because the couple often personally choose who will bear their child. It becomes a complex legal situation, with a contract signed by both parties.

In the legal contract, the onus is on the host mother to produce a healthy child. A damaged child can be grounds for breaking the contract, as can the behaviour or lifestyle of the host mother during pregnancy if that is written into the contract.³⁰ The terms of payment are also laid out. The cost of using a surrogate service is high--about \$25,000 U.S., with \$10,000 of that going to the host mother.³¹

Because surrogacy is so new--the first known case was in the United States in 1977--there are few laws governing it. Business people, doctors

²⁹Surrogate means substitute. The woman who is inseminated uses her own egg and uterus and gives birth, thus she is the mother, not the surrogate mother, of the child. The surrogate mother, if there is one, is the female partner of the genetic father. Somer Brodribb, "Reproductive Technologies, Masculine Dominance and the Canadian State", occasional paper, Centre for Women's Studies in Education, (Toronto: Ontario Institute for Studies in Education, 1984), p. 11.

³⁰Corea, p. 241.

³¹Andrews, p. 206; Quindlen, p. 26.

UNITED STATES DEPARTMENT OF THE INTERIOR

and lawyers have leapt into the breach to provide this commodity to infertile couples by starting up surrogate centres.³²

In Canada, the legal status of surrogacy is unclear.³³ This may be why a growing number of Canadians are turning to the United States to find surrogates to bear their children.³⁴ In England, surrogacy is illegal.³⁵ In the U.S., often laws concerning adoption and AID are used when complications arise.³⁶

Surrogacy, like most forms of artificial insemination, is medically straight-forward, but emotionally risky. Despite a legal contract, the host mother can change her mind. That's what happened in a well-known case in New Jersey in Spring 1987. The father of the child, William Stern, went to court and eventually received custody of Baby M (as she was named by the court), although not before intimate details of the lives of everyone involved in the case became coffee-break conversation all across North America.³⁷

The host mother is the vital ingredient in this three-parent mix, yet very little screening is done to ensure that this relatively anonymous woman will fulfill the terms of her contract.³⁸

And this is what is all-important, that she comply with the contract. William Stern, Baby M's biological father, made that clear when he went to

³²Corea, p. 214; Andrews, p. 205.

³³In 1985, the Ontario Law Reform Commission proposed that surrogate childbearing arrangements be legalized. Graham Fraser, "Sociologist calls for Probe of Reproduction Technology", The Globe and Mail, March 3, 1987.

³⁴CTV National News, June 7, 1987.

³⁵Thorpe, p. 21.

³⁶Andrews, p. 228.

³⁷Michele Landsberg, "Baby M decision gives legal backing to inhuman practice", The Globe and Mail, April 4, 1987.

³⁸Susan Ince, "Inside the Surrogate Industry" in Arditti et al., p. 102.

67-10000-10000

court to get custody when the host mother changed her mind. The public seems to agree. In a Globe-Enviro-nics poll, 59 per cent of those polled agreed that the couple should get the baby even if the host mother changed her mind.³⁹

According to the biological fathers of these children, to the public and to the law, the host mother is the means to fulfilling a contract and nothing more.

These are rigid terms for the 600 or so⁴⁰ known host mothers. What kind of woman would rent her womb for nine months and give up her own child after its birth?

To begin with, and most importantly, she is most often poor. "Wouldn't it be nice to see a woman on Park Avenue having a child for an infertile couple who are factory workers? But that is not the way it works," says American psychologist Dr. Lee Salk.⁴¹

The average host mother is in her mid-20s, married, low-income or on welfare, with some high school education.⁴² If she is employed at all, it is in a low-paying, low-status job.⁴³

The primary reason for taking on the host job is economic. Nine out of 10 surrogates in a study by a Michigan psychiatrist said that money was a "necessary factor".⁴⁴

³⁹The Globe and Mail, "Globe-Enviro-nics Poll: Surrogate Motherhood", Aug. 1, 1987, p. D2.

⁴⁰Quindlen, p. 25.

⁴¹Ibid., p. 26

⁴²Andrews, p. 208; Brodribb, p. 18.

⁴³Corea, pp. 228 - 230.

⁴⁴Brodribb, p. 12.

UNIVERSITY OF CALIFORNIA

Surrogate firms and lawyers actually prefer that the economic reason for the job be a prime motivation for the women. They feel this reduces the chances that the women will change their minds.⁴⁵

The host mothers who come forward to talk about their surrogacy also mention more altruistic reasons. Interestingly, they all feel strongly about "filling the empty arms" of another woman.⁴⁶ They relate to the partner of the biological father of the child because of her lack of motherhood, even though it is the father alone with whom they have the contract.

Comparing these two variations of artificial insemination--AID and surrogacy--is interesting. AID is a response to male infertility. It is almost always kept secret by those who use it. The male partner must consent to the procedure before the child is considered his and legitimate.⁴⁷

Surrogacy, on the other hand, is a very visible and public response to female infertility. It is intended to substitute another woman for the infertile female partner, who is almost always the wife. So surrogacy is also a response to an infertile woman as a wife: Her husband takes a second-class wife on a contract basis to provide him with genetic progeny. Unlike in the case of AID, the wife is never asked to give her consent to this procedure. No woman has ever hired another woman to bear a child for her.⁴⁸

AID continues, after 100 years, to be rejected by most infertile couples and by the public as a viable reproductive option because it endangers the patriarchal family. Surrogacy, which uses the man's genetic

⁴⁵Corea, p. 229.

⁴⁶Ibid., p. 223; Andrews, p. 207.

⁴⁷Brodribb, p. 6.

⁴⁸Ibid., p. 17.

Official Business

material, has not raised a similar furor on these grounds. The key to this difference is that AID "weakens men's claims to paternity; surrogate motherhood strengthens it".⁴⁹

As startling as surrogacy may seem, it is only the latest in a series of unusual reproductive techniques. It was in vitro fertilization (IVF) that blew the top off reproductive technologies less than a decade ago. Since then, specialized in vitro clinics and the numbers of "test-tube" babies have proliferated.

As of 1985, there were 115 in vitro clinics in the United States, eight in Canada and 50 others around the world, notably in England and Australia.⁵⁰ More than 2,000 babies have been born,⁵¹ including the first American baby (in 1981), the first Canadian baby (1983)⁵² and the first baby from a frozen embryo (in Australia in 1984).⁵³

The next Canadian IVF clinic will be in Ottawa, where provincial funding is expected for a start-up date in late 1988.

IVF is a "complex and disruptive" procedure,⁵⁴ one which is not undertaken lightly by infertile couples.

First, the couple must find an IVF program near them. Currently, residents of Eastern Ontario must travel to Toronto. The closest clinic to the Maritimes is in Quebec City. No clinic serves Manitoba or the northern areas of Canada.

⁴⁹Corea, pp. 244 - 245.

⁵⁰Keeton with Baskin, p. 94. There are 138 IVF clinics in the U.S. as of mid-1987. The Ottawa Citizen, "Fertility clinics, counselling growing: study", July 14, 1987.

⁵¹Yuzpe, oral presentation, Planned Parenthood forum.

⁵²Debra Pilon, "Conception without Sex", Healthsharing, 6 (September 1985): 21.

⁵³Keeton with Baskin, p. 96.

⁵⁴Pfeffer and Woollett, p. 98.

UNIVERSITY OF CALIFORNIA

Then they wait, sometimes for four years.⁵⁵

Before they are accepted into the program, they must meet the criteria established by their chosen clinic. For most clinics, this is a matter of the woman's age (less than 37 or 40 is usual) and the completion of a preliminary medical evaluation (looking for tubal disease and general suitability). Clinics usually require that the couple "be in a stable married relationship", as the patient information sheet at McMaster's IVF program phrases it.⁵⁶

At the start of the cycle when IVF is attempted, the woman is given Clomid and Pergonal to stimulate the growth of more than the usual one egg. Daily blood and ultrasound tests monitor hormone levels and follow the development of egg-containing follicles in the ovaries. When the follicles look mature, a shot of HCG is given to complete the maturing process.

Within 36 hours of the HCG shot, the woman undergoes a laparoscopy to remove as many ripe eggs as can be found. The eggs are placed in a special fluid and examined. Meanwhile, the man produces a sperm specimen. The sperm are added to the egg mixture and transferred to a growth medium.

About two days later, the fertilized and developing eggs are reimplanted inside the woman in a procedure similar to artificial insemination, only a catheter is used instead of a syringe.

The blood tests and ultrasounds continue after the implantation. It takes about two weeks before it is known whether the woman is pregnant.⁵⁷

⁵⁵Greg Ip, "Ottawa mom sets record with second Test-tube Baby", The Ottawa Citizen, June 11, 1987, p. 2.

⁵⁶Chedoke-McMaster Hospitals Fertility Clinic, "In Vitro Fertilization Program: Patient Information", pamphlet, undated, p. 1.

⁵⁷Ibid., pp. 2 - 3.

UNIVERSITY OF MICHIGAN

Success rates for IVF vary and are the subject of controversy. Twenty per cent is a commonly-accepted figure, but the rate at some clinics is higher than at others. In the United States, the country's oldest in vitro clinic at the Eastern Virginia Medical School claims a success rate of 31 per cent, but a significant number of miscarriages has not been factored into this figure.⁵⁸

This could mean a bug in a particular clinic's method or could simply be "the luck of the draw",⁵⁹ in terms of the infertility problems it sees. The rate of success rises sharply with the number of eggs that are "harvested" during the laparoscopy, from a low of 12 per cent with one egg to a high of around 28 per cent with three or four eggs.⁶⁰

Success can be linked to the length of time a clinic has been operating, although the London clinic is an exception with its early good results. Dr. J. E. H. Spence of the Civic Hospital feels Ottawa's soon-to-be-opened clinic will have a lower than average rate of success until "the bugs get ironed out". He is optimistic about eventual success: "We waited until we could attract people who had done it before to get rid of that 'reinventing the wheel' phenomenon". Spence quotes a 20 per cent figure to his patients.

Others insist that even 20 per cent is ridiculously high. Dr. Michael Soules, Director of Reproductive Endocrinology at the University of Washington, feels the truth in regard to IVF successes is widely abused by the practitioners themselves. He calls this "a failure of adherence to the

⁵⁸Quindlen, p. 25.

⁵⁹Spence interview, July 24, 1987.

⁶⁰Barwin interview, June 5, 1987.

Office Memorandum

highest ethical standards of truth" and says the "unmanipulated" rate of success world-wide for IVF is only 13 per cent.⁶¹

Gena Corea points out in her book, The Mother Machine, that early results during the explosive time following the first successful IVF birth were even worse. She estimates the live birth success rate for human IVF stood in December 1980 at .04 per cent or less than one per cent.⁶²

Compared to the first results, test-tube babies abound. But does a 13 per cent success rate justify the experimentation on human women? The British Medical Research Council didn't think so. In 1971, it refused funding to Steptoe and Edwards, the medical fathers of IVF, because it considered their work unethical. The council felt they had not conducted enough trials on non-human primates and that they were unable to justify using laparoscopies for experimental purposes.⁶³

Infertile couples do not complain about the low success rate, but they do feel their doctors misrepresent it to them. The 30 or 35 per cent figure from the Virginia clinic is often quoted without the vital information about the high number of miscarriages, which can run as high as one-third of pregnancies achieved.⁶⁴

In Ontario, the medical cost of IVF is no longer a problem since OHIP began covering the costs of the procedure, but in other areas of Canada IVF is not covered by provincial medical insurance. The price tag on one in vitro

⁶¹Michael Soules, "The In Vitro Fertilization Pregnancy Rates: Let's be honest with one another", Fertility and Sterility, 43 (April 1985): 511.

