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EDITORIAL FOREWORD

University of Liverpool Editorial Team

Welcome to the latest edition of Medical Sociology online (MSo), where we are presenting our first themed edition, exploring two aspects of infertility. We have plans to develop future editions around specific themes in medical sociology, and are currently preparing a call for papers for later this year. If you have a proposal for a themed issue that you would like to discuss please email the editorial team at MSo@liv.ac.uk.

In this edition, Elizabeth Ettorre has written a stimulating guest editorial around the two papers, both of which, in their different ways, contribute not only to ongoing debates within medical sociology, but to the wider sociological tradition of critical social research.

If you would like to submit an article for peer-review to Medical Sociology online, please use the link: <http://www.medicalsociologyonline.org/submissions.html>

We look forward to hearing from you,

Helen Bromley, Sara Edwards

Paul Harrison (Web Editor), Julia Hiscock

Suzanne Hodge, Paula Hodgson, Ciara Kierans

Mona Killey (Book Review Editor), Pauline Lybert

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The University of Liverpool MSo Team

GUEST EDITORIAL

'Paying attention to the journey': the cultural costs of infertility

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The journey from infertility to family, someone once said,
is like taking a train ride;
Never knowing whether
you'll reach your desired destination.
There are plenty of stops along the ride.
And each of the passengers
makes its own decision
when it's time to get off.

Some never need to take the train.
Others ride it for a lifetime.
But whether you reach your destination or not,
pay attention to the journey.
If you will,
as painful as it is,
it may reward you in unexpected ways.¹

Whether or not we agree that the experience of infertility 'rewards one in unexpected ways', as stated above in Divon's poem, we will most probably concur that infertility is a contested terrain. Infertility may bring uncertainty, despair, stigma and pain (both emotional and physical) for those 'suffering' from 'this problem'. For those wanting to change an infertile status or diagnosis, contact with medical professionals is inevitable.

As I introduce you, the readers of *MSo* to both of the following articles, one by Susana Silva & Helena Machado (*The diagnosis of infertility: patients' classification process and feelings*) and the other by Catherine Donovan (*It's not really seen as an issue, you know, lesbian infertility it's a kind of 'what's that?': lesbians' unsuccessful experiences of medicalised donor insemination*), I am struck by how this field has developed by contributions from feminist scholars as well as medical sociologists. In terms of the former, there has been a long tradition of feminist scholarship which questions the primacy of motherhood as a signifier of womanhood and infertility as a symbol of failure as a woman. On the other hand, medical sociologists have helped us to see how relatively easy it has been for medical knowledge to develop and adapt various basic technologies as assisted conception techniques and 'treatments' for infertility. At the centre of these contributions, we see clearly the bodies of women which are disciplined, managed and having a whole variety of procedures 'done to them'.

Both articles build upon these sorts of contributions. Donovan's work pushes the boundaries a little further by demonstrating how lesbians approaching private clinics for donor insemination are put in a subordinate position in relation to their heterosexual

1 © 2000 Ronen Divon. <http://www3.fertilethoughts.com/forums/archive/index.php/t-64404.html>

counterparts. Simply, a double standard exists between infertile lesbians and infertile heterosexual women in these clinics when different judgments are made concerning the types of fertility problems, level of suitability and extent of intervention lesbians are able to have. Silva & Machado demonstrate the transformative power of 'infertility treatment' for both men and women involved with the uncertainties of these medical practices. More strikingly, their work reveals the gendered constructions of these procedures and everyday processes which individuals either endure or embrace to become 'fertile'. Both articles manage to convey the difficult task of demonstrating *empirically* women's experiences of infertility 'treatment' as being very different from the glossy accounts in women's magazines or public perceptions. Both articles also evidence how medical and technological surveillance of a woman's 'wanting to become pregnant' body has become deeply embedded in our consumer cultures.

In my view, we need to extend beyond debates about essentialism, individual choice and reproduction as a feminine resource to those considering the everyday experiences of those who encounter infertility and attendant technologies face to face. The authors do just that. They also help us to begin to see more of the financial, physical, emotional and cultural costs for those living with an infertile label. Along with Divon's above poem, I would suggest, those interested in infertility need more to 'pay attention to the journey'. Certainly, our authors do just that and they should be commended.

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The diagnosis of infertility: patients' classification processes and feelings

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ABSTRACT

This paper is about patients' accounts of the processes through which a medical diagnosis of infertility is made, in particular of the medico-technical procedures and practices of the definition of, and clinical intervention in, the 'fertility problem'. It uses data drawn from interviews with couples who were medically diagnosed with infertility and had achieved a non medically assisted conception after at least one IVF treatment. By examining the place of the physician's expertise in helping lay people make sense of the diagnosis of infertility, we aim to understand the heterogeneities and complexities that shape the relationships between infertility patients' agency and feelings, medical knowledge production and the design of technical practices. Linking phenomenological and constructivist approaches, we suggest that these connections often take singular and uncertain forms that challenge traditional notions of passive subjects being objectivised in order to be medically known. We explore some of the processes involved in patients' translation of the medical diagnosis of infertility and of the expert's authority, to argue that this phenomenon is constructed within existing social relations, in particular gender relations, and that fertility investigation technologies are re-invented within everyday contexts.

KEYWORDS

Infertility, Medical diagnosis, Uncertainties

Introduction

Medical diagnosis of infertility represents a fertile location for observing many of the social conflicts within the context of medicine, as the social construction of infertility begins at the time when medical professionals and other parties determine the existence and legitimacy of this condition. The social construction of a diagnosis of infertility involves a multiplicity of understandings, relationships and actions that are constantly in flux and combine to promote a reconfiguration of the category 'infertility'. By analysing how the diagnosis of infertility is socially constructed, we explore how symbolic interactionism and social forces shape patients' understandings of, and actions towards, infertility (Brown, 1995).

According to the *European Society of Human Reproduction and Embryology* classification, which is consistent with standard practice and the WHO glossary, infertility is defined in medical terms as the diminished ability, or the inability, to conceive and have offspring. Infertility is also defined in specific terms as the failure to conceive after at least one year of intercourse without contraception (Vayena et al., 2002). The medical definitions of infertility often do not adequately account for factors that may influence conception, such as the frequency or timing of intercourse. Moreover, the establishment of one year of intercourse without contraception as a clinical criterion for an infertility diagnosis might be uncertain, ambiguous and misleading (Habbema et al., 2004), because this period can clinically vary from 6 months to 5 years and there are differences in thresholds when comparing clinical and epidemiological studies:

A threshold of 1 year to fulfil the definition of 'infertility' has become the gold standard for clinical purposes. (...) A threshold of 2 years, however, is used in many epidemiological studies (ibid: 1498).

Despite these arguments, some recent work on medical definitions of infertility has shortened the period of time that should be allowed before considering the possibility of infertility to 6 months (Brosens et al., 2004) with the presence of certain factors leading to a further shortening of the period before a diagnosis of infertility is made, such as a history of amenorrhoea, total impotence, previous male or female sterilisation, ovulation disorders and the age of the woman being 39 years or older (Homburg, 2005: 318; Steeg et al., 2005). The definition of the length of time in which couples have been unsuccessful at conceiving is especially important in a context where couples consult a specialist doctor about infertility at an increasingly early stage (Olsen et al., 1996), which might result in unnecessary over-treatment due to false-positive diagnoses of infertility (Balasch, 2000).

These discourses assume that specialist physicians of reproductive medicine are the only experts that can analyse, interpret and explain the biological body in order to *confirm* a diagnosis of infertility. But this confirmation procedure is mediated by the technologies that allow access to body parts, render them visible and malleable, and apparently reveal the silent symptoms of infertility through the results of a set of medical tests on the uterus, fallopian tubes, ovaries and sperm, within a process described by Pickstone (2000) as 'techno-medicine'. These contemporary technologies are powerful instruments in the diagnosis of infertility, but they produce forms of diagnosis that are more likely to depend on the language of probabilities and uncertainties than on the language of causality (Webster, 2002: 447). Therefore, the recent debate concerning the ambiguities and uncertainties that distinguish the medical definition of infertility highlights issues such as the tensions between the desire to produce a more 'accurate' diagnosis of infertility and the present capacities of available diagnostic tests and treatments (Gleicher and Barad, 2006). Medical and scientific recognition that the uncertain and partial nature of the diagnosis of infertility may be irresolvable (Siristatidis and Bhattacharya, 2007) may result from the acceptance of the idea that any diagnosis is, to some extent, artefactual and contingent (Mol, 1998).

During the process of diagnosing infertility, female bodies are subjected to a set of processes at the disposal of the medical profession, such as pelvic exams, several ultrasounds, laparoscopy and hysteroscopy (Cussins, 1996). In fact, fertility tests are part of a long history of medical procedures designed to be used almost exclusively on women's bodies (Douglas, 1991; Ploeg, 2001). These medical examinations aim at identifying the biological mechanisms that cause infertility, in order to act on them through a medical and technical intervention (Habbema et al., 2004; Homburg, 2005). Fertility treatment is thus constructed as preferable to other options, such as adopting a child or remaining childless, hence privileging the traditional, heterosexual, preferably married, concept of family and biological kinship (Stanworth, 1987; Edwards et al., 1999) and reinforcing the assumption of motherhood as a biological destiny and fatherhood as a way of proving men's capacity for genetic continuity.

The words used to describe the specific causes of infertility are expressed very personally (Cussins, 1996: 591) and reinforce the idea that infertility is not a neutral term (Bowker, 2001). The use of medical jargon, such as 'hostile mucus', 'blocked fallopian tubes', 'incompetent cervix' and 'failure to conceive', reflects the ways in which women's infertility has been constructed as a physical impairment. In comparison, male causes of infertility are described in less conclusive terms, using concepts such as 'subnormal' or 'low sperm mobility' (Ulrich and Weatherall, 2000: 324).

This qualitative study was undertaken to explore patients' accounts of the processes through which a medical diagnosis of infertility is made, in particular the medico-technical procedures and practices and clinical intervention that construct the 'fertility problem'. We reflect on the place for physician expertise, by exploring the way patients make sense of what is happening to them during the waiting time before commencing fertility investigations. We go on to analyse the processes involved in translating and reinventing the expert's authority

and in understanding the technical practices encountered within the context of the uncertainty that precedes a diagnosis of infertility. In sum, we aim at mapping out some of the relational contours between the physician's expertise and lay perspectives in the context of an infertility diagnosis.

As Ian Shaw argues, in actively searching for meaning, patients can adopt basic stances and fundamental concepts of the expert/physician's explanations and interpretations of their 'medical' condition as a means of orientating themselves in their everyday life and can come to accept such rationality, but they also utilise these experiences as a way of negotiating and critiquing the medical knowledge (Shaw, 2002). In short, the way people understand health experiences and make sense of these implicate complex negotiations and mutual reconfigurations (Hamlin, 1992; Mackay et al., 2000; Shaw, 2002; Webster, 2002), including how they relate to institutional structures, where interaction takes place, and how they play out their social roles (Brown, 1995). An understanding of medical knowledge and practices, and of diagnostic procedures, associated with having a 'fertility problem' demands an examination of the main modalities of codification and interpretation undertaken both by medical experts and the infertile couples. Our analysis of the institutional strategies developed by the medical system to define infertility leads us to argue that these processes are uncertain and aim at reinforcing existing behavioural norms and social beliefs about motherhood and fatherhood, justifying medical intervention for *abnormal* couples in this domain, that is, couples unable to conceive a biological child.

Method

We intended to identify lay accounts that have been filtered through medical rationality and then 'owned' by patients. Based on the assumption that to question the power base of the diagnosis of infertility is particularly relevant in the cases of couples who were medically diagnosed with infertility and had achieved a non-medically-assisted conception after at least one IVF treatment, this qualitative study was undertaken to explore, in depth, these couples' scrutiny of the medical diagnosis of infertility. A qualitative phenomenological methodology was selected because this method is useful when little is known about a phenomenon, as it can be used to explore the patients' processes of classification and feelings within a diagnosis of infertility and, in particular, to analyse their detailed descriptions of the complexities and uncertainties in a diagnosis of infertility (Alderson, 2001). We attempt to follow Strauss and Corbin's "grounded theory" approach: an interpretative and qualitative research methodology, which is characterised by a hypothetic-inductive perspective (Strauss and Corbin, 1990).

Participants were recruited through newsletters; the first author sent a newsletter via e-mail to colleagues at work and friends and asked them to pass the message to other people, in a snow-ball strategy. Semi-structured tape-recorded interviews, lasting about one hour, were conducted at the house or work place of the women and men who volunteered to take part in this study. The tapes were transcribed verbatim. The interviews were completed between June 2005 and February 2006. We used a purposive sample, which means that we added new data to the analysis when it was of theoretical interest, and its size relied on the concept of 'saturation', that is, recruitment continued until no new themes emerged from the interview data. According to Guest et al., basic elements for metathemes were present as early as six interviews (Guest et al., 2006). Our degree of data saturation over the course of thematic analysis was ascribed in the first seven interviews. Data were systematically coded and synthesised by four main themes: how patients' make sense of the waiting time before starting a fertility investigation; how knowledge of the body and the conjugal organisation of sexual intercourse are reconfigured in a context of a 'fertility problem'; what are the main factors involved in the decision of looking for medical help; how patients appraise medical practices and, in particular, fertility tests. The processes for arriving at conclusions conformed to standard conventions of qualitative analysis (Becker and Bryman, 2004).

