Beyond (financial) accessibility: inequalities within the medicalisation of infertility

Ann V. Bell

Department of Sociology, University of Michigan, Ann Arbor, USA

Abstract There is a significant class disparity within the provision of medical treatments for infertility in the United States. Common explanations attribute this inequality to financial inaccessibility due to sparse insurance coverage and exorbitant costs. However, little is known as to why disparities still exist without the presence of such constraints, such as in states with comprehensive insurance coverage of infertility treatments. Drawing on in-depth interviews with women of low socioeconomic status (SES), this paper aims to explore the structural and political barriers to receiving medical care for infertility within the United States context. The paper argues that much of the invisible, unidentified treatment disparities of infertility stem from the social control mechanism of medicalisation. Medicalisation perpetuates the stratified system of reproduction through its *structural* inaccessibility and the institutionalised classism apparent within medicine's reproductive health practices and policies. The women in this study, however, actively and creatively identified ways to overcome the reproductive limits with which they were faced. In doing so, their solutions served both to accept *and* reject dominant norms of motherhood and medicine.

Keywords: infertility, medicalisation, social class, inequalities

> Medicine as a profession and reproductive medicine in particular, have played central roles in the mediation, (re)production, and regulation of sexuality and particular definitions of 'legitimate' family. These, in turn have had serious implications for the shaping of a range of social inequalities and specifically for the importance of medicine in that process (Steinberg 1997: 35).

The medicalisation of infertility, or its treatment as a pathological condition rather than a natural or social one, dramatically increased and came to the fore with the development of assisted reproductive technologies (ARTs) in the 1970s. Between 1968 and 1984, US medical visits for infertility tripled from 600,000 to 1.6 million (Greil 1991). More recently, between 1995 and 2002, the use of ARTs doubled from nearly 60,000 cycles in 1995 to approximately 116,000 cycles only seven years later (Jain 2006). Not all individuals, however, are receiving such treatments. In 2002, according to the US National Survey of Family Growth, only 10 per cent of women with less than a high school education received any infertility service[1] compared to nearly 18 per cent of women with at least a bachelor's degree. These provisions do not align with the prevalence of infertility among these groups. Indeed, more women with less than a

high school degree report impaired fecundity[2] compared to their college-educated counterparts, 14 per cent vs. 12.5 per cent respectively (Chandra *et al.* 2005).

Why are those more affected by infertility less likely to receive medical treatment for the issue? The most common explanation for such disparity blames the inaccessibility of infertility treatment due to its exorbitant cost and sparse insurance coverage. On average, one cycle of *in vitro* fertilisation (IVF) costs \$12,400 (Wright *et al.* 2008), yet only four states mandate comprehensive insurance coverage for such a procedure (Jain *et al.* 2002). In other words, only those who can afford infertility treatment will receive it. As Conrad and Leiter (2004) have explained, this context places infertility in a private medicalised market in which consumers drive its medicalisation alongside institutional mechanisms.

Researchers have shown, however, that even when accessibility is standardised, or equal across strata due to mandated insurance coverage, disparities still exist. For instance, Jain and Hornstein (2005) found that in Massachusetts, a state with mandated comprehensive insurance coverage, the use of services had indeed increased, but it had done so among the same demographic that receives treatment in other states without insurance coverage—the white, wealthy, and educated—thus, the disparities remained. According to the authors, inequality was most significant along educational divides; of the patients receiving IVF services, none had less than a high school diploma while 85 per cent had at least a college degree. While subsequent researchers have echoed these findings (Bitler and Schmidt 2006, Schmidt 2007), few, if any, studies[3] have examined *why* the inequalities persist or what mechanisms drive inequalities beyond financial accessibility issues.

I aim to overcome this limitation by examining the experiences of infertility among women of low socioeconomic status (SES). Doing so not only reveals a more complete understanding of disparities in infertility treatment specifically, but it also provides an ideal arena for examining the complexities of the medicalisation process in general. Medicalisation is powerful, deemed a 'hegemonic authority' over individuals' (or society's) troubles and problems (Turner 1997: xiv). I argue that much of the invisible, unidentified treatment disparities of infertility stem from this social control mechanism of medicalisation (Conrad 1992). Medicine is built upon, and reifying of, dominant ideologies; for example, physicians are reflexive of cultural values when they define behaviours or conditions as pathological, such as hyperactivity or childlessness in women (Ballard and Elston 2005). In the case of infertility, medicine serves as a gatekeeper determining who should and should not mother according to hegemonic norms of motherhood, particularly along socioeconomic divides. Stereotypical images of 'good' mothers encompass heterosexual, middle-class, white characteristics, while 'bad' mothers are the 'other', including poor and working-class women (Sandelowski and de Lacey 2002). The process of medicalisation naturalises these representations through its class-based provision of infertility treatment, veiling their social construction and inequality. Hence, previous research has relied upon *medicalised* explanations for inequalities in infertility treatment, such as unequal financial access to healthcare, while overlooking other intrinsic disparities present in the medicalisation process itself.