⁶²Corea, p. 116.

⁶³Ibid., p. 111; Pilon, p. 24; Williams, p. 14.

⁶⁴Keeton with Baskin, p. 94.

UNITED STATES

attempt ranges from \$1,500 to \$3,000.⁶⁵ Couples travelling to clinics in the United States will have to pay between \$3,000 and \$6,000. With travel, accommodation and other costs, such as taking leave from work, it could cost from \$10,000 to \$25,000 to make the trip to the U.S.⁶⁶

For some, the medical intervention involved in IVF is too much to bear. For others, it is a simple enough progression from the regimens they are already undergoing: "When you've been through the workup for a year or so, the extra intervention for in vitro doesn't sound quite as bad," says Rob, who with his wife goes to the doctor 10 times a month already.

Whatever the feelings about the medical side of the procedure, infertile couples are aware of the stress IVF could put on them. Some just aren't prepared to risk the extra pressure on their relationship. "We drew the line at IVF, but not because of the technology itself," says Marie Morrissey, the founder of the Infertility Self-Help Support Group, about her and her husband's decision not to try the procedure. "We knew what kind of stress was involved with in vitro, we knew how much stress we could withstand--and we were at the point where we were very, very stressed."

Caution about the emotional effects of IVF is justifiable, given reports from those who choose it. One man described his and his wife's three attempts at IVF:

When IVF attempts fail, the disappointment changes.
The first time, you fall from the sky. ...[T]he fall hurts, and hurts badly.

⁶⁵Linda S. Williams, "But what will they mean for Women?: Feminist Concerns about the New Reproductive Technologies", (Ottawa: Canadian Research Institute for the Advancement of Women, 1986), p. 14.

⁶⁶Maynard, p. 109.

UNIVERSITY OF MICHIGAN

The second time, you go feeling a bit negative, knowing by experience that the odds are against you. The disappointment hurts, but you feel cheated. After all, the only reason you try IVF is one of hope.

Attempt number three is filled with self-imposed positive determination, and a little indignation. It has worked for others, and now it's our turn. The pain this time is the most cruel yet. I don't want to think about number four.⁶⁷

The other side of the coin is the euphoria that comes from success. Gail and Ron Lyons know how it feels. They recently became parents for the second time; Both their children are "test-tube" babies. "I have been extremely lucky," Gail Lyons emphasizes.⁶⁸

Just as with artificial insemination, a "pre-selection" mechanism seems to come into play with couples who choose IVF. In a recent study, women who underwent IVF unsuccessfully were asked how they viewed their reproductive options. Although one-half of the couples in the study had abandoned attempts to conceive a biological child, 93 per cent indicated they would try any new options that would enhance the likelihood of a biological pregnancy.⁶⁹

This is a totally different response from those who reject the IVF option out of hand. Obviously, those who attempt in vitro are fully prepared to go to extreme lengths to become biological parents. Interestingly, for all

⁶⁷L. B., "Hard to Bear - Moments from a Husband's Experience with Infertility", Infertility Self-Help Support Group, newsletter, 1 (September 1985): 7.

⁶⁸Ip, p. 1.

⁶⁹S. R. Leiblum, E. Kemmann, D. Colburn, S. Pasquale and A. M. DeLisi, "Unsuccessful In Vitro Fertilization: A Follow-up Study", paper presented at the 42nd Annual Meeting of the American Fertility Society and the 18th Annual Meeting of the Canadian Fertility and Andrology Society, 1986, Toronto.

UNITED STATES

their desire to become parents, only one-third of the respondents in the post-IVF study had applied to adopt a (non-biological) child.⁷⁰

One variation of IVF is called Gamete intrafallopian transfer, or GIFT. When cervical factors prevent egg and sperm from meeting or if a minor seminal factor is involved, GIFT can help.

The procedure starts the same as IVF, with a "super" ovulation induced by drugs, a laparoscopy to retrieve as many as eggs as possible and placement of the eggs in a laboratory dish. The difference is that while the woman is still under anesthetic, her partner's sperm is mixed with the eggs and the mixture is immediately placed in her fallopian tubes.⁷¹ Fertilization thus takes place where it does normally--in the tubes. IVF bypasses the tubes, but GIFT depends on them to work.

Ovum transfer, also called embryo transfer and in vivo fertilization, is another variation. Ovum transfer is also dubbed the "donor egg" technique, as it combines aspects of AI with IVF. If ovulatory problems impede conception, an egg donor is inseminated with the sperm of the male partner. Before the fertilized egg can implant in the donor's uterus, it is flushed out and placed in the uterus of the infertile female partner.

Canada's first egg donation program is starting up in Fall 1987 at The Life Program, Toronto East General Hospital's clinic. Egg donation operates like a sperm bank, with the eggs frozen until needed.⁷²

The reproductive possibilities seem endless. What about the host uterus technique? A woman who produces eggs but has no uterus and her fertile partner can have their own genetic embryos placed in another

⁷⁰Ibid.

⁷¹Garner, p. 132.

⁷²CBC Television, "The Journal Diary", July 28, 1987.

UNITED STATES DEPARTMENT OF JUSTICE

woman's uterus to carry the pregnancy to term.⁷³ Then there is cryopreservation, the freezing of embryos instead of implanting all of them during IVF. This reduces the incidence of multiple pregnancies and means the woman need undergo only one laparoscopy.⁷⁴

A magazine article that describes these new techniques gives them a glowing report:

"Impossible" pregnancies have become a regular occurrence. The techniques are easier and increasingly successful. And with each new step, more and more infertile couples are able to bring home a baby at last.⁷⁵

It sounds good--the ultimate goal within reach at last. Most couples seem to want the social acceptance and legitimation, not to mention the joy, a child can bring to their lives.

But the stakes are also high for those who develop the technologies and those who control them. And the infertile are often the silent and forgotten partners in the baby-making race.

It all seems so straight-forward. Nice people want to become parents. Other nice people want to help make their dream come true. But this is only the foreground of the situation. In the background lurk complex ethical, legal and moral issues surrounding the new technologies that won't go away.

In the foreground, doctors hope to relieve human suffering through increasingly-sophisticated diagnoses and treatments, manipulating nature slowly but surely as they have since the first remedy was tried and

⁷³Garner, p. 132.

⁷⁴Ibid., p. 131.

⁷⁵Ibid., p. 129.

UNIVERSITY OF MICHIGAN

worked.⁷⁶ And babies do relieve the suffering of infertile people. In the background, in vitro fertilization has paved the way to still more reproductive variations that exploit babies as marketable commodities with infertile men and women as the eager buyers. In fact, the infertile are the forgotten reason behind reproductive technologies. These days, remaking baby-making is big business. In the five years after Surrogate Parenting Inc. opened for business in Louisville, Kentucky in 1979, at least 19 other surrogacy firms set up shop in the United States.⁷⁷

The fees for U.S. surrogacy services are rising sharply. Once, a baby could be "signed, sealed and delivered" for \$20,000 to \$25,000 U.S. Recent reports suggest that in some areas of the U.S., the cost has risen to a maximum of \$27,000 for pregnancy achieved through insemination with the contractor's sperm. For a child conceived using in vitro fertilization or embryo transfer, the maximum appears to be about \$42,000.⁷⁸

The fees break down like this: Anywhere from \$2,000 to \$15,000 for medical costs,⁷⁹ \$9,500 for administrative and legal fees, \$2,000 for psychological counseling, \$1,000 for life insurance for the host mother. Miscellaneous costs could reach \$4,000. These fees are paid to the surrogate firm, which divides them among the members of the professional team on staff.⁸⁰ The host mother still gets \$10,000, the same fee established in the first surrogacy contracts in 1979.

⁷⁶Andrews, p. 12.

⁷⁷Ibid., p. 317; Corea, p. 214

⁷⁸Trish Maynard, "Surrogate Parenting", Infertility Self-Help Support Group, newsletter, 3 (August 1987): 8.

⁷⁹Canadian contractors would not, of course, incur the high medical costs common in the United States because of provincial medical insurance.

⁸⁰Ibid.

1.
UNITED STATES

Interestingly, if the host mother's fee is averaged out over the nine months of the contract, her wage for her services (which includes hard labour!) works out to about \$1.54 per hour.⁸¹ Yet, the professionals at the surrogacy firm make thousands of dollars for work that is often routine and cursory. Psychological counseling for screening potential host mothers, for example, often takes little more than a couple of hours in the psychologist's office.⁸² And it is hard to understand how a standard legal contract, however many clauses might be added or amended to suit the individual couple or host mother, could use \$9,500 of a surrogacy firm's time.

The number of people it takes to produce a baby for an infertile couple increases dramatically with the use of high technology. Traditionally, conception was something that happened when a man and a woman got together behind closed doors. In infertility investigations, the gynecologist and the infertility specialist arrived on the scene. Now, sperm donors, surrogates, psychologists, scientists and lawyers crowd the room.

Asking "who's the father of the baby?" is not a facetious question. Dr. Robert Edwards, who along with Dr. Patrick Steptoe pioneered the in vitro process, "was hailed as the father of the century--[first test-tube baby] Louise Brown is seen as *his* product."⁸³ In cases of artificial insemination by donor, settling the paternity of the child depends very much on where one lives rather than what role is played in conception.⁸⁴ With high technology,

⁸¹Brodribb, p. 18.

⁸²Ince in Arditti et al., p. 102.

⁸³Jalna Hanmer, "A Womb of One's Own", in Arditti et al., p. 440.

⁸⁴Quebec and the Yukon have the only Canadian legislation pertaining to AID. Under these laws, legitimacy is extended to an AID child if the husband consented to his wife undergoing the procedure. Brodribb, p. 6; Daniel Drolet, "Wombs for Rent: The Dilemma of Surrogate Motherhood", The Ottawa Citizen, January 31, 1987, p. B1.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

we must also ask for the first time who the mother is: "These biomedical techniques allow us to distinguish between genetic mothers, uterine mothers and social mothers."⁸⁵

The new technologies redefine so much of what was taken for granted before in reproduction, from the identity of the parents to their function in giving or maintaining the new life. For infertile women, socialized like most women into accepting a definition of womanhood that includes motherhood, the technology to have a baby by any means--no questions asked--is an exciting prospect.

The "no questions asked" part of it is not as ludicrous as it seems. Lesley Brown, the mother of the first in vitro baby, admits she did not understand that the procedure had never worked before in humans.⁸⁶ She assumed hundreds of babies had been born by the method. Although the public is now more aware of the technologies through media headlines such as "Ottawa mom sets record with second test-tube baby",⁸⁷ the problem is now reversed. Most people believe successful use of technologies is common-place when they see yet another headline about it in the local newspaper.

"The media make it sound so accessible," laments Wendy, whose friends pressure her to try the new procedures they read about. "They assume it can be done next month."

Instead, there is a 300 to 400-name waiting list for the Ottawa in vitro clinic alone. It hasn't even opened its doors and won't until late 1988.

