

7

**PSYCHOSOCIAL DISCOURSE AND THE "NEW" REPRODUCTIVE  
TECHNOLOGIES: A CRITICAL ANALYSIS**

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**B.A. Hons., U.C.T.**

A dissertation submitted in partial fulfillment of the requirements  
for the Degree of Master of Arts in Clinical Psychology

**University of Cape Town**

**1989**

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*"The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle."*  
(Scheper-Hughes & Lock, 1988, p.31)

## ABSTRACT

The "new" reproductive technologies (NRTs) have gathered substantial momentum in recent years. 'Psychological' discourse on these techniques has tended towards uncritical preoccupation with intra-individual, constitutional factors, and has ignored the sociocultural, political and economic contexts of these practices. Within an inter-disciplinary, social-constructionist framework, this study presents a feminist critique of the NRTs in which they are argued to be biopsychosocially noxious to women. Modern biomedicine's appropriation and ownership of infertility as "disease" is argued to be consistent with the agendas of capitalism and patriarchy. Results of fieldwork within a particular medical setting are presented to develop a hermeneutic of the discursive interface between medical gatekeepers and the applicant 'patients' with whom they negotiate treatment. In a concluding section a dominant theme in gatekeepers' talk, "the well-being of the child", is ideologically analyzed; women-centered strategies are briefly discussed; and implications for the interface between psychology and reproductive technology are drawn.

## ACKNOWLEDGEMENTS

The following people are sincerely thanked for their help towards this work:

Ann Levett, my supervisor, whose depth and scope of understanding, enthusiasm and steady support have been greatly valued.

Leslie Swartz, for supervision during the earlier stages and for originally introducing me to the medical anthropological perspective in 1986.

Members of staff at the Infertility Clinic and in the Andrology Department, particularly Suzanne Van Lill, Klaus Wiswedel, and Petro Prins for their willingness to be observed in action and to openly and self-reflexively talk about their work.

The numerous 'patients' who kindly consented to being observed during the course of fieldwork.

# TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b>	1
<b>PART I : A FEMINIST CRITIQUE</b>	6
Medicine's ownership of infertility	8
The physical risks to women	11
NRTs as commerce	13
Motherhood, the family and the illusion of "choice"	15
Sex-selection and eugenics	18
Summary	20
<b>PART II : PSYCHOSOCIAL DISCOURSE IN CONTEXT</b>	21
Methodology	21
Figure 1 : Management Routes	23
Management Routes	24
The Operational Philosophy	27
Figure 2 : Relative Clarity of Operationalizations	28
Strategies at the Gatekeeper-Applicant Interface	28
Accommodating the Model	33
"The child must have a chance": The ideology of disqualification	36
"Good Human Material"	37
"Par for the Course" : Family Ideology	39
<b>SUMMARY AND CONCLUSIONS</b>	41
<b>GLOSSARY</b>	45
<b>REFERENCES</b>	47
<b>APPENDIX I: Typical interview format: nursing sister</b>	54
<b>APPENDIX II: Typical interview format: social worker</b>	55
<b>APPENDIX III: Fictitious case presented to doctor and social worker</b>	56
<b>APPENDIX IV: Interview with doctor and social worker</b>	57

## INTRODUCTION

This study is developed within a multi-disciplinary framework, methodologically informed by social psychology, sociology and medical anthropology. Utilizing discourse theory, its principal aim is a critical analysis of aspects of the dominant discourse on the "new" reproductive technologies (NRTs).

Some preliminary definitions are called for. While the term "reproductive technology" broadens to include contraception, "new reproductive technology" more specifically denotes those techniques associated with artificial reproduction, including artificial insemination by husband (AIH), artificial insemination by donor (AID), in-vitro fertilization (IVF), surrogate motherhood, surrogate embryo transfer, sex selection, and sex preselection, all of which are actually practised currently; together with techniques that may become feasible but are as yet unactualized, such as ectogenesis (artificial wombs) and cloning. I have drawn attention to the term "new" since this is a misnomer in the case of artificial insemination, a technique that apparently dates back to the fourteenth century (Small & Turksoy, 1985). All of the above terms are defined in a glossary at the back of this text.

"Discourse" is an elusive, multiply-formulated construct, and for present purposes it will be used as detailed by Foucault in his *The Archaeology of Knowledge* (1972). Very briefly, a discourse is defined as a regulated system of statements and the practices used to produce, appropriate and communicate these statements (Henriques, et al. 1984; Young, 1987). In this particular form of discourse analysis, the content, function and social significance of language are at issue (Kress, 1985). A discourse on an area of social life will define, describe and delimit what is possible and impossible to say with respect to it, and how it may be talked about (Ibid). In this sense reality is "socially constructed" (Berger and Luckman, 1966), and it is through discourse's simultaneous enablement and constraint of action and understanding that knowledge and power are linked (Young, 1987). Critical discourse analysis points to how language contributes to social inequality (Fowler, 1982), and confronts the role of state and institutions in authorizing, promoting and legitimating the particular forms of discourse that sustain these relations of domination (Van Dijk, 1982; Thompson, 1982).

## LITERATURE SUMMARY

In a precursor to the present study (Brokensha, 1986) a summary of the literature revealed that the legal, ethical and religious implications of AID had received considerable attention. It was noted that studies addressing the 'psychology' of AID were focused around the following themes:

- i The psychological health of those requesting AID.
- ii Typical sequences of experiences undergone by recipient couples, and their attitudes.
- iii Whether or not the selection of recipients should involve psychological assessment.
- iv The advisability and nature of providing psychotherapeutic support for recipient couples.
- v The psychological sequelae of AID for recipients and offspring.
- vi Sperm donors' motivation and their attitudes.

Literature on the 'psychological' aspects of AID revealed a preoccupation with intra-individual, constitutional factors; the search being for "the typical" donor or recipient. I proposed that this tendency could reflect an eagerness on the part of those providing AID to establish the respectability and normality of donors and recipients, in an effort to receive social sanction of such services. With these as the dominant terms in the 'psychological' discourse on AID, it was evident that no space had been given to the consideration of socio-cultural and political parameters. "Towards a Contextualist Understanding of AID" (Brokensha, 1986) was an attempt to redress this imbalance, and a medical anthropological framework was employed to elucidate some of the cultural bases of medical belief and action regarding AID. A study of the literature from 1985 to date on AID and other "new" reproductive technologies reveals that the field has expanded rapidly. In early 1984 the first successful results of egg donations by IVF; egg donations by lavage; and embryo freezing were reported. In an ethical review of 1984, entitled "Reproductive Technology Poses Perplexing New Problems", Gray (1985) commented:

"The speed with which reproductive technology advanced last year was startling ... The new reproductive technologies are so novel that the terminology with which to discuss them doesn't yet exist."

The increasing number and deployment of reproductive technologies has induced a corresponding convolution of legal, religious and ethical concerns, (eg. Andrews, 1987; Christiaens, 1988; Geller, 1986; Grobstein, 1985; Rapp, 1987). At the time of writing, for instance, a legal precedent was in the making during the first ever "frozen embryos divorce case", wherein a divorced couple fought

over custody of seven fertilized embryos they had frozen under IVF-treatment during their marriage. The woman sought to have the eggs reimplanted into her uterus against her ex-husband's wishes for them to remain frozen. The judge finally granted temporary custody to the mother in the "manifest best interests of the children". (Cape Times, 22/09/89).

In the U.K., a 'Committee of Inquiry into Human Fertilization and Embryology' had been appointed by the Conservative Government in 1982 to examine key issues in reproductive technology and make recommendations for practice. The Report of the Committee (the "Warnock Report") was published in 1984 and its recommendations adopted by the British medical fraternity. Similarly, in the United States the American Fertility Society "felt that (reproductive) technology was getting ahead of us. No one in the United States was taking a stand and establishing guidelines." (Ethics Committee member, Edward Warnock, quoted in Kolata, 1986.) The Ethics Committee of the Society thus released a 94 page document, "Ethical Considerations of the New Reproductive Technologies" in September 1986.

In South Africa, NRT practices are informally guided by Britain's Warnock Report, and officially constrained by local legislation. The *Human Tissue Act* of 1983 for the first time legalized the donation of sperm and ova in this country. An annexure to this Act (Department of National Health and Population Development, June 1986) stipulated that "no person except a medical practitioner or a person acting under his supervision may remove or withdraw a gamete from the body of a living person for the purpose of the artificial insemination of another living person" (p.29). Also, this "competent person shall not effect the artificial insemination of any person other than a married woman ..." (p.31) The *Human Tissue Amendment Act, 1988* (Ibid., June 1988) broadens the above restrictions to all artificial fertilization practices (not just AID). It outlaws the payment of donors (though loosely allowing for "remuneration" of costs incurred), and provides stricter control of access to identifying data. And the *Children's Status Act* of 1987 has legislated that in all cases of gamete-donation to a (married) couple the resultant child becomes the legitimate offspring of that woman and her husband.

Schaffer (1986) has observed that "... at present the (psychological implications) are still so difficult to identify. And yet there is considerable apprehension among members of the mental health professions as to what is in store for them." (p. 772). The same preoccupations as noted above prevail in the literature dealing with the 'psychology' of AID and other RTs (eg. Berger, 1986; Blaiser, Maloigne-Katz, & Gigon, 1988; Brand, 1987; Humphrey & Humphrey, 1987; Leiblum, Kemmen, & Lane, 1987; Sokoloff, 1987). However, two new

tendencies are evident:

Firstly, the RTs are now receiving attention from psychoanalysis. Huber and Bydlowski (1987), in discussing the "biopsychological problems created by the new procreation techniques", report that

"Biologists and psychoanalysts are currently working together to determine the interfacing of such diverse approaches as the histology of human ovaries and the unconscious desires invested in the reproduction instinct."

They go on to claim that "only psychoanalysis can reveal the mental processes underlying these new 'procreations' ... and the separation of the sexual drive from the self-propagation instinct" (Abstract). Tort (1987) has proposed that "the role of psychoanalysis" in AID "... consists chiefly in defining and helping the subjects to internalize appropriate superego models" (Abstract).

Secondly, several writers have sought to define the role of mental health professionals in relation to clinical and assessment aspects of the RTs: Bell (1986), Daniels (1986), Greenfeld, et al. (1986), and Needleman (1987) have all discussed the potential roles of Social Work in such cases. Richardson (1987), proposes a role for the psychiatric consultant in "evaluating the likely effect of AID on the family's integrity and stability" (Abstract); and Micioni, et al. (1987) describe their methods of assessing "doubtful and negative psychological indications for AID".

Probably the most significant new development in the discourse on AID and related technologies has been a growing body of works that seek to make sense of these practices in terms of their sociocultural, political and economic contexts. In a 1987 supplement to the Hastings Centre Report, the interface between public debate and state policy on RT is examined in France, Israel, The Netherlands, Britain, Japan and Australia. (Bai, Shirai, and Ishii, 1987; de Wachter & de Wert, 1987; Fagot-Largeault, 1987; Gillon, 1987; Shapira, 1987; Waller, 1987.) Dagnaud & Mehl (1988) explore gynecologists' relations with their patients and with public authorities and discuss the relationship between cultural changes and advances in RT. Basker (1986) and Brody (1987) have drawn attention to the power held by physicians as arbiters, gatekeepers and decisionmakers in the reproduction of the infertile and pointed to their agency in social control. Robinson (1988) has sought to elucidate how the legal structure has been redefining familial relationships in response to the development and diffusion of reproductive technology. Vandelac (1986) suggests that medically assisted procreative techniques have given rise to "an entirely new economy of human reproduction" (Abstract) and, similarly, Gimenez (1988) has offered an historical materialist analysis of RT.

The following critical analysis of the NRTs proceeds by two distinct but interrelated means. Part I is devoted to the development of a selective feminist critique of the NRTs, in which I argue that these practices, in their present and projected forms, are physically, psychologically and politically noxious to women. Against this backdrop, Part II explores NRT discourse within a specific medical milieu, developing a hermeneutic of the discursive interface between medical gatekeepers and the involuntarily infertile people who petition for their services. In a concluding section, these particular, situated discursive features are made sense of in terms of the feminist critique, by analyzing their ideological function in legitimizing social discrimination. The direct implications of this analysis for psychology, especially clinical psychological practice, are briefly considered.

## PART I : A FEMINIST CRITIQUE

Reflecting the complex diversity of feminist theory in general, women-centered discourse on the NRTs constitutes a non-unified field. Prevailing analyses are often competitive and mutually exclusive at quite fundamental levels. From the perspective of social constructionist theory (Gergen, 1985), which views all knowledge as the product of historically situated interchanges amongst people, the vicissitudes of feminist discourse may be seen to flow from a diversity of socio-political agendas. Utilizing a social constructionist framework, this section is aimed at developing a necessarily selective feminist critique of the NRTs. Specifically, I argue from a socialist feminist position (Eisenstein, 1979) that these practices are closely wedded to both patriarchy and capitalism and thus oppressive to women.

In contrast to marxist feminism, which proposes a reductive relationship between women's oppression and class oppression, socialist feminism contends that women's freedom is predicated on the undoing of both capitalism and patriarchy, recognizing that these latter

"function as a mutually dependent totality, (yet) also operate as differentiated and conflictual systems. As such they remain two systems that are relatively autonomous from each another, never totally separate today and yet always differentiated in purpose."  
(Eisenstein, 1982, p.92)

Acknowledging this complex relationship between capitalism and patriarchy, I do not attempt to analyze how their symbiosis is played out within the NRTs. Rather more modestly, I point to some of the ways in which each of these obtains within the discourse under study, and how these forms are noxious to women. There is no generally accepted or rigorous definition of 'patriarchy', and for the purposes of this study it will be defined, in keeping with a trend in feminist anthropology, as "male dominance in general ... (including both) the absolute authority of the male in the domestic domain ... and male monopoly on public social discourse, political and economic decisions ..." (Seymour-Smith, 1986).

### *A Feminist Dilemma?*

The historic role of reproduction in the oppression of women suggests the need for careful appraisal of any new technology in this domain. However, at first glance it is not easy to discern whether feminism should welcome or defend against the NRTs. Several feminist writers have admitted with some discomfort to points of friction within their own discourse, points at which conflict

arises between two or more women-centered values, (e.g. Salladay, 1981; Murphy, 1984; Minden, 1985; Rowland, 1985; Rapp, 1987). Notably, the broad question of whether and to what extent the NRTs should be permitted lands feminism on the "horns of a feminist dilemma" (Peterson, 1981, p.197). This is a double-bind commonly expressed in terms of women's unavoidably losing power, though this is formulated slightly differently across authors. Thus the potential of the NRTs to further subjugate women to patriarchal medical control is juxtaposed with their potentially beneficial therapeutic value (Holmes, 1981; Oakley, 1984), while from another perspective they are seen as potentially freeing women from reproduction yet removing the only value clearly granted to women by patriarchal society (Peterson, 1981; Salladay, 1981). And Powledge (1981) advocates the prevention of prenatal diagnosis on grounds that it is sexist, yet is reluctant to "provide an opening wedge for legal regulation of reproduction in general" (p.197).

The preoccupation of feminism in the early 1970's was with women's liberation from the burdens of reproductive labour and hence at this time feminist health care interests were located outside of maternity (Oakley, 1984). The importance of effective contraception was in its transformation of involuntary reproductive labour into voluntary reproductive labour, an impact that has led to the notion that social and political change in the status of women is principally "technologically driven" (Kronenfeld & Whicker, 1986, p.47). This was the ideological climate within which de Beauvoir (1974) unquestioningly accepted the evaluation of childbirth as an inferior animal activity and the curse of femininity, and the radical feminist writer Firestone (1972) labelled pregnancy as "barbaric", advocating that women be emancipated from the "tyranny of reproduction by every means possible" (pp.188;193). Firestone optimistically viewed the NRTs as the *sine qua non* for women's freedom, and a wave of feminist science fiction reflected similar utopianism, notably the parthenogenetic societies in Russ' "The Female Man" (1975), Charnas' "Motherlines" (1978) and Gilman's "Herland" (1979).