In a total of seven interviews, two couples (woman and man), four women and one man participated in this study. The nine participants in this study were all Portuguese, heterosexual, married and white. The age of the participants ranged from thirty to thirty-eight.

Five interviewees held a university degree, one a master's degree, one a PhD, one had nine years of education and one had twelve years of education. Four of the seven family units had a family income of between 2500 and 3000 Euros a month and two less than 2500 Euros. The occupations of the female interviewees were the following: nurse, bank clerk, civil engineer, financial manager, chief technician in a biotechnical company and commercial employee. In the case of men, one was a university teacher, one a manager in a biotechnical company and one was a commercial employee.

Ethical approval for this study was obtained from the Foundation for Science and Technology (Portuguese Ministry of Science, Technology and Higher Education). We followed the Code of Ethics of the International Sociological Association.

Infertility patients' narratives around the diagnosis of infertility

We conclude that patients develop a set of criteria to judge the medical knowledge and technical expertise that surrounds diagnosis and decision-making in the area of infertility, creating an awareness of the uncertain and partial nature of medical diagnostic knowledge and the armamentarium that accompanies it.

Lay making sense of the waiting time before starting a fertility investigation

The period spent trying to conceive before the interviewees approached a specialist doctor in reproductive medicine varied between six months and two years. The decisions about when to start a fertility investigation are usually taken under the authority and expertise of physicians, mainly gynaecologists. Medical knowledge tends to dominate interviewees' making sense of the 'adequate' waiting time before starting an infertility evaluation, but lay perspectives and aims can be mobilised in order to shorten (or to extend) this period. Hence, time might be a resource to manipulate, either by the medical experts or the infertile couples, with the intention of maximising the possibility of reaching their goal (pregnancy). For instance, one couple who initiated fertility investigations before one year of trying to achieve a pregnancy did so because the male partner intended to work abroad and the female partner wanted to get pregnant before he left the country:

We were trying for less than a year (...) but we were conditioned because he was going to Europe and I wanted to get pregnant. (33-year-old woman, university degree, bank clerk)

The possibility that the woman might not be able to get pregnant if and when a couple wants to might be one element that leads women to take responsibility for the 'failure' of the project of getting pregnant. The female interviewees stated that they were the first ones to think that there was a possibility of having a problem in conceiving, forming hypotheses based on their personal health history and hunches about what might be going wrong in their own case:

It was easy to convince myself that there might be a problem. Not because I am pessimistic but because of my personal health history. (33- year-old woman, university degree, financial manager)

Unlike the women, the male interviewees seemed to be 'thoughtless', because they did not think there could be a 'problem' with the couple's fertility. Consistent with common cultural assumptions regarding fertility and pregnancy being a woman's issue, men report that they comfort their wives through reassuring them that 'these things' take time (Webb and Daniluck, 1999). This adoption of the protective role on the part of the male interviewees may well reflect differences in the ways in which men and women have been socialised to cope with a negative affect, associated with the assumption that the male body is naturally fertile and that the female body has more need of medical help and intervention, and is, therefore, more vulnerable to screening processes. The creation of socially constructed notions of proper bodies, that implies a female fertile body that should achieve pregnancy if and when

the couple wants it, seems to delay the start of a fertility investigation. At the same time, it reinforces the social image of the women as being responsible for the 'failure' of the project of getting pregnant. In this sense, women who are concerned about infertility could occupy what Webster (2002: 445) called the 'therapeutic limbo', since they perceived themselves as patients, even without symptoms and a diagnosis of infertility. The female interviewees worried about the possibility of having a problem in conceiving, even when there was no 'fertility problem'.

Reconfiguration of knowledge of the body and the conjugal organisation of sexual intercourse

Becoming aware of the importance of when sexual intercourse occurs during the menstrual cycle (Brosens et al., 2004) appears to be the first element which launches an 'anticipatory socio-naturalisation' of women, in the sense that they are much more aware of the phases of the menstrual cycle and the need for timing intercourse (Cussins, 1996: 581-2). According to one of the female interviewees, the first step in the process of a fertility evaluation is usually a therapy involving ovulation induction and ovarian stimulation, that is, the use of hormone therapy to stimulate oocyte development and ovulation (release of the ripened egg in midcycle). This therapy also involves learning to determine the fertile phase of the menstrual cycle, in order to promote fertility-oriented intercourse:

At the time what he [gynaecologist] did was to prescribe some medication (...) that stimulated ovulation. Then he got my temperature and made graphics of temperatures. When it was ovulation time a raise of temperature was supposed to occur. In those days I should have sex. (32-year-old woman, university degree, chief technician in a biotechnical company)

The assumption related to this medical suggestion is that difficulties in achieving pregnancy are caused by possible irregularities in ovulation or because the particular couple doesn't have sexual intercourse during the fertile period. In the context of having to schedule sexual intercourse, in order to assure that it takes place during the fertile period, one of the female interviewees talks about the difficulties that she and her partner experienced in having to 'function' [to have sexual desire] (38-year-old woman, university degree, nurse). One of the male interviewees also admits that the regulation of sexual intercourse in order to accomplish medical objectives was problematic:

It meant measuring exactly when ovulation took place and having sex around that period, sometimes in days when it would not be normal because, I don't know, I was more tired or something else? (36-year-old man, manager in a biotechnical company).

These narratives highlight the intersection of biogenetic, mental, social and emotional factors involved in sexual intercourse and show how men might also be implicated in the absence of pregnancy, through, for instance, possible alterations in sperm quality that might occur during periods of increased anxiety or tiredness (Pook et al., 1999). They also show how modern bodies are technological artefacts that are made and remade through medicine and technology. The specialists in reproductive medicine seem to develop new forms that allow an increasing access to bodies. Whether fertile or infertile, bodies are viewed as empirical objects that should be regulated through reproductive medicine and self-discipline (i.e. control of desire, passion and need) in order to ensure a fertility-oriented intercourse and a successful reproduction.

Deciding to procure medical help and the change from hope to disappointment

It is clear from the interviews that decisions to seek medical help in conceiving are frequently made by women. In the opinion of one of the female interviewees, this has to do with the fact that usually women have more initiative than men in relation to fertility and that men are afraid of finding something wrong with them:

She has more initiative to do something than he has! That's my impression. I know one couple who is going to start the fertility consultations and I suppose he also fears to go to the consultations. He fears, he is afraid of finding something wrong with them. (38-year-old woman, university degree, nurse)

The fact that it is usually women who take the initiative to start fertility investigations reflects the traditional gender relations that operate in relation to emotional work and may reflect women's longstanding involvement with medicine during their lives (Webb and Daniluck, 1999: 20). The assumption that women are more emotionally fragile than men and that they experience greater overt distress in response to infertility also supports the belief that women have greater need of medical advice and treatment. In sum, both women and men have gender identities which structure their experiences and this influences decision-making and feelings in the context of the diagnosis of infertility.

The interviewees describe their first encounter with a specialist doctor in reproductive medicine using terms such as 'normality' and 'optimism'. These experts are symbolically elected as the ones who can resolve their 'problem'. But there are some situations that reconfigure this 'hope' into a disappointment: when the commercial issue comes out in the first consultation (contrasting with the couples' 'non-profitable' motives for having a child); when couples who have had a negative response from one doctor seek the opinion of a second doctor, only to have to answer the same questions and be forced to retell their clinical histories; or when the doctor doesn't recommend an immediate therapeutic procedure when the couple has already spent a long time waiting to have a child. Most of the interviewees say that their main recollection of the first encounter with an expert in assisted reproductive medicine concerns the quantity of medical tests required, and they underline the fact that most of the tests were aimed at the women. The interviewees tend to 'normalise' and 'naturalise' the experience of undergoing these tests, perceiving them as everyday clinical practices.

Clinical intervention in the human body can be seen as being legitimised through the anatomic-pathological examinations that aim at identifying the probable causes of the 'problem' and arriving at a suitable technical intervention that is its solution. So, the relationship between a specialist doctor in reproductive medicine and patients in the context of the first encounter due to a diagnosis of infertility is described by the female and male interviewees as being based on technical knowledge. Ethical, moral and social issues are redefined as technical and, thus, doctors are becoming 'technologists of the body' (Webster, 2002: 451).

Appraisal of the tests of fertility

The discourse of the male interviewees relating to having to produce and submit sperm samples for laboratory analysis is characterised by the reconstruction of pressure. This event is translated into an anecdotic episode in order to make sense of it in the context of their everyday world (Webster, 2002). There seems to be a need to develop a positive reconstruction regarding the 'threat' of infertility which relates to the socially constructed belief about masculinity that men should struggle against adversity (Machado and Remoaldo, 2007). For example, one of the male interviewees describes the collection of sperm as 'horrible' and the necessity to deliver it was understood as an 'awkward' situation. The conception of the spermogram as a medical exam is, in this case, reconfigured comically and, mostly, through the transformation of the 'medical' act of semen collection into a private and intimate act performed at home and not in a laboratory or fertility clinic.

[The collection of semen] was horrible. (...) We didn't do it in a clinic; we did it at home, so it wouldn't be such a medical act, and a little bit more personal. (...) It was all to do with the necessity to deliver my semen. It was a little more embarrassing. At a point, we were just laughing. (36-year-old man, PhD, manager in a biotechnical company)

Another male interviewee describes the process of the collection and delivery of sperm as very 'stressful', emphasising the troublesome transportation of the sample of semen, between the location of sperm gathering (his own home) and the analysing laboratory, particularly the ways used to keep the 'adequate' temperature and the possibility of being caught for exceeding the speed limit during its transportation in order to deliver the sample on time (within one hour after ejaculation):

At the time it was very stressing, because I had to get there [private clinic] from home in a hurry. (...) My thoughts were 'I'm going to get caught for speeding'. The sample bottle was in my pocket, next to my chest, so it wouldn't get cooler. All I could think was: they [the police] were going to stop me and all I could say was: 'Look! You see this in my pocket? I have to hurry. Do you know what it is?' That was all I could think about. (36-year-old man, 12 years of education, commercial employee)

The importance of the material conditions in which the collection of sperm is completed, such as the appearance of the toilet, the degree of privacy allowed and the lack of access to magazines and erotic movies is illustrated by one of the female interviewees, who reveals the difficulties that her husband experienced in producing a sperm sample:

When he [the husband] went to do it [produce the semen sample] (...) he said, it was in a toilet, a very small one. It had two doors; he and another went inside at the same time; one to one side, the other to the other side. He said: 'It was horrible; it was an old toilet cubicle; there was nothing there: there was no...The cup was there in front of me!' Then he said he was getting desperate, because someone had gone into the next cubicle, gone out, another had gone in and gone out, again. All he was saying was: 'Ah! I won't be able to do this!' (32-year-old woman, university degree, chief technician in a biotechnical company)

The dominant view of masculinity perpetuates the idea that men can control their anxieties and emotional states by controlling the external environment. In the context of the diagnosis of infertility, this brings some particular consequences for men: they are alienated from meaningful intimacy and restricted in the ways that they can experience and/or express emotions. So men tend to prize the external world rather than their internal feelings in these discourses; moreover, they tend to minimise the impact that these medical tests have on them in comparison with the tests their wives have to undergo. The ways these narratives emphasise control of the adverse elements (both emotional and material) surrounding the act of sperm collection can be understood as being associated with the 'deleting' of men's suffering, allowing them to maintain identity processes socially attached to masculinity, namely those based on values such as competence and strength (Webb and Daniluck, 1999). There seems to be a need to develop a positive reconstruction following the 'failure' of infertility, in accord with the principle that men should be 'strong' (Machado and Remoaldo, 2007).

By contrast, the female interviewees frequently refer to the suffering and pain, in physical terms as well as in affective and emotional terms, and the changes of form and function in their own bodies (and the perception they have of them) as part of the process of being subjected to the diagnostic tests. However, these processes of dissection, interference and transformation of the woman's body are minimised by the female interviewees and can be understood in terms of providing them with the opportunity to prove their love for their potential future children (Lupton, 2003).

The different gendered constructions of the fertility tests and the interpretation of them by the individuals who underwent such tests are highly relevant – they reveal the male discomfort with, and the female acceptance of, the procedures. The fertility tests are largely focussed on women and are often highly invasive and frequently painful or uncomfortable. Yet it is the men who submit sperm samples (which are non-invasive and manually collected by the individual men via masturbation – albeit sometimes, but not always, in a clinical context), that describe the tests as 'horrible' and 'awkward'.