⁸⁵Ibid., p. 19.

⁸⁶Corea, p. 167.

⁸⁷Ip, p. 1.

UNIVERSITY OF MICHIGAN

Most infertile people will never have the opportunity to try the new methods of reproduction. In vitro clinics are so rare and people so desperate for a child that very strict social and medical criteria are used to cut down the waiting lists.

In fact, the criteria used raise some serious questions about who has access to the technology

The biological criteria seem simple enough. Most clinics will accept couples only when the woman has a tubal problem. There is an upper age limit, usually around 37, for the woman at the time she applies for the program.

Then it gets dicey. Some programs insist that the couple have no children.⁸⁸ This eliminates women with children from a previous marriage who might have undergone sterilizations that destroyed their fallopian tubes. Other clinics require that the couple must be married and in a stable relationship.⁸⁹ This puts the clinic in the position of deciding which marriages are stable. It also excludes unmarried couples and single women.

One private clinic, the Toronto Fertility and Sterility Institute, also screens couples to see if they will make good parents. Institute director Dr. Firouz Khamzi "is looking for what he calls the middle class" in his assessments.⁹⁰

The ethics committee at Ottawa Civic Hospital decided it was important not to exclude people and "to take people from all walks of life",⁹¹ but one of its criteria is that the clinic will serve women with no living

⁸⁸Spence interview, July 24, 1987.

⁸⁹Dr. Albert Yuzpe, oral presentation, Planned Parenthood forum.

⁹⁰CBC Radio, "Sunday Morning", July 5, 1987, "Hot in the Pursuit of Parenthood", Mary O'Connell.

⁹¹Spence interview, July 24, 1987.

12
Official Version 12

children. This excludes women with children who might be in a second marriage or relationship.

Cost of technology is also a factor, although one that requires self-selection by the couple before they get to a clinic. Infertility is expensive. In the United States, the cost of tests and treatment per pregnancy in 1984 is estimated at \$10,700.⁹²

In Canada, most tests and treatments in the infertility investigations are covered by provincial medical insurance. The exception is the often expensive drugs for ovulatory problems. This can amount to more than \$100 per month. In vitro fertilization has only recently come under OHIP, reducing the cost of one attempt from \$2,100 to \$700 in Ontario. Patients from outside the province will pay about \$3,000.⁹³

Once the financial constraints are added, a narrow portrait of successful in vitro candidates emerges: They are heterosexual, married, childless and, at very least, middle-class. They are also predominantly white and Anglo-Saxon.⁹⁴

So far, the limitations of reproductive technologies have been put in terms of in vitro fertilization. The same concerns apply to any infertility

⁹²Glinda S. Cooper, "An Analysis of the Costs of Infertility Treatment", American Journal of Public Health, 76 (August 1986): 1018.

⁹³Williams, p. 14.

⁹⁴Only 10 per cent of married black women and 12 per cent of married Hispanic women use infertility services in the U.S., compared to 15 per cent of white married woman, according to the U.S. National Centre for Health Statistics. Yet black women are more likely to be infertile than white women in significant numbers--21 per cent against 13 per cent. The Ottawa Citizen, "Fertility clinics, counselling growing: study", July 14, 1987; "Infertility - United States, 1982", MMWR: Morbidity and Mortality Weekly Report, 34 (April 12, 1985): 198.; In Canada, no profile has been undertaken of the infertile couple, although "the vast majority of those attending clinics are in the middle-class". Collins interview, July 16, 1987.

100
UNIVERSITY OF CALIFORNIA

service or reproductive technology. Medical criteria are being mixed with social criteria formally, as with IVF screening, but also informally. Middle-class, white Anglo-Saxon couples who find they are infertile are more likely to seek help. In Canada, factors that could possibly affect the socioeconomic profile of an infertile couple--cultural or ethnic background, for instance--have not been studied.⁹⁵ It is somewhat of a self-selection process, although the selection is socially-based. Just as the background and reproductive history of middle-class women lead them to believe they can make an individual reproductive choice when it concerns birth control, they also exercise their right to reproductive choice by choosing to attend infertility clinics. Non-white, non-middle-class women do not make this choice.

Mixing medical criteria with social criteria, with the clinics as the final arbiters, effectively excludes a significant portion of the needy infertile population. By choosing some infertile couples over others, the practitioners of reproductive technologies shape a future generation. As these technologies are used more and more by those who are not infertile, but who wish to have some say in shaping the final product--the child--society will in effect be reproducing itself the way it wants itself to be.

The legal considerations of reproductive technologies remain in limbo, as law-makers struggle to keep up with the innovative twists and turns of modern reproduction.

In the United States as of 1985, no less than 71 state statutes have been enacted on issues relating to new forms of conception. In the same pre-1985 period, U.S. courts made 30 legal decisions concerning new conceptions.⁹⁶

⁹⁵Ibid.

⁹⁶Andrews, pp. 296-310.

PHILIP W. WHEELER

In Canada, the first surrogacy case to hit the courts concerned a surrogacy firm from Michigan, a host mother from Florida and a Canadian contractor, a man from Scarborough, Ontario. The ruling of the Ontario Supreme Court in that case established the Scarborough man as the legal and biological father of the child. He was given permanent custody. (The infant had been seized by the Metro Toronto Catholic Children's Aid Society immediately after its birth in Canada.)⁹⁷

It was only after the 1982 surrogacy case that the Ontario Law Reform Commission (OLRC) was urged to report to the Ontario Attorney General on legal issues surrounding artificial conceptions. When the OLRC made its report in 1985, it recommended that surrogacy be legal but under stiff controls. Most importantly, surrogacy contracts, the commission said, should be binding for all parties.⁹⁸

Despite the OLRC report, surrogacy and other reproductive technologies remain an area of caution and concern for lawyers. The report made recommendations, but they are still only guidelines, not laws which map out the rights of those involved.

In terms of ethics and morality, it is much simpler. At least, the Catholic church thinks so. In a major policy document released March 10, 1987, the church came down heavily against surrogate motherhood, artificial insemination and sex selection, calling them "contrary to human dignity" and to "the unity of marriage".⁹⁹

⁹⁷Brodribb, p. 11.

⁹⁸Ontario Law Reform Commission, Report on Human Artificial Reproduction and Related Matters, 1985, in Thorpe, p. 36.

⁹⁹"Congregation for the Doctrine of the Faith: Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation Vatican City 1987" (Ottawa: Canadian Conference of Catholic Bishops, 1987), p. 19 and pp. 23 -25.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

The document suggests that infertile couples adopt or busy themselves with services for poor or disabled children, but that they not pursue morally illicit ways of conceiving. Although a child is "the supreme gift" ¹⁰⁰ and conjugal love is designed specifically for procreation, couples must use only reproductive techniques that include sexual intercourse. ¹⁰¹

There is no way of telling what effect the Vatican's pronouncement has on infertile couples, but it appears to be minimal among those couples already attending infertility clinics. ¹⁰² It seems that if the choice has been made to seek help, couples do not let the church stand in their way.

It is a confusing array of choices for the infertile couple, whose plight supposedly spawned all this activity in the first place. They cannot ignore the allure of reproductive technologies, but they must at some point make a decision concerning their future as a family. Those infertile people who have reached this point in the last decade have found that the nature of reproduction is changing swiftly and irrevocably, making it all the harder to come to a satisfactory resolution of their infertility.

¹⁰⁰Ibid., 34.

¹⁰¹The Globe and Mail, "Test-tube fertilization immoral, Vatican rules", March 11, 1987, p. 1

¹⁰²Slover interview, May 28, 1987.

UNIVERSITY OF CALIFORNIA

CHAPTER 7

CONCLUSION:

RESOLVING INFERTILITY

You know that nightmare you have when you wake up in a public place and you don't have any clothes on? You just feel so humiliated and ashamed and exposed. When I'm in a group of people and they start talking about their children and they take it all so for granted, that's how it feels.

At some point, the shame and humiliation stop. As they come closer to the end of their infertility experience, infertile people start feeling less vulnerable and less out of control. Infertility stops being their life companion, the cause of their shame, and becomes, instead, "an old friend" who still sits on their shoulders from time to time.

This is not a transition that happens overnight. Regaining personal control over their lives is an ongoing process. When Marie Morrissey founded the Infertility Self-Help Support Group, she believed she had resolved her infertility. Four years down the road, she says, "I'm still resolving it".

For those who have come through the crisis infertility was a "very rewarding experience", as Trish Maynard puts it. She believes it made her "a completely new person", one who is "far more compassionate, far more caring." What's more, she credits infertility with "making me a person that I like a lot better than I did before".

Susi, who is now pregnant, says she will always feel infertile, that it's part of her identity. She marvels at her own strength in surviving the experience: "I've come through a breakdown more or less, a miscarriage

UNIVERSITY OF MICHIGAN

and a career change. I'm attributing my strength to the infertility. I have a feeling it will help in the future when I have a crisis to deal with."

Many infertile women learn to be more assertive with their families. For those who have played a nurturing role in the family for years, as many infertile women do, this is a tough transition. "My family was restraining me (from being myself)," admits Sylvie. "They were always calling me and I couldn't say no to them. But I've learned to be more assertive. Who am I, God?"

"I don't think that when you go through infertility that you ever forget what you've been through," says Morrissey. "You internalize it, you mature with it."

What they learn as they resolve infertility is that it is not divided into "life before" and "life after", but that the life they make for themselves during the experience changes their values and perceptions about the kind of life that follows. "Where I would once have talked of my family I now talk of a community," says Barbara Carroll, who chose a child-free option.¹ For Jane, it was important to focus on herself and her partner as the family unit: "I hope we don't lose that perspective, that life doesn't necessarily have to include children."

Recognizing the magnitude of the crisis helps resolve it. They may be proud of the strength they gained, but they still remember the terrible emotional cost: "No one dies of infertility. You just wish you could."²

When success comes in the form of a pregnancy, motherhood is often not all it's cracked up to be. It is difficult for infertile women to admit to their post-birth frustrations of being tied down at home with only an

¹Barbara Carroll, "After Infertility - The Child-free Option", p. 8.

²Quindlen, p. 24.

Practical Utility

infant to talk to--"and you don't dare breathe those feelings to your infertile friends because they're liable to hit you", says Morrissey, a two-time mother

For some, pregnancy obscures any other possible goal. Either one succeeds and gets pregnant or one fails and does not. The bottom line for the medical profession, after all, is pregnancy. As Dutch gynecologist E. V. Van Hall writes: "There comes a moment at which one should honestly ask the question: 'Who really wants the baby, the doctor or the patient?'"³

Using pregnancy as the litmus test misses the point, according to Morrissey. "Success as far as we are concerned in the ISSG is not a pregnancy. It's coming through infertility and coming out the other end happy with whatever decision you have made about your life."

The decision infertile couples make comes in two phases. Knowing when to quit is the first part of the decision. Knowing what to do next, the second part of the decision, comes only gradually.

Trish Maynard has strong feelings about when to call a halt to hopes of bearing biological children. "You have to know what you can accept and what you can't accept and you have to keep assessing it as you go along, instead of letting the doctor do it for you," she says. "You have to know what your limitations are."