In addition to the naturalising effects of medicalisation, prior literature misses such nuances within disparities in infertility treatment for two main reasons. First, previous research on infertility focuses on the experiences of those receiving medical treatment, typically women of high SES (Heitman 1995). Focusing on women already receiving medical care does little to enhance our understanding of why some women are absent from such care. Moreover, this literature maintains a medicalised understanding of the infertility experience and is situated in a dominant, normative context, unable to recognise potential inherent disparities. Secondly, most research on the topic examines the process of medicalisation at

the institutional level, including broad variation between states or among women as a whole (Dillaway and Brubaker 2006). These macro-analyses overlook more nuanced inequalities within medicalisation that may exist at the meso- and micro-levels. For example, research has examined how medicalisation has an impact on women's experiences of infertility; however, there is little investigation on how medicalisation plays out in women's everyday lives, especially based upon women's own views of medicalised infertility. Attaining this micro-level understanding would allow exploration of how the medicalisation of infertility varies between social locations, exposing potential disparities. As Dillaway and Brubaker note, 'No research…has been done on whether women from different class locations make different choices about [reproductive] medical interventions, or perceive the procedures themselves or the information about procedures differently' (2006: 20). Because the drivers of medicalisation include individuals, it is important to understand the micro-level processes of medicalisation, optimally from individuals' experiences (Plechner 2000).

In this paper, I examine the process of medicalisation and how it contributes to the development of disparities through its perpetuation of dominant ideologies. In other words, I explore the *social* exclusion of women of low SES from the hegemonic ideals of motherhood and medicine (Bhalla and Lapeyre 1997). Examining the medicalisation of infertility reveals how poor and working-class women are not only marginalised along economic dimensions, but social and political dimensions as well. As Bhalla and Lapeyre describe in their conceptualisation of social exclusion, the political dimension of such exclusion involves an institution that 'is not a neutral agency but a vehicle of the dominant classes in a society' (1997: 420). The process of medicalisation is precisely the vehicle used by medicine in order to preserve and naturalise the stratified system of reproduction on which it is based.

In constructing this argument, I initially review the literature on the medicalisation of infertility, particularly how the process is informed by dominant narratives of class and motherhood. Next, through economically disadvantaged women's narratives, I examine how medicalisation perpetuates the stratified system of reproduction through its *structural* inaccessibility and the institutionalised classism apparent within medicine's reproductive health practices and policies. Finally, I reveal how women actively negotiate experiences of infertility within such exclusive contexts. Ultimately, I explore how dominant discourses of medicine and motherhood intersect to frame the social context in which women of low SES are excluded from infertility discourses, representations, and resolutions. In other words, this paper examines the intersectionality of the two institutions that control reproduction—motherhood and medicine—and the maintenance of social norms between them.

The medicalisation of infertility

Motherhood has been venerated as society's 'maintainer of morality' given its role in reproducing appropriate citizens that adhere to dominant norms (Sydie 1994). In order to succeed in such a capacity, however, ideologies of motherhood define who should mother as well as how one should mother. For example, the current ideology of 'intensive mothering' idealises women who can afford to stay home with their children, be self-sacrificing, and child-centred. This is based upon a heterosexual, white, middle-class context thereby excluding all 'other' mothers from achieving such standards (Hays 1996). Dominant narratives of motherhood thus empower some groups to reproduce while trying to diminish that action among others.

This stratified system of reproduction is apparent in discourses on infertility. Despite nearly two million women experiencing infertility in the US (Chandra *et al.* 2005),

mainstream understanding of the affliction is primarily based upon the stereotype that infertility occurs among the white and the wealthy (Ceballo 1999, Inhorn and Fakih 2005). This representation is contrasted with images such as the welfare queen, crack babies, and teen mothers depicting poor women of colour as excessively fertile and unfit to mother, thereby justifying and naturalising their exclusion from infertility narratives (and its treatment) (Sandelowski and de Lacey 2002).

The false dichotomy of the very fertile and the not fertile enough, and the ideologies about who should and should not mother, have become embedded in various social institutions. Social control around reproduction is especially salient within the medical establishment. Since the medicalisation of childbirth, and more recently, the development of medical treatments for infertility, the institution of medicine has participated in the naturalisation of the structural inequities within motherhood.

The medicalisation of infertility assists in maintaining the norms of family and motherhood. It has redefined and further entrenched the role of motherhood within society by shifting the normative expectations surrounding fertility. Prior to the development of ARTs, involuntary childlessness was constructed as a disappointing, inevitable act of nature, whereas it is now expected that infertility is something to be overcome (Donchin 1996). Sandelowski (1993) reflects that 'infertility has only recently come to mean the potential to have a child of one's own, rather than merely the incapacity to have a child on one's own' (1993: 45). Medicalisation has reinvented infertility as an indeterminate, liminal state of 'not yet pregnant', making the onus of motherhood all the more prominent (Greil 1991).