Uncertainties and the lack of 'objectivity' of medical practices

The transmission of test results and the corresponding diagnosis of infertility are a fundamental moment in the course of the interviewees' trajectories. The interviewees' sensations are contradictory: the test results provide an explanation for the absence of a pregnancy and therefore give some 'relief' for the interviewees if followed by a proposed 'solution'; at the same time, this particular period is accompanied by feelings such as 'disappointment', 'grief', 'confusion', 'resentment' and 'isolation'. The interviewees emphasise in particular the fact that the medical classification of the causes of infertility ('female' or 'male' causes) reinforces the localisation of the 'problem' not in the couple, but in the woman or/and the man, endorsing feelings of individual culpability.

The issue of individual culpability resonates through the experiences of many people undergoing infertility investigations. While the clinics treat 'the couple', often it is related to issues with the individual – and thus, tensions arise. The resolutions of these challenges by the individuals also influence their experiences and feelings related to seeking infertility treatment. The way the interviewees talk about the simultaneous existence of 'female' and 'male' causes illustrates strategies of rationalisation that intersect with emotional and physiological factors that follow from the diagnosis of infertility. A simultaneous female and male infertility makes the search for a 'solution' (the possibility to have a biological child) more difficult, but facilitates the sharing of feelings within the couple, which might be perceived as positively reinforcing the conjugal relationship:

She: We didn't have that kind of reaction, maybe more rational way of thinking: this [conjugation of female and male causes of infertility] could be worse than the cause being from only one side, isn't it? He: But we had that more rational side, which was to consider that this situation makes it easier, makes it easier ... eases communication, understanding, accepting, eases a lot of things. (33-year-old woman, university degree, financial manager; 36-year-old man, 12 years of education, commercial employee)

However, tests do not always identify the cause of infertility and, consequently, the couple are left with the result of 'unexplained infertility'. This situation of uncertainty is described as 'much more confusing', 'more distressing' and 'more complicated'. One of the female interviewees admits that she prefers to have a problem instead of not knowing the reason for not getting pregnant:

I would prefer that the doctor could have discovered a problem; it might have been solved and then overcome. (33-year-old woman, university degree, bank clerk)

The interviewees' assessment of the lack of objectivity, exactness and assurance regarding the criteria used in the diagnosis of infertility is also expressed in relation to different situations: when two or more experts interpret differently the results of tests and thus propose different therapeutic approaches; and when a pregnancy is achieved without the support of medicine or any assisted reproductive technology after a diagnosis of infertility.

Paradoxically, the uncertainties surrounding both the medical assessment of the tests and the processes of categorisation of a couple as 'infertile' have encouraged the search for more objective and accurate technical and medical information as a way of judging the merits of specific medical procedures (Webster, 2002). Hence, in a context of uncertainty, the female and male interviewees are likely to develop practices that help to establish trust and confidence in medicine and technology. The interviewees report practices they have developed for judging expert authorities, like looking for an expert considered to be more competent; simultaneously attending private and public fertility services; repeating the medical tests in laboratories considered to be 'reliable' and to have a guarantee of 'quality' according to the recommendations of the doctor seen by the couple. Another common practice is to search and access health information and treatment in diverse sources at a global level, in particular in the media and on the Internet. The female interviewees emphasise the importance of other women who have undergone fertility treatments by the dissemination of personal

experiences, preferably successful ones.

I knew a colleague who had fertility treatment and I have asked her where she had it. She has told me about all the places [where fertility treatment could be accessed]. (38-year-old woman, university degree, nurse)

A person in my family had difficulties in getting pregnant because she had a problem (...) she suggested that we went to the same doctor who had seen her for a long time. (33-year-old woman, university degree, bank clerk)

In sum, patients' understandings of and actions toward a diagnosis of infertility can be reformulated as new experience and information is fed in. Assessing the merits and capabilities of expert authorities and searching for information emerge as socially accepted practices perceived as rational and morally acceptable that can be mobilised in order to negotiate and critique medical practices and knowledge (Shaw, 2002). What is important here is the role played by lay people as autonomous, active agents in helping to reduce the uncertainties that surround the diagnosis and management of infertility.

Conclusion

The complexity of the processes through which a diagnosis of infertility is made leads us to conclude that infertility is not a neutral phenomenon but is rather produced in different ways in different diagnostic sites. Both women and men have gender identities which structure their experiences of the medical diagnosis of infertility, the medical construction of the 'fertility problem' and the design of clinical interventions. Of particular importance seems to be the fact that the diagnosis of infertility is supported by techniques that are almost exclusively applied to women's bodies, in the context of a medical approach to women's bodies that understands them as the 'natural' and 'given' subject of medical investigation and intervention (Ploeg, 2001). In the case of the diagnosis of infertility the modalities of translation and lay reinvention are mediated by the social relations and cultural expectations related to gendered relations regarding reproductive matters and the essentialism of biological parenthood. The medico-technical procedures and practices involved in diagnosing a 'fertility problem' and the associated clinical interventions reveal exercises of kinship 'construction' which serve to reinforce the privileging of biological kinship as a social norm (Thompson, 2001). This is largely justified by cultural assumptions related to the roles of women and men in society, such as the discourses and beliefs about motherhood as a biological destiny and an inevitable outcome of a woman's biology or, in the case of men, as a way of proving strength, virility, a sense of responsibility and the capacity for genetic continuity (Webb and Daniluck, 1999). Prevailing gender relations and the normalisation of the desire to have children combine with the belief in the miraculous nature of medicine and technology, in spite of the frequent experience of disappointment resulting from the uncertainties and lack of 'objectivity' that attend the diagnosis of infertility.

In the context of the 'socialisation of clinical diagnosis' (Webster, 2002: 448) new forms of engagement between the medical profession and lay people emerge in the domain of the diagnosis of infertility. The symbolic meanings attached to the physician's authority and to the technical practices associated with it are continually being negotiated and reinvented in order for the infertile couple to make sense of their everyday world and their relationship. Lay people are increasingly presenting a challenge to the epistemological and professional authority of medical and technical practices, through the translation of the diagnosis of infertility into lay language, the demand for more precise forms of diagnosis, the willingness to assess the merits of experts and the search for medical advice and information in diverse sources. But this challenge seems to occur in the context of an ongoing search for the miraculous solution to the 'fertility problem' alongside the wish for greater patient involvement in defining, diagnosing and managing infertility, rather than in the context of a demand to develop 'counter-discourses' in reproductive medicine. Our findings suggest that it

is important to make the diagnosis of infertility more 'accurate' and gender-sensitive, which could be linked to the development of an embodied ethics within reproductive medicine.

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'It's not really seen as an issue, you know, lesbian infertility it's kind of "what's that?": Lesbians' unsuccessful experiences of medicalised donor insemination

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ABSTRACT

As increasing numbers of lesbians grow in confidence to become parents of children conceived using medicalised donor insemination (DI) there is a parallel but little heard of group who are unsuccessful in their attempts to become biological mothers. In this paper, I explore the experiences of a small group of lesbians who were not successful in their use of medicalised DI to investigate two questions: what is the response of biomedicine to these women; and what is the impact on the self-identify of these women that they cannot conceive? The experiences of lesbians who are not successful in their use of DI provide further evidence of the ways in which fertility services and biomedical understandings of fertility problems are shaped by norms of heterosexual conception and fertility. In their accounts of the impact of their lack of success in achieving conception on their sense of themselves, respondents describe the ways in which it is heterosexual femininity that bears most pressure for achieving conception which releases them from any sense of the 'failure' reported by heterosexual women unable to conceive. In conclusion I suggest that the dominant definition of 'infertility' that shapes the provision of fertility services ill serves the experiences of lesbians. I also argue that by exploring lesbians' understandings of their inability to conceive light can be shed on dominant ideas about motherhood and the maternal instinct.

KEYWORDS

Infertility, lesbian parenting, donor insemination

Introduction

Since at least the late 1970s (Forster and Hanscombe, 1982; Saffron, 1994) lesbians have realised that insemination by donor is a workable method of achieving pregnancy and have employed it either by organising it themselves – usually called self-insemination (SI) - or by gaining access to medicalised donor insemination (DI) through fertility clinics. As lesbians gain in confidence to become mothers and create families using DI, the attention of the academy has been on those who have been successful. This work has made an invaluable contribution to current debates about what constitutes family and the importance or not of fathers in their children's lives. However, unlike in the field of heterosexual women's infertility, there has been very little exploration of the experiences of lesbians for whom the use of DI is not successful. In this article a small pilot study of lesbians who found themselves unable to conceive using DI is explored to begin a discussion about two key research questions: how do biomedicine and lesbians themselves respond to lesbians' inability to conceive. The article is organised into five sections. First is a discussion about the way in which fertility has been medicalised through a heteronormative lens. There then follows a brief historical overview of the emergence of the lesbian mother and a review of the debates about the suitability of lesbians to mother. In the third section the methodology of this pilot study is outlined and this is followed by a discussion of the findings in relation to the

two research questions outlined above and some concluding comments.

Medicalisation of fertility

In 1978 the first so-called 'test-tube' baby was born as a result of In Vitro Fertilisation (IVF). Recognition of the potential of this and other Assisted Conception Techniques (ACTs) to revolutionise the medical management of conception and family life resulted in the Government appointing the Warnock Committee to consider, amongst other things, the social, legal and ethical implications of the ACTs. The Warnock Report (1984) can be read as a rationale for the medicalisation of fertility as it argued that infertility is a malfunction of the body and as such is a legitimate concern of medicine. However, infertility is a contested term. It implies that there is a 'malfunction' that the use of (ACTs) can treat. Yet, the cleverness of ACTs is that they by-pass problems to achieve conception, and it is not malfunctions of the body that are treated but the desire of the woman to have children (Donovan, 1993). The medicalisation of DI illustrates the way in which the term 'infertility' is, rather, a value laden term that constructs heteronormative assumptions about individuals. In its simplest form insemination requires no more than a needleless syringe to introduce donated sperm into a woman's vagina when she is ovulating. Hence self-insemination. The naming of DI as a treatment for infertility belies the fact that it does not 'treat' anything and can only work if the woman is fertile. Such naming implies and imposes the presence of a male who has fertility problems that need to be by-passed by the use of donated sperm and acts to make lesbians' use of DI problematic. For example, Baroness Warnock (2002) recently considered lesbians' use of ACTs in a chapter entitled 'Are those who are not infertile entitled to assisted conception?'

In practice what this has meant is that, until recently, lesbians have difficulty accessing DI at NHS clinics (Saffron, 1994) but have more success at private clinics. Apart from the discrimination this results in for lesbians in terms of their access to public health services, it also means that their experience of accessing DI is through the paradigm of the private health care system. As I will explain later, this had a big impact on the lesbians in this study. However, using medicalised DI is attractive for lesbians for several reasons: medicalised DI can be seen as the safest, most practical option for achieving pregnancy. 'Safety' here can be understood in several ways: because sperm has been health screened and tested for fertility; and because children born as a result of this are legally fatherless. That lesbians are able to take advantage of the legal framework to safeguard their families was an unintended outcome of the legislation but it provides a level of security for lesbian mothers and co-mothers about their family that is less easy to achieve with self insemination where the genetic fathers can and do make legal claims for paternity, parental responsibility and residence; and can be pursued for child support (e.g. Smith, 2006).

Klein (1989), Franklin (1990) and others have written about the experiences of heterosexual women and men who have had fertility problems and resorted to the use of ACTs – usually IVF – either successfully or, more usually, unsuccessfully. There is very little written about women's failure to conceive in DI and even less on lesbians' failure to conceive. The former can be explained because in the medical model the ACTs are presented as a continuum of methods requiring more and more intervention, the goal of which is conception. Failure in the use of DI does not necessarily mean failure to conceive in the way that failure to conceive with IVF does. If DI does not work there is always something else to try. If IVF does not work options dramatically diminish and surrogacy can be the only option left for achieving genetically related children. The lack of focus on lesbians' unsuccessful use of DI is not so surprising given that the medical model of fertility starts out from the premise that heterosexual women and their male partners are the focus of their work. Yet lesbians are increasingly using DI (Ferrara et al., 2000) and therefore there will be more lesbians who are unable to conceive using DI. In conducting this pilot study it was intended to begin to address the experiences of this group.

Historical Context and debates about lesbian mothers

Weeks et al., (2001) talk about the ways in which, since the 1970s in Europe and North America, new stories about lesbian parenting are being told. Stories of opportunities relate to lesbian mothers who came out having had their children within heterosexual relationships whilst stories of choice relate to lesbians who come out and then decide to parent. Both reflect the increased confidence of lesbians to create families. This confidence has been recognised in the UK by changes to legislation since 1997 to recognise the intimate relationships and families of those in same sex relationships, particularly the Civil Partnership Act (2004) and the Adoption Act (2002). In addition, the realisation that insemination is a viable and relatively successful route to conception which provides choices about how families can be organised has also meant that more lesbians are opting into motherhood. Insemination with known donors allows the opportunities for children to become knowledgeable about or have some level of involvement with the donor, their genetic father, whilst anonymous insemination provides some security that the couple and parenting relationships will not be threatened by a third party (e.g. Donovan and Wilson, forthcoming).