With hindsight, these views are naively biologicistic. They are no longer fashionable, and have been displaced by the insight that it is not motherhood or even the family in themselves that are problematic, but the patriarchal institutionalization of these. (Rich; 1977; Friedan, 1981; Wishart, 1982). An adequate analysis must recognize the central social relations in operation, and appreciate their virulence - that is, their ability to remain unchanged across the vicissitudes of technology.

It is a "technocratic illusion" that relations of oppression and exploitation can be overcome by more sophisticated technology since this is only

possible by a revolutionizing of these relations (Mies, 1985); and it is naive to assume that women's appropriation of the NRTs would automatically eliminate their misuse. On the contrary, the projected radical feminist agenda of employing the NRTs to abolish men (Firestone, 1972) is apparently nothing other than a vengeful reversal of the oppression (Powledge, 1981). It is informed by a fallacious biologicistic interpretation of what is in fact a social and historical relationship: "bisexuality as such is not our problem, but the relationship of exploitation and domination between men and women" (Mies, 1985, p.557). Thus as Rothman has put it, "all (RTs) empower and they all enslave, they can all be used by, for or against us" (1984, p.33, original emphasis), depending on the social relations they serve. Despite the distinctiveness of women's biological capacities, then, it is the historical and social context of childbearing and childrearing that principally determines their structure and meaning.

### ***Medicine's ownership of infertility***

The term "medicalization" has been used to describe the overproduction of 'illness', as a social construction, in contemporary advanced industrial societies (Scheper-Hughes & Lock, 1988):

"The proliferation of disease categories and labels in medicine and psychiatry, resulting in ever more restricted definitions of the normal, has created a sick and deviant majority ... Radical changes in the organization of social and public life in advanced industrial societies ... have allowed medicine and psychiatry to assume a hegemonic role in shaping and responding to human distress ... (and resulted in) the funnelling of defuse but real complaints into the idiom of sickness ..." (Ibid.,pp.26-27)

Similarly, the concept of "ownership" has been used to refer to a group's authoritative ability to construct the public definition of a social problem (Gusfield & Weiner, 1975, 1980 in Parton, 1985). Biomedicine has not only medicalized (and to some extent pathologized) the normal female life processes of pregnancy and birth, reconstituting them as specialized, technical subjects ("antenatal care" and obstetrics), but additionally asserted ownership of infertility by labelling this as "disease". Medicine's ownership of infertility sanctions shifting the focus of research from the later stages of pregnancy, over which successful control has now been achieved, to its beginnings. By influencing the release, fertilization and reimplantation of eggs in women's bodies, a predominantly male medical and scientific establishment is rapidly increasing its control over all aspects of the reproductive process.

An understanding of medicine's "technological takeover" of reproduction requires exploration of how such practices are ideologically imbedded. As Noble (1979) has argued:

"There is always a range of possibilities or alternatives that are delimited over time - as some are selected and others denied - by the social choices of those with the power to choose, choices which reflect their intentions, ideology, social position, and relations with other people in society. In short technology bears the social 'imprint' of its authors." (quoted in Koch & Morgall, 1987, p.173)

Technology is thus a socially shaped institution, containing values implicit in its design. It gives control over lives - "biopower" (Foucault, 1979) - and inevitably plays an instrumental role in the differential power relations between people. In this sense the NRTs are an instrument of the "body politic" - "... the regulation, surveillance, and control of bodies ... in the service of some definition of collective stability, health, and social well-being" (Scheper-Hughes & Lock, 1988, pp.7-8). Bush (1983) has developed a feminist model for technology assessment in which she stresses the concept of "advantage" - technologies are accepted and promoted because they are advantageous to certain groups. Evaluating technology on the grounds of its differential social utility lays the basis for a "conflict-oriented" feminist analysis (Koch & Morgall, 1987).

Although women are the principal consumers of reproductive technologies they are systematically excluded from decisions about their development and deployment. The practices surrounding these technologies are mystified and professionalized, placed under the jurisdiction of biomedicine. It must be conceded that to a large extent this is practically necessary in the case of more complex procedures such as IVF, which require sophisticated technical skill. Artificial insemination, however, preceded biotechnology, with a history extending as far back as the fourteenth century, when Arabs impregnated mares of their enemies with semen of 'inferior' stallions; the first documented human artificial insemination by husband being in 1793, and by donor in 1884 (Small & Turksoy, 1985). Artificial insemination is simple to the extent that the British Pregnancy Advisory Service provides a BPAS 'do-it-yourself kit' to facilitate self-impregnation of women (Samuels, 1982), while a recent study revealed no statistically significant difference in success rate between "home-inseminations" carried out by the recipient's partner and those clinically performed (Hogerzeil, et al., 1988). Yet by resituating artificial insemination under the rubric "new reproductive technology", medicine has claimed custody of it.

Since in this case medicine has extended its control to a practice not predicated on specialized medical expertise, it is implied that the appropriation is ideologically impelled. More correctly, because of AI's simplicity, its ideological underpinnings are more transparent than those of other, actual, reproductive technologies, where social agendas are just as active but more difficult to unravel from technological mystique.

As the custodian of AI and other RTs, medicine strictly controls who is granted access. In addition to a physical work-up, prospective recipients' social, economic, psychological and marital status are all brought under scrutiny to inform a final judgement as to whether they are deemed "fit for parenting". Thus a vast scope of non-medical considerations are employed as a basis for prescribing or prohibiting a medical treatment, extending medical jurisdiction into the realm of social control. In general, policies of access discriminate against poor women, black women, lesbians, and single women, though it should be noted that practices do vary internationally. In the Netherlands, for example, there is a trend to include celibate woman and lesbians (de Wachter & de Wert, 1987).

"Social arrangements now acquire a medical pathology and doctors' personal biases or bigotry about the social value of those arrangements become reclassified as objective medical evaluations which can be used to limit women's reproductive options ..."  
(Steinberg, 1986)

In this gatekeeping process, physicians act as moral arbiters, expressing their own standards of normality and deviance or those of the culture to which they are, perhaps unwittingly, captive (Brody, 1987). In a careful study of journal articles between 1980 and 1985, Basker (1986) sought to examine the dominant ethical considerations that were being raised in medical literature to potentially inform physicians' decisions and practices concerning technologically-assisted reproduction. S/he found that ethical issues were given minimal attention in the medical discourse, and that such attention was selective.

"The issues the journals seem to ignore are those which call into question practitioners' judgement and motives, their ultimate authority, their capacity as gatekeepers, their control over their patients, the experimental nature of the procedures - issues which might be seen as threatening to some of the basic tenets of medicine."  
(p.238)

The opinions appearing in the medical literature are predominantly written by males, for a male audience; and the conspicuous absence of any discussion of women-centered issues indicates the trivialization of these by the medical fraternity.

### *The physical risks to women*

Virtually absent from the dominant discourse is any discussion of the physical risks to which women are exposed as consumers of the NRTs. When it does appear, the 'physical risks' argument tends to be strategically invoked, for reasons that are not women-centered. In a careful feminist study of the Warnock Report, Spallone (1986) observes how the Enquiry Committee only draws attention to the physical risks of those methods they judge to be socially unacceptable. Ethical medical literature systematically ignores the significant proportion of infertility that is of iatrogenic origins (Basker, 1986) - notably that caused by previous tubal ligation (tied tubes) and pelvic infection induced by IUD's. This is an omission that cloaks the embarrassing irony of using reproductive technology to remedy that which it caused in the first instance. Similarly, the significant contribution to infertility of pesticides, herbicides, and hazardous environmental waste has been ignored.

Some of the documented risks of the NRTs are as follows. Selective abortion following amniocentesis may only be performed in the second trimester of pregnancy, increasing the risks of maternal death (Nentwig, 1981). The 'flushing' or 'lavage' technique employed in surrogate embryo transfer (SET) carries risks of infection and ectopic (tubal) pregnancy for both donor and recipient women, but in addition the possibility of a 'retained pregnancy' - that is an *unwanted* pregnancy - when flushing fails, leaving the donor to either abort (spontaneously, if she is lucky) or carry to term. Risks entailed in IVF include adverse effects of hormonal hyperstimulation (to obtain the highest possible number of mature ova in one cycle); trauma to the ovary from multiple follicle puncture by laparoscopy; risks from anaesthesia with repeated operations; risks from procedures for monitoring IVF; increased risks of spontaneous abortion and multiple pregnancy (this is because of the practice of transferring multiple embryos in order to raise the probability of a successful implantation); potential damage to the uterus; and risk of ectopic pregnancy (Hynes, 1985; in Kock & Morgall, 1987; Brody, 1987).

In a recent editorial in the *Journal of In Vitro Fertilization and Embryo Transfer*, Meldrum (1989) has expressed concern at "... the casual approach to sterile techniques during the transvaginal aspiration of follicles by many using this method of oocyte harvest" (p.1), and cites a case of serious infection by this procedure in which a 32 year old woman had to undergo removal of her uterus, tubes, and ovaries.

The mitigation that these are risks taken in order to bypass reproductive dysfunction in the woman flies in the face of the increasingly enthusiastic

application of IVF to cases of unknown aetiology and to cases of positively diagnosed *male-factor* infertility. At the University of Goettingen, when confronted with vexing cases of "unexplained sterility" which "can be the result of either psychosomatic factors or anatomic-physiological misfunctions", standard practice is to perform a so-called "diagnostical IVF". (Hinney, Kuhn, & Michelman, 1985. Abstract). They take successful in vitro fertilization (qua fertilization) as a basis for further intrauterine insemination cycles combined with psychotherapy, but conclude that "if there is no fertilization of the oocytes [eggs] in at least two IVF cycles even psychosomatic [sic] attempts to fulfill the patient's desire for a child seems senseless." (Ibid.)

When the liabilities of IVF, in terms of cost, physical risks, and minimal efficacy already call into question its status as a 'therapy', its deployment as a diagnostic tool seems outrageously unjustified - particularly since the odds are equal that it will lead its managers to conclude that further investigations are "senseless". Such unwieldy usage would seem to reflect a feature of the biotechnical revolution described by Brody (1988) as "the perceived imperative of using any available technology to solve problems defined as medical without reflective definition of where the patient's best interest actually lies." (p.204)

The 'success rate' of IVF may be expressed in a number of ways: per woman, per laparoscopy, or per embryo transfer; counting all pregnancies (including those ending in spontaneous abortion and tubal pregnancies) or only actual live births. Currently, in the United States, at least, no standard protocol exists for reporting IVF performance statistics (Stein, et al., 1989. Abstract). Collins et al. 1983, have also drawn attention to the existence of 'treatment-independent' pregnancies - pregnancies that are incidental to technological intervention yet for which the technologists take credit. At the 'Sixth World Congress on IVF and Alternative Assisted Reproduction' in Jerusalem in April 1989, a spokesperson for the WHO dismayed his audience by presenting a world-figure estimate of the IVF "1 month take home baby" success rate as only 7%.<sup>\*</sup> On these grounds the WHO no longer recognizes IVF as an established therapeutic treatment. Rather, it is viewed in its present form as an experimental procedure.

However, the increasing popularity of IVF as an intervention for positively diagnosed *male-factor* infertility is precisely due to its efficacy in this application. Data collected in 1987 by the U.S. IVF Registry reflects that IVF had higher success rates in male than in female-factor cases - 17% and 15% of

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<sup>\*</sup> W. Wagner, W.H.O., 2100, Copenhagen, Denmark. Cited in personal communication.

IVF patient cycles with tubal disease and endometriosis respectively, achieved clinical pregnancy; while 23% with oligospermia (low sperm count) resulted in clinical pregnancy (Hartz, Porter & Danforth, 1989. Abstract)

Wolf (1989) writes:

"Sperm processing in vitro to compensate for abnormal motility or abnormal acrosomal status is on the horizon. Ultimately it should be possible to effect fertilization in extreme male-factor cases .... The use of IVF to treat male infertility obviously has a bright future." (Abstract)

Thus it is quite probable that IVF will be most commonly consumed by fertile women married to infertile men. Clearly the risks entailed for such women are considered to be less important than, (i) preserving the genetic relationship between husband and child. This link would be disrupted by the low-risk option of AID; and (ii) avoiding the trouble of repeated attempts at AIH, which boosts the husband's sperm but presumably does not afford the same degree of control over sperm that IVF does. It could be speculated that IVF presents a more 'challenging' option to biotechnicians than these low-tech (if not no-tech) alternatives. Again it appears that, in ambitious pursuit of the technologically innovative, biotechnicians allow careerism to precede needs-assessment, particularly the needs of women.

### ***NRTs as commerce***

Notwithstanding the philanthropic intentions of its medical agents, the role of economic motive in the promotion of NRTs should not be minimized. Brody (1988) observes that "the biomedical research enterprise is central to the economies and reward systems of the industrialized world ... (offering) support, gratification and increased social power for a growing elite, the clinician scientist, and increasingly for the clinician-scientist-entrepreneur." (p.204)

U.S. legislation's reticence in responding to the NRTs has left these wide open to economic exploitation under 'free enterprise'. It is estimated that in the U.S.A. during 1988, when the going rate for a completed IVF procedure (i.e. a single attempt) averaged \$5 000, subfertile couples chanced \$90 million in the hope that the technology would allow them to take home a child this year (Stein et al., 1989. Abstract). The technique of surrogate embryo transfer (SET) was not funded by the U.S. National Institute of Health, but by a profit based firm, "Fertility and Genetics Research Incorporated" (FGR), which has a policy of offering company shares to its researchers (Rowland, 1985). Market researchers hired by FGR to assess the availability of women willing to serve as regular egg donors reported that "donor women exist in cost-effective abundance" (quoted in

Morris, 1988, p.20). FGR applied for a patent on the instruments used in SET and on the process itself. Similarly, in 1984, Australia Monash University was arranging to sell in vitro technology to an American commercial company. These competitive ownerships prevent evaluation by outside researchers, and inhibit information on and availability of these as potential services (Annas, 1984).

In the U.K., issues associated with health and reproduction are less blatantly exploited for profit than in the U.S. (Stacey, 1985), and the *Surrogacy Arrangements Act* of 1985 outlaws commercial surrogacy. Yet this restriction is being circumvented by a Washington-based agency which recruits British women to serve as surrogate mothers for British couples willing to pay up to \$32 000, thus conducting the entire transaction outside the U.K. (Morris, 1988).

South Africa is considerably behind the U.S.A. and U.K. in the development and dissemination of NRTs and tight legislation prohibits the commercialization of gametes (see Introduction). Nonetheless, the costs of treatment are high, though fortunately for recipients these are either covered by medical aid or determined on a sliding scale. At Groote Schuur Hospital, drugs for hormonal hyperstimulation during IVF are supplied at cost - somewhere between R220 and R500. Separately, each IVF "attempt", which includes hospitalization for ovum pick-up and later again for embryo transfer, costs around R510 if fully charged. Considering that some patients undergo as many as eight or nine attempts, this translates into substantial cost.

There is evidence of biases and straightforward misinformation within the medical literature, in the service of promoting NRT. For example, an article in the *Journal of the American Medical Association* (Blumberg, 1984) claiming that the 'non-surgical' procedure of embryo transfer by lavage is safer than IVF, was based on promotional material which the same author was paid to write under contract to the procedure's originator and his team (Annas, 1984). Annas comments:

"One expects the professional literature to be somewhat more objective ... The article will probably seem balanced to most of JAMA's non-legal readers, but it is biased in favour of SET ... Neither the author nor the editors of JAMA tell the readers that the author was paid by Dr Buster and his research team... Thus what should have been presented in the professional literature as a brief in favour of SET is presented as an opinion of a neutral observer" (Ibid., p.26, quoted in Basker, 1986, p. 235)

In an editorial in *Fertility and Sterility* headed "The In Vitro Fertilization Pregnancy Rate: Let's be Honest with One Another", Soules (1985) has spoken out:

"The truth with regard to the expected pregnancy rate after IVF procedures has been widely abused (primarily by IVF practitioners)

and has tainted an otherwise meritorious record of scientific and clinical achievement ... The widespread practice of exaggerating the IVF pregnancy rate appears to be a market ploy to lure prospective infertile couples into becoming active IVF patients ... [it] amounts to deception and exploitation of patients and is deplorable." (p.512-513)

The NRTs court what Rothman (1985; 1987) has called the "commodification of life", the process whereby people and their parts are treated as marketable commodities. The commodification process is most explicitly instantiated in the NRTs when money changes hands, but is also active at more subtle levels, often revealed quite vividly in the language surrounding these practices. It is evident in calculations of the "costs" and "burdens" of rearing disabled people, from which amniocentesis and selective abortion purportedly "saves" us (Rothman, 1987). It is disclosed to us in terms such as "sperm bank"; in an RT pioneer's speculation that it might be possible in future to open an "embryo supermarket" (Corea, 1984, p.132). It is present in the description of a mature woman's ovaries as "a production line of eggs", egg removal as "egg harvesting", and the high number of unused eggs and automatically aborted embryos as "egg and embryonic wastage" (Edwards, Bavister & Steptoe, 1969. Quoted in Murphy, 1984, p.71) And Modell (1989), in a study of how the concept of "odds" appears as a recurrent rhetorical theme in the negotiation of IVF between doctor and patient, has noted how doctors frequently draw on metaphors of gambling - one physician comparing IVF to a "roulette wheel" (p.29).