This new sense of hopefulness constructed by the medicalisation of infertility also makes biological childlessness all the more deviant. Women many times feel that they are being forced to give or receive information in dialogue with others about their childless state (Sandelowski and Jones 1986). Infertility must be verbally medicalised in order for childlessness to achieve legitimacy (Becker and Nachtigall 1992). In this sense, infertility adapts characteristics of Parsons' 'sick role' in which sickness is interpreted as the legitimisation of social deviance (Turner 1997).

Childlessness, however, may not be deviant for everyone in society. In addition to reinforcing norms of family, similar to ideologies of motherhood, medicine also controls to whom those norms apply. Not only does it do so explicitly through the private medicalised market in which only a few individuals can afford treatment, medicalisation also implicitly reinforces stratified reproduction through its inherent characteristics. For instance, the medicalisation of infertility individualises the experience. It transforms a social process into an individual trait whereby infertility becomes a label adhered to a patient (Greil 1997). This sense of individualism promotes a 'culture of poverty' mentality in which individual blame is prescribed. This framework places the root of infertility in women's past actions or choices that do not align with social norms. However, there is a class bias to this blame. Women of low SES are admonished for their 'promiscuity' and subsequent sexually transmitted infections (STIs), while middle- and upper-class women are empathised for their late marriages and delayed childbearing. This characterisation legitimises the class-based provision of reproductive services which in turn naturalises the inequality between poor and working-class women and the attainment of motherhood via medical means.

In addition to individualising social processes, another consequence of medicalisation is focusing on treatment rather than prevention. Dominant reproductive narratives encourage immediate, individual solutions to social problems (Marsh and Ronner 1996). Doing so unconsciously encourages ignorance around the public health aspects of infertility (Michie and Cahn 1997). Over 20 per cent of infertility is preventable, as it is caused by sexually transmitted infections' damage to reproductive organs, previous surgical sterilisation, pelvic

inflammatory disease (PID), delayed childbearing, and occupational and environmental hazards (Henifin 1993). Many of these preventable causes are more common among women of low SES, yet they are ignored due to the focus on treatment (Green *et al.* 2001). Furthermore, these preventable causes legitimate and propagate the notion of individual blame and justify the medicalisation of infertility as a form of social control determining who is worthy and not worthy of treatment.

Not only does medicalisation participate in the construction of infertility, but it also results in the decontextualisation of that experience. Individualising the experience of infertility, as well as focusing on its treatment rather than its etiology, ignores the fact that infertility is a social issue, situated in various contexts and shaped by social forces. Additionally, medicalisation's presupposed objectivity disguises its own contextual basis. It is a process informed by the norms in which it is situated (Fisher 1986). Failing to examine the construction of medicalisation itself overlooks its framing and thus its role as a mediator of hegemonic ideals. Examining the context in which medicalisation is framed alongside the context of the infertility experience will reveal much about how medicalisation participates in the maintenance and reification of the social norms of class and motherhood, in turn exposing implicit disparities of medicalised infertility.

In sum, the medicalisation of infertility is the intersection of the ideologies of medicine and motherhood. Motherhood has deemed certain groups worthy of its status and medicine perpetuates that construction via the process of medicalisation. The medicalisation of infertility naturalises the ideology of motherhood and its inherent stratification by providing the option of reproduction to some groups and not to others.

The study

Like all individuals, practices, and policies situated in dominant contexts, the context of medicalisation is constructed as one of neutrality, not needing analysis or mention because it is assumed. Therefore, in order to examine its context as well as how that context informs its construction, it is necessary to move beyond analysing medicalisation within its own dominant setting and instead, study it from an external, marginal perspective. Prior research on infertility focuses on convenient, treatment-based samples, typically composed of women of high SES (Heitman 1995). While this provides insight into one type of infertility experience, it maintains ignorance to inequality beyond the medicalised market because it focuses on the dominant group—that which is neutral and to which all else is compared. In order to analyse mechanisms enmeshed in dominant norms, such as medicalisation, it is necessary to do so from the perspective of those excluded from those norms.

Because women of low SES are marginalised within the medicalisation of infertility, they are an ideal population for examining the process. Not only are they unable to afford infertility treatments, but they are stereotyped as highly fertile and unfit to mother, hedging any attempt at attaining a solution to their infertility. Davidson and colleagues (2006) found that individuals of low SES are aware that their socioeconomic position contributes to the health disparities with which they are faced. They are outsiders-within and have a 'consciousness of their victimisation' which allows women of low SES to reflect upon the dominant context of which they are not a part as well as develop ways to grapple with and resist the hegemonic forces placed upon them (Riessman 2000: 122). This recognition is rarely shared by individuals of high SES because it is an invisible privilege (*e.g.* McIntosh 2001).