However, lesbian mothers have never been fully accepted. Lesbian mothers coming out of marriages in the 1970s and 1980s had to challenge courts decisions that awarded child custody to their fathers because of the sexuality of their mothers (Forster and Hanscombe, 1982). Likewise, those lesbians seeking access to DI have had to contend with a legal requirement for licensed practitioners to take account of the welfare of any children being born through use of donated gametes, including their need for a father¹ (Donovan, 2006). Lesbian mothers are assumed to pose a risk to the welfare of their children, for example, in their psycho-social development, the development of their sexuality and their treatment by others because of their mothers' sexuality and their lack of a father (e.g. Baetens and Brewaeys, 2001).

The increased visibility of and debates about lesbian mothers has led to an interest within the academy in these new families. This research can be - albeit simplistically - divided into two kinds. Since the 1970s quantitative, psychologically based work has been done to provide evidence for resisting heteronormative assumptions about lesbians' fitness to parent once they had come out (e.g. Tasker, 2005 for her overview of this research internationally). The research provides evidence that children brought up by lesbian mothers are not disadvantaged in comparison with their heterosexual counterparts. Similarly, research has been done comparing children born to lesbian mothers and heterosexual parents as a result of DI, and similar results have been found (e.g. Tasker, 2005). Some interesting findings have also emerged that have broader application in the debates about the role of fathers (see also Parke, 2004). For example, Bos et al. (2004), comparing lesbian and heterosexual couples, found that lesbian mothers had a much more equitable division of labour in relation to paid work, housework and child care than heterosexual couples do; and that non-biological mothers are more involved with their children on a day to day basis than heterosexual fathers. This has led Patterson (2006: 242) to argue that parental sexual orientation is not related to children's adaptation, rather the quality of the relationship between parents and children is more indicative of children's wellbeing than their parents' sexuality. The lack of debate about these differences has been remarked on by Stacey and Biblarz (2001) who argue that in the rush to evidence parity in the quality of parenting across heterosexual women and lesbians

¹ This requirement is being debated currently (early 2008) in the UK Houses of Parliament with the Government recommending its removal from the new Human Fertilisation and Embryology Bill. However, there are strong voices of opposition especially from the Catholic Church in the UK (see Murphy-O'Conner, 2007)

these differences that challenge heteronormative assumptions about the role of biology, gender and sexuality in optimum parenting have been overlooked. Whilst acknowledging the pragmatism, others have also questioned the wisdom of a research strategy relying on comparisons with a heterosexual norm to make a case that validates lesbian mothering (e.g. Clarke and Kitzinger, 2005).

The second kind of research (e.g. Lewin, 1993; Donovan and Wilson, 2005; Almack, 2006) focuses more on exploring the ways that lesbians themselves understand and practice family; and the ways that social and biological parenthood are negotiated, recognised and reflected in family stories (e.g. Donovan and Wilson, forthcoming). The work of Gartrell et al. (2000; 2005) straddles the two kinds of research. This longitudinal study of lesbian couples who are bringing up children conceived with insemination focuses on comparing outcomes for children with known and unknown donors; and with heterosexual norms for psychosocial development. Again, this study finds that the children measure up well against these norms and that those with unknown donors are not disadvantaged in comparison with those with known donors.

All of the research has concentrated on lesbians' successful use of insemination. There is very little attention paid to the stories told by lesbians who have unsuccessfully used insemination and it is these stories that this article begins to tell for what they reveal both about the organisation of DI and our understandings of the impact of infertility on women's sense of self.

The Study

This article describes a pilot study exploring the experiences of lesbians unsuccessfully using DI. Not surprisingly this is a difficult group to recruit both because of the sensitivity of the topic and because they are a hidden group within a still relatively marginalised group. Ethical approval was secured from the University of Sunderland Ethics committee and recruitment depended on the circulation of a leaflet among friendship networks and a self-organised group of lesbians and gay men wanting to adopt in the North of England. Four respondents agreed to take part. All were white, self-identified lesbians, one of whom identified as working class and the other three middle class. Three had started the process of trying to conceive in their early to mid thirties and one in her early forties. All were in their early to mid forties when they took part in the interviews. They had tried to conceive over periods ranging from about 2 and half years to 10 years. Three had tried both self-insemination (SI) and DI. They were all in relationships at the time they tried. In line with findings from other studies (e.g. Dunne, 1998; Leiblum et al., 1995) all had taken some years considering before they began inseminating. Interviews took place in locations of their choosing and lasted between 1.5 and 2.5 hours.

Interviews were transcribed by the author and thematically analysed looking particularly for ways respondents understood and experienced the medical provision of DI; and the ways that they made sense of their inability to conceive. The accounts given were retrospective and this means they are shaped by subsequent experiences and rationalising (see also Bos et al., 2003). In addition, respondents' accounts were co-constructed by the interview schedule which focussed on particular aspects of their experiences (Duncombe and Marsden, 1996). However, whilst there was no expectation that these interviews would reveal the incontrovertible truth about their experiences, they do provide a narrative truth (Plummer, 1995) which gives an insight into their experiences and how they have made sense of them. The first of two core themes being explored in this article is the heteronormativity of medicalised fertility. The second core theme is the impact of being unable to conceive on women's understandings of themselves.

The heteronormative medical provision of DI

Weeks et al. (2001:41) used the term heterosexual assumption to describe ‘an all-embracing institutional invalidation of homosexuality and presumption in favour of heterosexuality’. The heterosexual assumption was evidenced in these women’s accounts of their experiences of using DI clinics and the health services by their invisibility as potential and actual clients to the clinics; their anxieties about being out to health professionals; and the casual assumptions made about them by health care professionals. In addition however, the actual provision of DI was embedded in assumptions about heterosexual ‘infertility’ such that the lesbians received a quite different service to that of their heterosexual counterparts.

The Heteronormative Constitution of Protocols

There is a consensus that heterosexual couples should have been trying to conceive for a minimum of a year before being referred. Lesbians coming to a clinic may not have ever tried to conceive and, as was the case with the respondents in this study, may assume fertility. As Isobel explains, she felt sorry for the heterosexual women in the waiting room at her clinic because they were ‘...at the end of the road...whereas for me it was the start because I didn’t question my fertility.’

All understood clinics not as a venue in which their fertility might be problematised but as a source of sperm. However, all of the women were treated as if they too had been trying to get pregnant for at least a year beforehand and were offered the same interventions; numerous tests of their fertility before inseminations began; and a package of either five or six cycles dependent on the clinic. The variety of experience between the women’s experiences belies the rationale given by each clinic for their protocol as the best i.e. only way of providing DI.

The fact that all of the women were using private medicine for the first time also had an impact on how they understood this presentation of clinic protocol. Most were cynical of their clinic’s presentation of more and more investigative tests and use of drugs at what seemed to them quite an early stage in their attempts to conceive and saw this as a way of clinics making money. However, they were often at first convinced by the rationale given: that it was better to undertake the initial screenings to eliminate potential problems so that the inseminations had the best chance of succeeding. It was the immediate problematisation of their bodies that some women found questionable if only in hindsight.

All began with an initial five or six cycles of insemination (one insemination per cycle with varying degrees of ovulation monitoring from daily blood tests from day seven/eight of their cycle to using an ovulation predictor strip). When this was unsuccessful they had a review after which they were offered or advised to have a laparoscopy for investigative reasons and to flush tubes out. Then they were all offered another package of inseminations with hormones and more intrusive monitoring of ovulation (daily or monthly vaginal scans). Their journey through this regime made it clearer that DI was presented not as a method of achieving pregnancy but as part of a treatment process for people with fertility problems that is embedded in a range of investigations, interventions, drug use, ovulation monitoring and so on that were part of an on-going, conveyor belt of activities whose goal was pregnancy. Anna explains:

I felt like I could go within my head ‘I’m just accessing the service. I’m accessing sperm’. That’s what I want. But they’re, they’re coming from the thing about ‘we’re going to manipulate your fertility to get pregnant’. (...) there are some people who won’t get pregnant but there are others who will and those who will, all we have to do is find the right combination of things to unlock it

In a similar vein Stephanie spoke about how ‘carrots’ were held out to her at each point where she might have stopped or taken time to reflect. These carrots (with their added costs) were further investigations, different fertility drugs, and tests that kept her hooked into continuing:

...he didn't say, you know, you're nearly 40, you realise your chances are quite slim. What they said was well there's a 10% chance and there's no reason why you couldn't get pregnant. No one's found one so far so (...) they give you these bits of hope and that I think is deceitful actually. Well in my case I think it was.

These experiences are not exclusive to lesbians but given that these lesbians were only just beginning their efforts to get pregnant the cost - both emotional and financial - begins much earlier in their biography of trying to achieve conception. Women believed there was a financial incentive for clinics to present the range of options they did in the way that they did i.e. as carrots or hooks. However, there was also the belief that the compliance of patients with the routinised process, utilising all the interventions and investigations along the way improved the clinics' statistics which made it more successful and improved its reputation. The use of statistics to 'convince' participants of the efficacy of the clinic's methods and procedures were incredibly important in participants' stories about how clinics' operated.

Stephanie, Anna and Isobel made a decision to withdraw from the clinics because they had reached their limits both financially and in terms of the emotional costs of the interventions being offered. In medical terms they were all considered fertile - no explanation was given to any of them of why they were not able to conceive within the parameters of the clinics' protocols without more intervention than they were prepared to accept. They are left still wondering what could have happened if they had been treated as heterosexual women and given 12 months insemination before embarking on the protocol designed for heterosexual women who had been trying for 12 months before they reached the clinic. The provision of the same intervention protocol to lesbians and heterosexual women actually resulted in lesbians getting different treatment that was more costly. Abiding by the biomedical norms, being based as they are on heterosexual norms, results in their particular social circumstances being ignored.

All women using ACTs are faced with similar decisions about whether and how far they should continue with the interventions but lesbians, especially those for whom there is no apparent reason for not conceiving, have to come to these decisions much earlier in the fertility journey than their heterosexual counterparts. Here is Anna explaining how she felt after she had received the news, after unsuccessfully inseminating for 6 cycles, about her reduced chances of conceiving:

I came out of the session and I just felt completely devastated (...) [b]ecause I had completely changed my perception of someone who was just going along for access to sperm, to somebody who suddenly had a problem getting pregnant and that wasn't why I was going there. ... I think he [the doctor] was quite surprised by my reaction, (...) most people go there because they're having difficulty getting pregnant and so he probably saw this as just the next step. You come here, you're having donor insemination because you're having some kind of difficulty getting pregnant which I wasn't and the next step, oh just a laparoscopy, (...) but for me it was completely different. I was entering a completely different ball game.

The emotional impact for Anna of unexpectedly being addressed as a person with fertility problems illustrates the inappropriate response of fertility clinics to lesbians and the lack of understanding that exists both about their particular social situation and their reasons for requesting DI. Three of the four women stopped using DI having been told that there was no reason why they theoretically could not conceive. Morag was the only one who was given an explanation.

Women's sense of self

The literature suggests that infertility might impact on heterosexual women and lesbians differently. Bos et al. (2003) compared the parenting motives of lesbians and heterosexual couples and found that whilst they are mainly similar, happiness is more important to lesbian couples, whilst identity (the achievement of motherhood) and gender roles (fulfilling ideas about femininity) are more important to heterosexual women. That lesbians and heterosexual

women differ in this respect is interesting given the dominant understanding of motherhood as being driven by instinct. In the pilot study, lesbians were aware that their inability to conceive impacted on them differently to the ways it might impact on heterosexual women because of their contested identity as women and their contested doing of femininity. When asked whether they felt that their identify as women had been changed or challenged at all - as some heterosexual women say it is - their accounts make a distinction between the social construction of heterosexual femininity and lesbian identity. Here is Stephanie:

I think the whole area of being a lesbian and feeling like a woman is an interesting one. (pause) I think I feel less of a woman being a lesbian than I do (laughing) not having a baby. (...) I think lesbians, we are externally made to feel that we're not quite women in a way (...) I think maybe I did think that I would be a grown up woman when I had a baby in terms of my family. It's all kind of external pressure from family. Not friends. You know it's still the case that the majority of lesbians don't have children (...) There's an awful lot of pressure on women to have children in the heterosexual world. In a way I feel more sympathy for women who are heterosexual who can't have kids than, say, lesbians because in their world it's still much more (struggling to find the word) *pointed* (...) it was interesting the attitudes of other lesbians because there's still this feeling among some lesbians that 'why on earth would you want to have children' ... whereas in the heterosexual world you get more sympathy but maybe (...) I'm sure that comes with its own difficulties.