Often, those who do not choose to take treatments as far as possible are wracked with "what if" scenarios.⁴ Even those, like Maynard, who are firm in their decision to end treatment relatively early in the process, must put up with comments from other infertile people who would do anything to have a biological child. "I have been called a 'quitter', which is an interesting

³Van Hall, p. 364

⁴Dianne Lupinska, "Knowing when to Quit", Infertility Self-Help Support Group, newsletter, 2 (February 1987) 5

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

term that infertiles use," she says. "They say, 'you could have tried IVF, why didn't you?' (But) just because it's there doesn't mean it's right for you."

Knowing what to do after the decision to quit is made takes a little longer to figure out. Most infertile people just aren't ready to call up the Children's Aid Society and initiate a "home study", the assessment by a social worker that is a prerequisite for adoption. Nor are they ready at this point to consider child-free living. What they do is reflect on the infertility experience and try to come to terms with life after treatment--with or without children.

The decision to quit gives them back a sense of control over their lives. This is heightened by the realization that two options--adoption and child-free living--are still open to them.

But first, they must consider what biological parenthood means to them, first by trying to come to terms with why they want to be parents, then by examining the meaning to them of the choices that remain.

They do not do this in a vacuum. The social meanings attached to parenthood are so strong as to have already led them through years of infertility tests and treatments. Becoming a parent is not just a biological act, but has "a host of other meanings which are culturally defined".⁵

Parenting can be seen as a civic as well as a moral responsibility, the acceptance of a gender role, as giving meaning to marriage, as a sign of normalcy and maturity. Above all, it is seen as natural.⁶

Motherhood in particular is an essential part of the female role and there is a lot of social pressure for adult women to conform to it. The desire

⁵Williams, p. 9

⁶J. E. Veevers, "The Social Meanings of Parenthood", Psychiatry, 36 (August 1973): 293.

11
UNION OF REPUBLICS

in women to become mothers is so connected to socialized sex roles and expectations of motherhood as their prime life goal that they cannot disentangle it from what they presume is a biological urge.

When Susi, a committed feminist, admitted that the urge to have a child was so strong that she almost believed it to be biological, she said so with disbelief, but with wonder in her voice. "It's crazy," she says, shaking her head

Dr. Geraldine Finn, a lecturer in the Women's Studies Program at the University of Ottawa, does not believe there is a "biological necessity" to mating, pregnancy or birthing. "When we say it's biological, what we're doing is throwing up our hands and saying, 'It beats me, I don't understand the power of this desire'."

Infertile women seem no more articulate about their desire to be mothers than anyone else, despite the fact that their lengthy debilitating bout with infertility makes them question so much of what they once took for granted. They may question which treatment to take or whether to take treatment at all, but they rarely question the power of motherhood itself and its origins.

We know that because so many choose motherhood through adoption even if they cannot have pregnancy and birth. "A pregnancy lasts nine months. A baby is forever," says Elizabeth, who just adopted an infant. If it is true that we value more what we perceive ourselves to have freely chosen,⁷ then the choice of motherhood for an infertile woman must be doubly powerful.

⁷Nancy Felipe Russo, "Overview: Sex Roles, Fertility and the Motherhood Mandate" in Psychology of Women Quarterly, 4 (Fall 1979) . 12

11.
UNION OF SOVIETS

Infertility, then, is not just a biological problem which can be solved by medical breakthroughs, but "it is also a social phenomenon with a whole host of social and cultural meanings which can influence an individual's desire to become a parent in the first place".⁸

Reproductive technologies speak to a socially-created desire to become parents. In particular, they reinforce in women the feeling that they are meant primarily to be mothers.

Infertile couples currently come to the decision to quit medical treatments with much anguish and soul-searching. Even after the decision is made, it follows them through their lives. Women find it more difficult to leave infertility behind than men, who tend to compartmentalize the experience and put it behind them as soon as possible.⁹

The new technologies sabotage this decision by constantly giving them hope and encouraging them to continue to believe that their vision of themselves as biological parents can be fulfilled. The woman, already desperate for a child, is a captive to the constantly-reinforced mandate for motherhood presented to her. In the guise of trying to help her achieve this goal, reproductive technologies, with their hope on one side and their low success rates on the other, merely reinforce her inability to succeed at the one role that legitimates her.

A constant barrage of medical breakthroughs can only make it harder to make the decision to call it quits:

[A] woman faced with infertility today is less likely to mourn this crisis in her life and go on with other projects. The infertile woman now is far more likely to end up in an infertility clinic than she

⁸Williams, p. 11.

⁹Morrissey interview, July 17, 1987; McGrath Unruh communication, July 20, 1987.

UNIVERSITY OF CALIFORNIA

would have 10 years ago. She becomes caught in the extensive, debilitating, expensive and stressful process of 'treating' her infertility.¹⁰

Choosing to give up, to leave the vision of biological parenthood behind when the technology exists to pursue it further, is a reproductive option, but an unpopular one. And most people tend to choose socially-acceptable and socially-approved options. The option of giving up is merely an additional burden for infertile couples and not really a "choice" at all.¹¹

Reproductive technologies change the limits of options available, but they may not extend them. When they choose to continue treatment, infertile couples leave behind the choice to get on with their lives and to resolve their infertility at this time.

The changing limits of the new reproductive options will cause conflict and confusion with traditional values and beliefs until society can sort them out.¹² Such is the current state of confusion over surrogacy and other, even newer, innovations, such as cryopreservation and embryo transfers.

Chances are, society will sort itself out very fast. With baby-making a burgeoning industry, the law is currently lagging behind technology. This won't last long, as business people, lawyers and doctors find they cannot proceed without the rule of law to back them up.

But the proliferation of infertility clinics and specialized IVF clinics, the growing number of businesses associated with infertility and the scrambling of law-makers to catch up to the technology all tend to keep

¹⁰Achilles, p. 10.

¹¹Rothman and Arditti, al., p. 31.

¹²Miller, p. 1203.

4 of /de 4

MicroD

decisions beyond the control of the individuals experiencing the infertility problem

The earliest reproductive technologies--the first modern birth control methods--took some of that decision-making away from the individual and put it in the hands of the professionals.

In the case of more advanced reproductive technologies, the kind that both trouble and excite us today, even fewer decisions get made by the individual. Doctors, lawyers, business people and others have professionalized reproduction and turned it into an industry that is backed by governments through laws and professional codes. The input of these professionals is usually a part of any reproductive decision.

Reproduction is being redefined by necessity as technology advances. Infertility provides a tableau upon which the action takes place, although it remains on the periphery of the issue. The new reproductive practice of surrogacy, developed in response to female infertility and male desire for genetic progeny, clearly points to how marginal infertility can be where new technology is concerned.

In surrogacy, although a woman may be a child's natural mother, she can be denied custody of her child if she changes her mind--because she signed a legal contract. Pregnancy is being "judicialized", according to Dr. Margrit Eichler, a sociologist at the Ontario Institute for Studies in Education, because technologies like surrogacy misrepresent a social problem (wanting a child) as a medical problem (infertility).¹³

Advocates of surrogacy feel the host mother freely chooses to rent her body. They are ignoring how the woman's choice comes out of her

¹³"Sociologist calls for probe of reproduction technology", The Globe and Mail, March 3, 1987.

Un-der-stand

traditional nurturing role in society. The host mother and the infertile woman have the same feelings about the centrality of motherhood in their lives.¹⁴ They both want to fulfill the expected social role. The difference is that the host mother can do it and the infertile woman can't.

As laws to deal with surrogacy, artificial insemination by donor and embryo transfer become more common, the professionals will have even more say in reproduction. In effect, reproduction is being taken out of the family, where at least it had a limited freedom, and put in the hands of the state.

History is replete with examples of the state's control of reproduction, from those mentioned above to more innocuous laws concerning age at marriage or possible marital partners.¹⁵ The possibilities are disturbing for a future where the state controls what is, in effect, the fertility of women:

We are now moving into an era when we will have the scientific and technological knowledge to be able to deny women the opportunity to reproduce, or to reproduce only if they use the genetic material of others.¹⁶

Parts of bodies have become commodities to use on the open market. Sperm can be purchased at sperm banks and mailed on request. Wombs can be rented for nine months at \$15,000 a pregnancy. Eggs and embryos can now be banked awaiting future use.

¹⁴Andrews, p. 208; Corea, pp. 231-233.

¹⁵Brodribb, p. 20.

¹⁶Jalna Hanmer and Pat Allen, "Reproductive Engineering: The Final Solution" in Alice through the Microscope, Brighton Woman and Science Group, eds. (London: Virago, 1980), p. 211.

Chloroform

The spectre exists of a society that uses body parts at will to produce and reproduce "human material"--what used to be known as a baby-- that is socially acceptable.

Just as the birth control movement caught the interest of the eugenists, with their ideas of bettering the human race, reproductive technologies provide fodder for a new kind of population control.

The mixing of social with medical criteria to screen patients at in vitro fertilization clinics shows us how a narrow segment of society has access to these technologies. Those infertile couples who choose to approach a clinic for help are predominantly white, educated and middle-class.¹⁷ To the self-selected screening by the couple, the clinics add certain important criteria. Almost without exception, clinics demand that couples be married (sometimes for a set number of years) or in a long-term common-law relationship and that they have a stable relationship. They must be heterosexual and they must have no previous children.

The lack of clinics is not the reason for this rigid screening. It cannot be when doctors are already pointing to the day when the medical criteria for IVF will be broadened. Currently, only women with tubal blockages are eligible for IVF. The procedure, however, is being considered for women whose tubes are clear, but whose male partners have low sperm counts.¹⁸ And clinics in the U.S. are already under-attended and are crying out for customers.¹⁹

The consequence of the screening is that, consciously or unconsciously, the reproduction professionals are limiting the kind of people

¹⁷"Fertility clinics, counselling growing: study", The Ottawa Citizen, July 14, 1987.

¹⁸Williams, p. 15; Corea, p. 121.

¹⁹Soules, p. 513.

Chlorine

who get help. Inevitably, they are also limiting the kind of babies that are born

The Toronto Fertility and Sterility Clinic, a private clinic, accepts no unmarried people or homosexuals.

"We (at the clinic) work within a common ground of ethics," explains director Dr. Firouz Khamzi. "To deal with single men or women or homosexual men or women, that's not up to me. You do things that are tasteful."

The mixing of social with medical criteria illustrates Barbara Katz Rothman's arguments about "quality control" of reproduction at a disturbing level, because it embraces eugenic notions of race and class. With the new-found ability to pre-select gender, or at least determine it before birth through the technology of amniocentesis,²⁰ gender preference too becomes a part of the eugenic package. Most abortions in China, a country where the number of children per family is strictly limited by law, are performed on female fetuses.²¹ In North America, most people starting a family want a boy first. First-born children are typically high-achievers, hence sex selection techniques could mean female children would be "younger sisters", a less auspicious place in the birth order, in terms of achievement, education and intelligence.²²

Once the floodgate is opened on sex determination, other "quality" choices are likely to follow. If the fetus does not suit the parents or the

²⁰Amniocentesis is a procedure that can give pregnant women certain information about the fetus they carry, notably if the fetus has Down's Syndrome.

²¹Katz Rothman, p. 140.

²²Achilles, p. 14; Corea, p. 204; Williams, p. 25.

Chickadee

reproduction is "just a new version of the society we have now" because it keeps men--the scientists and other professionals--in control.