Given this premise, I conducted in-depth interviews with 27 women of low SES. Eligibility criteria included ever having been involuntarily childless for at least 12 months, having less

than a college degree, and being between the ages of 18 and 44 years. Because of the difficulty of recruiting women along all dimensions of SES, inclusion was restricted to educational level. However, in the culminating sample all women were considered low SES along at least one dimension of the status—education, occupation, and income. Additionally, all subjects were considered poor or working-class according to US Census Bureau, Department of Labor income and occupation statistics (2000). Nearly half of the participants were unemployed (48%), 17 (63%) completed some college education, while the remaining third never went beyond high school. Seventy per cent of the women resided in households with annual incomes of $35,000 or less.

Beyond socioeconomic characteristics, the study sample was diverse. Nearly half (48%) of the participants reported a non-white race (10 Black, 2 Latina, and 1 Asian). Health insurance status varied between women; most participants received private, employer-based health insurance (59%), yet 11 per cent were uninsured and 30 per cent were Medicaid or Medicare recipients. Over one-third (37%) of participants had never married; 15 per cent were divorced; and 48 per cent were married, including one participant in a committed partnership. The average age of study subjects was 33 years [Range: 20-44].

I recruited participants within Southeastern Michigan, a state with no mandated insurance coverage for infertility treatments, via flyers at public venues (*e.g.* libraries and grocery stores) and organisations affiliated with low-income populations (*e.g.* shelters and food programmes). Additionally, I posted an advertisement under the volunteers section of the web-based classified ads site, *craigslist.org*. The women were recruited about equally from each tactic and no differences were identified between the groups. Upon interview completion, participants received a $10 grocery store gift card.

I conducted the majority of interviews between April 2008 and October 2008 in study rooms of public libraries. I began the session by having participants complete a brief demographic questionnaire and then proceeded with the semi-structured interviews. On average, interviews lasted approximately 90 minutes, with a range between 30 minutes and 150 minutes. Within the dialogue I asked participants to reflect upon their childbearing aspirations, experiences of childlessness, conceptualisations of motherhood and 'infertility', and their experiences (if any) with the institution of medicine.

All interviews were transcribed verbatim. From the transcripts, I coded and developed analytical, categorical reports using HyperResearch 2.8 (2008). I then developed hierarchical, multi-layered thematic reports that identified patterns and variations in responses. I analysed the reports in order to parse out the contextual experiences of infertility, both within the medicalisation process as well as the participants' social milieus. I report how inequalities go beyond issues of financial accessibility as the conflicting contexts of medicalisation and women of low SES implicitly drive treatment disparities. Additionally, I relay how subordinated women negotiate infertility experiences when excluded from medical solutions.

Beyond (financial) accessibility: inequalities within the medicalisation of infertility

The medicalisation of infertility is based on a private medicalised market, which results in a for-profit, business structure of healthcare provision (Bates and Bates 1996). As Carrie[4], a white, lesbian, 32-year-old participant reflects, 'It's a money making business is what it is'. While fertility doctors may be 'living the high life', the institution of medicine cannot be reduced to such simplicity. The commercial activity is situated in and informed by a specific ideological context. In addition to securing a profit, medicine aims to maintain and secure the

norms on which it is based. Consumers help drive the medicalisation of infertility (Conrad and Leiter 2004), yet, based upon its foundation in social norms, the institution of medicine still explicitly and implicitly determines who those consumers are.

The middle- and upper-class context of hegemonic motherhood is at odds with the context of women of low SES. For instance, intensive mothering discourages working outside the home, but for poor and working-class women, that option is not available (Hays 1996). Similarly, the context of medicalised infertility in which medicine is a 'middle-class constituency', is incongruent with that of women of lower classes (Steinberg 1997: 40). The sequence and scheduling of appointments is based on a middle-class context in which autonomy and flexibility at work (or at home) are assumed. However, for poor and working-class women, such characteristics are non-existent. Nicole, a married, white, 28-year-old, reflects:

> Ann: How about the medical world and […] how you're kind of being juggled between all of these different people?
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> Nicole: […] the only way I could ever talk to [physicians] is if I have an appointment and I don't understand that. And they—it's like they don't understand that, you know, we can't just always pay $20 all the time or $25 every time just to have an appointment just to talk to you for two seconds. You know, and that's the frustrating part is that they don't get it. And then they always want you to have an appointment in the middle of the day and, you know, well, you know, I go to work to be able to afford this appointment (laughs), you know? It's—and it's very frustrating. Yeah, so I mean like last year I went to doctors' appointments so many times and it was—I had to work, you know, my bosses were giving—giving me like, 'Okay, why do you have so many doctors' appointments?' And, 'I'm, you know, dealing with a lot of stuff and medical issues right now' and luckily I kept my job, you know, they didn't let me go or anything, which I was really grateful for and so everybody understood and this year I just let it go for the most part because I just can't do that all the time. Just—I mean my job is my number one priority right now. I've got to keep my job.