Here, Stephanie refers to two different gender/sexuality cultures that she negotiates in her everyday life. Heterosexual femininity expects the wish for and achievement of motherhood, hence her sense that heterosexual women who cannot conceive might feel more a sense of failure. Yet lesbian identities are also constructed in relation to heterosexual femininity as the norm and consequently Stephanie has felt that she is not a woman because she is not heterosexual but that she might achieve womanhood in the eyes of her family if she were to be a mother. In lesbian networks, Stephanie says there is less, if any, expectation that she should be a mother. For Stephanie, it is not her inability to conceive that has diminished her sense of being a woman but her lesbianism; and her lesbianism is seen – by heterosexuals and some lesbians as precluding her from motherhood or the pressures of being a mother.

Isobel also talked about societal disapproval of lesbian parenting but resisted the idea that her inability to become a biological mother undermined her womanhood:

I say I am a woman based on the fact that I'm not a man, because men can't do it [become pregnant]. So there you go I am a woman and a lesbian. No I don't feel any questioning of my femininity. ... I know because every single month my body tells me ... so I can't forget it and my Granny left me the biggest tits in the world and my womanness has always been in front of me (laughs) for want of a better word. No, no I've never felt funny about that.

Here, Isobel gives a strong sense of the way in which she embodies her womanhood which anchors her sense of being a woman. And she still retains a sense of herself as a fertile woman even though she has not been able to conceive. All of the women experienced an enormous sense of loss when they stopped trying to conceive but three of them decided that they could still be mothers (one already co-parents her partner's biological child) and were being assessed as adoptive parents.

Heterosexual women's sense of failure in terms of their inability to become a (biological) mother has both been explained by and held up as evidence of the essentialist construction of the maternal instinct: that all (heterosexual) women are genetically/biologically driven to be mothers; and that, conversely, all (heterosexual) women are only truly fulfilled when they fulfil their biological destiny and become mothers (e.g. Franklin, 1990). The heteronormativity of these understandings of infertility are revealed when we consider how lesbian mothers are responded to in the UK. Their position as selfish, unnatural individuals who present a threat to their children suggests that not all women are included in the dominant construction of motherhood and womanhood (e.g. Warnock, 2002). Similarly, single heterosexual women and disabled women's experiences reveal the ideal version of

heteronormativity constructed in the dominant discourse of motherhood: that it should be performed in able bodied, heterosexual relationships (McIntyre, 1976); and Franklin (1990) argues 'for socially acceptable women, biology should be destiny, whereas for socially unacceptable women, the demands of biology should be restricted by social sanction.'

Conclusion

The size and composition of the sample means that the findings from this study are limited in scope and generalisability. This was a pilot study that intended to map out some of the themes emerging from the experiences of lesbians who are unable to conceive using DI. Exploring the particular experiences of lesbians undergoing medicalised DI and being unable to conceive allows us to gain insights into the way the biomedical model of fertility management is embedded in a heteronormative context. The fact that the respondents' access to DI was through private medicine brought into sharp focus the ways in which the biomedical model embeds DI into a conveyor belt of fertility management, the goal of which is the elimination of risks and obstacles to achieving conception rather than being a stand alone service that may or may not result in pregnancy.

The medical provision of DI is based on a heteronormative narrative in which the heterosexual couple attempts to conceive over at least 12 months before they qualify for a referral to a fertility clinic. This has several consequences for lesbians who attend clinics requesting access to DI. First they are immediately problematised as patients with potential fertility problems when in fact there may be no evidence to support this. Second, because of their sexuality, they are problematised as potential parents and 'counselling' is used as a device to screen their suitability. Third, they are not given the same opportunity to test their fertility as heterosexual women since they are given the same DI protocol of five or six months of insemination before review and further invasive and costly interventions, surveillance and medication. Heterosexual women have already been testing their fertility for at least 12 months before they attend the clinic, lesbians usually have not been doing this. Finally, they are faced with emotional and financial costs at a much earlier stage in their fertility journey than heterosexual women and this can come as quite a shock for them especially if they are also being told that there is no reason why they should not conceive.

The impact on their identity as women unable to conceive is worthy of further investigation as from these women's accounts there seems to be an interconnectivity between notions of femininity, adult womanhood, sexuality and motherhood which can be understood as social and embodied experiences. Existing work provides evidence that lesbians' and heterosexual women's reasons for becoming mothers are broadly similar and Chabot and Ames (2004) accept this as a reflection of 'a basic human instinct'. Yet heterosexual women who conceived using IVF were significantly more likely, particularly with age, to cite social pressure to mother as a motive to parent than heterosexual women who have conceived ordinarily (Colpin et al., 1998). In addition there is also some evidence that in lesbian couples requesting access to DI, there is usually only one of the couple who wishes to be the biological mother (e.g. Chabot and Ames, 2004). The accounts given in this pilot study suggest that the maternal instinct does not originate in biology but in the social and cultural production of heterosexual femininity since lesbians describe the ways in which motherhood is not expected of them because of their lesbian sexuality. Other studies support a similar conclusion when they present findings of non-biological mothers understanding themselves as equal mothers with their partners (e.g. Bos et al., 2004) and that 'nurture was as strongly associated as biology with mother-child bonding' (Gartrell et al., 2000: 362). This suggests that there are particular ways in which heterosexual femininity is constructed that differ from the ways in which lesbian women's femininity is constructed the investigation of which would benefit discussion about motherhood and different ways to understand what is called the maternal instinct.

Acknowledgements

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BOOK REVIEWS



Ann Oakley

Fracture: Adventures of a Broken Body

The Policy Press 2007 £12.99 (pbk)

(ISBN 9781861349378) 192pp

Reviewed by Erica S. Alabaster, Cardiff University

Perusing MSo's list of books for review, I should have been drawn towards Vincent et al.'s (2006) publication. After all, ageing is one of my key academic interests. I was drawn instead to the above, not just because of the obvious appeal of a new Oakley but, also, due to a recent injury which left me (among other things) fractured, a stick user and analysing the meaning of a situation in which movement, sensation, visibility and function took on previously unrealised significance.

So it was with Oakley, where a fracture to her right arm during a pre-conference stay in the USA became the basis for a reflexive account of an extended field trip into the connected territories of embodiment, disability, identity, quality of life, medicalisation and the 'big pharma', non-Western views of health, personal litigation and gendered ageing. Beginning with her accident and surgical treatment, she encompasses the diverse and profound sequelae of an apparently innocent fall, prompting consideration of issues around the social scientist's use of self as instrument, bio-politics and how the body's vulnerability is capitalised on by external agencies. Importantly, given the place of patient stories in health care's current quality agenda, she gives insight into the impact of living with long-term nerve damage in the face of medical satisfaction with her function, the relentlessness of rehabilitation when seen in terms of bodily housekeeping, suffering without ennoblement, and the process of accepting a 'new normal'.

It would be easy for an unenlightened undergraduate to take a cursory look at *Fracture* and dismiss it as an anecdotal, self-centred stream of academic consciousness. However, the book's presentation would make it equally easy to turn this around. In using her unfolding experience skilfully as a hook and writing in her usual engaging manner, Oakley succeeds in unpicking the messiness of human 'being' from the perspectives of both subject and social scientist. As she observes, '(t)heory, like everything else, starts with the self' (p23).

There are some relatively minor niggles. The health worker who assumed prominence in her care when medicine 'could do no more' is called variably a physio and an occupational-therapist (Chapter 6). This has more than semantic implications in view of fundamental differences in disciplinary roles and foci. In addition, White Creek Lodge, where her accident takes place, becomes White Tee Lodge (Chapter 7).

Breadth being the narrative's strength means that depth and detailed discussion are naturally limited, and this perhaps risks generalisations being interpreted as hard and fast. For example, issue might be taken with the notion that the traditional hierarchy amongst health workers in relation to medicine persists universally in the face of developments in interdisciplinary and cross-boundary working, these being particularly prominent in non-acute, rehabilitative care. It can also be questioned whether the traditional, reductive view

which Western medical practitioners hold of the body remains disconnected from that held by 'holistic' complementary health workers or, rather, whether these approaches now represent opposing poles of a practice continuum.

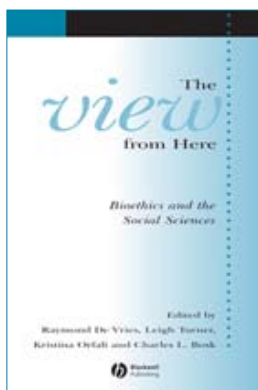
Oakley also adopts a perhaps deliberately provocative stance when discussing medical screening, arguing that its primary function is to produce patients rather than prevent disease. In so doing, it merely represents gendered targeting, creates anxiety amongst those awaiting results and feeds the treatment industry. She cites uncritically one study of screening in the Bristol area to demonstrate that 1000 women need to have cervical smear tests for 35 years to prevent one death (Raffle et al. 2003). This, however, only involves each individual undergoing 7 tests during that period and another author, albeit with vested interests, indicated that the researchers possibly underestimated prospective, premature deaths in an unscreened cohort (Sasieni 2003). Despite understanding that screening's pros, cons and consequences are far from straightforward, the personal approach of this book meant that I couldn't help but wonder how a woman who has thus avoided the misery of invasive cervical cancer would feel about her life being debated in these terms.

Reference is made to selective published work throughout and this is helpful to the reader in following Oakley's thinking. In view of the ascendance of evidence-based clinical practice, which she mentions, it was surprising to see sources from the mid-1980s used to support discussion of hand rehabilitation. Perhaps this might be because, as she explains, the book's draft-publication interval was prolonged by numbness which impaired her ability as a right-handed writer and persists some seven years post-trauma.

Fracture is a small volume which I thoroughly enjoyed. It explores so many issues, poses so many questions and stimulates a great deal of thought. Oakley's experiential exemplar provides something rare in combining this with simply being a good read, so can be recommended readily to students of health or social sciences and anyone interested in the relationship between the body, medicine, society and self.

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Raymond De Vries, Leigh Turner, Kristina Orfali and Charles L. Bosk (Editors)

The View from Here: Bioethics and the Social Sciences

Blackwell Publishing 2007 £19.99 (pbk)

(ISBN 978-1-4051-5269-3) 232pp

Reviewed by Martyn Pickersgill, University of Nottingham

In recent years, social scientific interest in biomedical ethics has increased, with a number of scholars treating ethics (in both individual and institutional practice) as an object of

sociological concern. The ensuing debate between sociologists and philosophers has not always been pretty, with both groups painting unflattering pictures of one another's analytic projects. In *The View from Here: Bioethics and the Social Sciences*, De Vries and co-editors have risen above this backbiting and produced a collection of papers that together create a space for more productive dialogue between the disciplines.

Part of the Sociology of Health and Illness Monograph Series, *The View from Here* assembles papers originally published in a special issue of *Sociology of Health and Illness* in 2006. All the chapters are based upon empirical research, ranging from critical sociological analyses of macro ethical discourse, to fine-grained investigations of the ways in which medical professionals negotiate and frame the every-day ethics of practice. The 12 chapters (excluding introduction) are delineated by the editors into four rather broad themes: the ethics of research, bioethics and the work of biomedicine, bioethics and social policy, and the bioethical imagination.

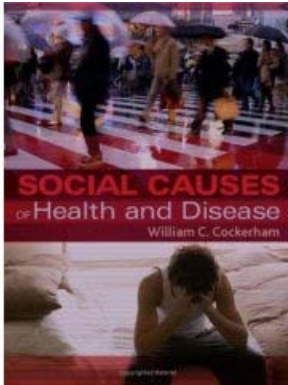
In the first section of the book, Jill A. Fisher reveals the tensions that emerge as professionals are asked to move between different roles. Far from being confined to 'special cases', Fisher powerfully shows how ethical negotiation is a day-to-day occurrence. Michelle M. Easter and colleagues demonstrate the ambiguity of the concept of 'care' in clinical settings; their study, undertaken by an inter-disciplinary team utilising both qualitative and quantitative methods, exemplifies the spirit of open-mindedness and collaboration that *The View from Here* seeks to foster. Finally, Renée R. Anspach and Nissim Mizrahi turn the analyst's lens back upon themselves to examine the ethical difficulties they have navigated in their own research, producing a chapter that is at once candid and instructive without sinking into narcissistic navel-gazing.

The second subdivision, 'Bioethics and the work of biomedicine', opens with an analysis by Steven Wainwright and fellow investigators on stem cell ethics. Here the authors invoke the science and technology studies (STS) notion of 'boundary-work' to illuminate how the 'ethics-talk' of scientists is used as a resource to define and defend their work. Jackie Leach Scully et al. also make use of STS in their chapter. Specifically, work which complicates the 'deficit' model in the public understanding of science literature is drawn upon in an analysis of 'lay' public debate on bioethics, and the role this should play in wider bioethical discourse. The section ends with Hedgecoe's acute analysis of medical rationing, or rather, 'what rationing tells us about the limits of the bioethical model of clinical decision-making.'

In the next section, issues of power and politics are emphasised. Klaus Hoeyer articulates well the nuances of the power of ethics, arguing that whilst ethics can be used self-interestedly by powerful groups, it can also be wielded as a tool with which to challenge those elites. Heleen Weyers highlights the ways in which bioethics can function as a form of social control, and consequently suggests the sociology of law is useful for sociologists of bioethics to draw on. Lastly, Orla McDonnell and Jill Allison elucidate the complex relationships between religious structures and ethical discourse in Ireland.