### ***Motherhood, the family and the illusion of "choice"***

The NRTs have led to an interesting tension between two ideological components: on the one hand they facilitate fertility, while on the other they threaten the dissolution of the nuclear, patriarchal family. Indeed, it is possible these days to have up to five parents - an ovum donor, a sperm donor, a gestational ("surrogate") mother, a caretaking mother and a caretaking father. The need to systematize patrilineal inheritance has always generated preoccupations with legitimacy. In addition to compounding the age-old difficulties of establishing paternity, the NRTs potentiate alternative family structures within which men, apart from their initial gamete contributions, are wholly redundant. These are the lesbian and single mother families. The tension between these conservative and subversive valencies is resolved by selectively structuring NRT practice such that it is only carried out in forms that uphold and promote the traditional family.

Discourse on the NRTs thus contains a set of unspoken assumptions about women's role in 'the family'. Most of the dominant debate about human reproduction situates women within the private realm of the family, and the latter is presented as natural, unproblematic and unitary. This is most dramatically evident in the politics of a neofascist movement rapidly gaining momentum in the U.S.A. and elsewhere, the "New Right", a sector of which comprises antifeminist "pro-life" and "profamily" groups. Eisenstein (1982) observes that in a

"fundamental sense the sexual politics of the New Right is implicitly antifeminist and racist: it desires to establish the model of the traditional white patriarchal family by dismantling the welfare state and by removing wage-earning married women from the labour force and returning them to the home." (p.78)

Prevailing images of women prescribe for them certain ranges of acceptable behaviour. Within the pro-natalist context of most societies, motherhood is central to the conventional definition of woman, and departures from this are construed as deviant. (Albury, 1984; Osborne, 1984; Rowland, 1985) Preoccupation is with the 'biological' link between mother and child, while alternative forms of parenting (adoption) and caregiving are devalued (Crowe, 1985).

Notions of 'rights' and 'needs' are strategically invoked to reinforce the equation of womanhood with motherhood: the criminalization of abortion is vindicated as protecting the "rights of the embryo"; while technologically-assisted conception is pleaded in terms of the "right to have children". Motherhood is thus upheld by being compelled and enabled by these notions respectively (Albury, 1984). But such claims to put women in possession of a 'natural right' are refuted by the highly discriminatory selection of 'suitable' recipients.

In support of such interventions, it is often argued that "women want it" (Crowe, 1985). Yet, it has been pointed out, an apparent 'choice' can be the result of subtle coercion and manipulation, a compulsion to choose the socially approved alternative (Hubbard, 1981; Arditti, 1985).

"The 'right to choose' means very little when women are powerless ... Women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions which they themselves create, but under social conditions which they, as mere individuals, are powerless to change."  
(Petchesky, 1980, p.674. Quoted in Rothman, 1985, p.192)

Conceding that prenatal diagnosis and selective abortion has valid applications under circumscribed circumstances of genetic indication, Hubbard (1985) points out that its routinization creates difficulties for the majority of women, who

have no reason to suspect problems. A pregnant woman who refuses the test - or has it and decides not to abort in the knowledge that the fetus is disabled - is held responsible for the social, medical, and economic problems that result. Rothman (1985) argues that while amniocentesis does indeed offer new choices, such choices are made within an ever-narrowing social structure. The power to control the 'quality' of our children may cost the choice of *not* controlling that quality, as bearing and rearing a handicapped child could become normatively unacceptable.

Although the risk of genetically induced disability is much less than that of acquiring a handicap later in life, the availability of amniocentesis and selective abortion creates the illusion that support services for the handicapped will become unnecessary. For example, as soon as prenatal diagnosis of Huntington's disease became possible, funding began to disappear for researching its cure (Hubbard, 1985). Society could renege on its recent commitment to disability rights (Kenen, 1981). (See Finger, 1984, for a discussion of the problematic interface between the disability rights and reproductive rights movements.)

While traditionally abortion has centered around the question of whether or not to bear a child - any child, prenatal diagnosis introduces the question of *what kind* of child we are prepared to bear. Women can now choose not to give birth to a *particular* fetus. This generates a contradiction in definitions and demands, especially since amniocentesis can only be performed in the second trimester of pregnancy.

"It asks women to accept their pregnancies and their babies, to take care of the babies within them, and yet to be willing to abort them ... (women) want to have amniocentesis to identify and to be able to abort a damaged *fetus*, but are afraid of the procedure's possible harm to their *baby*. (Rothman, 1985, p.190, original emphasis)

Oakley (1984) has observed that while in the 1920's and 1930's the high incidence of maternal death in childbirth necessitated medicine's attending to the mother, by the 1950's such risks were minimized, and consequently mothers gradually became medically reconstructed as the containers of fetuses. Fetuses have gained "patient" status. Despite the physical unity of mother and fetus, these are treated as two distinctly different patients (Harrison, 1982). In a current legal trend in the U.S.A. women are identified as the 'prime fetal hazard' and legally penalized and restricted in the name of "fetal rights". Gallagher (1984) has documented cases in the U.S.A. where hospitals have obtained court orders forcing women to undergo caesarian sections in the supposed interests of their "fetal patients". In 1981, after a welfare agency had found her unfit to care for herself, a woman was confined to hospital for

the last two months of her pregnancy by a juvenile court which "took jurisdiction" of her pregnancy. Similarly, women of childbearing age are being barred from certain high-paying, traditionally male-occupied jobs under its "fetal vulnerability" policy, while there has been no attempt to exclude fertile women from lower-paying, traditionally women-occupied jobs in which the presence of reproductive hazards is well established (Ibid.).

An effect of the NRTs is the fragmentation of motherhood: women can be assigned discrete, partial mothering roles - egg-donating "genetic" mother, 'surrogate' "physiological" mother, or "social" mother.

As Murphy has put it:

"By dividing women into 'two classes' - layers and hatchers, our productive functions are further used to enforce reproduction as our essential being. Two reproductive classes of women can degrade women as 'parts' of 'reproductive bodies' and diminish our chances of obtaining reproductive rights for all women." (Murphy, 1984, p.73)

### *Sex-selection and eugenics*

Although amniocentesis was initially developed in order to detect genetic defects, it is now commonly employed solely to determine the sex of a fetus - facilitating "sex-selection" by abortion if the fetus is not the gender of the parents' choice. Similarly, "sex preselection" techniques have been developed that intervene before conception, either by means of artificial separation of androgenic and gynogenic sperm and subsequent fertilization by artificial insemination, or by timing the occurrence of intercourse and making use of functional differences between the two sperm types (Nentwig, 1981; Hoskins & Holmes, 1984).

Unlike sex-selection, sex-preselection does not involve the destruction of a fetus, and might thus seem more defensible (Powledge, 1981). But such reasoning begs the "pro-life" versus "pro-choice" polemic and to my mind misses the real issue - that both sex-selection and preselection facilitate evaluating human beings fundamentally in terms of their sex. There is an overwhelming preference for male offspring within patriarchal societies. In the few cultures whose daughters are preferred, this is due to their economic utility (Rowland, 1984). In China, one-child families are encouraged and abortion is freely available to this end. An article in the *Chinese Medical Journal* reports that of 100 sex predictions made at one particular hospital, 30 resulted in planned abortions, a full 29 of which were of girls. (Cited in Nentwig, 1981, p.185.)

On such evidence it does not seem overreactive to refer to such techniques as "femicide" (Hoskins & Holmes, 1984) and the "previctimization" of women (Raymond, 1981), and to point to the potential dangers of "semi-extinction" of

women (McCormack, 1985). Steinbacher (1981) has pointed out that the preference for first-born sons, taken in conjunction with evidence that first-born children generally are advantaged in terms of intelligence, self-esteem, independence and achievement, potentiates a biological reinforcement of the traditional sex-role stereotype. Further, since poor women have restricted access to abortion, the number of first-born males would rise among the privileged and remain relatively unchanged amongst lower socioeconomic classes. Increasingly, women would be locked into poverty while men predominated in positions of power.

The specialist-technicist mystification of amniocentesis and genetics for the lay person entails dependency on physicians and scientists' decisions about which disabilities are to be 'targeted'. Categorization of genes as 'good' or 'bad' are political as well as medical decisions, and amount to judgements about 'who should and who shouldn't inhabit the world' (Hubbard, 1985).

There are signs of eugenic ideology in the practices surrounding artificial insemination by donor. Donors in the AID programs are typically medical students or graduate students, and while this may in part be due to practical convenience in recruitment, perhaps this practice also allows its agents to rest assured that their donors are 'superior specimens'. Far more explicitly, a "Repository for Germinal Choice" was founded in 1976 to collect the sperm of Nobel Prize winners, for those who will be satisfied with only 'the best' (Arditti, 1985).

Egg donation, in practice since 1983, similarly allows for differentiating 'good' eggs from 'bad' ones. Current Israeli legislation provides a point in case: In 1986 the Ministry of Health published draft regulations to the effect that implantation of a fertilized ovum may be performed in a woman only if the ovum is her own or if it was retrieved from a "woman of the same People [i.e. ethnic-national origin] ... on grounds of the welfare [i.e. best interest] of the child" (quoted in Shapira, 1987, p.14, original parentheses). Earlier, the Supreme Helsinki Committee, an advisory body to the Ministry of Health, had initially advised permitting human egg donations from unmarried women only, because of the Jewish religious law of bastardy which attaches the stigma of bastardy to a child born to a married woman and not fathered by her Jewish husband. Later, however, the Committee authorized the acceptance of an ovum donation from a married woman, in exceptional instances of identified, "within the family" egg donations (Ibid.).

Overall, consumers of the expensive NRTs comprise an elite population, while it is well-documented that poor women, black women and women from minority groups suffer sterilization abuse (Clarke, 1981; Savage, 1982). Intended or unintended, this constitutes class eugenics.

## *Summary*

In this section, I have developed a selective feminist critique of the NRTs, pointing to some of the ways in which these practices enact and reinforce the more general discriminatory social relations within which they take place. From a socialist feminist viewpoint, attention has been on the intersection of the NRTs with both patriarchy and capitalism. It has been shown how NRT practice is moulded into a particular form that preserves the traditional nuclear family and suppresses alternatives; and equally that capitalism has significantly captured and exploited this "new mercantile frontier" (Finkelstein & Clough, 1983), in orchestration with an arguably inadvertent but nonetheless operative class eugenics. While emphasis has been on how the NRTs militate against the biopsychosocial well-being of women, the suffering is also acknowledged of those involuntarily childless men whose life-worlds are compromised by these practices.

Against the backdrop of issues raised here attention is turned, in Part II, towards NRT discourse within a particular medical setting.

## PART II : PSYCHOSOCIAL DISCOURSE IN CONTEXT

### METHODOLOGY

The concerns of this study might seem only loosely related to the discipline of psychology as it is commonly conceptualized. It takes its place, however, within a contemporary "social constructionist movement" in modern psychology, which critically reconsiders the foundations of psychological explanation by placing knowledge within the process of social interchange (Henriques et al., 1984; Gergen, 1986).

"The explanatory locus of human action shifts from the interior region of the mind to the processes and structure of human interaction. The question 'why' is answered not with a psychological state or process, but with a consideration of persons in relationship" (Gergen, 1986, p. 271).

Social constructionist psychological analyses have covered a wide range of subjects, including gender, aggression, mind, causality, person, self, child, motivation, emotion and morality; and the aims of social constructionism affiliate psychology with a host of interpretive disciplines - sociology, anthropology, ethnomethodology, history, dramaturgical analysis and literary theory (Ibid.). In that it is explicitly political, the constructionist framework is central to the search for a "feminist science" based on principles alternative to those of traditional empiricism, which has served patriarchy (e.g. Witt, et al., 1989; Harding, 1989; Halpin, 1989). Constructionism rejects traditional empiricist claims to objective foundations for knowledge through sense data, at the same time acknowledging its own failure to supply any alternative truth criteria, and hence recognizing its vulnerability to problems of relativism (Gergen, 1986).

Part II involves the application of critical discourse analysis (as outlined in the Introduction) at a specific, situational level. Rather than seeking to test hypotheses and make generalizations in the empiricist mode, discourse analysis has as its goal hermeneutic understanding. It aims to achieve an overall interpretation of cumulative meaning, and validity is achieved by way of coherence (Levett, 1989). Subjectivity and selectivity of interpretation are acknowledged as paradigmatic. In this sense, the relevance of moral criteria for research are reasserted (Gergen, 1986). Analysis of discourse commonly examines texts, written or spoken, to discern recurring themes and make sense of these within a matrix of practices. Clearly, numerous different analyses of a single text are possible just as 'the context' may be variously described (Kuipers, 1989). Selection of themes in this particular

study was to an extent informed by the wider discursive topography traced in Part I.

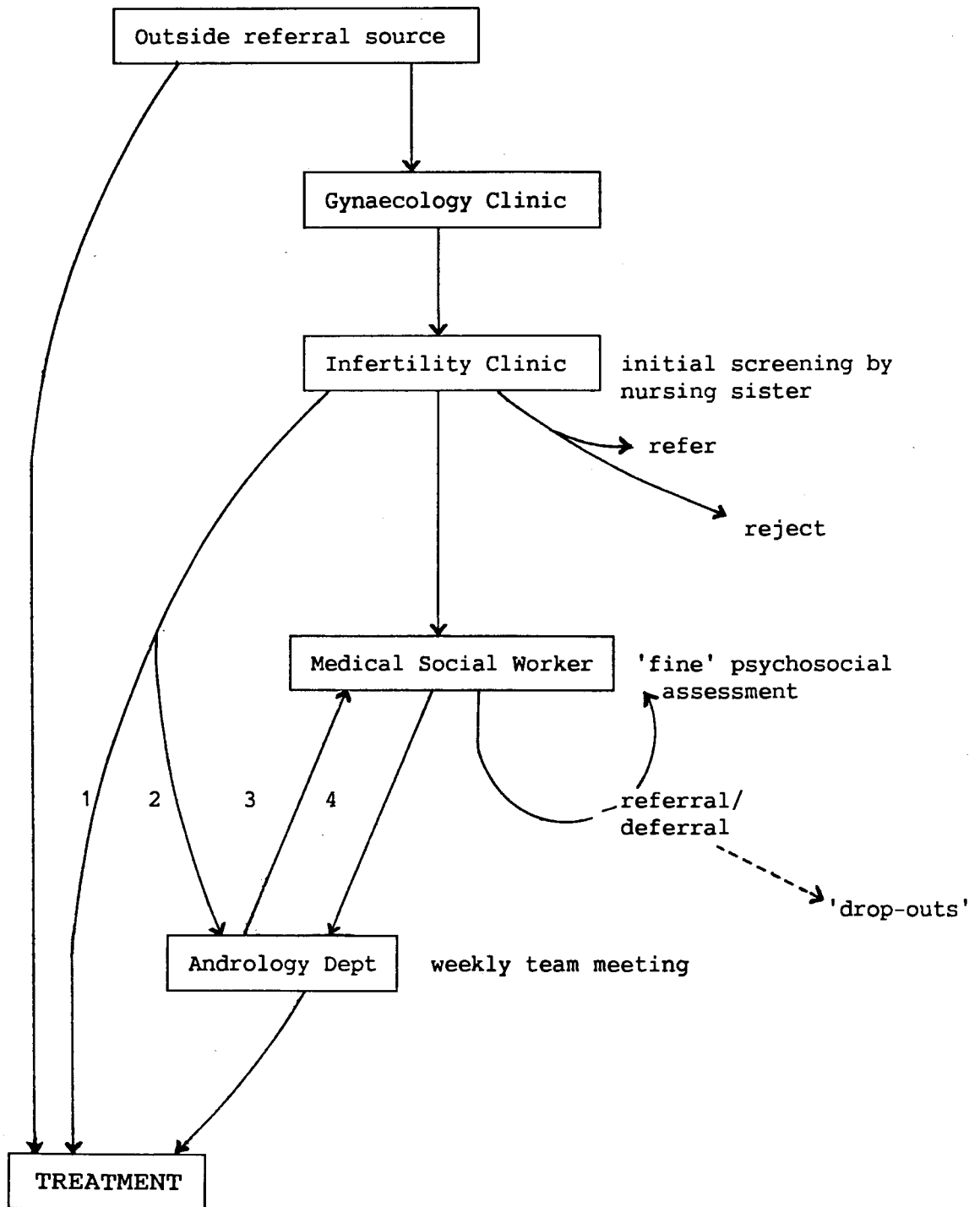
Data was gathered in the Infertility Clinic and the Andrology laboratory of Groote Schuur provincial hospital, with the aim of understanding the discursive parameters of how applicants for NRT are managed in this context. A first stage involved orientation to the system, by means of

- (i) attending initial intake interviews conducted by a nursing sister
- (ii) attending assessment interviews of applicants by a social worker
- (iii) attending weekly meetings in the Andrology lab at which patients were discussed
- (iv) informal discussions with clinic and lab staff.