"They don't have to look after babies, they don't have to share the world, they don't have to change the premises of their lives, they don't have to put themselves second in any way."

Instead, the "compulsive, obsessive drive" to produce babies, although seen as heroic and doing good, is "another version of men producing babies for which they assume no responsibility" and is no different from the past.

The new reproduction is really a new biological determinism, fed by technologies which emphasize the motherhood role for women over any other. Sex selection is one technique that not only reinforces this, but actually creates a biological base to legitimate it.

The people left out are those who were promised so much to begin with--the infertile. They are led to reproductive technologies partially through socialization which urges them to become parents. The technologies reinforce this, but low success rates mean they do not come through with the anticipated results. "It's another game of chance," says Susi--and infertile people can be the losers.

The sad reality of infertility is that those going through it always think they can eventually get some control over the process if they try hard enough. Reproductive technologies "just perpetuate that feeling of control," says Barbara Carroll. "At some point, we have to face the fact that we do not have control over this. It's such an emotional price to pay for that expectation of control." She is reflective as she adds quietly, "I wonder if in the long run it wouldn't be kinder to say to people, 'look, here's the end of the rope and when you get there, then we'll have to deal with it'." It

untouchable. She raises the finger to her mouth and sucks greedily... She looks up suddenly. Ian is watching her. Her finger is still in her mouth like a shy child, like a mad woman trying to re-create the image of an innocent childhood. He opens his arms away from his side a little. She does not know if it is an invitation or a gesture of despair. She takes her finger out of her mouth and moves toward him. They are both crying. Huge tears pour down their faces... In each other's arms... they weep. They weep there for a long time ³⁸

It can take years to pull themselves out of their personal hell. Most infertile women carry the experience of infertility with them throughout their lives. For many infertile men, the door remains firmly closed in front of their experience with infertility, but it cannot be totally forgotten.

Slowly and painstakingly, they build a family life that is different from what they had expected and find it to be just as sweet. They become just like other families on the street.

But for the infertile, no matter how far they have come, the image of Liz sucking greedily on the forbidden fruit of choice is forever a part of them.

³⁸Sara Maitland, Daughter of Jerusalem (London: Pan Books, 1978), pp 206 - 208.

reproduction is "just a new version of the society we have now" because it keeps men--the scientists and other professionals--in control

"They don't have to look after babies, they don't have to share the world, they don't have to change the premises of their lives, they don't have to put themselves second in any way."

Instead, the "compulsive, obsessive drive" to produce babies, although seen as heroic and doing good, is "another version of men producing babies for which they assume no responsibility" and is no different from the past

The new reproduction is really a new biological determinism, fed by technologies which emphasize the motherhood role for women over any other. Sex selection is one technique that not only reinforces this, but actually creates a biological base to legitimate it.

The people left out are those who were promised so much to begin with--the infertile. They are led to reproductive technologies partially through socialization which urges them to become parents. The technologies reinforce this, but low success rates mean they do not come through with the anticipated results. "It's another game of chance," says Susi--and infertile people can be the losers.

The sad reality of infertility is that those going through it always think they can eventually get some control over the process if they try hard enough. Reproductive technologies "just perpetuate that feeling of control," says Barbara Carroll. "At some point, we have to face the fact that we do not have control over this. It's such an emotional price to pay for that expectation of control." She is reflective as she adds quietly, "I wonder if in the long run it wouldn't be kinder to say to people, 'look, here's the end of the rope and when you get there, then we'll have to deal with it' It

Chelidonium

(reproductive technology) is postponing what for a lot of people is the inevitable. But where do you draw the line?"

The new technologies have very little to do with infertility, when all is said and done. But if infertility is not central to the development of reproductive technologies, then what is? Professor Finn believes it keeps scientists "on top" in the name of "doing good". Robyn Rowland, a lecturer at Deakin University in Australia, is concerned about how infertile people are being used in the name of technological advancement. In her article, "Reproductive Technologies: The Final Solution to the Woman Question?", she writes: "I have developed an overwhelming sympathy and empathy for the plight of the infertile. But I cannot divorce this from the feeling that they are being used by the medical profession in order to gain funding for research which is not intended to help the infertile person."²⁵

Although there is no statistical evidence for Rowland's point of view, there is nonetheless concern that the growing awareness of infertility is being fed by those who might have vested interests in increased fertility funding for research.

Dr. John A. Collins, the head of Obstetrics and Gynecology at McMaster University Medical Centre, is blunt about why all the hype exists about infertility and the supposed help that is available to infertile couples.

"Infertility is somewhat of an exploitative industry," he says. "More doctors are willing to see more patients. They're not doing hysterectomies (any more) and they have more time."²⁶

²⁵Robyn Rowland, "Reproductive Technologies: The Final Solution to the Woman Question?" in Arditti et al., p. 360.

²⁶Dr. Collins is referring to the use of hysterectomy in the recent past as a common cure-all for gynecological problems. Mary Daly, Gyn/ecology (Boston: Beacon Press, 1978), p. 238.

Chlorophyll

In addition, fertility control is so effective that the birth rate is declining and the need for obstetrical services along with it.²⁷ In response to the decrease in the volume of patients needing these services, doctors with an interest in women's health are expanding their specialties to include endocrinology, andrology (the study of male hormones) and infertility.²⁸

Dr. Collins disputes the commonly-held belief that the rate of infertility is rising, which is the reason often given for increasing funding for infertility research. Most literature about infertility and most doctors emphasize the growing extent of the problem, but Dr. Collins does not agree.

"Our medical texts always said that the rate of infertility was 10 per cent," he explains. "It is more common since I've been in practice (the thinking goes), therefore it must be 20 per cent."

Dr. Collins points to the Morbidity and Mortality Weekly Report for figures on the number of married women in the U.S. who are infertile. In 1965, the figure was 13.3 per cent. In 1976, it rose to 14.3 per cent, but dropped back to 13.8 per cent by 1982.²⁹ Although these figures do not include either single women or those who don't know they are infertile because they've never attempted to conceive, the figures remain close enough together to question assumptions about the rising rate of infertility.

What he does acknowledge is the increased use of infertility services, which is a different thing altogether. Visits to American fertility specialists quadrupled, from 600,000 to more than two million, between 1968 and 1983.³⁰ And the U.S. National Centre for Health Statistics reported recently that "15 per cent of white, sexually-active women in their

²⁷Menken, Trussell and Larsen, p. 1393.

²⁸Aral and Cates, p. 2330.

²⁹MMWR: Morbidity and Mortality Weekly Report, p. 198.

³⁰Ibid., p. 197; Aral and Cates, p. 2327.

Chandler University

childbearing years have used infertility services",³¹ giving credence to Dr. Collins's belief that doctors in greater numbers are welcoming infertility patients in greater numbers for treatment.

Other doctors allow that the actual rate of infertility may not be on a sharp upward curve, but they have seen their practices burgeon with hopeful infertility patients. They are still tentative and reflective, however, about a more serious revelation made by Dr. Collins in his own research.

He has conducted studies which indicate that doctors are getting no more pregnancies by treating infertility than they are without treatment.³² In other words, there is no significant difference between the rate of pregnancy for those who go through all the treatment, called treatment-induced pregnancies, and the rate for those who do not go through it, the so-called treatment-independent pregnancies. This is not for the advanced technologies, like IVF, but for standard treatments (like hormone therapy or drugs for certain conditions) of all kinds of factors involved in infertility.

Collins's findings, although they have raised some medical eyebrows, were recently corroborated by the leading article of an important source--the *British Medical Journal*. The article sums up the situation concerning the effectiveness of treatment for infertility in its first sentence:

Many doctors and lay people think that the great technical advances in the past 20 years in treating infertility have led to high success rates in treatment, but this is a myth.³³

³¹ "Fertility clinics...", *The Ottawa Citizen*, July 15, 1987.

³² Collins et al., p. 1201.

³³ Richard J. Lilford and Maureen E. Dalton, "Effectiveness of Treatment for Infertility", *British Medical Journal*, 295 (July 18, 1987): 155.

CHALLOU UNIVERSITY

This is not to say that infertility specialists cannot help women get pregnant. The same number of women will get pregnant with treatment as without treatment, but they will not be the same women. Dr. Elaine Jolly, head of the Fertility Clinic at the Ottawa General Hospital, says certain interventions are necessary before conception can occur. Without these treatments, such as tubal repairs and ovulation-inducing drugs, no pregnancy could take place. But as for some other infertility factors, well, the passage of time helps.

"God is a better infertility specialist than I am," she smiles, but she also adds, "Together we make good partners."

Dr. J.E.H. Spence at Ottawa Civic Hospital's clinic tells a story that illustrates how a treatment-independent pregnancy can be mistaken for a treatment-induced one:

"There's a patient who came in this morning... I did nothing for her, apart from an HSG. Two months later, she was pregnant after four years of infertility." Although this pregnancy would be classed as one that occurred without treatment--an HSG merely pushes dye through the female reproductive organs to test for blockages--"I cannot believe that shooting the dye through the mucous was not helpful. I told her, look, I didn't do anything, but she's going home with a pregnancy and she thinks that's wonderful.

"I am more realistic and accept that there is a limited capacity that I have," he adds, "but I couldn't get up in the morning if I thought I was doing nothing."

Infertility clinics, even when they do not offer high-tech low-success treatments, must also contend with a rate of success that is going down rather than up. It used to be that clinics would say that one in every two

CHALCUM UNIVERSITY

couples would get pregnant after treatment. That was when they were seeing everyone who wanted help before gynecologists started doing the basic tests themselves. Now, clinics see only the problems, the ones that do not solve themselves or that cannot be solved with minimal intervention. The success rate at both Ottawa infertility clinics has declined to about one in three, which confirms Dr. Collins's findings of 35 per cent. (Both clinics are highly-respected and have average to better-than-average success rates compared to other Canadian clinics.³⁴)

Basically, if the infertile couple is not pregnant after about three years--with or without treatment--the future is not optimistic for biological parenting. Given the hard facts, infertile couples must ask themselves if the medical intervention is justified for the little benefit that comes out of it. A tubal repair, a drug regimen to induce ovulation or a dose of donor semen often has an immediate positive result. But, beyond this, how much of *any* medical intervention is worthwhile?

Once intervention starts, if left in the hands of the medical profession, there is no end to it, says Trish Maynard. She objects to in vitro fertilization technology in particular.

"I am so tired of hearing about the (IVF) success rate. I would much prefer that they talk about the 80 per cent failure rate. The 20 per cent success is the 20 per cent who get pregnant, but 20 per cent don't have babies. Doctors should be more realistic, but they can't be realistic and attract customers at the same time."³⁵

³⁴Garner conversation, Aug. 20, 1987.

³⁵The world-wide IVF success rate has been tabulated at 13 per cent. Soules, p. 511.

CHALLIS UNIVERSITY

Dr. Collins and Dr. Spence feel infertility clinics serve a purpose, although Dr. Collins is more cynical about that purpose. In vitro fertilization clinics, he says, "have one good quality: They keep people on ice for two years. IVF gives people hope while they are waiting". What they are waiting for is a pregnancy to happen, but chances are, if it's going to happen, it will be without treatment.