The final part of the book contains chapters by Mark Tausig and colleagues, Helen Busby and David Armstrong, and is perhaps the most explicitly normative section of the text. Tausig and co-authors bring bioethics and medical sociology together in a consideration of how to tackle infectious diseases, whilst Busby deftly excavates and problematises the assumptions of altruism embedded within practices of biobanking. Armstrong concludes the section and the book with a critical historical sociology of medical ethics and its relationship with public health.

The diversity of papers in the collection reflect the multiplicity of ways through which social scientists can engage with (bio)ethics and provide a valuable resource for those new to the area. The only caveats I have are, firstly that the book lacks any concluding thoughts from the editors, and secondly that the book may perhaps seem a little expensive to some, given many institutions will have free online access to the original versions of the papers. In spite of these relatively quibbling points, this is an excellent collection, and is highly recommended to medical sociologists in general, not just those with an explicit interest in ethics.



William C. Cockerham

Social causes of health and disease

Cambridge

Polity 2007 £55.00 (hbk)

(ISBN 978-0-756-3588-0) 232pp

Reviewed by Steven Martin, University of Warwick

Cockerham quickly sets out the aim of this book, which is to assess the evidence indicating that 'society may indeed make you sick or conversely, promote your health' (p.1). *Social causes of health and disease* is largely an American-centric book, focusing on, and using much evidence from the USA. Thankfully, Cockerham frequently contrasts the US with Britain in aspects of theoretical contributions to the field of the sociology of health, the distinctions of the US and British health care systems and individual case studies.

There are many good aspects of the book. Cockerham quickly targets the agency/structure debate in sociology, identifying that a consequence of the recent focus on agency has been 'direct effects of social structures being disregarded' (p.48). While he is critical of this he does appear to concede that this is obviously not all negative. Through agency sociologists can account for individual action in lifestyle choices, that is, individuals are taking more responsibility through the choices that they make. As a result the doctor/physician is no longer the automatic first choice for the individual when something goes wrong, and the ill individual is therefore able to address the way they lead their own lives.

In the early chapters of the book Cockerham gives a good account of the functionalist perspectives that have influenced the study of the sociology of health. However, I feel that he has too easily disregarded contributions made from other theoretical perspectives, in particular Marxism, which he describes as having a 'lingering influence' (p.32). The bulk of these rejections from what I can derive are based on the political situations that occurred in the Soviet Union, and this I find odd considering statements such as '(s)ocial class...is the strongest predictor of health, disease causation, and longevity' (p.75). This is a common theme but not endemic through the book. The chapter on the debates surrounding the influence of class are very good at describing, again from a largely functionalist perspective, whilst also giving a basic Marxist and Weberian understanding of the impact of class. However, much of the book is dismissive. This is particularly challenging as, in conceding that class is the 'strongest predictor' of ill health, Cockerham does not fully engage with and explore a more critical approach, such as that adopted by Weber or Marx.

Cockerham also gives an interesting account of how age, gender, race and ethnicity impact on the fundamental causes of health and disease. He concludes that age is a fundamental contributor; however the same cannot be said about race and ethnicity. In particular, they fail 'to be a cause because its effects are undercut by the power of class', that is race/ethnicity are socially constructed as compared to age which is biological. This is an interesting position to take. Unfortunately I do not feel Cockerham permits enough 'space' in the book to fully explore these arguments, resulting in the feeling that much more could be said on this issue.

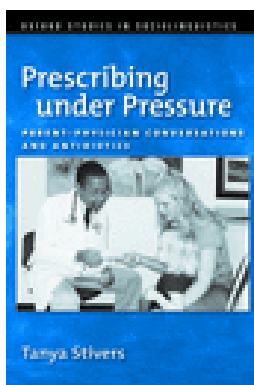
In his chapter on living conditions Cockerham offers the most comparative chapter looking at the USA and UK, with large sections devoted to the comparisons of neighbourhood disadvantage. The main theoretical drive of this chapter is that the 'health effects of living

conditions involve much more than the quality of housing, water...but also include the structural conditions of disadvantaged neighbourhoods in cities' (p166). This is an interesting theme and not one that is explored in comparable literatures. Similarly, another chapter I enjoyed was on social capital, where Cockerham addresses interesting and important problems about how social researchers measure social capital. This chapter, in particular, I feel could be very useful to undergraduate students, as it has large sections dedicated to well known works, such as Robert Putnam's *Bowling alone*, and the work of Pierre Bourdieu (as expected on this topic), and that through this chapter students could be made aware of wider reading on issues relating to social capital and health.

There are some problems within the book that I feel need to be addressed. The biggest issue is that Cockerham has constructed a textbook that can adequately describe the situation, context and the debates in the literature, but there is very little in the book about 'where we go from here'. That is, what can be changed to benefit those who suffer from illness. Whilst this is not one of the aims of the book, I feel that the overly critical approach to some sociological perspectives has diminished the potential for this type of debate in the text.

There are other subtle themes throughout the book that I would also like to draw attention to, and there are methodological problems that I believe stand out, in particular, the almost non-critical attitude towards hierarchal linear statistical models (p.22). Whilst these models are better than their predecessors, they should still be embraced with a degree of reflexivity. This leads on to problems of causation, as I feel Cockerham does not distinguish between causations and correlations, for example, in stating that 'class...is the most powerful determinant of health' (p.124). This critique is not to say that class structure does not have an impact on health, obviously it does, but to say it determines health I think is too strong a claim. Similarly, 'these findings [in relation to neighbourhoods] show that the structural conditions elicit illness responses' and 'social factors cause health and disease' (p.189). With this in mind I feel that, on occasion, the language and statements that Cockerham produces are too strong and too deterministic. I also find it curious the way Cockerham refers to variables, seemingly as something that *are* the world, 'variables are decisive in this [poor health] outcome' (p.75), rather than as traces *of* the world. There is also little qualitative methodology discussed in the book, although these are side issues, and not the focus of the book, so I will stop here.

What Cockerham has achieved is a fast paced book which will offer interesting perspectives into the debate on the sociological nature of health. It is a good book for students and academics to engage with for interesting debate, although I feel at times Cockerham is not critical enough with regard to social institutions. Having said that, the book was never intended to be a critical text and Cockerham never put himself forward as a critical sociologist. The theoretical base of this book is American and British functionalism and structuralism (although not strictly). This view point creates a good basis for contrast and comparison development.



Tanya Stivers

Prescribing under pressure: Parent-physician conversations and antibiotics.

Oxford University Press 2007 £ 32.99 (hbk)

(ISBN13 9780195311150) 232pp, 221 pp.

Reviewed by Paul ten Have

This excellent book exemplifies some recent trends in the study of doctor-patient interaction. In earlier years, analysts of various persuasions tended to focus on the actions of physicians. The analysis was often framed in terms of 'power' or 'control'. Later studies were more balanced, depicting consultations as truly *interactions* and at times negotiations. Some of the findings of early studies are still being maintained, or rather used, in recent work, especially the general idea of a phase-oriented organisation of the consultation. This is clear in the major collection of studies edited by Heritage & Maynard (2006) reviewed in [Volume 2\(1\) of this journal](#), but it is also true of the book presently under review.

The major point of the book is that a substantial proportion of parents with children suffering from upper respiratory ailments who seek medical help put pressure on physicians to prescribe antibiotics, even when this is medically inappropriate. Whether physicians give in to such pressures depends on the flow of the conversation, rather than on a medical algorithm. For society at large this can be dangerous because the prescription of antibiotics for viral illnesses is an important cause of increasing bacterial resistance to antibiotic treatment. The book details how the subtle negotiations between parents and physicians may contribute to this major socio-medical problem.

In an introductory chapter the author sketches the overall problem and gives background information on her conversation analytic approach, earlier studies and the data she uses. The next four chapters discuss episodes in which parents, mostly in *covert* ways, lobby for antibiotics. For example, by mention of antibiotic treatments in cases which were in some way similar to the present one during the phases of problem presentation, history-taking, diagnosis and treatment proposal. Chapter 6 deals with *overt* forms of negotiations, while 7 describes physician behaviour that influences parent negotiation practices. A concluding chapter offers a summary of the findings and some speculations about possible solutions.

The paediatric situation is a special one, as it involves caregivers consulting for health problems of dependent children. A basic preoccupation of adults consulting on their own behalf is to demonstrate the 'legitimacy' of their claim for medical attention and to have this claim validated by the physician. In the paediatric context, this is apparently somewhat different. Parents seem less hesitant in presenting their claim and in reporting on body symptoms, while they are more prone to offer a candidate diagnosis. The discussion of treatment options also appears to be different as both parties seem to feel a greater pressure to cure a child of an illness. A proposal to 'just' wait for the child to get better without treatment or to only use over-the-counter medicines may be resisted for various reasons. It may be felt to undercut the legitimacy of the visit and parents may be unhappy to have to wait until the child recovers by itself, for emotional and/or practical reasons. Furthermore, parents often use an illness model of upper respiratory ailments being caused by 'germs', which have to be 'killed' somehow. The obvious treatment, then, would be antibiotics.

The bulk of the book offers a detailed treatment of the ways in which parents exert pressure for antibiotics and how physicians react to it. This is done by a detailed analysis of selected fragments in which parents can be seen to pressure for antibiotics. These episodes are rendered using the Jeffersonian transcription system that is standard in conversation analysis, and the analysis relies on a wide range of insights produced in the CA tradition. Parents' pressures can take a multitude of forms which most often are rather indirect and subtle. The most frequent one is to offer a candidate diagnosis during the presentation of the reason for the visit (chapter 2), like: 'So I was thinking she had like uh sinus infection or something', or 'I thought I saw the little white dots (..) because sh- there's strep throat going around in her class'. This is remarkable since the default way of problem presentation is the reporting of symptoms. During history taking, in which the initiative is with the physician, parents may offer additional symptoms or mention alternative diagnoses in addition to a straight answer to the physician's question: 'But the cough is wearing worse' and 'but his brother an' his sister have ear infection' (chapter 3).

When the physician mentions a 'no problem' diagnosis, which therefore projects a light treatment, this may also be resisted, mostly in subtle ways because diagnosing is typically a

professional prerogative, for instance by producing a 'newsmark' like 'really?' which invites further elaboration or reconsideration, or by reporting a suspicion, like: 'So you don't think there's- it's in thee ear I just didn't want thee ear thing' (chapter 4).

In contrast to diagnosis, both physicians and parents act in ways that demonstrate their orientation to the treatment proposal as in need of acceptance by the parent, and therefore negotiable. Therefore, a clear, though covert and passive way to resist the proposal is to withhold acceptance. More active forms also occur: 'Are you gonna give her ana-antibiotics?', or references to other occasions on which this or another child or even the parent was 'on antibiotics'. This can lead to quite extensive negotiations, at times with back-tracking to earlier phases of the consultations, or even giving in by the physician (chapter 5).

Whether parents resist a non-antibiotic treatment recommendation at all, passively by withholding acceptance or actively, depends importantly on the formulation of that recommendation. 'Negative' (don't do X) and unspecific recommendations are more likely to be resisted than 'positive' (do Y) and specific ones. Parents apparently want to have something done to cure the illness and alleviate the symptoms, both to get rid of the problem and as a legitimisation of their decision to consult (chapter 7).

Space limitations prohibit more extensive summaries of the study's findings. However, what I think is most remarkable are the subtle and indirect ways in which parents may 'resist' the conclusions and recommendations of the physicians. In so doing, they show their respect for the professional authority of the physicians, even when for one or another reason they dislike their proposals. It is this real-world property of the consultations that necessitates the careful, detailed case-by-case analysis that Stivers presents in her book. The rewards of reading this well-written and well-organised book transcend the issues of antibiotics prescription and parental pressure. Stivers' artful application of a wide range of conversation analytic concepts and insights provides the reader with resources to deepen his or her understanding, not just of the problem of resistance, but also of the complexity of human interaction as such.



Julian Tudor Hart

The Political Economy of Health Care: A Clinical Perspective

The Policy Press 2006 £15.99 (pbk)

(ISBN 1861348088) 336pp

Reviewed by Deborah Humphrey, Oxford Brookes University

Julian Tudor Hart's *The Political Economy of Health Care* is a fascinating and interesting book about the shape of the National Health Service (NHS). In a wide-ranging and passionate account, Tudor Hart uses historical, bio-medical, psychological and sociological analysis to look at how the NHS in the UK has evolved into its current position as one of the great political institutions of our time, albeit one that functions as a production system. However, as Tudor Hart points out, this is an institution with flaws, and its future is open to debate.