Notes were taken informally in each of these settings. Once an ecological understanding of these practices was gained,

- (v) a semi-structured interview with the social worker was audiotape-recorded. This was selectively transcribed for analysis, and is not appended.
- (vi) A 'fictitious case' was constructed and presented to the doctor and social worker (see Appendix III). The individual details of the case history were closely matched to details of cases actually observed. Deliberately, however, the case was unrealistically condensed, with far more 'problem areas' than are typically encountered in one history. These 'problems' were also purposefully ambiguous in order to elicit assumptions that might otherwise not have surfaced. This interview was audiotaped and a full transcription is included as Appendix IV.

Figure 1 : Management Routes



- 1 recommended
- 2 query
- 3 psychosocial query
- 4 recommended

## ***Management Routes***

Referred to the hospital by general practitioners, privately practising gynaecologists and other health agencies, applicants for infertility treatment encounter a complex system, assessing them on a host of parameters to inform a judgement as to their fitness for parenthood. On this basis, reproductive technology is either permitted or withheld, and its guardians either combat or collude with applicants' involuntary childlessness.

There exist a network of possible routes along which applicants may be conducted in sorting the eligible from the ineligible, as schematized in Figure 1.

After an initial physical assessment at the Gynaecology Clinic, infertile patients are referred to the Infertility Clinic where they undergo an initial assessment of their "social background" by a nursing sister. Due to the heavy case-load, each assessment interview is limited to around 10 minutes. This constitutes a 'coarse' selection stage, the main aim of which is to rule out or pass applicants on any of three unambiguous criteria:

- (i) Only couples legally married for at least one year and producing a marriage certificate are accepted.
- (ii) They must have less than two children, unless one of the partners has not experienced biological parenthood.
- (iii) The woman must be under 40 years, though some latitude is permitted.

If each of these criteria is fulfilled, the nursing sister superficially scans their financial status, housing circumstances, marital relationship and substance use/abuse. (See Appendix I for Sister's interview format.)

In the absence of any apparent or suspected anomalies on the applicants' psychosocial profile, they are cleared for infertility treatment. However, if problems are perceived the couple is booked an appointment (several months thence) with the Medical Social Worker in Gynaecology, who conducts an hour-long investigation into their psychosocial status. With African applicants (usually Xhosa-speaking) who are not fluent in English/Afrikaans, the Social Worker works through an interpreter, a cumbersome procedure that potentiates miscommunication and militates against rapport (Anderson, 1976). A case was observed where, at the end of an hour-long assessment, as the Social Worker explained to a confused and dismayed couple that they could not be helped because they did not fit the criteria, it emerged that the woman was in fact already pregnant. They had kept the appointment made for them some months earlier, not realizing its precise function. (This same case is presented (first) under 'dealing with confrontation' on page 31.) The Social Worker's assessment entails a much 'finer' filtering than before, both in the sense of closer scrutiny and of

'qualitative' evaluation. (See Appendix II for Social Worker's interview format.) Least ambiguous criteria applied by the Social Worker are in the following two areas:

- (i) *Employment and finances* : the couple are only accepted for treatment if the husband is formally employed. This is rationalized in terms of his being the sole breadwinner during his wife's pregnancy and postparturium, and financial resources flowing from informal-sector enterprise and the wife's earnings are not considered in the equation. Although no minimum-earnings figure is formally applied, the Social Worker is reluctant to consider anything below R200.00 per month. Of greater perceived importance is how finances are *managed*: detailed questions are addressed to breakdown of expenses, debts, savings, and insurance - in short, 'planning'.
- (ii) *Housing circumstances* : a room of their own and cooking facilities not in that room are requisites. These are reasoned in terms of overcrowding being noxious to the future child; the need for privacy, especially under the stress of the infertility treatment regimen; and the hygienic problems and fire-hazards of cooking and baby-minding in the same room.

Yet the Social Worker is further required to appraise what she terms "the quality of the people", and it is here that her assessment procedure is least standardized and most vulnerable to ambiguity, subjectivity and the influences of personal bias.

Appraisals cluster around:

- (iii) *marital relationship*, and
- (iv) "*personality*", including:
  - absence of psychopathology and drug-abuse
  - adequate and appropriate motivation
  - compliance
  - desirable character-traits

The Social Worker's assessment may lead her to instruct applicants to alter the structure of their lives in order to qualify, such as improve living quarters, or legally marry; she may send them away with "something to work on", a qualitative aspect of their marriage, for instance. Often these injunctions are accompanied by referral to outside organizations, commonly marital counselling and drug-rehabilitation centres and employment agencies. Applicants who fail on this first assessment are either given another appointment some months later for re-evaluation, or more vaguely told that they can always re-petition for treatment at any future point. In this way the Social Worker never formally and irreversibly rejects prospectors. Yet it was observed that most of her

appointments (either first or subsequent), were defaulted, suggesting that the actual effect of this protracted procedure is that many applicants, realizing the odds against them, simply give up.

The Social Worker presents both those cases she has deferred and those whom she has positively approved at a weekly meeting in the Andrology Department, attended by laboratory technicians, nursing staff and doctors. At the time of writing, a clinical psychologist became attached to the team for the first time. Also at this meeting, the nursing sister presents those cases that she deems problematic yet hasn't referred to the Social Worker - such as when applicants are suspected of misinformation; have repeatedly failed to keep appointments (after defaulting three times, they are discharged); are on disability grants; are on particular medications incompatible with treatment; or are requesting reversal of tubal ligation (untying of fallopian tubes). Such cases may either be discharged, accepted for treatment, or re-routed to the social worker. Applicants to whom 'suitability' has been ascribed then embark on a sequence of medical work-up and treatment interventions not detailed here.

Having outlined this elaborate filtering apparatus as it is visible and as it is formally presented by its exponents, it remains to comment on a feature that is easily overlooked if not concealed - what may be termed *backdoor referrals*. These are cases that, due to a liaison between an outside referral source and the doctor heading the Andrology team, circumvent all formal hospital assessments and pass directly on to treatment. An explanation offered by the nursing sister was that in such instances medical work-up has already been completed in private practice, making further physical investigations at the Gynae and Infertility Clinics unnecessary. This fails to explain why such patients are exempted from the psychosocial assessment routinely undergone by all other applicants. Private gynaecologists do not commonly subject their patients to formal psychosocial evaluation. As the head of the Andrology team put it: "In private everybody gets treated." It cannot be the case, then, that backdoor patients have been comparably psychosocially assessed elsewhere, and the only remaining explanation for their fuss-free acceptance must be that their suitability for parenthood is deemed "obvious". Since treatment in private practice is prohibitively expensive, backdoor patients referred from private are likely to be socio-economically advantaged over routine applicants. Suggested in this management practice is that socio-economically privileged patients, by virtue of their social status and power, are in turn granted privileged access to reproductive technology - sparing them the discomfort and inconvenience of psychosocial scrutiny. Their suitability is assumed.

## *The Operational Philosophy*

Transcendent discursive statements and abstract ideologies must be concretized if they are to provide practical parameters for decision-making and action in particular contexts, giving rise to formulations that Smith (1977) has termed "operational philosophies":

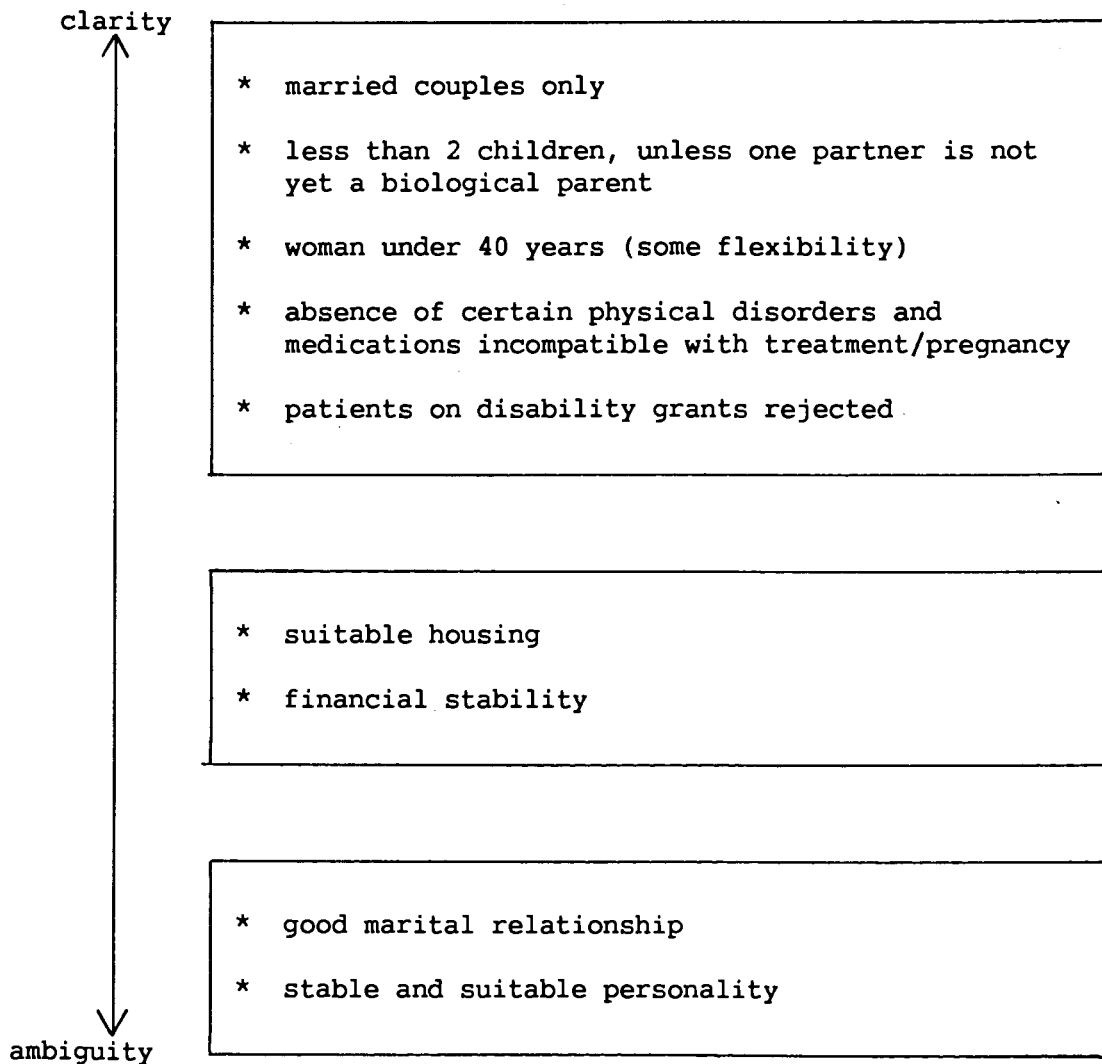
Like ideologies operational philosophies are coherent sets of ideas. They are consistent with the respective ideologies which they interpret at the situational level. An operational philosophy can therefore always be justified by referring to the ideological position which is itself seen as requiring no further justification (quoted in Parton, 1985, p.14).

Operational philosophies are thus usefully vivid substantiations of ideology, into which they may be sublimated under careful scrutiny. The operational philosophy employed in the setting under study may be conceptualized metaphorically as having:

- (i) a *central core* : made up of operationalizations that are relatively unambiguous. These are the criteria and injunctions constituting the 'official' version, as explained by its exponents.
- (ii) a *peripheral 'umbrated' region* : comprising those considerations brought to bear on practice that are less clearly formulated. Although 'unconscious' in the sense of not being officially articulated, these are no less influential.

Figure 2 arranges the principle operational components along a continuum from clarity (analogous to the 'core') to ambiguity ('umbration').

**Figure 2 : Relative Clarity of Operationalizations**



Thusfar the principal features of this fairly complex decision-making apparatus have been detailed. The next section considers some of the agentic manoeuvres employed by gatekeepers and applicants as the model is played out between them.

### ***Strategies at the Gatekeeper-Applicant Interface***

Discourse analysis is a diverse field. Kuipers (1989) has identified three principle approaches to the study of medical discourse as referential, (post) structural, and interactional. The first approach treats language as a practical tool of reference, and thus does not address issues of power and social control. The second has as its focus the interrelation between language, power and differential social relations, but at a level transcendent of day-to-day situational realities. In contrast, the third methodology seeks to

rigorously describe discourse as it is interactively constructed in specific contexts.

Kuipers points to the dilemma that while the (post) structural approach is weakened by its vagueness as a transcendent construction, equally, interactional micro-analyses are bound by their situation-specificity. He proposes a synthesis by viewing these two perspectives as stages in the institutionalization of discourse, the process of "entextualization":

This term describes the ideological, linguistic, and interactional processes by which a given piece of discourse comes to be gradually detached (de-centered) from its immediate conversational and contextual surround, thus removed from the hazards of interruption, face-threatening negotiations, and challenges to its very existence ... [and transformed into] the decontextualized "texts" of biomedical knowledge. (Kuipers, 1989, p.101)

Information and meanings initiated in the clinical encounter embark on a "semiotic career", systematically coded and recoded at successive institutional levels in obedience to specific bureaucratic constraints. (Ibid.)

It will not be attempted here to systematically trace the de-centering of discourse within the present milieu. A more focused aim of the following section will be to elucidate some of the interactional strategies that go into shaping the interface between applicants and gatekeepers. Within the context under study reproductive technology is a scarce and valued commodity, eagerly sought by the prospective patients and closely guarded by its medical keepers. At stake in the face-to-face negotiations between guardians and applicants is no less than the latter's legitimacy for and chance of parenthood, and this loadedness invites tactical behaviour from both sides.

#### "Something fishy there" : Silence and misinformation

The gatekeepers are well aware that applicants often know the acceptance criteria in advance and strategically and selectively furnish false information in order to receive treatment. Consequently, applicants' accounts of their psychosocial profile are not taken at face value, and interviewers are sensitive to any inconsistencies - within a single interview, across interviews (often patients deliver contradictory accounts to the nursing sister and social worker), or between verbal and (perceived) nonverbal behaviour. Thus the nursing sister described her role as: "sister, policeman (sic) and detective".

Case example: The nursing sister is interviewing a woman who has been accepted for treatment and upon whom several tests have been completed, but whose husband failed to attend his appointment for a sperm test. Asked why her husband did not accompany her to the present appointment as requested, the woman at first explains "he's away on work", but when told that treatment cannot proceed until the test is completed, she shifts to "he doesn't like the hospital."