Dr. Spence says it's much easier for patients to live with themselves if they understand the reason for their infertility. Even if they don't conceive, they at least have an answer and can live with it. "But to close down every infertility clinic would be detrimental to people. They like to just come and talk, too, because most people really aren't very sympathetic. Most people who have children at home don't realize what it's like when you can't have one of the most important things in the world to you. (Here) they can meet someone who'll take an interest in their problem."

Dr. Spence need not fear that infertility clinics will cease to exist. As long as women are brought up to feel a compelling desire to have a child and as long as that desire is used either altruistically or opportunistically to give infertile people the babies they want so badly, then reproductive technologies are here to stay.

Infertility is a life crisis that has lasting effects on those in its grasp. It is a time of great personal anguish, but also a time for great personal growth. The forever-hopeful world of reproductive technologies does not make it any easier, but very few infertile people can reject it outright. To do so would take away that hope for some other infertile couple.

Infertility is a disease of choice and lack of choice. In a sense, infertile couples choose infertility, because they choose to be treated, but

they do so in a social atmosphere that makes it almost impossible to choose to do otherwise

It is what Professor Margarete Sandelowski has called "Sophie's Choice", a catch-22 situation of choosing between two difficult options.³⁶ The infertile can either accept infertility without treatment "in a social context in which being infertile violates a norm of behavior" or they can submit to treatment, which can lead to "hardship, the postponement of other life goals, and no cure".³⁷

The choice is made even more difficult in a world where the New Right is asserting pro-family values, where technology encourages biological parenting at a stiff emotional cost and where the belief is that having babies can be controlled by the individual.

British novelist Sara Maitland describes the feelings of Liz, an infertile woman, at the moment of her choice. It is the bleakest moment of her infertility. Ironically, she has just helped a pregnant friend through the first stage of labour in Liz's own living room. After the labouring woman leaves for the hospital, she notices a damp puddle of amniotic fluid on the carpet

She thinks she will get a cloth to wipe it up, but instead kneels fingering the wetness, disgusted at herself, embarrassed lest Ian [her husband] find her here, and yet still reaching out with her finger...

Quickly, nervously she rubs her finger in the pile of the carpet, her other fingers curled in tightly as though afraid to touch the

³⁶Sandelowski is referring to a character in a novel called Sophie's Choice by William Styron. In the novel, Sophie makes an impossible choice between two equally-destructive alternatives. The choice she makes follows her through her life and leads ultimately to her death. William Styron, Sophie's Choice (New York: Bantam, 1979).

³⁷Sandelowski, p. 449.

CHANDLER UNIVERSITY

untouchable. She raises the finger to her mouth and sucks greedily... She looks up suddenly. Ian is watching her. Her finger is still in her mouth, like a shy child, like a mad woman trying to re-create the image of an innocent childhood. He opens his arms away from his side a little. She does not know if it is an invitation or a gesture of despair. She takes her finger out of her mouth and moves toward him. They are both crying. Huge tears pour down their faces... In each other's arms... they weep. They weep there for a long time ³⁸

It can take years to pull themselves out of their personal hell. Most infertile women carry the experience of infertility with them throughout their lives. For many infertile men, the door remains firmly closed in front of their experience with infertility, but it cannot be totally forgotten.

Slowly and painstakingly, they build a family life that is different from what they had expected and find it to be just as sweet. They become just like other families on the street.

But for the infertile, no matter how far they have come, the image of Liz sucking greedily on the forbidden fruit of choice is forever a part of them.

³⁸Sara Maitland, Daughter of Jerusalem (London: Pan Books, 1978), pp. 206 - 208.

CANALIZING UNIVERSITY

APPENDIX

RESOURCE LIST ON INFERTILITY

BOOKS TO READ

Books on infertility:

Sara Maitland, Daughter of Jerusalem (London: Pan Books, 1981)

This is a novel about a woman trying to get pregnant. It is an honest and sensitive look at the woman's confused feelings, her tumultuous relationship with her husband and her resentment of her doctor as she undergoes infertility investigations.

Barbara Eck Menning, Infertility: A Guide for the Childless Couple (New Jersey: Prentice-Hall, 1977)

Menning has emerged as the foremost lay authority on infertility in the United States. She has personal experience of infertility. Her book is one of the first handbooks directed at the infertile couple and, although 10 years old, is still relevant. She covers most areas of concern to infertile couples within the two areas she maps out, medical aspects and psychosocial aspects of infertility.

Naomi Pfeffer and Anne Woollett, The Experience of Infertility (London: Virago, 1983)

This is a woman-centered approach to infertility. It has no section on the social and emotional dimension of infertility per se, but includes extensive personal experience stories throughout.

Books on Motherhood.

Ellen Peck and Judith Senderowitz, Pronatalism: The Myth of Mom and Apple Pie (New York: Thomas Y. Crowell and Co., 1974)

An excellent book that explores the neglected area of why women want to be mothers. It is, unfortunately, out of print, but can be obtained through inter-library loan services. The National Library of Canada has a copy.

CANALIS UNIVERSITY

Books on Reproductive Technologies:

Margaret Atwood, The Handmaid's Tale (Toronto: McClelland and Stewart, 1985)

A chilling fictional look at reproduction and the situation of women set in the near future.

Rita Arditti, Renate Duelli Klein and Shelley Minden, eds., Test-tube Women: What future for Motherhood? (London: Pandora Press, 1984)

If there is confusion as to why women are concerned about reproductive technologies, read this book. The book is divided into sections with descriptive titles which give hints as to their explosive contents: "Test-tube Women", "The Motherhood Market" and "Women taking Control: A Womb of One's Own" are some of the titles.

Gena Corea, The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs (New York: Harper and Row, 1986)

There is some interesting historical material in this very contemporary book. It starts with eugenics, moves on to artificial insemination in animals and ends with a portrait of happy breeder women in breeding brothels that is reminiscent of Atwood's book.

Barbara Katz Rothman, The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood (New York: Penguin, 1986)

Amniocentesis, a procedure designed to tell pregnant women the state of the fetus they are carrying, is changing the range of reproductive choice available. Rothman discusses the meanings of these choices, which have changed how we think about birth and parenthood.

PUBLICATIONS OF INTEREST

Infertility Self-Help Support Group Newsletter
c/o Planned Parenthood Ottawa
505 Kent Street, Suite 2
Ottawa, Ontario K2P 2B8

This is the only known regular newsletter in Canada dealing with infertility. Articles are written by people experiencing infertility and by medical practitioners. A membership in the group (\$20

CAMELIUM UNIVERSITY

annually) includes six issues, otherwise a subscription can be obtained by sending the same amount to the address above.

ISSUE: Newsletter of the National Association of the Childless
318 Summer Lane
Birmingham B19 3RL England

A quarterly newsletter published by NAC, which also produces pamphlets on infertility.

Perspectives on Infertility
Center for Communications in Infertility
P.O. Box 516
Yorktown Heights, New York
U.S.A. 10598

An American publication started by an infertile couple, Perspectives is published bimonthly (six issues a year). Subscriptions cost \$15 U.S.

Perspectives Press
905 West Wildwood Avenue
Fort Wayne, Indiana
U.S.A. 46807

The only known press to publish books solely on the subjects of infertility and adoption. They will send on request a list of their publications in print.

Resolve Newsletter
Resolve, Inc.
National Office
5 Water Street
Arlington, Massachusetts
U.S.A. 02174

The newsletter is published five times yearly and is the most well-known and widely-circulated of newsletters published by lay people. Resolve will send a sample copy of the most recent newsletter for \$2 U.S. A full subscription comes with a membership of \$20 U.S.

SUPPORT GROUPS AND INFORMATION

Bereaved Families of Ontario
Ottawa-Carleton Chapter
P.O. Box 9384, Terminal A

CAMLETON UNIVERSITY

Ottawa, Ontario K1G 3V1

A support group for those who have lost a family member, Bereaved Families also provides support for those who have experienced miscarriage. The main office is in Toronto.

Canadian Pelvic Inflammatory Disease Society

P.O. Box 33804, Station D

Vancouver, B.C. V6J 4L6

The society offers counseling and resources to women with PID.

Endometriosis Association

P.O. Box 92187

Milwaukee, Wisconsin

U.S.A. 53202

There does not appear to be a Canadian-based organization which provides support to women with endometriosis. This group in Milwaukee, however, has been sending information on request to Canadian women for years.

Health Sciences Library

University of Ottawa

451 Smyth Road

Ottawa, Ontario

This library has a large number of periodicals dealing with infertility, notably the medical journal Fertility and Sterility. Other publications of interest in the library's holdings include: Journal of Obstetrics, Gynecology and Neonatal Nursing, Contemporary Obstetrics and Gynecology, New England Journal of Medicine and AORN (Association of Operating Room Nurses) Journal.

Infertility Facts and Feelings

Toronto Chapter

639 Petrolia Road

Downsview, Ontario M3J 2X8

This is a largely-inactive support group run by two infertile couples. It has published a newsletter on an irregular basis, although not recently.

Infertility Facts and Feelings

Kitchener-Waterloo Chapter

c/o Theresa Daly

Department of Social Work

St. Mary's General Hospital

CANLEIUN UNIVERSITY

911 Queen's Boulevard
Kitchener, Ontario N2M 1B2

This support group is a branch of the Toronto group.

Infertility Self-Help Support Group
505 Kent Street, Suite 2
Ottawa, Ontario K2P 1Y4

The ISSG is very active, with small groups of infertile women and men meeting for a series of about 10 self-help sessions. New groups begin four to six times a year or whenever there is enough interest expressed. The ISSG also offers counseling and referrals and organizes public forums on infertility.

The Open Door Society
c/o 1370 Bank Street
Ottawa, Ontario K1H 7Y3

The society is a support group for adoptive parents and potential adoptive parents. It offers group sessions and periodic information sessions.

Resolve, Inc.
National Office
5 Water Street
Arlington, Massachusetts
U.S.A. 02174

Resolve was founded by Barbara Eck Menning in 1974 to provide information, referral and counseling for infertile couples. Those interested may join one of Resolve's 46 chapters throughout the U.S. or the national Resolve at a cost of \$20 U.S. Resolve has a large number of excellent pamphlets on various medical and emotional aspects of infertility. Write for a complete publications list.

MEDICAL HELP

If you think you might be infertile, make an appointment with your doctor to discuss your concerns. Unless there is an obvious problem for which your own doctor can give you treatment, ask for a referral to a specialist.

If you plan eventually to have a family, consider seriously a method of birth control that will not impair your fertility. Be aware that the longer you wait before childbearing, the more problems you may have in conceiving.