The book covers a huge amount of material and is entirely ambitious in this aim. Tudor-Hart is a well published author and a doctor who practised in primary care in a South Wales mining community. It is clear that he is passionate about this work, and has the experience and ability to draw on a wide range of contemporary and historical sources. This integration of wide-ranging literature gives the reader a much greater understanding of the complexity of

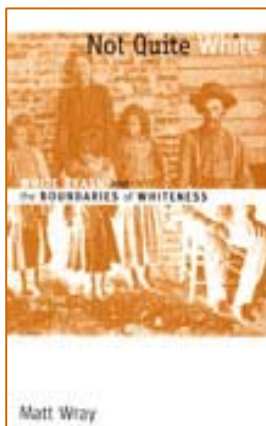
the health care system. The central premise of the book is how health care can be delivered equitably when it is shaped by market forces and seen as a commodity.

There are six broad chapters in total and each chapter is accompanied by a lengthy notes section, which is very helpful in adding to the depth of the book. Chapter one explores the NHS as a system and examines progress, the economy of the NHS and the many crises it has faced. Chapters two and three examine what and how the NHS creates. This involves a challenging exploration of the NHS as a production system for health gain. However, the measures of health gain are challenged and who actually gains from the production system is one of the complex questions posed by the author.

Chapters four and five examine ownership and solidarity within the NHS and how patients play a part in this. A history of the development of ownership of health aligned with political developments is a useful aspect of chapter four. The concluding chapter looks to the future, a future in which the NHS can be a model for a 'more generous and sustainable future.' However, this would mean changing some of the fundamental principles of the current system, in that society would need to advocate for a system that was constructed around meeting human needs. This book therefore presents a radical vision that challenges each of us to look to ourselves and question the effectiveness of the NHS as a system based on a market commodity.

The read is challenging and will no doubt provoke the reader to question their own value base about health care delivery in the twenty first century. In essence we need to ask if health care should be based on economics and productivity, similarly to many other product based delivery systems e.g. manufacturing or the food industry, or whether we look at the health service as a social gift economy. As mentioned earlier in this review Tudor Hart has many years' experience as a practising doctor as well as an author. His practice experience is used in the book and this helps to bring the rather difficult debates to life. Furthermore, it is this experience that provides a humane foundation to this book, and Tudor Hart writes with a searing honesty when reflecting upon some of his own practice.

This book will appeal to many different readers; the author states that the book is intended for students, health professionals, academics and NHS users. I think that students of many disciplines should be encouraged to read the book and it will certainly be useful for those researching social policy, health care and the social history of medicine. It may be that some of the concepts may be challenging for those not familiar with economics, although the economic narrative is balanced by, for example, political history and patient experience. Ultimately, however, I was immensely pleased to read a book on the politics of health care that kept humanity as a central premise. As Tudor Hart explains at the beginning of the book, this is a book for '*people who want to make health science available for the whole of society*'.



Matt Wray

Not Quite White: White Trash and the Boundaries of Whiteness

Duke University Press 2006 £12.99 (pbk)

(ISBN 0822338734) 213pp.

Reviewed by Jacqueline Watts, *Open University*

This socio-cultural text draws on historical perspectives to explore meanings of stigmatised 'whiteness' that contrast with more familiar readings of 'whiteness' associated with power and privilege that have come to dominate the development of US social and political structures. It addresses ideas of 'whiteness' connected to relative disadvantage that unsettle the ideology and practice of white supremacy that depends for its authority on the collective stigmatisation of non-white categories. The emergence of a displaced liminal category of landless poor whites, hovering between the black slave class and the white moral upstanding property owning inheritors of the American republic, is well conveyed, with the question of citizenship of implicit relevance throughout. Wray offers the reader a critique of the changing representations of poor whites from the early eighteenth to the mid twentieth centuries invoking the language of both race and class to present an engaging analysis of the stereotype of white impoverishment characterised by ignorance, violence, criminality, 'worklessness' and sexual immorality. This well-written and clear account will make a significant contribution to the interdisciplinary study of race and racism.

Taking boundary theory as its major theoretical orientation, the book traces different forms of social, cultural and racial separation: white Southern planter elites from landless white freeman, proslavery secessionists from antislavery abolitionists, and immigrants from blacks. Wray skilfully applies boundary theory to the disciplines of eugenics and the economics of the labour market to offer the reader insights into constructs of moral and sexual degeneracy that he argues frame contemporary discourses of 'underclass'. His arguments are persuasive and of particular interest to medical sociology scholars is his discussion of the ways in which poor physical, mental and 'social' health amongst marginalised whites in America have made them increasingly subject to intervention by health and social care professionals in ways similar to many disenfranchised black communities.

The book is organised chronologically in five chapters tracing the politics and social development of rural America that is the backdrop for the major part of the analysis. A picture emerges of a fragmented, feckless, work-shy white population living outside the control of law and operating as inbred subsistence communities. Chapter three in focusing on the role that eugenics has played in shaping and reinforcing this cultural stereotype, is particularly persuasive, and Wray successfully demonstrates how the theory of 'race betterment' has served as a form of scientised prejudice that feeds discourses of 'natural' hierarchies of race, class and gender. The implications for policy, that included involuntary sterilisation to prevent the proliferation of poor hereditary stock, are thoroughly addressed and incorporation of this 'surgical solution' as routine practice for feebleminded whites within institutional care is a key focus of the discussion. He correctly makes the point that the earlier goal of containment of poor white stock was gradually giving way to the aim of biological eradication. Coercive reproductive control increased rapidly in the early part of the twentieth century and by the 1920s had become widespread in poor rural white communities across the republic. This chapter would have benefited from greater attention to issues of gender; whilst both male and female sterilisation is discussed, the targeting of women as the primary agents of immorality and improper sexual conduct merits further exploration, particularly in relation to the potential threat posed to the institution of motherhood.

A greater part of chapter four, entitled 'The disease of Laziness', is devoted to a fascinating discussion of the intestinal disease of hookworm that achieved almost epidemic proportions amongst poor whites, particularly in the south, in the late nineteenth century. A major cause was the eating of 'dirt' and this became a focus for health reformers with a consequent conflation of degeneracy and disease and an ensuing moral panic about the potential for the gradual contamination of respectable white society by the disease-ridden white poor. Given Wray's argument of strict separation between these two white populations, clues about how this contamination might occur across these boundaries would have strengthened this section of the text.

The pioneering social work of the Rockefeller Sanitary Commission, in its efforts to eradicate hookworm, was instrumental in highlighting that this disease was as much a function of social inequality as it was a matter of individual responsibility. One of the principal effects of the hookworm campaign was the rendering of a healthier but more

exploitable white workforce, with their behaviours subject to higher levels of surveillance by the educated 'civilised' white business owning class. The economic imperative to improve the health of poor whites to enable them to join a rapidly expanding industrial and manufacturing workforce, particularly in the Southern states during the late 1880s, is a theme running through this chapter that sets the scene for contemporary understandings of the term 'white trash'.

Wray defines 'white' as a social category, not a racial category, but acknowledges that the term carries undeniable racial meanings. The case that white is also relative and socially constructed is made very convincingly, with the reader left in little doubt about the social and symbolic boundaries that give shape, meaning and power to different forms of whiteness. I would like to add one last style comment in respect of the extensive notes (34 pages) that support the main text. These act as additional theoretical and empirical discussion of the key themes and ideas and add significantly to the context of the narrative. As such they are not an 'optional extra' as sometimes is the case with explanatory notes but should be referred to at the appropriate points to enhance understanding of this excellent work.

Submitting a book review

MSo welcomes the submission of book reviews within the discipline of medical sociology. A list of books available for review will be published in each edition (see below), and books may be obtained from the editorial team. However, the editorial team will also be happy to consider reviews of books not listed, provided they are of relevance to the medical sociology community. There is no prescribed format for reviews, although reviewers should provide the full reference of the book, including the price, number of pages and the ISBN. Book reviews should be no longer than 1000 words. Completed reviews should be submitted as a Microsoft Word document via email to mso@liverpool.ac.uk. Book reviews will not be subject to peer review, and the decision to publish will be made by the editorial team. The editorial team also reserve the right to edit articles prior to publication.

The editorial team would also strongly encourage readers of MSo to specify particular areas of medical sociology that they would like to see book reviews in, or key medical sociology texts they would be interested to read a review on.

Books available for review

Sarah Payne (2006) *The Health of Men and Women*. Cambridge: Polity Press

Tim Blackman (2006) *Placing Health: Neighbourhood renewal, health improvement and complexity*. Bristol: The Policy Press

Margaret Voysey Paun (2006) *A Constant Burden: The Reconstitution of Family Life*. Aldershot: Ashgate Publishing Limited

Mark Davies (2007) *Medical Self-Regulation: Crisis and Change*. Aldershot: Ashgate Publishing Limited

Alison Hann (Ed.) (2007) *Health Policy and Politics*. Aldershot: Ashgate Publishing Limited

Ian Shaw, Hugh Middleton and Jeffery Cohen (2007) *Understanding Treatment Without Consent: An Analysis of the Work of the Mental Health Commission*. Aldershot: Ashgate Publishing Limited

Martin Davies (Ed.) (2008) *The Blackwell Companion to Social Work (3rd Edition)*. Oxford: Blackwell Publishing

Robert Dingwall (2008) *Essays on Professions*. Aldershot: Ashgate Publishing Limited

Bruce M Z Cohen (2008) *Mental Health User Narratives: New Perspectives on Illness and Recovery*. Basingstoke: Palgrave Macmillan

If you wish to review one of books listed above please contact the editorial team, mso@liverpool.ac.uk

CURRENT RESEARCH

This section allows researchers and postgraduates to share details of new and current research projects and recently awarded research grants of specific interest to medical sociologists. If you would like to include details of your own current research or recent award in the next edition of MSo please go to: <http://www.medicalsociologyonline.org>

Medical genetics in Colombia: Doctor-patient communication during genetic consultation and counselling – case study in five genetic clinics in Bogotá-Colombia



PhD researcher: Maria Clemencia Rodas-Perez

University of Warwick

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Maria Clemencia Rodas-Perez began her PhD in October 2005 on a part-time basis. The research project is being developed in collaboration with the Bogotá Health Service (Ministry of Health and Social Protection of Colombia), the Colombian Association of Medical Genetics, and the Health Sciences Research Institute, University of Warwick (UK).

Supervisors

Dr John Powell (University of Warwick)

Professor Margaret Thorogood (University of Warwick)

Aims and Objectives

The main aim of the project is to provide information which will assist the Bogotá Health Service to improve the service offered to patients and families in need of genetic counselling. The purpose of this work is to observe and analyse the interaction between physicians and patients during consultation in genetic clinics in Colombia. We expect to identify the difficulties that physicians experience in delivering genetic information, and also the expectations, perceptions and opinions of patients. Interviews with physicians will focus on communication skills and their opinions of the medical genetics training received in medical schools in Colombia. A survey of current provision for teaching of genetics in medical schools will also be conducted.

Methods

To date, twenty-five semi-structured interviews have been conducted with patients and/or relatives before and after a genetic consultation. In addition, non-participative observation was conducted during the genetic consultations.

Twenty semi-structured interviews have also been conducted with doctors involved in genetic consultation and counselling to establish their views about their professional performance, needs, and counselling skills.

A survey at the accredited medical schools in Colombia is being conducted to determine the structure of the current academic curriculum related to basic and clinical genetics.

Description of argument / Results to date

In Colombia and Latin America, genetics is a relatively new area of health research and practice. At the moment, there is no literature regarding the interaction between physicians and patients during consultation and counselling in Latin American countries in general or Colombia in particular. We expect that the findings of this project will provide information that will enlighten the future development of an effective and acceptable genetic counselling service in Colombia.

At present, the thematic analysis of the interview transcripts with patients and doctors is underway. Partial results of this analysis show that there is a discrepancy between physician perception and patient comprehension. Initial findings from the observation during consultation and counselling reveal that effective communication is inhibited by patient, family, practitioner and environmental factors.

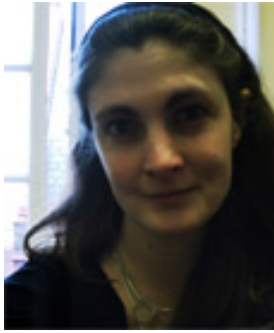
The survey of current medical education in genetics in Colombian universities and the data analysis are to be completed this summer.

Contact details

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The peer appraisal of professional behaviours by medical students



PhD researcher: Jayne Garner

University of Liverpool

jayneg@liv.ac.uk

Jayne Garner began her PhD in March 2006 on a part-time basis, whilst working full-time as a Research Fellow, and is currently conducting the pilot study. The project completion date is expected to be March 2010. The research is funded and will be awarded by the University of Liverpool, School of Medical Education Centre of Excellence in Teaching and Learning (CETL) (HEFCE).

Supervisors:

Dr Helen O'Sullivan (CETL, University of Liverpool)

Dr Reverend David Taylor (School of Medical Education, University of Liverpool)

Aims and Objectives

Over the past decade there has been a growing amount of interest in the professional behaviours of medical students and doctors in both medical education and the general public domain. Recently the General Medical Council and Medical Schools Council published 'Medical Students: professional behaviour and fitness to practice' (September 2007) which highlights the importance of good professional behaviours expected of medical students. The issue of how to effectively assess and evaluate professional behaviours has been generating research, instruments and criteria internationally. However, with differing teaching and learning methods employed across medical schools and issues regarding validity and transferability, assessment of professional behaviours can be subjective. This is the first study in the UK to look at developing tools for medical students to peer appraise their own professional behaviours.