In response the nursing sister comments: "die vrou loop haar skoene stukkend en die man sit lekker by die huis" (while the wife runs around the husband relaxes at home). Another appointment date is given, and after the interview she comments that since that will be his third appointment it is "taken with a pinch of salt". (Patients are usually discharged after defaulting three times.)

Case example: After an assessment interview, the social worker comments on the couple's marital relationship:

"They say they're happily married, but you can see by the way they're communicating while they're sitting there that they're telling a lie about their marriage ... I don't know how to explain it ..."

And of another case: "I had an idea that he was beating her and carrying on. But they did not confirm this in the interview and I still referred them (for marital counselling) because I just had the feeling it was there."

Often applicants are reticent in talking to the interviewer about their lives, and such silences may not necessarily be strategic, but also possibly due to shyness, suspiciousness, limited social skills, the problems of working through an interpreter, or simply ignorance about what constitutes 'relevant information'. Discussing the difficulty of obtaining information on 'family history', the social worker comments:

"I want to know more ... but they don't give me what I want - I've got to get it from them ... Party keer moet ek dit uittrek uit hulle (sometimes I have to pull it out of them)."

"It's like an exam" : Dealing with confrontation

Infrequently, applicants openly protest when they are denied access to treatment. The following two case examples illustrate how, when challenged face-to-face, the gatekeeper does not enter into any rationalization of why the

rules are applied, but reiterates that they are there to be obeyed, thus shifting responsibility onto the system and minimalizing her agency in the process, (in a manner reminiscent of a prisoner of war divulging only name, number and rank in accordance with the Geneva Convention).

Case example: A young couple are both unemployed and living with and being supported financially by the wife's brother. Social worker (through Xhosa interpreter): "We can't help people who don't have employment ... We can't help people to have babies if others have to look after them ... the house is O.K., everything is O.K. ... but there's this problem ... I can't go to the team because they'll just say no ... INTERPRETER: "He says he has money in the bank." S.W. : "He must have secure employment." (To the observer: "Money is in the bank, but others must pay for him?") INTERPRETER: "He says: but he helped his brother-in-law when he was unemployed." S.W.: "We have certain rules ... all those criteria the team has decided upon must be met ... and a very important one is employment ... I didn't make the rules, the team did ... it's like passing exams at school ... We'd like to help you."

Case example: A woman earns over R300.00 per month and her husband is not formally employed but earns some money fixing household appliances at home, and has been promised employment within the next month. The social worker explains the employment criterion and asks that he bring her the details of his job once this is underway. Later in the interview the husband interjects: "I'm worried if the doctors don't give us a baby. We want a baby like everyone else." S.W. : "It's like an exam. We want to help you, but you must fit the criteria." H : "On the other hand, I am doing work ... so I am getting money." S.W. : "I can't take something hanging in the air to the meeting." H : "I understand."

While prospective patients may elect to be silent, deliberately mislead, or openly challenge their arbiters in seeking access to reproductive technology, the gatekeepers to this commodity utilize a number of stratagems aimed at taking stress of themselves and the system they deploy:

"Shields and retreats" : Criteria as pretexts

Sometimes the selectors have misgivings about a particular applicant for reasons they choose to conceal. Usually in such cases other, more formalized, criteria are invoked as a basis for exclusion, and it is these with which the gatekeeper may unassailably say no while preserving the secrecy of more personal sentiments.

Doctor: "Occasionally we had problems where we had lesbian couples coming in. And that was our easy way out in all of that. We'd say: 'Look, you're not married, we cannot treat you.' Simple. So it was a kind of a shield to push in front of you though its actually not the reason why you don't want to treat them. It's just because yourself you feel a bit uncomfortable or threatened by it ..."

Case example: A woman sterilized eight years ago has applied for reversal of tubal ligation. She claims to be aged 40, though her date of birth indicates that she is 45, and her husband works part-time. They had two children, one of whom was shot dead by police. The nursing sister presents the case to the team querying their financial eligibility. The doctor comments: "We are even reluctant at age 40 to treat ... we can always retreat to that unless somebody's keen."

"Give them a chance" : Token deferments

Although the social worker frequently does not accept applicants, she nonetheless manages to avoid the discomfort of actually rejecting them. The unaccepted are treated as having the power to reshape their social worlds into an improved form, an approach consistent with the liberal individualist ideology, 'life is entirely what you make it', and they are given the overt message that they are welcome to return should they manage, through application and determination, to more closely fit the received psychosocial template.

Social Worker: "I won't say 'no, never' - I would say 'just go and try and see if you can sort this out', by referring them ... When I'm not sure, I let them come back to me in three months' time - work on something and then come back... If it's really a problem that I think can't be sorted out, I will in any case give them the benefit of the doubt ... give them a chance."

Just as the decision-making apparatus is placed under stress in the face-to-face realities of gatekeeper-applicant interactions, it also is tested against the personal beliefs and ambivalences of those who implement it. This forms the focus of the next section.

## *Accommodating the Model*

A single text may be multivocal, simultaneously harbouring anomalous and contradictory discourses. Commonly, dominant discourses are accompanied by other, less obvious, themes that subtly work to subvert them, in the service of what Foucault has named the "underside" or "counterstroke" of relations of power (1977, in Gordon 1980; Levett, 1989). In this way, discursive heterogeneity potentiates social change (Henriques et al., 1984).

The particular form and dynamics of the decision-making system under study flow from a dialectical process between gatekeepers' individual, personal beliefs and agendas on the one hand, and on the other, the imperatives of the bureaucratic and political structure to which these people are obedient by constraint. Personal values and structural injunctions are not always isomorphic, and this section is aimed at illustrating some of the frictions at their interface.

Two contradictory tendencies are discernible within the gatekeepers' talk about their model, namely vindication, and expression of discomfort.

### "There was just no control" : Gatekeepers' vindications

The current selection procedure was initiated approximately two years ago, and its principal rationalizations may be summarized as follows:

- (1) *Due to finite resources and heavy demand, it is not possible to treat everyone, and thus selection is unavoidable.*
- (2) *Preference should be given to "those who need it most".*
- (3) *Careful selection ensures greater effectiveness and hence improved accountability to critics.*

Doctor: "(It) has saved us a helluva lot of trouble, and a helluva lot of waste of investigation ... especially where the whole thing costs a lot of money and you had to be responsible to other departments who accused you of wasting money on a luxury like IVF. So you must be able to defend yourself and say 'look, I've got very, very strict selection criteria, and these are the only types of patients I'm treating.'" (The fact that more advanced treatments are financed by the patients themselves is also used to rebut critics.)

- (4) *Some people should not be parents.*

Doctor: "We came to find that actually lots of our patients were socially *completely* unacceptable ... you know, really they came from the darkest backgrounds you could imagine ... I mean there was just no control" .....

Social Worker: "... some of the people really do not qualify to be parents."

Reason (1) simply begs the question of what form that selection should take. Principle (2)'s answer to this is very circumscribed - preference should be given to those with no children or the least children, and those who have not yet experienced biological parenthood. (It is striking that the perceived importance of biological parenthood overrules the number of children whom that person parents socially, as well as any concerns about population growth. Thus, if a partner is not a biological parent, they may have well in excess of two children in the family and, as long as they can financially 'afford' another child, be accepted for treatment.) Reason (1) does not address the wide range of other psychosocial variables that are weighed in the assessment.

Rationalization (3) is of a pragmatic-strategic nature: selecting compliant and socially attractive patients saves "trouble" and "waste", ensuring greater cost-effectiveness and presenting a cleaner image to those who have the bureaucratic power to sanction or restrict the technology. However, in the overall cost-effectiveness balance, patient non-compliance surely contributes minimally to the very low success rate of IVF. And again the host of other variables brought under scrutiny are not explained. Without diminishing the practical-logistical constraints of limited resources and accountability, it is evident that these factors are somewhat arbitrary contingencies compared with the fundamental fourth proposition, that *some people should not be patients*. This fourth belief not only exerts itself independently of specific bureaucratic contexts, but also extends beyond the simple counting of children, into a *valuative* domain.

The discursive roots of these judgements will be elucidated after first examining, in the following section, some of the subversive elements within gatekeepers' talk about their practices.

#### "Skating on thin ice" : Gatekeepers' discomfort

When gatekeepers expressed their misgivings, this tended to evidence the intrusion into their discourse of "common sense", or what has been termed "folk knowledge" (e.g. Locke, 1982).

Doctor: "(Infertility) could happen to all of us!... If there were nothing wrong with them (the applicants), nobody would ask them ... they would take the decision anyway ... In principle it should be the patient themselves who decide on whether they have a child or not ... I mean, who am I to decide ...? ... Only if she's got a medical disease is it my duty to advise her 'hey, it's no good for you to fall pregnant'. But on grounds that she's got two children to tell her 'hey, look you mustn't have another child'... it's actually not my duty ... so, with that I feel very uncomfortable..."

Each of the gatekeepers expressed in some way an experience of alienation from their performed role. Thus the nursing sister described the system she deploys as being "like a sausage machine"; and the doctor speaks of being "... pushed into that situation, it's not that I want to be there." Yet also evident are attempts to reconcile these conflicts, to achieve coherence of belief and action.

Doctor: "We're not telling them they mustn't fall pregnant. Nobody says that. We will not tell them 'look, you mustn't have a child' ... we say 'look we've got so much at our disposal, we cannot help everybody, and we must select somehow.'"

Are they really not telling applicants, implicitly and explicitly, that they should not have children? Only in cases where refusal is on grounds of the number of children they have, since this is purely statistical. All other criteria, (aside from those addressing physical contraindications to pregnancy), carry implicit value-judgements as to applicants' psychosocial fitness for parenthood. Hence all people rejected in terms of such criteria are being told, albeit implicitly, that they should not become parents, with or without the assistance of reproductive technology - at least not in their current psychosocial condition. It is quite likely that refused applicants detect this implicit message, and perhaps this partly explains why so many applicants fail to keep their appointments with the social worker. If so, it is possible that such a refusal would be received as a rejection, and most likely compound feelings of failure and low self-esteem probably already present as a result of the infertility. There is conspicuously absent from the selection apparatus any procedure for 'picking up the casualties'.

Social Worker: "I feel I'm skating on thin ice/... I feel unsafe because I've got to make a decision on the quality of the people ... and I don't know if I'm right or wrong, or if I'm too strict or too lenient. I've got to use my knowledge of people or my sixth sense or whatever, but I've got to use something to come to that conclusion ... I know something of their (i.e. African and "Coloured") culture, but I don't know everything. I'll accept or condemn them in my frame of reference, and then I've got to tell myself, 'you can't look at it that way, you've got to think about what they see as right and wrong' ... I've got to work on myself because of my very strict upbringing. I'm not sure sometimes whether I'm really giving them the benefit of the doubt or taking something away from them/.... I try to stay very objective/.... I think it's better to be too strict than too lenient."

Aware of the dangers of ethnocentrism, the social worker is nonetheless caught in a contradictory position: she tries to stay "very objective", yet is forced to use her "sixth sense"; she genuinely endeavours to obviate cultural

bias but, as she admits, has limited understanding of "their culture". Folk beliefs regarding 'ethnic differences' abound in gatekeepers' discourse. Unfortunately space constraints do not enable any detailing of these. Ultimately, as the following quote illustrates, the social worker's impression overrules applicants' accounts of their own psychosocial world.

Social Worker: "What I sometimes think is not such a good marriage they accept as a very good marriage. It's different from person to person, so I look at the marriage (in terms of) what they are expecting from it - if they are satisfied, I accept it. That's why I'm not arguing whether they're happily married, unless I can see in the way they're interacting that it's not so good."

### Marginalization

The social worker's role is structurally marginalized in that she is a consultant working in the department of another speciality. Yet quite paradoxically, she is given considerable power in her capacity as psychosocial 'specialist'.

### ***"The child must have a chance": The ideology of disqualification***

As we have seen, once the issues of limited resources and bureaucratic-logistical constraints, together with purely physical contraindications to pregnancy, and the essentially statistical cut-off criterion of two children are all cleared to one side, what remains is the fundamental impetus of the system: the discursive statement, *some people do not qualify to be parents*.

This section explores how this statement and its related practices are ideologically upheld by a pervasive preoccupation - the well-being of the technologically potentiated child.

The rationale of excluding people from treatment in the 'best interests of the child' was seldom spontaneously disclosed in gatekeepers' talk, as if it were somehow self-evident. Eliciting it often required 'naive' questioning of flat imperatives such as "they must ...", or "he's got to ...".

Doctor: "I try to put a motive in front of all of what we are thinking about when we make a decision about whether to treat a couple or not: Is the environment conducive to child education?"

Social Worker: "They must have ... quality of life ... The child must have a chance if he's got the ability."

The pervasiveness of this consideration is evident across both clearly operation-alized criteria and ambiguous considerations:

re: Financial Security

Social Worker: "He's got to have a permanent job/... he's got to have a stable income/... because they've got to make some kind of provisions for that child's future."

Doctor: "You cannot feed a family on that (amount)"

re: Adequate Housing

Social Worker: "They've got to have proper housing. We can't let a baby grow up in a zinc hok ... although there are some that are fairly smart inside - they can make it quite nice/.... Overcrowded places are not safe for a small baby - all the germs and things like that."

re: Education

Social Worker: "People who are trying to get a better education will try to give their children a better education - will go out of their way to give their children what is important to a child. Somebody with a Std. II or III wouldn't really back their child up or put in a special effort to make it possible for that child to really better himself."

re: Personality

Social Worker: "Their values must be right - honesty with the interviewer mean they will be honest with their children."

re: Marital Harmony

Social Worker: "It's to give the child security. If the parents don't have a good relationship, there won't be lots of love or security or anything in the house for the child."

Doctor: "I think a child should get a world picture which contains mother and father, and these two are supposed to stay together."

Social Worker (discussing a case): "I'm looking at their quality as future parents ... I think a marriage like this and a guy like him spells security for the child."

***"Good Human Material"***

We have discerned within the gatekeepers' operational philosophy that some of the considerations shaping their practices are poorly formulated, unofficial, and relatively unconscious, but nonetheless dynamically influential.

These unbrated criteria are most noticeable within the orbit of the Social Worker, to whom 'finer' psychosocial scrutiny is delegated. It is her task to assess "the quality of the people" and make recommendations as to whether or not applicants constitute "goeie mens materiaal" (good human material).

Two considerations feature prominently in this appraisal, namely of 'marital relationship' and 'personality'; and this section seeks to trace the discursive features of the "good personality" specifically.

Some of the evaluative summary statements made by the social worker at weekly meetings included:

- \* "A very well-balanced couple - I think they will be fine parents in the end."
- \* "everything's fine"
- \* "they seem O.K."
- \* "very suitable"
- \* "good quality parents, I think"

At times her template becomes transparent in interaction with applicants as she directly expresses approval or becomes didactic in prescribing certain behaviours. Some exemplary comments include:

- \* to a husband who does not save: "It's good to put a little bit away."
- \* to a husband who has been in the same employment for the last seven years: "dis mooi, baie mooi" (good, very good).
- \* of a husband: "he's a lucky man - he won't ever have a button off."
- \* to a husband: "jy't 'n baie op en wakker vrou" (your wife is very on the ball).

The following passage comprises selected excerpts of the social workers' talk with respect to 'personality'.

"She's not doing anything at home - she's just sitting, not doing housework or anything ... she expects others to do what should be done in the house ... it's her whole attitude at the moment - she's definitely not very mature yet as a person/.... I like them to have something that they're interested in while they're at home ... I've got such a lot of things that I'm interested in that I can't just sit. I must always be occupied. But I can't evaluate them on my standards though I always ask them about it, just to see/.... An active person, with an active brain who thinks for themselves and plans has something they're interested in ... I mean I'll allow you to sit and read but not just sit - that first woman said she's just sitting doing nothing! And I mean, what kind of personality can she have - she's going to become duller and duller/.... I like them to plan for their future, not to accept things as they are, but to do something about it. I'm looking at character a lot - decent, honest ... A lot of it is about working with people over a long time, getting used to certain things and spotting certain things which you know are negative/.... (re lying in interviews): Dit wys vir my hulle betroubaarheid en eerlikheid ... kwaliteit (It demonstrates that reliability and honorability ... quality)/.... She's a very "stabiele soort mens" (stable sort of person), she's been working at the same place for eight years already/.... He's changing, he's getting more western in his approach to things ... to fit in here he's got to have that to survive. The real 'rou' (raw) persons coming here - they never survive ... And the fact that he wants to study and get somewhere - that's the western society influence too ... they're both intelligent enough to survive ... He's got a very strong personality this guy - he's actually a very, very interesting person ... I can see that he's going to be a man who will be there for his wife - he'll be there to solve problems should there be any ... he's obviously the one she's listening to/.... I find that people who've got a strong religious background are - not always, but in some ways - 'meer stabiel' (more stable) than others.