The appointment structure of reproductive care is a prime example of how medicine is constructed by middle-class interests, neglecting the circumstances of women of lower SES. Nicole had to 'let [fertility treatment] go' because of the inflexibility of her job. In a sense, she had to choose between having a family and earning a living, a choice many women of higher economic standing do not confront. Physicians, however, 'don't get' the dilemma in which they have placed Nicole. Given her unique positioning as an outsider-within, Nicole offers alternative ways that medicine could function in order to adapt to her circumstances. Physicians could communicate between each other and with her over the telephone rather than use Nicole's time and money for 'two seconds'. These options are unrecognised by medicine due to its middle- and upper-class lens and ignorance around context.

The decontextualisation present in medicalised infertility may explain why even when women are insured, as in states with comprehensive coverage, disparities still exist. For instance, according to some participants, physicians conduct more procedures when they are aware a patient is insured in order to get maximally reimbursed. Jennifer, a white, married, 34-year-old, describes such practices:

> Jennifer: I don't think [the physicians] want me to be informed of the process.

Ann: Why not?
Jennifer: I'm not sure. I don't know if they're just billing the insurance company just to get the money and ultimately it's going to end in nothing and they're just, you know, now that they know I have a $20,000 maximum, they're just ticking it away. […] You know, that's the only thing I can think of and if—if I find out that it ultimately is it, that would be a very big problem for me (laughs). I haven't come out and said it but, you know, they're all of a sudden I'm getting charged for certain fees that I was never charged for before and now because I have insurance?

This excessive use of procedures is especially troublesome for women with limited disposable income, as the extra fees and more frequent co-payments (payments made by individual insured patients to insurance companies each time a medical service is rendered) are significant expenses. Jackie, a white, married, 23-year-old, relays such difficulty:

Jackie: …I mean because I have insurance, [physicians] try to put me on this stuff, which I understand because our health coverage is great. All we've had to pay through this thing is like $40 to the doctor's office. […] But our actual prescription insurance is really awful and they put me on Premicare 1, which is the prenatal vitamins so they told me. And it was like a $92 co-pay[ment] every month I have to pay. […] And I mean we have a very tight budget because I don't work and that $92, I mean it doesn't really fit in (laughs).

Taking prenatal vitamins 'doesn't really fit in' to Jackie's budget. She is forced to prioritise and navigate all the services offered. Physicians' lack of awareness of the participants' financial contexts causes them to conduct more procedures and overlook excessive expenses. In effect, insurance places more constraints on the less financially well-off and hinders the proper care of poor and working-class women. Even when treatments are accessible, a hierarchy of care remains.

The contextual oversight of the medicalisation of infertility, as portrayed through the appointment structure and response to insurance coverage, leads to the *implicit* exclusion of women of low SES from receiving infertility treatment. However, the policies and practices of health clinics themselves also *explicitly* exclude poor and working-class women from receiving fertility treatment. Jodi, a single, white, 25-year-old, describes her experience of seeking general medical services at a low-income health centre:

Ann: So what made you get on the Depo [Provera] in the first place?
Jodi: They made me (laughs): my [Social Service] workers. Even though I was—I was still technically a virgin when […] I started it but it was—I don't know—something about […] they don't want their kids to go out and have a baby or something. I don't know. […] So that was one of the agreements, you know, for me getting, you know, going to the health clinic if I would get on birth control even though I was still a virgin. So I'm like, 'Okay, fine'.

The clinic 'forced' childlessness upon Jodi by exchanging contraception for health services. Jodi was explicitly excluded from mothering even though she was a virgin, did not yet desire to mother, and did not adhere to the stereotype of poor women's excessive fertility. The health clinic has employed a fertility policy, implicitly based in a eugenic logic, in which the reproduction of poor women is controlled (Steinberg 1997). This is especially troublesome for

Jodi, as she blames her long-term (approximately six years) use of Depo-Provera, and thus the health clinic's policy, for her current conception difficulties. She now distrusts the medical system so does not seek medical advice for her reproductive issues. Doing so further perpetuates the class inequalities in infertility treatment. Jodi's experience reflects the presence of the ideologies of class and motherhood within reproductive policies and practices and the influence of those ideologies on the medicalisation of infertility.

Disparities are also perpetuated by doctor-patient interactions. Michelle, a single, Black, 25-year-old, describes how she never considered seeking medical consultation for her fertility issues because physicians, in past encounters, always discouraged her from becoming pregnant;

Ann: Have you been to the doctor about [your infertility]?
Michelle: No. […] Because I thought that, I was thinking you could just get pregnant. I don't know what–well they probably could tell me some stuff that I could do. But most doctors try to talk you out of getting pregnant.