CARLETON UNIVERSITY

For a list of infertility specialists, infertility clinics and in vitro fertilization clinics in your area, consult:

Canadian Fertility and Andrology Society
2065 Alexandre de Seve, Suite 409
Montreal, Quebec H2L 2W5

BIBLIOGRAPHY

- Adler, John D. and Boxley, Russell L. "The Psychological Reactions to Infertility: Sex Roles and Coping Styles," Sex Roles 12 (1985): 271-279.
- Achilles, Rona. "New Age Procreation," Healthsharing. 6 (Fall 1985): 10-14.
- Allison, Janet R. "Roles and Role Conflict of Women in Infertile Couples," Psychology of Women Quarterly. 4 (1979): 97-113.
- Alper, Michael M.; Barwin, B. Norman; and Jolly, Elaine E. "Endometriosis: A Therapeutic Dilemma," Modern Medicine of Canada. 39 (April 1984): 455-459.
- Andrews, Lori B. New Conceptions: A Consumer's Guide to the Newest Infertility Treatments. New York: St. Martin's Press, 1984.
- Aral, Sevgi O. and Cates, Jr., Willard. "The Increasing Concern with Infertility: Why Now?", JAMA (Journal of the American Medical Association). 250 (Nov. 4, 1983): 2327-2331.
- Arditti, Rita; Klein, Renate Duelli; and Minden, Shelley. Test-Tube Women: What Future for Motherhood. London: Pandora Press, 1984.
- Atwood, Margaret. The Handmaid's Tale. Toronto: McClelland and Stewart, 1985.
- Barwin, B.N. "Artificial Insemination by Donor with Frozen Human Sperm," Male Reproduction and Fertility. (1983): 295-301.
- Barwin, B.N. "Intrauterine Artificial Insemination by Husband--A Neglected Field," Male Reproduction and Fertility. (1983): 303-307.
- Barwin, B. Norman. "Infertility," undated pamphlet.
- Bell, J. Stephen. "Psychological Problems among Patients attending an Infertility Clinic," Journal of Psychosomatic Research. 25 (1981): 1-3

CANLITA UNIVERSITY

- Bond, Pamela M. "Three Months at a Time: Male Infertility and AID," Resolve Newsletter, April 1984, p. 5.
- Bram, Susan. "Women and Children First or How Pop Planning Fucked Over Mom," Heresies, 6 (1978) : 65-73.
- Brand, Handré J. "Psychological Stress and Infertility. Part 2: Psychometric Test Data," British Journal of Medical Psychology, 55 (1982) : 385-388.
- Brodribb, Somer. "Reproductive Technologies: Masculine Dominance and the Canadian State." Occasional Paper No. 5, Centre for Women's Studies in Education, Ontario Institute for Studies in Education: Toronto, 1987.
- Canadian Conference on Catholic Bishops. "Congregation for the Doctrine of the Faith: Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation." pamphlet. Ottawa, 1987.
- CBC. "The Journal." July 28, 1987.
- CBC. "Sunday Morning." July 5, 1987. ("Hot in the pursuit of Parenthood.")
- Chedoke-McMaster Hospitals Fertility Clinic. "In Vitro Fertilization Program." undated pamphlet. [Hamilton, Ont.]
- Cohen, Lynne. "Obstetrics and Gynaecology at the Civic: A Growing Department," Civic: The Newsmagazine of the Ottawa Civic Hospital, 9 (Spring 1987) : 11-14.
- Collins, John A. ; Wrixon, William; Janes, Lynn B.; and Wilson, Elaine. "Treatment-Independent Pregnancy among Infertile Couples," The New England Journal of Medicine, 309 (1983) : 1201-1206.
- Coman, Carolyn. "Trying (and Trying and Trying) to Get Pregnant," Ms., May 1983, pp. 21-24
- Cooper, Glinda S. "An Analysis of the Costs of Infertility Treatment," American Journal of Public Health, 76 (August 1986) : 1018-1019.

- Corea, Gena. The Mother Machine. Reproductive Technologies from Artificial Insemination to Artificial Wombs. New York: Harper and Row, 1986.
- Corson, Stephen L., M.D. Conquering Infertility. Norwalk, CT: Appleton-Century Crafts, 1983.
- CJOH. "Newslite." July 21, 1987.
- CTV. "Lifetime." July 2, 1987.
- CTV. "News." June 7, 1987.
- Daly, Mary. Gyn/ecology. Boston: Beacon Press, 1978.
- Dodd, Dianne. "Birth Control and the Politics of Reproduction". unpublished B.A. Honours Paper, Department of Psychology, Carleton University, 1981.
- Ehrenreich, Barbara and English, Deidre. For Her Own Good: 150 Years of the Expert's Advice to Women. Garden City, NJ: Doubleday, 1978.
- Faulkner, Wendy, ed. Smothered by Invention : Technology in Women's Lives. London: Pluto Press, 1985.
- Finn, Geraldine. "Women and the Ideology of Science," Our Generation. 15 (1982): 40-50.
- Frost, Carol. "Feminism and Infertility." Resolve Newsletter. [1980]: 5.
- Garner, Mary. "'Impossible' Pregnancies, Miracle Births: Breakthroughs that are turning Infertile Couples into Families," Self, June 1987, pp. 129-133
- Gimenez, Martha E. "Feminism, Pronatalism, and Motherhood", International Journal of Women's Studies. 3 (1979): 215-240.
- The Globe and Mail. "Baby M awarded to Father in 'Best Interest' of Child." April 1, 1987.
- The Globe and Mail. "Baby M Ruling a Milestone for Surrogate Motherhood." April 2, 1987.

The Globe and Mail. "Globe-Environics Poll: Surrogate Motherhood."
Aug. 1, 1987.

The Globe and Mail. "Sociologist calls for Probe of Reproduction
Technology." March 3, 1987.

The Globe and Mail. "Surrogates left divided by debate over Baby M."
March 3, 1987.

The Globe and Mail. "Test kit to predict Ovulation Period goes on sale
tomorrow in Canada." May 18, 1987.

The Globe and Mail. "Test-tube Fertilization immoral, Vatican rules."
March 11, 1987.

The Globe and Mail. "Women who used banned IUD await vital decision."
July 17, 1987.

Gordon, Linda. "The Politics of Birth Control, 1920-1940: The Impact of
Professionals", International Journal of Health Services 5 (1975):
253.

Gordon, Linda. Woman's Body, Woman's Right: A Social History of Birth
Control in America. New York: Grossman Publishers, 1976.

Greer, Germaine. Sex and Destiny: The Politics of Human Fertility. London:
Picador, 1984.

Griffin, Martha E. "Resolving Infertility: an Emotional Crisis," AORN Journal
(Association of Operating Room Nurses). 38 (1983): 597-601.

Grover, John W., and Miller, Charles E. "Human Infertility: Diagnosis,
Therapy, and Outcome," The New England Journal of Medicine. 309
(1983): 1243-1244.

Hare-Mustin, Rachel T. and Broderick, Patricia C. "The Myth of Motherhood:
A Study of Attitudes Toward Motherhood," Psychology of Women
Quarterly. 4 (1979): 114-128.

Hanmer, Jalna and Allen, Pat. "Reproductive Engineering: The Final
Solution?" In Alice through the Microscope, pp. 208-227. Edited by
The Brighton Women and Science Group. London: Virago, 1980.

CARLETON UNIVERSITY

Infertility Self-Help Group [sic] of Ottawa and Canadian Committee for Fertility Research, "Infertility: Concepts and Controversies", a public forum, November 5, 1985, Ottawa, Ontario.

Infertility Self-Help Support Group, Newsletter, Ottawa, 1984-1987.

Jacobson, Mark, "Baby Chase: Struggles with the Inconceivable," Esquire, May 1987.

Kearney, Helen R. "Feminist Challenges to the Social Structure and Sex Roles." Psychology of Women Quarterly, 4 (1979): 16-31.

Keeton, Kathy and Yvonne Baskin. Woman of Tomorrow. New York: St. Martin's/Marek, 1985.

Keeton, Kathy with Yvonne Baskin. "Birthtech: The Ideal Sperm Donor," Omni, December 1985, pp. 90-97.

Kipper, D., Zigler-Shani, Z., Serr, D. and Incler, V. "Psychogenic Infertility, Neuroticism and the Feminine Role: A Methodological Inquiry," Journal of Psychosomatic Research, 21 (1977): 353-358.

Knoppers, Bartha. "Women and the Reproductive Technologies." In Family Law in Canada: New Directions. Edited by Elizabeth Sloss. Ottawa: Canadian Advisory Council on the Status of Women, 1985. pp 211-225.

Kraft, Adrienne; Palombo, Joseph; Mitchell, Dorene; Dean, Catherine; Meyers, Steven; and Wright Schmidt, Anne. "The Psychological Dimensions of Infertility", American Journal of Orthopsychiatry, 50 (1980): 618-628. 618-628.

Landsberg, Michele. "Baby M decision gives Legal Backing to Inhumane Practice." The Globe and Mail. April 4, 1987.

Leiblum, S.R.; Kemmann, E.; Colburn, D.; Pasquale, S.; and DeLisi, A.M. "Unsuccessful In Vitro Fertilization: A Follow-up Story", Abstracts: Scientific Papers to be presented at the 42nd Annual Meeting of the American Fertility Society and the 18th Annual Meeting of the Canadian Fertility and Andrology Society. In Fertility and Sterility, Sept. 27, 1986, p. 20.

- Lilford, Richard J. and Dalton, Maureen E. "Effectiveness of Treatment for Infertility", British Medical Journal. 295 (July 18, 1987): 155-156.
- MMWR: Morbidity and Mortality Weekly Report. "Infertility - United States, 1982", Atlanta, Georgia: U.S. Department of Health and Human Services, 34 (April 12, 1985): 197-199.
- Mahlstedt, Patricia P. "The Psychological Component of Infertility," Fertility and Sterility. 43 (March 1985): 335-346.
- Mai, F. M. M. and E. E. Rump. "Are Infertile Men and Women Neurotic?" Australian Journal of Psychology 24 (1972): 83-86.
- Maitland, Sara. Daughter of Jerusalem. London: Blond and Briggs, 1978.
- Marchand, Philip. "How Infertile Couples become Parents," Chatelaine, November 1983, pp. 72, 100-102, 109-111.
- Mazor, Miriam. "Barren Couples," Psychology Today, 12, (May 1979): 101-112.
- Mazor, Miriam. "The Problems of Infertility." In The Woman Patient: Medical and Psychological Interfaces, vol.1. Edited by Miriam Mazor. New York: Plenum Press, 1978.
- Mazor, Miriam D. and Simons, Harriet F. eds. Infertility: Medical, Emotional, and Social Considerations. New York: Human Sciences Press, Inc., 1983.
- McBride, Angela Barron. The Growth and Development of Mothers. New York: Harper and Row, 1973.
- McCormick, T.M. "Out of Control: One Aspect of Infertility," Journal of Obstetrics, Gynecology and Neonatal Nursing (JOGN Nursing). 9 (1980): 205-206.
- Menken, Jane; Trussell, James; and Larsen, Ulla. "Age and Infertility", Science. 233 (Sept. 26, 1986): 1389-1394.
- Menning, Barbara Eck. "Counseling Infertile Couples," Contemporary Obstetrics and Gynecology. 13 (1979): 101-108.