The research is currently being developed within the context of medical education. However as it is emerging that issues including accountability, whistle blowing, identity and behaviour are key in this research, thus medical sociology can add an exciting new element and inform the project.

Methods/ Approach

A voluntary online survey was developed by the Northern Personal Professional Development Group (PPD) and University of Liverpool CETL to baseline students' attitudes to peer appraising professionalism as a pilot study. They were asked if they had experience of receiving feedback on their work previously, how comfortable they would feel appraising their friends and what kind of behaviours they would feel comfortable commenting on. This

was emailed to students at Liverpool, Leeds, Lancaster, Hull York, Manchester and Sheffield medical schools. The survey uses a 5 point Likert scale to rate a series of statements related to peer assessing professionalism. One open-ended comment question was given at the end of the survey.

Description of argument / Results to date

Of the 4693 students emailed the online survey link, 500 responded (giving a 10.65% return). The majority of respondents (76%) agreed that they would feel comfortable receiving feedback about their professional behaviours from peers, more respondents agreed they would feel guilty about reporting negative professional behaviours of a friend (66%) than a peer (48%) and a quarter of respondents (26%) had not received peer feedback previously in school, college or employment. 75 respondents made a comment and these were mostly regarding bias and friendships, training and feedback methods.

Conclusions/ recommendations

Respondents are keener on receiving peer feedback than on giving it. Overall respondents seem to agree that peer assessment would be a good way to measure and reflect upon their professional behaviours. However, the following issues need consideration to ensure that respondents would be comfortable assessing their peers' professionalism:

- Peer assessment should be used formatively
- Peer assessment should be anonymous, conducted in groups of 6 or more students
- Training is required to enable students to differentiate between personal opinion and professional assessment
- Support and guidance from tutors will be required for the successful use of peer assessment

While the return rate of this survey was considered good, the number of respondents is not significant considering the full population of the medical schools. Therefore the generalisability of the results is limited. However, as a pilot study the findings are useful for shaping further research.

The next stage of this pilot study will be focus groups with students who have been peer assessing professionalism at different medical schools (April 2008) and a follow up anonymous online survey (May 2008) to see if attitudes to peer assessing professionalism have changed over the year. A wider study based upon the findings of the pilot research will begin in medical schools nationally next academic year (2008/9)

Conference presentations

University of Liverpool CETL Symposium, Foresight Centre, Liverpool. 6th February 2008.
Peer Assessment of Professionalism – Oral presentation and workshop session

Contact details

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CONGRATULATIONS

Narelle Warren, Monash University

Narelle.Warren@med.monash.edu.au



Congratulations to Narelle Warren who was awarded her PhD in December 2007 for her thesis entitled 'Markers of midlife: interrogating health, illness and ageing in rural Australia.' Narelle's PhD was conducted on a part-time basis and awarded by the University of Melbourne.

ABSTRACT

The aim of this thesis is to explore rural women's midlife experiences and interrogate the roles of health, social and community factors in these. In the cultural imagination, midlife signifies the onset of ageing and is thus framed in a discourse of decline. For women, it is often considered in terms of menopause and the end of fecundity and fertility. I propose that women's experience of midlife is much broader than this; instead, it is characterised by transformation in multiple life domains and health status is important. I suggest that the continuity theory of ageing is useful when conceptualising the life course. The concept of habitus enables exploration of how identity is re/constructed during the ageing process in response to changing bodily circumstances, such as health problems. Fieldwork was conducted in Waterside (pseudonym), an isolated Australian community, between 2001 and 2003. In-depth interviews were conducted with twenty-four women who self-defined as midlife; three participated in follow-up interviews. I also conducted a focus group discussion with midlife women, in-depth interviews with the local doctors and participated in community life. These provided important contextual data. Midlife encompassed several decades: participants ranged in age from 41 to 62 years. My sample was ethnically homogenous, consisting of women from Anglo-Australian or Western European backgrounds. Reproductive histories, family structures, social networks and the health status of participants were varied.

Women described how health status shaped their midlife experiences and mediated their identity construction. Personal narrative analysis demonstrated the polysemous nature of the term 'menopause,' which women often used to refer to midlife. Participants used four narrative strategies to describe their midlife experiences. These were not exclusive: some women drew upon two strategies in telling their stories; others described temporal shifts in the strategies used as their health status changed. Women who experienced few health problems tended to use Maintaining narratives, in which they described their efforts to preserve their current health status. Contemplating narratives were told by women who personally had good health yet whose experience was shaped by the illness of close others (e.g. partners or parents). Personal growth was central to their stories. Women who experienced long-term health problems employed Negotiating narratives to describe their on-going project of bodily management. The final narrative strategy, Navigating, was used by women who experienced adverse health events during midlife; these were often related to their menopausal transition. Midlife for them was about reconstructing their identity to incorporate their changed health status. The role of place was important in women's self-health-management practices and

health-seeking behaviours.

Interrogating health and illness in the ageing process has important implications for midlife health promotion. Although participants often referred to midlife as menopause, health was conceptualised more broadly than dominant models of ageing suggest. My findings suggest that health services, and the cultural scripts informing them, need to incorporate the diverse needs, goals and aspirations of midlife women in order to support women when they ‘...enter that other age.’

Related publications

Markovic, M., Manderson, L. and Warren, N. (In press, accepted 25/7/2007, published online 30/11/07). Pragmatic narratives of hysterectomy among Australian women. *Sex Roles*

Manderson, L., Warren, N. and Markovic, M. (In press, accepted 17/9/2007).

Circuit-breaking: Pathways of treatment-seeking for women with endometriosis in Australia. *Qualitative Health Research*

Markovic, M., Manderson, L. and Warren, N. (in press, accepted 11/3/06) Endurance and contest: women’s narratives of endometriosis. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*

Warren, N., Markovic, M. and Manderson, L. (2006) Typologies of rural lay-health advocacy among rural women in Australia. *Women & Health*, 43(4): 27-47

Related conference papers

Warren, N. (January 2007) Sorting through the myriad of symptoms: women seeking health-care during menopause. [poster] *Approaches to Narrative Research Symposium*, Victoria University and Monash University, Melbourne, Australia.

Markovic, M., Manderson, L. and Warren, N. (November 2005) ‘My experience is fairly typical’: disruptive gynaecological symptoms and women’s search for diagnosis. *3rd Asia Pacific Conference on Reproductive & Sexual Health*. Kuala Lumpur, Malaysia

Warren, N., Manderson, L. and Markovic, M. (November 2005) Living in a chaotic body: phenomenology and polycystic ovarian syndrome. [poster] *3rd Asia Pacific Conference on Reproductive & Sexual Health*. Kuala Lumpur, Malaysia

Warren, N. (November 2005) Sorting through the myriad of symptoms: midlife women seeking health-care during menopause. [poster] *3rd Asia Pacific Conference on Reproductive & Sexual Health*. Kuala Lumpur, Malaysia

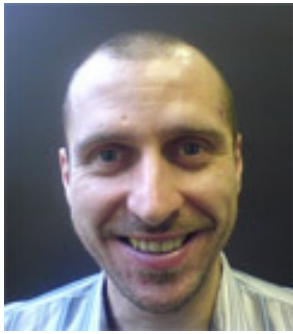
Current and future work

Narelle is a Research Fellow in the School of Psychology, Psychiatry and Psychological Medicine at Monash University (Australia), where she has been located for the past few years, conducting research into the lived experience of chronic disease, caregiving and associated disablement, with a particular focus on lower-limb amputation and stroke (both associated with cardiovascular disease and diabetes). She has several publications arising from her doctoral research under preparation and is intending to submit several of these for publication in the next two months, before taking some maternity leave.

During the next twelve months or so, she is hoping to obtain some post-doctoral funding, submit two book proposals (nearly ready!) - a single authored monograph based on her PhD and a co-authored book with Professor Lenore Manderson, and spend four months (Oct 2008-Feb 2009) in Malaysia conducting research into medical tourism and technological medicine.

John Hughes, University of Liverpool

John.Hughes@liverpool.ac.uk



Congratulations to John Hughes who was awarded his PhD in January 2008 for his thesis entitled 'Acupuncture For Rheumatoid Arthritis And The Impact Of Acupuncturist Affiliation To A Traditional Or Western Theoretical Framework: Exploring The Perceptions Of Acupuncturists And Patients'. John's PhD was funded and awarded by Manchester Metropolitan University.

Supervisors

Dr Juliet Goldbart (Manchester Metropolitan University)

Professor Eileen Fairhurst (Manchester Metropolitan University)

Dr Katherine Knowles (Manchester Metropolitan University)

Aims and objectives

The study outlines acupuncturists' perceptions of treating patients with Rheumatoid Arthritis (RA), and RA patients' experiences of receiving treatment with acupuncture, exploring the impact of practitioner affiliation to a traditional or western theoretical framework.

Methods/approach

This is a qualitative study utilising Grounded Theory. Nineteen acupuncturists were chosen via theoretical sampling, thirteen patients self-selected. Data collection, organisation and analysis were performed concurrently. In-depth semi-structured interviews were tape-recorded and transcribed. Field notes were taken. Open, axial and selective coding were performed.

Description of argument/results to date

Inter-affiliatory differences were identified between traditional and western acupuncturists in the treatments administered and scope and emphasis of intended therapeutic effects. Limited divergence was found between acupuncturists' perceptions of treatment outcomes. Factors perceived as impacting on treatment outcomes were identified. Patients perceived acupuncture as alleviating a number of RA symptoms, and eliciting non-RA effects. These RA and non-RA effects allowed patients to *feel normal again* and *regain their lives*. Acupuncturist affiliation impacts on both patient experience and perception of effects.

Conclusions/recommendations

Acupuncture elicits a range of effects which contribute to improvements in RA patients' quality of life. Varied levels of congruence were identified between the intended therapeutic effects of acupuncture and patients' perceptions of effects. Clinical trials of acupuncture in RA appear to have failed to administer a treatment which reflects that administered in clinical practice. The outcome measures employed in clinical trials of acupuncture in RA, as well as established outcome indices for RA, lack the necessary breadth in perspective to accurately assess acupuncture's efficacy. Acupuncturist affiliation has demonstrable implications for the practice and research of acupuncture.

Related publications

Hughes, J.G., Goldbart, J., Fairhurst, E. and Knowles, K. (2007) Exploring acupuncturists' perceptions of treating patients with rheumatoid arthritis. *Complementary Therapies in Medicine*, 15(2): 101-108

Related written work in progress

Hughes, J.G. 'When I first started going I was going in on my knees, but I came out and I was skipping': Patients with RA perceptions of their treatment with acupuncture. Paper submitted.

Hughes, J.G. 'I cry many times, but nobody sees that': Exploring the impact of rheumatoid arthritis on patient's lives. Paper submitted.

Related conference presentations

Hughes, J.G., Goldbart, J., Fairhurst, E. and Knowles, K. (2002) The intended therapeutic effect of acupuncture for rheumatoid arthritis (RA): findings from preliminary interviews. *9th Annual Symposium on Complementary Health Care*, University of Exeter, 4-6th December.

Hughes, J.G., Goldbart, J., Fairhurst, E. and Knowles, K. (2003) The intended therapeutic effect of the treatment acupuncturists administer for rheumatoid arthritis. *Developing Research Strategies*, University of Southampton, 16th May.

Hughes, J.G., Goldbart, J., Fairhurst, E. and Knowles, K. (2004) Rheumatoid arthritis patients' perceptions of receiving treatment with acupuncture: findings from preliminary interviews. *Developing Research Strategies*, University of Southampton, 14th May.

Hughes, J.G., Goldbart, J., Fairhurst, E. and Knowles, K. (2004) Rheumatoid arthritis patients' perceptions of receiving treatment with acupuncture: findings from preliminary interviews. *Diversity and Debate in Alternative and Complementary Medicine: An academic & experiential conference for researchers & practitioners*, Nottingham University, 1st-2nd July.

Forthcoming related conference presentations

Hughes, J.G. (2008) Acupuncture For Rheumatoid Arthritis And The Impact Of Acupuncturist Affiliation To A Traditional Or Western Theoretical Framework: Exploring The Perceptions Of Acupuncturists And Patients. *3rd International Congress on Complementary Medicine Research*, Sydney, Australia, 29-31 March.

Current and future work

John is a Research Fellow in the School of Population, Community & Behavioural Sciences

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The application of qualitative methodologies to improve knowledge of practitioner and patient perceptions of Complementary and Alternative Medicine (CAM); methodological issues surrounding the evaluation of CAM efficacy; the placebo phenomenon and non-specific treatment variables; and the impact of non-specific treatment variables on objective and subjective treatment outcomes for patients.