Dit gee ook sekuriteit aan die kind (it also gives the child security) when they're church-going people or something like that ... they've got very high values ... (though) you can have high values without being religious."

Thus, in addition to the requirements of absence of 'psychopathology' and 'drug-abuse', adequate and appropriate motivation, and compliance, there exist a host of subtle, unbrated personality traits that are not formally or systematically applied, but aggregated a highly subjective fashion to inform a final conclusion as to whether applicants are of sufficient "quality" to be parents.

The ideal traits evident in the social worker's talk form a model of someone decent, reliable, honest, honorable, preferably religious but at least of high values, stable, mature, educated and/or educationally ambitious, intelligent, westernized, an independent thinker, a planner and problem-solver, strong of character, interesting, a 'survivor', active and industrious.

There is also evidence in these constructions of distinct sexual stereotypes, but limited space prevents further examination of these.

### **"Par for the Course" : Family Ideology**

Gatekeepers are legally prohibited from applying reproductive technology to anybody other than a married couple (see Introduction) and both the social worker and the doctor obey but distance themselves from this injunction.

Social Worker: "I ask this for the sake of the criteria so that I can report back - it's not that important to me ... it spells more security for the family, but not necessarily."

Doctor: "... this is not one of my criteria ... 10 years together and they don't get married for their personal reasons, but they're intent to stay together for the rest of their lives, they can be perfectly good parents - why should they not have a child? ... they've got a very good relationship, they've stayed together..."

Even though the doctor is implicitly referring to committed heterosexual relationships, this very same argument could support making reproductive technology available to lesbians who fit the above description. But he goes on:

"Occasionally we had problems where we had lesbian couples coming in ... Is the environment conducive to child education? It's an extremely difficult question. (With) a gay couple even more difficult ... To grow up in an environment like that - I don't know, I just feel a bit ... reluctant ... I don't want to be part of it. It's my personal thing./(re. single mothers): (If) there was a couple who were together and they went apart and now she or he is a single parent ... now that's just par for the course ... But to start *ab initio* with something like that - I don't feel quite right. Maybe there I'm also a bit old-fashioned, but I think that a child should get a world picture which contains mother and father, and these two are supposed

to stay together ... so I'm actually quite happy about marriage being in the law, though there are some patients I would say (for whom) it's not indicated ..."

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The discursive parameters of this particular medical milieu have illustrated the extent to which medicine reaches beyond the biophysical and into the psychosocial. It is somewhat ironic that for medicine to apply itself to a human problem (infertility) that it has so adamantly insisted belongs under the wing of medical biotechnology, psychosocial discourse is so heavily relied upon.

## SUMMARY AND CONCLUSIONS

In this work I have not sought to argue that all of the new reproductive technologies are in every aspect inherently noxious to women. Though they are unified in certain important ways, there also exist quite substantial differences between these interventions. Suffice it to highlight the differences between IVF and AID with respect to technologization, physical risks to women, and financial cost.

On the assumption that technology is inevitably shaped to the advantage of certain groups, focus has been on the social relations played out on the NRT stage, and how these transactions are ideologically mediated. Although in the cloak and make-up of modern biotechnology, the leading actors are easily recognized to be patriarchy and capitalism. And in obedience to these, western biomedecine has constructed and claimed ownership of infertility as "disease", serving as the institutional vehicle for the body politic (Brown & Adams, 1979; Scheper-Hughes & Lock, 1988).

I wish now briefly and selectively to make ideological sense of one discursive theme that pervaded gatekeepers' talk in Part II: a preoccupation with the well-being of the potential child. Although the NRTs are hospitable to patriarchy in that they potentiate fertility, they at the same time threaten the dissolution of the traditional nuclear family structure. This ideological tension is evidenced in the equivocal and contradictory discourse on the deployment of the NRTs: witness the 'rights of adults to procreate', cited in vindication of the NRTs, running up against the 'rights of the (potential) child' to have 'suitable' parents, an argument invoked to justify withholding treatment. Similar equivocality is to be seen in the doctor's talk about selection: "... in principal it should be the patient themselves who decide on their own whether they have a child or not", versus "Is the environment conducive to child education?"

Silences and omissions within discourse are as significant as predominances (Levett, 1989; Kuipers, 1989), and 'rights of the child' discourse bears a reciprocal relationship to the 'rights of women'. Women are simply not accorded a substantive existence within the dominant discourse. If not altogether invisible, women are implicated only in a peripheral and subsidiary relationship, constructed in terms of 'the rights of the embryo' and its amplification 'the well-being of the child.' It is argued here in agreement with Spallone (1986), that child-centered

discourse on the NRTs serves a strategic function in policing women's sexuality and maintaining the moral superiority of the patriarchal family. It also further functions to vindicate a subtle and arguably inadvertent class-eugenics. To argue that it is in the interests of the child that the parents be financially secure, have a room of their own, be legally married, etc is to skew selection dramatically in favour of the socio-economically privileged, as does the practice of *backdoor referrals*. The contextual realities of these procedures include an alternative African 'lobola' system of formal marriage, rampant unemployment amongst the working class, and an acute housing crisis in Cape Town - an official state survey conducted in 1988 estimated an average of 3,2 people to a bed in the "single-sex" hostels of Langa, Nyanga, and Guguletu (in the Weekly Mail, 1989).

It is vitally important to extend feminist critique of the NRTs into strategic women-centered action. To these ends, a "Women's Emergency Conference on the New Reproduction Technologies" was held in July 1985 in Sweden by FINNRET (Feminist International Network on the New Reproductive Technologies), now named FINNRAGE (Feminist International Network of Resistance to Reproductive and Genetic Engineering) (Arditti, 1985). It seems unrealistic to call for a moratorium on all NRT as Mies (1985) does, though it is encouraging that the WHO is alive to feminist health issues (Koch & Morgall, 1987; Brody, 1988) and has critically declared IVF to be experimental and not (yet) therapeutic, recommending that finances more appropriately be directed into researching the initial aetiology of infertility. The need to carefully monitor the NRTs has been stressed (Arditti, Klein & Minden, 1984; Hanmer, 1984; Minden, 1985), and of particular importance, given the considerable momentum of this field, is to anticipate future research directions. It is vital that feminists remain as informed as possible and disseminate relevant information wherever possible (Corea, 1985, in Arditti, 1985), and it would seem especially valuable to forge links with women practitioners and scientists working within these technologies. Continued critical evaluation of the shape of feminist science - in terms of both theory building and actual scientific practice - is essential. The current polemic between feminist critics of "bad science" and feminist critics of "science as usual" is examined by Harding (1989), who proposes a dialectical relationship between these: "... the tension between them is important to maintain as our feminisms attempt to remake the production of knowledge in conditions not of our own choosing" (p.271). Clarifying feminist agendas for science will have

important implications for women and "feminist men" working within the orbit of the NRTs.

'Psychological' discourse on the NRTs has been implicitly obedient to dominant ideology - a situation begging careful feminist and social constructionist research from within psychology. Clinical psychologists attached to NRT programmes need to be aware that although structurally marginalized within a medical hierarchy, they nonetheless wield tremendous power - (as do social workers) - as 'psychosocial specialists'. This necessitates a critical, self-reflexive appreciation of the ways in which their practices might be complicitous with medical social control. Many writers have suggested a paradigmatic incommensurability between clinical psychology and biomedicine (Elfant, 1985; Miller, 1988). Additionally, it has been noted that although multidisciplinary "teamwork" is the popular management model in contemporary medicine, its espoused values of open communication and shared leadership are largely cosmetic, since in actuality "different professionals add their piece of the clinical puzzle but look to one members to put it together" (Shaw, 1986, p.63). Tension is thus to be expected in situations where clinical psychologists seek to bring critical, women-centered values into their work with the NRTs, as this would cross purposes with the presiding model, introducing a subversive discourse.

Three potential roles exist for psychology within the field of the NRTs , namely research, assessment, and counselling/psychotherapy. From the thesis of this study, psychological research has a pivotally constructive role to play provided that such work is not co-opted to sexist and classist agendas. This carries the implicit injunction that all psychological research into the NRTs should exhibit a self-reflexive appreciation of its ideological locus.

It is the second of these spheres, assessment, where psychologists' involvement in the NRTs is the most problematic, since it is here that they (i) become directly implicated in social engineering by deciding who may and may not procreate, and (ii) affiliate themselves with and therefore implicitly support a biotechnology that carries considerable physical risks to its recipient women, has a less than one-in-ten chance of success, and is exorbitantly expensive (I focus here on IVF). A thorough discussion cannot be ventured here of the ethical implications of clinical psychological practice (Steere, 1984) in this assessment capacity. At the very least, however, clinical psychologists performing this role should be

aware of the ideological matrix within which they act, and seek to similarly conscientize their gatekeeper-colleagues.

The third role, that of counsellor/therapist, represents a potential contribution for clinical psychology that is tangible, practical and at the same time relatively free of valuative underpinnings. Intervention in this capacity would seem most obviously indicated in the following ways:

- (i) Providing a supportive counselling facility for those applicants who are turned away.
- (ii) Assisting prospective recipients in resolving ambivalences about whether to enter into treatment, *realistically* discussing the chances of success and preparing them for the experiences commonly undergone on the programme.
- (iii) Supportive counselling during treatment. The stresses of IVF programmes are well-documented (e.g. Johnston, Shaw & Bird, 1987; Leiblum, Kenman & Lane, 1987) and acknowledged by practitioners.

In conclusion, while this critique has focused searchingly and at times pointedly on practice within a particular medical setting, I wish to emphasize that criticisms are not raised to cast doubt on professional integrity. It must be realized that gatekeepers working within this context are powerfully influenced by socialization and the structural constraints of medical protocol and legislation. Frequently, despite our best intentions, things remain invisible to us until pointed out. It is hoped that this work offers a 'fresh perspective', some clarification of issues that are not easily unwrapped, and goes toward constructively defining the interface between psychology and reproductive technology.

## GLOSSARY

### **Artificial Insemination by Husband/Donor (AIH/AID)**

Non-coital placement of sperm into the upper vagina or womb. Usually used to aid conception in cases of male-factor infertility, but also utilized non-medically by gay women and single celibate women who wish to become mothers. (See Hanscombe & Forster, 1982.)

### **In-vitro fertilization (IVF)**

Usually used in cases of female-factor infertility, but increasingly being utilized in situations of male-factor and also undiagnosed infertility ("diagnostical IVF"), this technique was originally designed chiefly to bypass dysfunctional fallopian tubes. The procedure involves hyperstimulation of the ovaries in order to obtain the highest possible number of mature ova in one cycle; surgical removal by laparoscope or transvaginal aspiration of the ova for fertilization (usually but not always by the husband's sperm) in a cultured medium. Roughly two days after fertilization, several of the resulting embryos are transferred to the woman's uterine cavity through her vagina. The pregnancy rate might be improved by increasing the number of transferred embryos, but this incurs an increased risk not only of spontaneous abortion, but of multiple pregnancy. The remaining embryos can be deep frozen for later use. (Van Hall, 1987, in Brody, 1987).

### **Oocyte (egg) - donation**

Analogous to AID in that it involves the donation of a gamete, this is an IVF procedure - the eggs are surgically removed from a donor woman, fertilized in-vitro with the 'husband's' sperm to create embryos that are placed into the 'wife's' womb.

### **Surrogate Motherhood (SM)**

Most commonly, SM involves a 'surrogate' mother gestating a genetic mother's embryo - either because pregnancy is medically contra-indicated for the genetic mother, or in order to save her the labour of pregnancy and birth. This is most commonly achieved by in-vitro fertilization of the 'wife' and 'husband's' gametes, followed by implantation of the resultant embryo into the womb of the surrogate-mother, who then carries the fetus to term, and if the agreement is honoured, hands over the baby to its genetic parents after birth. (See Morris, 1988 for a discussion of custody disputes in surrogacy arrangements.)

A variant of this involves the artificial insemination of the surrogate mother by the 'husband's' sperm. In such cases the surrogate mother is the genetic mother and the 'wife' is the social mother.

### **Surrogate embryo transfer (SET)**

Similarly, this involves the artificial insemination of a fertile woman with the sperm of an infertile woman's partner. In this case, however, the resultant embryo is "flushed" from the donor woman's body (a technique called "lavage") and placed in the uterus of the infertile woman.

### **Sex-selection**

This involves the detection, by amniocentesis, of the sex of the fetus, and selective abortion if the fetus is not of the gender desired by its parents.

### **Sex pre-selection**

"... we possess a variety of emerging techniques for sex pre-selection before conception either through artificial separation of adrogenic and gynogenic sperm and subsequent fertilization by artificial insemination, or by timing the occurrence of intercourse and making use of functional differences between the two types of sperm." (Nentwig, 1981, p.185)

### **Ectogenesis (Artificial wombs)**

This refers to the gestation of a fetus entirely outside of a human body. (See Rowland, 1985, for a feminist discussion.)

[In response to a recent article describing an "early human pregnancy in vitro utilizing an artificially perfused uterus" (Bullei, et al., 1988) appearing in *Fertility and Sterility*, the editor comments:

"This fascinating study is the first report of an early human pregnancy attained in an in vitro model. Although the authors received approval for their study by their Ethical Review Board in Bologna, Italy, it should be noted that the serious ethical and legal concerns involved would not permit this experimentation in the United States." (p.995)]

### **Cloning**

A technique bypassing sexual reproduction, in which a new individual is created with a genetic constitution which is identical to that of the parent of the original cell nucleus. (See Herlands, 1981, for a more detailed discussion.)

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**APPENDIX I**  
**TYPICAL INTERVIEW FORMAT: NURSING SISTER**

Married?

Produce certificate?

Married how long?

Children from marriage - how many?

Children from extra-marital relationships?

To both husband and wife:

Age?

Employed?

Occupational position?

Occupational history?

Current earnings?

Re: Housing :

Where staying?

Owned or rented?

How many occupants?

Number of rooms?

Who sleeps/cooks where?

Re: Substances :

Smoke?

Drink / dagga?

Re: Marital relationships :

Sexual frequency?

Re: Gynaecological :

Regular menses?

When last menses?

**APPENDIX II**  
**TYPICAL INTERVIEW FORMAT: SOCIAL WORKER**

Introductory explanation vis-à-vis certain criteria to be met; that information gathered is relayed to a team who then make a decision; "we can't help everybody."

Date of birth? (Both partners)

Family background? (Where grew up / family structure / relationships with each other's family - both partners)

Occupational : Job type? Salary? Previous employment?

Education : How far educated? Aspirations?

Marital

relationships: How did they meet? Courtship? Happily married? ("non-verbals")

Leisure activities: Hobbies? Wife - knitting, sewing?

Housing : Where? What? Rented? Other occupants? Own room?  
Cooking arrangements?

Financial : Living expenses - rent, electricity, water ...  
Insured? Debts? Savings? How much?

Religion : Which church? Frequency of contact?

Children ?

Substances : Alcohol (tends only to ask husband)

Family pressure for fertility / Self-motivated?

(note: only asks this of Black applicants)

How motivated for baby? Has infertility led to marital tension?

### APPENDIX III

#### FICTITIOUS CASE PRESENTED TO DOCTOR AND SOCIAL WORKER

Mr and Mrs K. are a Xhosa couple, aged 32 and 27 respectively, who have approached Groote Schuur Hospital requesting assistance in bearing children. They have been living together for eight years, during which time they have been involuntarily childless. Despite this, they married two years ago by traditional Xhosa rites. Mrs K has never had children, but Mr K has a ten year old daughter from a previous relationship; she is cared for by his parents in King Williamstown, and he does not supply maintenance.