Michelle could not conceptualise the medicalisation of infertility given her previous interactions with physicians in which they tried to 'talk [her] out of getting pregnant'. Doctors had normalised Michelle's exclusion from reproduction in two ways: first, by discouraging her from even trying to become pregnant, and second, by Michelle's internalisation of that exclusion which subsequently prevented her from seeking their assistance when she was having difficulty conceiving. They discouraged both her fertility as well as the resolution of her infertility. Many times doctors utilise their construction as experts as a way to discourage 'unfit' mothers from reproducing. Fisher (1986) has argued that women, particularly marginalised women, have been socialised to accept the authority of others. 'Doctor knows best' is the epitome of physicians' institutional authority, and it is exemplified within their interactions with patients. For instance, doctors are meant to advise patients, and many times attempt to persuade them by 'implying dire consequences' if the patient does not comply (Fisher 1986: 30). This tactic is evident within Keisha's experience. This single, Black, 33-year-old, describes an interaction with physicians after she had a miscarriage at age sixteen:

Keisha: … They—they just—they just seem like they just didn't want me to have any kids (laughs) at all. At all. And that was sad. They, you know, they scared me into even trying to have any more. They tried—they tried to get me not to even have any more […] They was really scaring me. That's why I—I said, 'Oh (laughs). Never again, Holy Grace Hospital. Never again'. Because they scared me and it was just—just crazy.

Physicians 'scared' Keisha into not trying to have any more children. She subsequently had two children and is now suffering from secondary infertility. Yet, the described incident, occurring nearly two decades ago, has precluded Keisha from seeking medical care for her current reproduction issues. As in the case of Michelle, medicine's initial explicit discouragement of procreation led to its implicit exclusion of Keisha from receiving infertility treatment. 'Never again' will Keisha seek the care of medical professionals regarding her trouble conceiving, which in turn serves to further drive the class-based divide of medicalised infertility.

Investigating medicalised infertility from the perspective of women at its margins reveals the multi-layered ways that medicalisation contributes to the disparities of infertility

treatment. Medicalisation's basis in dominant norms informed individual decision making, such as that of Keisha and Michelle, not to pursue medical care; it influenced doctor-patient interactions in which physicians enacted class-based assumptions of motherhood; and it constructed the structure of medicine that is built upon a middle-class context. Economically, consumers may drive the medicalisation of infertility; however, socially and politically, the drivers of medicalisation are much more complex. Its multidimensionality reveals how the process is also guided by the dominant norms which it aims to perpetuate.

Resisting (and reinforcing) hegemony: coping with infertility in an exclusionary context

It is important not only to examine how women of low SES are subordinated as mothers and excluded from medicalised solutions to infertility, but also how they resist domination by asserting their own desires of motherhood and developing alternative ways to negotiate their childlessness. As Reid and Tom (2006) relay, 'we should not think of dominant discourses as all-powerful and of individuals as submissive recipients. Instead, discourses are constantly being contested and challenged and are not always omnipotent' (2006: 403). Indeed, the women in this study actively and creatively identified ways to overcome the reproductive limits with which they were faced. Some women, as outsiders-within, were aware of their exclusion and avoided medicine altogether. They derived alternative, non-medical techniques to resolve their childlessness. Other participants, unaware of sociostructural constraints, primarily concentrated on overcoming the economic barriers to infertility treatment. Both tactics portray the resolve and fortitude of poor and working-class women, yet they also reveal the embeddedness and power of the norms in which they are based. The solutions serve both to accept *and* reject dominant norms of motherhood and medicine.

   Some participants attempt to surmount the financial constraints of infertility treatment by deriving innovative ways to pay for the services. Doing so may overcome their (economic) exclusion from medicine; however, the structural barriers remain. Unlike unique ways of accumulating money that have been reported among middle- and upper-class individuals (*e.g.* Greil 1991), such as re-mortgaging their homes, these opportunities may not be available to individuals of lower economic standing who do not own such assets. Instead, women of low SES must develop creative ways to utilise the limited resources at hand. Sherry, a white, married, 32-year-old, reflects:

   Sherry: [My husband's] got like if you see out there a bunch of old Camaros and, you know, and he had like somebody came out and like assessed his cars and stuff and he's got like $1.2 million in cars. He—yeah, old cars. He's got old cars everywhere. But, you know, it came to a point to where, you know, this is—this is what we decided to do. For the next year we're going to try and if it doesn't happen, he's going to take one of his old cars and he's going to sell it and we're going to go do in vitro (laughs).