- Menning, Barbara Eck. "Donor Insemination: The Psychological Issues," Contemporary Obstetrics and Gynecology. (1981) 155-172.
- Menning, Barbara Eck. "The Emotional Needs of Infertile Couples," Fertility and Sterility. 34 (1980): 313-319.
- Menning, Barbara Eck. Infertility. A Guide for the Childless Couple. New Jersey: Prentice-Hall, 1977.
- Menzies, Heather. "In His Image: Science and Technology as Ideology," This Magazine. 21 (May/June 1987):
- Michaelson, Karen. "Introduction: Population Theory and the Political Economy of Population Process." In And the Poor Get Children: Radical Perspectives on Population Dynamics. Edited by Karen Michaelson. New York and London: Monthly Review Press, 1981.
- Miller, Warren B. "Chance, Choice and the Future of Reproduction." American Psychologist. (November 1983): 1198-1205.
- NBC News Special "The Baby Business." April 4, 1987.
- Newman, Elkie. "Who controls Birth Control?" In Smothered by Invention: Technology in Women's Lives Edited by Wendy Faulkner. London: Pluto Press, 1985.
- Notman, Malkah and Nadelson, Carol. "Changing Views of the Relationship between Femininity and Reproduction." In The Woman Patient: Concepts of Femininity and the Life Cycle, vol. 2. Edited by Carol Nadelson and Malkah Notman. New York: Plenum Press, 1982.
- O'Brien, Mary. The Politics of Reproduction. London: Routledge and Kegan Paul, 1981.
- The Ottawa Citizen. "...And Baby Makes Five Billion." July 13, 1987.
- The Ottawa Citizen. "Fertility Clinics, Counselling growing: Study." July 15, 1987.
- The Ottawa Citizen. "Ottawa Mom sets record with Second Test-tube Baby." June 11, 1987.

The Ottawa Citizen. "Patients angry at delay in Test-tube-baby Program."
July 21, 1987

The Ottawa Citizen. "Vatican Study slams Artificial Reproduction."
March 7, 1987.

The Ottawa Citizen. "Wombs for Rent: The Dilemma of Surrogate
Motherhood." January 31, 1987.

Ottawa General Hospital, "Fertility Centre." pamphlet. Ottawa, 1981.

Peck, Ellen and Judith Senderowitz. Pronatalism: The Myth of Mom and
Apple Pie. New York: Thomas Y. Crowell Co., 1974.

Petchesky Rosalind Pollack. Abortion and Woman's Choice: The State,
Sexuality, and Reproductive Freedom. New York and London:
Longman, 1981.

Pfeffer, Naomi and Woollett, Anne. The Experience of Infertility. London:
Virago, 1983.

Pilon, Debra. "Conception without Sex," Healthsharing. 6 (Fall 1985): 21-
24.

Platt, J.J., Ficher, I.; and Silver, M.J. "Infertile Couples: Personality Traits
and Self-ideal Concept Discrepancies," Fertility and Sterility. 24
(1973): 972-976.

Quindlen, Anna. "Baby Craving," Life, June 1987, pp. 23-26.

Resolve, Inc. "Bromocriptine and Elevated Prolactin Levels." pamphlet.
Belmont, Massachusetts, 1981.

Resolve, Inc. "Clomid" pamphlet. Resolve, Inc.: Belmont, Massachusetts,
1981.

Resolve, Inc. "Deciding on In Vitro Fertilization." pamphlet. Resolve, Inc.:
Belmont, Massachusetts, 1983

Resolve, Inc. "Endometriosis." undated pamphlet. Resolve, Inc.: Belmont,
Massachusetts.

CARLETON UNIVERSITY

- Resolve, Inc. "Facts about Artificial Insemination" pamphlet. Resolve, Inc.: Belmont, Massachusetts, 1980.
- Resolve, Inc. "H.M.G (Pergonal)" undated pamphlet. Resolve, Inc.: Belmont, Massachusetts.
- Resolve, Inc. "Luteal Phase Defect." pamphlet. Resolve, Inc.: Belmont, Massachusetts, 1980.
- Resolve, Inc. "An Overview of the Infertility Work-up and the Tests Used." pamphlet. Resolve, Inc.: Belmont, Massachusetts, 1980.
- Resolve, Inc. "Semen Analysis." pamphlet. Resolve, Inc.: Belmont, Massachusetts, 1980.
- Resolve, Inc. "The Varicocele: Surgical and Medical Treatment." pamphlet. Resolve, Inc.: Belmont, Massachusetts, 1981
- Rich, Adrienne. Of Woman Born: Motherhood as Experience and Institution. New York: Norton, 1976.
- Rosenfeld, D. and Mitchell, D. "Treating the Emotional Aspects of Infertility: Counseling Services in an Infertility Clinic," American Journal of Obstetrics and Gynecology. 135 (1979): 177-180.
- Rothman, Barbara Katz. "How Science is redefining Motherhood," Ms. August 1982, pp. 154-158.
- Rothman, Barbara Katz "The Meanings of Choice." In Test-Tube Women: What Future for Motherhood. Edited by Rita Arditti, Renate Duelli Klein and Shelley Minden. London: Pandora Press, 1984.
- Rothman, Barbara Katz. The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood. New York: Viking, 1987
- Russo, Nancy Felipe. "Overview: Sex Roles, Fertility and the Motherhood Mandate," Psychology of Women Quarterly. 4 (1979): 7-15.
- Russo, Nancy Felipe. "The Motherhood Mandate," Psychology of Women Quarterly. 4 (1979): 143-153.
- Sandelowski, Margarete. "Sophie's Choice: A Metaphor for Infertility," Health Care for Women International. 7 (1986): 439-453

- Seibel, Machele M.; Berger, Merle J.; Weinstein, Frederick G.; and Taymor, Melvin L. "The Effectiveness of Danazol on Subsequent Fertility in Minimal Endometriosis," Fertility and Sterility. 38 (November 1982): 534-537.
- Seibel, Machele M. and Taymor, Melvin L. "Emotional Aspects of Infertility," Fertility and Sterility. 37 (1982): 137-145.
- Serono Laboratories, Inc. "Female Patient History." undated form, Randolph, Massachusetts.
- Shapiro, Thomas M. Population Control Politics. Philadelphia: Temple University Press, 1985.
- Silber, Sherman. How to get Pregnant. New York: Scribners, 1980.
- Slade, Pauline. "Sexual Attitudes and Social Role Orientations in Infertile Women," Journal of Psychosomatic Research. 25 (1981): 183-186.
- Snitow, Ann. "The Paradox of Birth Technology: Exploring the Good, The Bad and the Scary", Ms., December 1986, pp. 42-46, 76-77.
- Soules, Michael R. "The In Vitro Fertilization Pregnancy Rate: Let's be honest with one another," Fertility and Sterility. 43 (April 1985): 511-513.
- Stangel, John. Fertility and Conception: an Essential Guide for Childless Couples. London: Paddington Press: 1979.
- Styron, William. Sophie's Choice. New York: Bantam, 1979.
- Targ Brill, Marlene, "Infertility and You". undated pamphlet, Chicago, Illinois
- Thorpe, Murray "Infertility and Reproductive Technologies", unpublished paper, Department of Psychology, Carleton University, 1986.
- Unruh, Anita M. and McGrath, Patrick J. "The Psychology of Female Infertility: Toward a New Perspective", Health Care for Women International. 6 (1985): 369-381.

Van Gelder, Lindsay. "Countdown to Motherhood: When Should You Have a Baby?", Ms. December 1986, pp. 37-39, 74-76.

Van Hall, E.V. "Androgyny: A Model for Improving Gynecologist-Patient Relations," Journal of Psychosomatic Obstetrics and Gynecology, 1-2 (1982): 87-90.

Van Hall, E.V. "The Infertile Couple and the Gynaecologist: Psychosocial and Emotional Aspects." In Fertility and Sterility: The Proceedings of the XIth World Congress on Fertility and Sterility, Dublin, June 1983, held under the Auspices of the International Federation of Fertility Societies. Edited by R.F. Harrison and J. Bonnar W. Thompson. [Boston]: MTP Press, [1983].

Veevers, J.E. "The Social Meanings of Parenthood," Psychiatry, 36 (August 1973): 291-310.

Watters, Wendell W. Compulsory Parenthood: The Truth about Abortion. Toronto: McClelland and Stewart, 1976.

Weil, Robert. "Interview: Alan Trounson." Omni, December, 1985, pp. 82-88, 124-128.

Williams, Linda S. But what will they mean for Women?: Feminist Concerns about the New Reproductive Technologies. Feminist Perspectives No. 6, Canadian Research Institute for the Advancement of Women: Ottawa, 1986.

Williams, Wendy. "Thoughts on Infertility." unpublished article. Ottawa, 1987.

Zaner, R. "A Criticism of Moral Conservatism's View of In Vitro Fertilization and Embryo Transfer," Perspectives in Biology and Medicine, 27 (1984): 200-212.

INTERVIEWS

- Linda Austin, interviewed in Ottawa, July 10 and July 14, 1987.
- Dr. Norman Barwin, gynecologist, interviewed in Ottawa, June 5, 1987.
- Barbara Carroll, interviewed in Ottawa, June 7, 1987.
- Dr. John A. Collins, Director of Obstetrics and Gynecology, McMaster University, Hamilton; President, Canadian Committee for Fertility Research, interviewed in Hamilton, July 15 and July 16, 1987.
- Bozica Costigliola, interviewed in Ottawa, July 20, 1987.
- Dr. Geraldine Finn, lecturer, Women's Studies Program, University of Ottawa, interviewed in Ottawa, Aug. 5, 1987.
- Dr. Peter Garner, Reproductive Endocrinology and Infertility Clinic, Ottawa Civic Hospital, conversation in Ottawa, April 7, 1987 and Aug. 20, 1987.
- Janine Gauthier, research coordinator, Canadian Committee for Fertility Research, interviewed in Montreal, July 15, 1987.
- Dr. Pat Gervaise, psychologist and clinical researcher, Ottawa Civic Hospital, interviewed in Ottawa, Aug. 6, 1987.
- Susi Gruda, interviewed in Ottawa, July 8, 1987.
- Dr. Pierre Huard, gynecologist-obstetrician, conversation in Ottawa, Feb. 19, 1987.
- "Jane", interviewed in Ottawa, June 8, 1987.
- Sylvie Jolicoeur-Payne, interviewed in Ottawa, July 30, 1987.
- Dr. Elaine Jolly, Director, Fertility Centre, Ottawa General Hospital, interviewed in Ottawa, July 29, 1987.
- Dr. Firouz Khamzi, Director, Toronto Fertility and Sterility Institute, interviewed in Toronto, Aug. 4, 1987.
- Elizabeth Lambert, interviewed in Ottawa, Aug. 4, 1987.
- Trish Maynard, coordinator, Infertility Self-Help Support Group, Ottawa, interviewed in July 21, 1987.
- Marie Morrissey, coordinator and founder, Infertility Self-Help Support Group, interviewed in Ottawa, July 17, 1987.
- Nikkie Schekkerman, interviewed in Kemptville, Ontario, June 29 and Aug. 12, 1987.
- Michael Skaff, interviewed in Ottawa, July 8, 1987.
- Sandra Levine Slover, infertility counselor, Ottawa Civic Hospital, interviewed in Ottawa, May 28, 1987.
- Dr. J.E.H. Spence, Reproductive Endocrinology and Infertility Clinic, interviewed in Ottawa Civic Hospital, Ottawa, July 24, 1987.
- Dave Stapley, interviewed in Ottawa, June 10, 1987.

Shirley Stapley, interviewed in Ottawa, June 10, 1987.

Rob Williams, Ottawa, interviewed in July 13, 1987.

Wendy Williams, interviewed in Ottawa, July 13, 1987.

Anita McGrath Unruh, social worker and researcher, formerly of Psychology Research Lab, Health Sciences, University of Ottawa, written communication from London, England, July 20, 1987.

END

18-02-90

FIN