Mrs K is employed at a hospital, earning R250 per month. Mr K was last permanently employed in panelbeating in 1987. He has been unable to secure a steady job since then, but on a casual basis he fixes electrical appliances - which brings in about R100 per month, though he admits this is erratic.

The couple live in Side C, Khayalitsha, sharing a two-roomed zinc bungalow with Mrs K's brother. They occupy one of the rooms, in which they do their cooking. Living expenses include R30 rent and R80 for food each month.

The couple report that despite certain conflicts in their relationship they love each other and are committed to having children. Asked about their areas of conflict, it turns out that about four years ago, Mr K had another lover. On discovering this, Mrs K returned to live with her parents (in Guguletu) for a year, after which she returned to him as he promised to never see the other woman again. However, she admits to still being suspicious that he is secretly meeting with her, despite his reassurance. There is still antipathy between Mrs K and his in-laws around this issue. Mr K reports episodes during which she "behaves strangely and out-of-control" and has "fits".

Collateral from Pinelands Neuroclinic describes a six-week in-patient admission in 1987 with diagnosis of "hysterical conversion", related to family and marital stresses.

## APPENDIX IV

### INTERVIEW WITH DOCTOR AND SOCIAL WORKER

I/V How was the selection process (for infertility treatment) developed?

Dr I think obviously it was an evolutionary process...it was not that somebody sat down and said "let's make the criteria",... its... I don't know...you, see I took over the unit about three years ago... basically the amount of kids was not a criteria then...being married was a kind of loose criteria...age of 40 was then already...you know, there was nothing formalised...no strict guidelines...you could decide - if you want to treat the patient, that's fine... and of course the problem was then that there were several doctors also working part-time in the clinic...and you know the private guys, they trust anybody... whether they've got 12 kids or no kids...or whether they are psychologically or physically ill - it didn't make any difference - in private everybody gets treated. And so it was a big muddle. And the bigger problem was that once we started having a little bit more structured infertility treatment, especially IVF, where you really need a reliable patient, we came to find that actually lots of our patients were socially completely unacceptable...you know, really, you know they came from the darkest backgrounds you could imagine. And of course nobody ever looked into that. And then, with IVF - which I think was the initiator of all of that - with a long waiting list we just couldn't cope, because basically there was one person doing IVF. We said look we structure that somehow and have selection criteria of patients, and have to put it on a kind of a sound footing.

Especially where the whole thing costs a lot of money and you had to be responsible to other departments who accused you of wasting money on a luxury like IVF. So you must be able to defend yourself and say: "Look, I've got very very strict selection criteria, and these are the only types of patients I'm treating". And so this all started about 2 years ago, where we became very strict and there were just masses of patients descending on us. And that's how it started...basically I sat there...we had a meeting with the Sister, and Prof. Davies there asked what we should do, and I gave him the criteria, and that's basically how it all started.

I/V So you basically got the ball rolling in that area?

Dr Ja, sure, because I mean there was just no control. And then of course, one and a half to two years ago we got the social worker in, which was also a major advantage, that we also could look into the social backgrounds of patients which before, look everybody did it on his own little steam, you know; speaks to the patients and says "Hey, are you O.K. or are you not O.K.?" But there was nothing structured there, so since then we're getting slowly more and more involved with the patients to look into their backgrounds. And this is one of the reasons why you [to the interviewer] possibly will slot into that as well...but that will be just a widening of that whole investigation that we do of the patient before we treat them.

And that has saved us a helluva lot of trouble, and a helluva lot of waste of investigation...that we only accept patients who are highly motivated, who fit our criteria - which are strict, I admit... but I think we are still very liberal in many terms, especially financial terms, because

people who say "No, you must make a minimum salary or something", which I have constantly refused because I don't want to make it money-dependent. Firstly, because there's the so-called informal sector - you never know how much income there is really; and secondly there are other population groups who live with much less money, maybe more happily than we do with more money. So that should not really be a criteria.

But all the other criteria which now evolved more or less by the social worker - like housing should be O.K., there should be no addiction to drugs or alcohol or whatever, and intermarital relationships should be O.K.... you know, that only evolved over the last year or so. Especially Suzanna went more into that. And that's how it came about basically.

And then, of course, these meetings which started because we felt - before I just made decision and finished. I agree it's still very often like that, that I do...I've got the final say very often, as you can probably see in the meetings, you know nobody wants to say really, and I say "O.K., yay or nay? Anybody for or against it?" But basically it should be a group decision, it should not be a single decision, by a single person, whether we treat a person or not. Also, I think the patient feels treated fairer like this. It's also not the Sister, in the 23 Clinic, who says no, so if she's got a problem she brings it to the meeting, and we discuss it and say "shall we take them or not?" So it's a group decision. So, the group is relatively narrow. There're not enough people from...uh...fringe 24 specialities, but still you know, it's what we can muster at the moment. I think that's how it evolved, basically.

I/V OK, you've mentioned that you've had increasing numbers of people applying...and that you can't treat everybody...

Dr It's not so much anymore. There was an initial mountain that came to us, but I think we've been through it. Now it's a steady stream. So it's still more than we can cope with but it's not the masses of patients we had before, because it's mainly because of selection...stricter selection.

I/V And you also mentioned that you need to be accountable to certain people who put pressure on you to justify why you're treating certain people.

Dr It's basically all the critics of infertility programs...

IV Who are they?...

Dr And there are plenty: Family Planning, Community Health, Preventative Medicine, other hospital departments like the guys who do the financing up in the prefabs...OK... a lot of critics because they think IVF is a luxury they cannot afford...or infertility is a luxury which nobody can afford here in S.A. - and I don't agree with them...I think it's a disease, that must be treated, but of course they think differently...it's the same way they attach other medical specialities like open heart surgery. Everybody has to defend their speciality, but I think I've got a very strong point. Look, there are lots of critics, no questions, but by being strict in your selection criteria, and also by showing them that the more advanced infertility treatments like IVF are financed by the patients, we've actually got a very strong point against all these critics.

Because IVF and AID and all that is financed by these patients, and the rest is just a routine...sub-clinic of gynae outpatients.

- I/V So those are factors outside of the actual criteria themselves - the fact that you're under quite a lot of pressure; you've got a large number of applicants...
- Dr You see in principal it should be the patient themselves who decide on their own whether they have a child or not - it shouldn't be you. I mean who am I to decide whether somebody else wants to have a child or not?? And in principle, if somebody comes and says "look we've got 3 kids and would like to have another one", it's not really up to me to go and say "look, hey, this is not OK and this is not alright, and we cannot do it". So this is only born out of a kind of emergent situation...that we have to find a way of coping with patients.
- I/V Does that mean that you feel some discomfort with making rules?
- Dr Oh yes, very much so, very much so.
- I/V Do you feel it's not a completely clear situation?
- Dr No, I mean it's just not my duty to say, as a doctor, "I can treat you, or not", because she's got a problem - or that couples got a problem - and that's why they're coming to me. It's really not up to me to say "hey, that problems non-existent because you've got 2 kids already". And its mainly the amount of kids that comes into it - all the other ones one can talk about. Only if she's got a medical disease is it my duty to advise her "hey, it's no good for you to fall pregnant". But on grounds that she's got 2 children to tell her "hey, look you mustn't have another child"... it's actually not my duty, it's not up to me to decide, it's up to them to decide. So, with that I feel very uncomfortable, but I'm pushed into that situation, it's not that I want to be there.
- I/V Pushed by...? The system?
- Dr By the system...by what I've got available. And I must make criteria that I can take those patients, who according to these criteria need our help most. How you come to that decision - who needs our help most? - I mean that's the battle. But that's the system we build up in. And I think its more or less fair under the prevailing situation. But its definitely by far not perfect or by far not satisfactory. In principle everybody wants to have a child, OK, that's their business, I mean they can have a child. If nothing would be wrong with them, they would take the decision anyway. ..So there, that part, I feel very uncomfortable about.
- I/V So it sound like you don't perceive it as a perfect situation?
- Dr No, definitely no, no.
- I/V OK, do you think we could go now into looking at what the different criteria are?
- Dr Where do you want to start? I think marriage...this is a big...you see this is not one of my criteria, that a couple must be married. The Human Issue Act states that: Couple must be married for AID, for IVF, GIFT...everything that is a little bit more advanced: the couple must be married. It would be stupid now to have one type of patient - this is just from a practicality point of view - which you treat until a certain point, and then you stop because you cannot do it, because you're not allowed to

do it. So I think it's probably better to say right from the beginning "look we can only take a couple who is married". Because I agree 10 years together and they don't get married for their personal reasons, but they're intent to stay together for the rest of their lives, they can be perfectly good parents - why should they not have a child? But because here we are in the public eye in a provincial hospital where we have to send returns in every year to the Inspector of Anatomy, I cannot treat anybody who is not married. Otherwise you've got a kind of a two-tiered system: Here you've got patients, they get this kind of treatment, they're not married; here you've another type of patient who is married and there we can go further. And then of course, it's going to be an absolute nightmare. Fortunately, the requests are very few and inbetween. But, I think in principle it's better to have criteria right at the beginning and say "look, as for advanced treatment of infertility, I cannot treat you, or let's just not start investigating unless you're married." And I think also, in a way, it fits in the conservative environment of South Africa. Attitudes here, I feel, are more conservative than in Europe - concerning marriage, living together, premarital intercourse, and all that kind of thing - they're very much more conservative here than they are in the States or Europe, or Germany where I come from. It's much more liberal there. I personally have got nothing against is, but I think it fits in the conservative climate of S.A. And up to now we've had great problems with that.

Occasionally we had problems where we had lesbian couples coming in. And that was our easy way out - in all of that- we'd say "look, you're not married, we cannot treat you". Simple. So it was a kind of shield to push in front of you though its actually not the reason why you don't want to treat them. It's just because yourself you feel a bit uncomfortable or threatened by it, so that's why you don't want it. So you've got something else you've got that you can put in front of you.

So there it became a major problem because they'd say "Ay, man, why not?" But there, especially AID, it states, you must have somebody who is married. So there you just cannot do it.

I/V So if is were up to you, it sounds as though there are still certain cases where you would feel uncomfortable about treating: gay couples...

Dr Gay couples I would feel very uncomfortable... because you see, I try to put a motive in front of all what we are thinking about when we make a decision about whether we should treat a couple or not: Is the environment conducive to child education? It's an extremely difficult decision. A gay couples even more difficult. I don't mind if somebody's 18 or 20 years old and they make a decision - "I want to be gay" - that's fine, it's everybody's prerogative. But, to grow up in an environment like that, I don't know, I feel just a bit... reluctant... I don't want to be part of it. It's my personal thing. But they can go into private I mean they do it there, I know that and it's fine with me. I just feel personally a bit uneasy about it.

I/V And single parents? Single mothers?

Dr Now you're asking me personal questions, you know. I think probably the same applies as to lesbians. I don't think AB INITIO single parents should be there. If it happens to be like that in the end, you know, there was a couple who were together and they went apart and now she or he is a single parent...no that's just par for the course. That's just bad luck, because the relationship didn't work out. But to start AB INITIO with something

like that - I don't feel quite right. Maybe there also I'm a bit old fashioned, but I think that a child should get a world picture which contains mother and father, and these two are supposed to stay together...I mean its... I would feel uneasy about it. So I'm actually quite happy about the marriage being in the law, though there are some patients I would say it's not indicated - we could treat them anyway, because they've got a very good relationship, they've stayed together... for instance they might not get married for 74 tax purposes...something like that...or they're already together for 10 years... I wouldn't see any reason why we shouldn't treat them.

I/V So if it was a stable relationship ...a heterosexual relationship then you'd be happy. OK, that's marriage...

Dr Age?

I/V Age under 40?

Dr Ja, age is basically for medical reasons. Look, as you've probably seen, there's not such a strict cut-off point. We've got patients who are 40...41... I've got one patient who's pregnant who is 42. The problem is for the mother, if she's got pregnancy complications - diabetes, hypertension, and so on, a higher chance of getting it, operative delivery... And then of course, abnormalities in the baby - above the age of 38 increase quite significantly. I think if one counsels the woman properly, tells her what risk she's undergoing; and then once she's pregnant needs amniocentesis and genetic counselling for the risk of abnormality...and she understands it very well... then I think one can well go ahead and treat somebody above the age of 40. And we've done that in the past.

I/V So you're saying amniocentesis and ultrasound should be a back-up?

Dr Ja the amniocentesis...they all need genetic counseling, and they all must be aware that they need amniocentesis around the 14th or 16th week of their pregnancy...

I/V When you say 'all', do you mean all treated patients for infertility, or do you mean all patients over 40.

Dr Above the age of 38, actually. To make sure it's a normal baby. And they must be aware of what risks they run. And if they know, then it's OK, then I've got no strict...that's the weakest of all the criteria.

I/V So what makes it flexible, in a sense...what would sway you either way?

Dr If the patient still has regular cycles - that means she's still ovulatory at age 40 - and she has definite reasons why she didn't fall pregnant before - we get pretty often a career woman coming in...they get married late...and now suddenly the panic comes in...she's 38 or 39 and: "it's getting late now, I must have a child" I've got no problems with treating them. But sometimes you get patients who have been treated for 15 years at various institutions for infertility - I think there that at age 38 you should say "maybe that's enough now". Because you see patients who walk around - they've maybe been to Tygerberg for 5 years, go to private for a few more, and then they come here and we start all over again. But it's a weak criteria - it's just a recommendation really.

I/V What about the prospective father's age?

Dr That doesn't really come into it very much because if you look from a medical point of view, we look just at the sperm. If there it's good enough, that's fine. And if they're happy with that...it's OK. Because that is very much a personal thing... OK maybe he can't play football with his son, but maybe he can give other things. The main thing he must give is affection and that's not really age related. So from the father point of view, age doesn't really play a part.

[Interviewer suggests calling the Social Worker to remind her of this meeting, as she is now a half an hour late and may have forgotten to come. Dr W does so.]

I/V Less than 2 children unless they're all genetically related to one partner.

Dr Less than 2 kids. That's something that's been born out of an emergent situation, that we've got restricted means and we have to define those patients who seem to need it most...and what easier thing to say than those who have got no children. And the other thing, of course, is the recommendation by the World Health Organisation of zero growth. ...But basically it's out of a situation of restricted means. We've got only a few people working, so we cannot treat anybody.

I/V So if say there are two kids and they're genetically related to say the husband or the wife and are not of the union, then you consider treating?

Dr No. If each of them has one child from a previous relationship, we will not treat. If one of the partners has no kids, then we would see that as a possible exception. Maybe it's also very simplistic to think about, but I think everybody, somehow, should have that experience to have a child, male or female,. And if one of the partners has not had that, then I think there's something definitely missing. So if one of the partners has had no kind, I think this is an exception. Even if the partner has 2 kids.

I/V Do you think it is important for people to have the experience of being biological parents? Genetically have their own offspring?

Dr I think so. That's where it comes in as a possible exception - that somebody never had a child.

I/V Is there a problem if one of the partners hasn't had a child, and the other has had say 3, 4, 5 or 6... a large number of children... does that create a different situation?

Dr Ja, I think if there are many children coming in then it may create another situation, because then the social thing comes in - can they afford to have another child? How is the housing?... this is where the social worker comes in very strongly. If they can look after 6 kids, OK! With a little bit of a push, I would say yes, OK, why not? - because he never had a child, or she never had a child. As long as they're very well looked after, and that particular partner has shown that they would be a very good partner, I see no reason to say no.

I/V Then I've got other criteria here that I suppose involves Suzanne more [i.e. the Social Worker] - so maybe we should wait for her. Things like housing, finances, the marriage... There's one question I have about

disability grants. There was one case where both parents were on D.G.'s  
What's the policy there?

Dr No policy, but I think the general feeling is... and it's more what everybody feels and thinks... is that if somebody's already on a disability grant, and they have a child now, I mean this child must now have a maintenance grant. I think it's probably going to make their social situation worse. And...

[A knock at the door. The Social Worker enters apologetically, is welcomed, and oriented to the discussion topic].

Dr I just told Steve that the general feeling is that if both partners are on a disability grant already and have a child, the child would need a maintenance grant... It would be unfair to the community. It would probably make their social situation worse. And so, in general, we have been very reluctant.