Sherry suggests selling one or more of her husband's cars as a way to pay for IVF. They are willing to part with a hobby as well as their property to seek medical treatment for infertility. Carrie and her partner similarly make sacrifices to try to finance fertility treatment. Carrie left home at age 16 and did not communicate with her mother for the next decade. However, after making amends, Carrie decided to let her mother who had recently lost her home live with her and her partner in their trailer home.

Carrie: [My partner is] a bus driver (laughing). We are poor. […] My mom just went through a divorce after 21 years and it wasn't mutual and it was devastating and so he got the house and she wasn't ready to buy a house. And so she moved in with us. And she was going to give us $1,000 a month. So then I was hoping she would stay for a year and so then that's IVF.

While giving her mother a place to stay seems commendable, Carrie describes this choice as solely made on the basis of earning money for IVF. In fact, Carrie goes on to describe how she is charging her mother much more than she would any other tenant as a ploy to make money faster. Carrie's plan was unsuccessful. She became unemployed and had to use the money from her mother for living expenses rather than savings for fertility treatment. The following reflects Carrie's revised solution:

Ann: So how long do you think it will be until you can afford IVF?
Carrie: I think that I want to save half of it and then just go in debt for the other half. Because that seems more manageable than (pauses)—I don't—we're just so—we—we just—we live debt free, you know. So us going into debt is like a big deal. And we don't have the option of taking out a second mortgage on our house or, you know, other people do. I don't even know if I could get a loan. I am just assuming that I can. I have no idea.

Without options that 'other people' have, Carrie is forced to go into debt; a position she has not been in before. She has run out of other solutions to her infertility and 'there's nowhere to go but IVF'. Going into debt was a common theme among participants. For instance, Arti, a married, Indonesian, 44-year-old, asked, 'What else are credit cards for?'. Her husband subsequently suggested that they should 'write Oprah a letter' about their struggles with infertility in hopes of some assistance.

Interestingly, despite all of the creativity and time spent thinking about ways to afford medical treatment, particularly IVF, only one participant, Laura, a white, married, 40-year-old, actually received IVF services. The procedure, a 'gift' from her boyfriend who eventually became her husband, was unsuccessful and she went on to adopt two children. The lack of medical care among the participants reflects the difficulty of attaining monetary resources to afford infertility treatments coupled with potential structural and political barriers the women of low SES confront within their medical pursuits.

The participants, however, did not only pursue medical resolutions to their childlessness. Perhaps conscious of their exclusion from infertility treatment, the women of low SES develop alternative, non-medical solutions to resolving their childlessness. For instance, Donna attempts to rub pregnant women's stomachs in hopes of achieving conception:

Donna: Yeah, but it's supposed to be good luck if you rub (both laugh). […] I do that a lot (both laughing). I do that a whole lot, yeah. I can see a pregnant woman on the street and I'll be like, 'Please, can I rub your stomach? It's supposed to be good luck'.

Employing folk methods was commonplace among the participants. Cheryl, a white, married, 36-year-old, believed that wishing for pregnancy while holding an infant would increase her likelihood of pregnancy.

Cheryl: … When I held [a friend's] baby the first time […] I thought—because I—I—I just loved her up and I thought, 'I want one of these, I want one of these'. It was like wishing on a star or something, you know.

Avoiding medical solutions allows the women to experience infertility within their own contexts according to their own norms of motherhood. They are able to reject the norms embedded in the reproductive institutions simply by not facing them. Paradoxically, this strategy serves to perpetuate the class-based inequalities of medicine by maintaining the exclusion of women of low SES.

The participants are in a contradictory dilemma; deriving ways to pay for medical treatment does not overcome the structural inaccessibility and institutionalised classism the women face within medicine, yet developing alternative solutions furthers their exclusion from the institution. Due to this conundrum, many women, such as Heather, a married, Black, 29-year-old, 'come to grips' with their inability to conceive and move on with their life goals.

Heather: I have looked at all of these other things I am able to do now and [my husband and I] have talked about moving out of state and stuff like that. And so it's like, 'Why not? Why just limit yourself to wanting to be a mom and having kids when life has so many more things to offer than just that?'

Heather resists the norms of motherhood by not 'limiting herself to wanting to be a mom' and focuses on alternative aspirations such as travelling. Examples such as Heather's reveal how infertility is a social process with resolutions that far exceed 'liminal states' and abnormal statuses (Greil 1991). Indeed, by stepping outside the bounds of medicine, Heather also escapes the norms of motherhood. Previous research, embedded in a medicalised understanding of infertility, assumes that a lack of medical treatment is a detriment. Reviewing the stories of poor and working-class women overturns this assumption by offering a more holistic picture of the experience.

Discussion and conclusion

Through the example of hegemonic (non-)motherhood, I was able to examine *how* the process of medicalisation is a mechanism of social control. Exploring the infertility experiences of women who are placed outside the norms of motherhood revealed how medicalisation is a contextual process; it is situated in dominant ideals and serves as a gatekeeper determining who should and should not mother, or who should and should not remain infertile. It is common knowledge that women of low SES are excluded in the US from medical treatment for infertility due to its economic inaccessibility. However, 'to define reproductive choice/rights in terms of democratisation of access to treatment would seem to assume that women's reproductive agency is both without and transcendent of context' (Steinberg 1997: 45). The contextual circumstances of women of low SES alongside the institutionalised classism of medicalisation construct and constrain the women's choices around reproductive health.

This study is one of the first to examine infertility among the economically marginalised. Doing so not only exposed the stratified nuances apparent in the medicalisation of infertility, but also revealed the falsity of two dominant narratives: that poor women are excessively fertile and that insurance coverage for infertility will wholly resolve reproductive inequality.

There are several policy implications from these findings. They reveal that we need to not solely focus our efforts on access issues, but we need to begin resolving ideological ones as well. As Steinberg notes, resolving disparities within infertility will require 'more than simply a call for access to choices not of our own making' (1997: 45). Without reviewing the ideological notions of class-based motherhood and the classist structure of medicine, inequalities will remain in the provision of fertility treatments. Insurance coverage would not prevent the discouragement Michelle received nor would it undo the middle-class basis of appointment scheduling with which Nicole was faced. In addition to lobbying for comprehensive insurance coverage of infertility treatments, we also need to begin deconstructing the medicalisation of infertility in order to develop context-appropriate solutions such as those offered by Nicole—enhanced communication between fertility specialists and appointments during atypical working hours.

Completely focusing on medical solutions, however, is also a detriment to understanding experiences of infertility. Such research fails to recognise variation in infertility experiences by medicalised status and also serves to reinforce the social control, social norms, and biomedical understanding surrounding the medicalisation of infertility (Donchin 1996). While treatment disparities need to be resolved, we must also recognise experiences such as Donna's and Cheryl's in which non-medical, folk methods were employed. Future research must avoid 'westernizing' experiences that privilege biomedical solutions (Becker *et al.* 2006), and instead, step outside the normalised bounds of medicalised infertility to acknowledge experiences such as Heather's that are not medicalised, yet still 'successfully' resolved.

The results cannot be generalised to all women of low SES. The specificity and sensitivity of such a population and topic allowed for a relatively small sample size. However, given the size of the population as a whole as well as sample sizes of this population in past research, the group of 27 women is rather substantial. Their stories provide an initial glimpse into stratified reproduction, the intersection of dominant ideologies, and perhaps most importantly, how poor and working-class women navigate their infertility experiences within such contexts. Because most literature on infertility examines the experiences among women receiving medical care, it was critical to move beyond medicalised understandings based on dominant perspectives in order to recognise inherent disparities. Future research needs to continue studying marginalised groups, particularly how social class interacts with other social locations to shape unique experiences of infertility.

The experiences of women of low SES resemble those of women before the advent of reproductive technologies. Without the possibility of medical solutions, the participants developed alternative ways to resolve their childlessness. However, unlike their predecessors, women in today's society are aware of potential solutions that are unattainable. For instance, Tanya, a married, white, 38-year-old, 'felt like, "we gave it our best shot at trying to [become pregnant] besides these other treatments and everything. And—and it just wasn't going to happen". And that was kind of devastating there for a minute because it's like, "Okay, well, that's the end of that".' Tanya not only had to overcome the disappointment of her infertility, but she also had to face the 'devastation' of not being able to attain resources that could potentially resolve her childlessness.

Examining infertility among women who have this double burden exposes how medicalisation contributes to and perpetuates the ideology of motherhood at the exclusion of the lower classes. Rather than placing Tanya and other economically disadvantaged women at 'the end' of their journeys to motherhood, this study is a first step in reviewing reproductive policies and practices in order to construct new beginnings.

Address for correspondence: Ann V. Bell, Department of Sociology, University of Michigan, 3001 LSA Building, Ann Arbor, Michigan 48109-1382, USA
e-mail: avbell@umich.edu

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Notes

1 Any infertility service includes: advice, tests on woman or man, ovulation drugs, medical help to prevent miscarriage, surgery or treatment of blocked tubes, artificial insemination, assisted reproductive technology (Chandra *et al.* 2005).
2 A woman is classified as having 'impaired fecundity' if she reported that it is impossible for her (or her husband or cohabitating partner) to have a baby for any reason other than a sterilizing operation; it is difficult or dangerous to carry a baby to term; or she and her husband/partner have been continuously married or cohabitating, have not used contraception, and have not had a pregnancy for three years or longer (Chandra *et al.* 2005).
3 See White and colleagues' (2006) review paper examining disparities in help-seeking for infertility. They develop a theoretical model depicting factors that may influence individuals' behaviours.
4 All personal and place names are pseudonyms.

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