I/V So are you saying it would be a burden on the community in some way?

Dr In some way, and to themselves as well, because these disability grants are ridiculously small.

SW Like, with a maintenance grant they will pay for just one child, maybe for the second one. And say, for instance, they do have more children, they will have less money in the end.

[The 'fictitious case' is presented to the interviewees.]

I/V So the question is how, looking at that case and imagining them coming for treatment, what would the rationale be for deciding whether to treat or not? For what reasons. I've laid it out fairly systematically, so maybe we could go through it point by point.

SW The interesting thing about Xhosa maintenance - I found out yesterday, they explained to me yesterday - is that due to their tradition it's not necessary to pay a monthly maintenance...

Dr - A one off -

SW ... for their children. They just pay like six cows or something like that, or an amount like six hundred or four hundred rand once. And then they're free! (laughs)

Dr That's actually a big problem you know, because many of these old Xhosa rites - which are excellent customs - have been converted, or should we say have degenerated. For example, before: if you give somebody 6 cows for maintenance, this means that this child is looked after by these 6 cows...

SW - For the rest of his life -

Dr ... basically, for the rest of his life. Six cows - I mean they give meat and calves and things like that. It's capital which appreciates. But now, if they give 6 hundred bucks and that's gone after 2 months, that child is hungry. And that's a big, big, problem, and it's where you get intermingling of Xhosa and Zulu customs - which I also know very well because I worked up there for 4 and a half years - intermingling with kind of Western tradition or what, you know, where a cow gets replaced by money because there's no grazing for cows. It's a short-term lucrative thing for

the grandparents, but in the long term it means nothing. And that's actually a very big problem you know, and this once off maintenance that they pay to the child doesn't do any good.

SW So the children before the marriage that we're looking at - this is something that we more or less don't have to take into consideration really. On the father's side, it would be the same - who she had the child from would do the same thing. OK, in this case the mother is employed, earning R250 a month. And the father last was employed in 1987. Now this is something - for the husband I must say - that we do not accept. Because he's got to have a permanent job.

I/V What about the fact that he does work at home fixing radios, etc? That's not considered?

SW No, that's not stable income.

Dr You cannot feed a family on that.

SW He's got to have a stable income which gives him the opportunity to have unemployment money - so say he would lose his job and needed to find another one. For six months he could go on his unemployment money, It's not as much as his salary, but it's something to go on. And if he should become sick or anything, he's still got his sick benefits. So it's better for him to have a permanent job. He can always earn extra money with this casual employment in his spare time.

I/V And the fact that she's earning money at the moment? Is that not seen as a mitigating factor?

SW No.

[Peruses 'living arrangements']

SW There're not too many people from 2-roomed places... Is this now a two bedroomed place or just a kitchen and a room?

I/V Let's say 2 roomed.

SW Well, in the first instance there, they're sharing... Oh no, they're...

Dr - They occupy one of the rooms. -

SW ... living in a room where they're doing their cooking. That's not acceptable. They've got to have a separate cooking facility. I don't accept them cooking in the same room where they and the baby or they and the children are sleeping.

I/V Why is that? What is the reason for that?

SW I don't think it's very healthy, (laughs) do you think it's good? they're cooking on primus stoves and things like that...

Dr Danger factor.

SW Ja.

Dr That's why we get all the burns in Red Cross Hospital, because they cook in

the same room where the kids are sleeping. If that thing explodes, the paraffin goes all over the place.

SW Some of them are using gas bottles...

I/V OK. so it's dangerous and also unhygienic.

SW I don't mind them just having 2 rooms, like a bedroom and a kitchen. They must have separate cooking facilities. They either stay in with someone, and their house is not overcrowded... the couples got to have a bedroom on their own and they've got to have separate cooking facilities - never mind if they're sharing these with others in the house.

I/V Does that mean that if you had a very crowded house, and say there are 2 couples in one room, and they still had a separate kitchen, that's not acceptable?

SW No, I don't think if they are on the program that it's advisable to share the room with another couple. I don't know... Dr Wiswedel can bear me out... I don't think so.

Dr No, I don't think so [i.e. agreeing with her]

SW I don't accept that.

I/V For what sort of reasons?

SW Well, I think for any normal couple, being on the program - doctor will explain to you more about the program! (laughing) -

Dr I mean you don't want somebody living in overcrowded conditions.

SW And I mean it's not only overcrowded, I think they're in a way tense if there's 2 married couples sharing a bedroom. I don't think it's a healthy situation at all.

I/V So there are kind of emotional factors that you're implying... that they're under stress and need space of their own. Um... but then there's also overcrowding, and a feeling that that's not...

Dr But fortunately we very rarely see 2 couples living in one room.

SW I've got one case that I saw where there were 3 couples living in one room in double bunks. So you do get them.

I/V So - I just have to play dumb - I mean I'm just going to pretend I don't understand what you're saying! (laughs) OK? What it is about overcrowding that you see as the problem?

Dr There are kids there as well, you know...

SW I don't think that they can be really relaxed in that room, honestly.

Dr Also, to bring up a child there, to educate a child there in a room where 2 or 3 couples are and some kids... it falls under that thing of 'conducive to child education'. The child's going to be pushed in a corner, you know.

I/V OK.

SW Living expenses (looking at the case again)... If I can tell you that rent of R30, they must have a very smart house in the Black areas - they pay R6 - R8 for a house. R80 for food each month... is that enough for 2 people to live on?

They do live on this if... I dunno... maybe mealie meal is not so expensive.

I/V Put it this way: in what way would these amount become relevant in your assessment?

SW Well in the Black areas they don't pay more than... I haven't seen anybody staying in a brick house paying more than about R20 a month, and then it's a 2 or a 3 bedroomed place. When they're staying in ... you know, like a shack, they're not even paying rent. And normally when they're having a place in the backyard of somebody else - a small brick house or something like that it's 6, 8, 10 to 15 rand rent. They do live on R80 a month food but I don't think that that's...

I/V I've noticed though from watching some of the interviews that you sort of assess how they manage money: are they cautious?, do they save? So the whole way they manage their finances is quite important...

SW - Yes, it's important to me too. Because they've got to make some kind of a provision for that child's future. Say for instance that child want to go and learn in a school, it must have the opportunity to go and do so. That's why I'm asking about things like insurance. Dis vir hulle... how can I put it in Afrikaans now... vir hulle menswaardigheid... hulle lewenskwaliteit, moet daarna kyk [translated: it's for their quality of life]. And I'm also looking - he's in a job - and I try to find out: is he going to get increases, what's his changes of getting a better position. That too. The future. I mean, everything's getting more expensive now. Now maybe they can live on his salary now, but maybe next year they can't, so..

I/V So you're looking for some kind of economic stability.

SW Yes. They must be...

I/V - So that ties up with the husband being employed...OK.

SW [Looking at the case again.]

Now when I find something like this, that there was a third or a fourth person involved in the marriage relationship, I don't accept them immediately. I try to refer them to FAMSA, or if I have time - which is more or less never! (laughing) - try to counsel them on their marriage problems... just to make sure that the marriage is stable. Because I had a case now, I cancelled them - I phoned Peter [one of the doctors on the team] and asked him to take them off the program. I referred them because the husband had had dagga problems and they had marriage problems. I thought, I had an idea that he was beating her and carrying on. But they did not confirm this in the interview, and I still referred them because I just had a feeling it was there. And they bluffed FAMSA, and they bluffed the drug counselling people and they gave me a good report that everything was fine. And then on the program - about 6 weeks or 2 months ago we accepted them - and the same thing occurred again.

Dr He beat her up again.

SW He just beat her up again because he started to smoke dagga again, and when he got home he was upset about something and he beat her up. And she decided to divorce him now. And she moved away from him and everything and she doesn't want to go on with the marriage now. So this is what's making it very difficult for me - I've just got their word and other people's reports. There's nowhere for me to see for myself. And I've got to accept that, and I feel very unsafe because of that.

I/V So, again I'm going to play ignorant: What... Why is the marital relationship seen as important?

SW Well, it's to give the child security. If the parents don't have a good relationship, there won't be lots of love or security or anything in the house for the child. I think it's important for the child to know that he's safe where he is.

I/V Right. So, if you get wind of an extramarital relationship, does that make you very hesitant, or...?

SW I won't say "no, never" (laughs) I would say "just go and try and see if you can sort this out", by referring them to an organisation like FAMSA.

[Peruses the case again.]

You see, in a case like this with a marriage situation like this I would refer them and say "come back in six months time", and I would reassess them. And if I'm not happy I would refer them to come back in another six month's time. But if it's really a problem that I think can't be sorted out I will in any case give them the benefit of the doubt... give them a chance.

[Examines the case again.]

[Reading aloud]: "Mrs K reports episodes during which she behaves strangely and out of control and has fits..." There I would ask for an assessment from the psychiatric people...

Dr - Ja. -

SW ... to sort of give us a clue.

I/V And what is the general feeling as personality problems or psychological - stroke - psychiatric issues?

Dr I mean, infertility treatment is very stressful, so you must have a more or less stable personality. If there's something in the history... there was something went wrong, like hysterical conversion where they cannot cope with the stresses, where they take refuge into hysterical conversion. If that's the case, then there you make a big question - what's going to happen if she's going to go on IVF?

SW And say for instance, what's going to happen if she's got a baby with cholic?

Dr Ja. 3 o'clock in the morning, temperature of 39,5 and screaming.

SW Exactly.

Dr So there one needs psychiatric assessment. Well of course, you have by purpose chosen lots of points -

I/V - Of course, ja. -

Dr Which all fit in the grey area.

SW Ja.

I/V Sure, I mean that's to give us a base to -

Dr And, on each of these points, if you take each point isolated, you might say look with everything else OK it would be alright. But if you take them all together you say no. I mean that bucket is now full, you see. Like you can fill a bucket in one big full swoop, or drop by drop. And here I would say you've got lots of drops together - I wouldn't accept that patient, speaking in total.

I/V So you tend to take an overview.

SW Ja, I would never accept a case like this.

I/V [Looking at the case again.]

OK. there's also the fact that they've been living together - we spoke about marriage earlier - for 8 years and they got married by Xhosa rites a few years ago. Um...

SW It's interesting how many of those people now, because of the Western Society they're living in... "well, it's different now, we're going to get married in court". But they are married about 8 years now I think by Xhosa rites.

Dr You sure, in my opinion there is if they come here to Cape Town and they live permanently in Cape Town and they want to be treated in in Cape Town, I think they should be married in court because it gives the wife so much more security. Xhosa rites provide nothing, absolutely zilch. So if you are married in court it gives the wife security and it gives the child security, and that's what we actually want, alright. And that's why Xhosa rites I'm not happy with. If they really want to be together there's no sweat to get married in court. Simple thing - costs R35 or something.

SW - It costs R5 -

Dr R5. It costs nothing, really. If they want to be together, it's no sweat, and it's a commitment of the husband to the wife. The other thing is, if they come from the Transkei and they want to be treated by Western Medicine, I think they should adapt a little bit to the rules. That we actually want in return a little bit of stability on that side and a little bit of security on that side. That's what concerns me, these types of marriages, because here in these types of marriages which I know - prevented Xhosa rites here means the husband can do anything, and the wife has got no security whatsoever. And I don't accept that, because that did not exist in old Zulu or Xhosa customs. There the wife was very well looked after by the family; and this does not really exist in Western Society where also the wife is fairly secure, and it gets more and more. But they try to get inbetween, and I've got no sympathies there. They try to just make ... out of the ignorance of these women who actually don't

know what is at their disposal... what power they have actually, what rights they have actually - they don't know that. And I think that's wrong.

SW It's the same thing with their housing here. They very easily tell me: "we've got a big house in the Ciskei or Transkei", but in the meantime she's staying here with the husband and just going - and then I always ask now who is in this house - yes, her husband's family or something. So, that I don't accept. I don't accept good housing in Transkei or Ciskei. That's... "dis 'n ekstra" [that's an extra] (laughs) "wat in kom" [that comes in]. They've got to have good housing here, because she's going to stay here most of the time.

Dr I think, finally what one must say and what one always must be aware of: We're not telling them they mustn't fall pregnant. Nobody says that. We will not tell them "look, you mustn't have a child". Because we say, "look we've got so much at our disposal, we cannot help everybody, and we must select somehow". We are pushed into that situation. It's not that we really elevate ourselves onto a plateau where we can say, "OK, you, you're a nice chap, we can treat you". Alright, one gets pushed into that situation, so we must make some kind of selection.

I/V OK, so on the basis of that, that you need to select along certain lines, what do you think the overall value is that is contained in these criteria? What do you think the overall aim of choosing these criteria is?

Dr I've told you before, an environment conducive to child education. OK? And, then safety and security.

SW They must have... quality of life in a way.

Dr And, I mean when it comes to having a child it's not a matter of prestige or confirmation of manhood or something like that.

SW The child must have a chance, if he's got the ability.

IV So that's the question of motivation - what's motivating a couple to come and request a baby. And in certain cases you get a bit unsure - that certain motivations are questionable. Can you go into that a little bit more?

Dr And, in general, why do people want to have a child? That's an open question. Ask anybody "why do you want to have a child?" There's no answer to that. There's no answer to that, 'why do you want to have a child?'. This is the urge to procreate... to be still there after you are dead, you know in your child. I mean, who knows? Nobody knows why you want to have a child. But sometimes motivation is a little bit questionable. The guy who wants 8 kids you know, only that increases his prestige in the social environment. And very often women think that if they've got no children they've got no social standing. Bit I think that's a different matter - that's a cultural think, which has crept in there. But otherwise the question 'why does somebody want to have a child?' I don't think anyone can really answer. I mean, why do animals procreate? I dunno!

SW And in the Moslem society, the wife is scared the husband will leave her and go to a woman who can give him children.

- I/V Are there cases where you worry, as a social worker, about people's motivation?
- SW Ja, when there's a lot of pressure from the husband's family or something - it's not a healthy situation. I would go in deeper to find out -
- Dr - Ja, very often you get it that they say "either, you get a child or I divorce you". Then one gets very reluctant. Because he's actually not with that woman together because he wants her as his wife, as his companion for life. That means that the oath he swore, whilst he was standing in the magistrate's office - they want to be together for life - actually is not true.
- SW Well then I query the marriage relationship immediately. If he only married that wife to have a child, then their marriage relationship isn't really what it should be.
- I/V OK. Can I ask one more question. Klaus was saying earlier that he feels some discomfort about the process of having to say "you: yes, and you: no". Do you experience it similarly?
- SW Yes, I experience it similarly, but another experience that I have is that some of the people really do not qualify to be parents. But I mean how can I - it's only a decision that I'm making now. And that's why I really feel at the moment that I'm skating on thin ice (laughs). I'm not feeling really safe.
- Dr The thing is, if there were nothing wrong with them, nobody would ask them? They would just do it.
- I/V They would just go ahead.
- SW That's right. There are people who are acceptable without being referred to me. It's the queries that are coming through to me, I accept that.
- I/V Right. Well, thanks a lot.
- Dr Where do you see the role of the psychologist?
- I/V Well. that's the big question mark.
- Dr I see a place.
- I/V Ja, um...
- SW For support. I should think I can become more involved. If I was only working on infertility -
- Dr It could happen to all of us! (laughs)
- SW - with support to the people. And, really I sort of screen them now, and that's more or less the last time I see them unless they come into hospital. And, that's not really... you know, sometimes they come back and ask me some questions and they come and talk to me - 'nothing's happened yet', or something like that - and I just get the feeling that they do need to see me more often, not only for the screening. I'm not at all involved at the moment. And um, I don't know, this is not really the role that I

create (laughs), but I could really do with a psychologist working side by side.

Dr I think the very important role of the psychologist is where there are... like AID and like what we do now - gamete donation or oocyte [egg] donation - where that comes is in I think you have to... there you have to look very carefully into your couples, in order to find out whether they would withstand the stress of this burden, continuously for the rest of their lives. Often it doesn't appear like something, but I'm sure there's something there.

SW Like on some of them I would really like to have IQ tests too (laughs), for brain... what is it?... brain damage IQ (laughs)

INTERVIEW ENDS