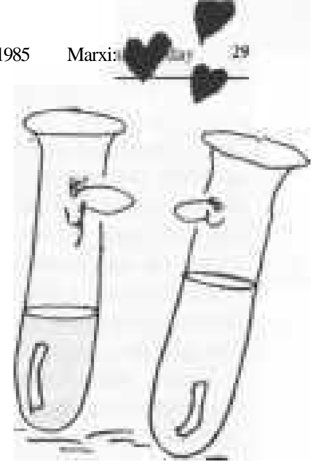


The issue of infertility has been largely ignored by the women's movement and the Left. We need to reach agreement as to what a socialist and feminist perspective is if we are to curtail the advances being made by the Right.

INFERTILITY - a Suitable Case for Treatment?

Marge Berer

THE PUBLICATION OF THE Warnock report on artificial reproduction and Enoch Powell's Unborn Children (Protection) Bill, which failed due to lack of time at report stage last month, has thrown the issue of infertility into sharp political relief for the first time. The debate that these measures have prompted has shown that both the Left and the women's movement have so far failed to address the issues of parenting and children sufficiently, and have chosen instead to concentrate on the politically clearer issue of birth control. It has taken a largely unpoliticised movement of infertile couples and advances in medical technology to drag us into this arena, and we now find that anti-abortionists have got there first and are dominating the public debate.

Infertility is equally a problem for men as for women. Approximately the same numbers of each are affected, and it is currently estimated that 1 in 7 people in Britain have fertility problems. But few of us are born infertile; infertility is usually a symptom of something that has gone wrong in our bodies. Certain social conditions are more likely to lead to fertility problems, for example, poverty, poor health and age - people in their 30s and 40s, thus, are more likely than teenagers to have problems because fertility naturally decreases with age and there has been more time for something to go wrong.

Infertility is caused in women by untreated pelvic infections (due to sexually transmitted diseases); IUDs or sepsis (following birth or abortion); hormone imbalances (that might be triggered off by pituitary, thyroid or other problems); poor nutrition; the effects of machines, chemicals and other hazardous substances used at work; drugs taken (for illness); damage done during abdominal surgery, endometriosis, fibroids and many other causes. Male infertility has also been linked to workplace hazards but the reasons why some men produce few or no fertile sperm are largely unknown. There is also infertility whose source is in both sexual partners, due either to antibodies in the woman to the man's sperm or genetic disorder triggered in a fertilised egg. Infertility, then, means being unable to produce fertile sperm or eggs or something preventing conception, implantation or development.

Some infertility can be prevented, some not. One of the problems with infertility is that we don't find out we are infertile until we have tried to have a child, and with more people putting off childbearing until their late 20s, 30s and early 40s, there is more likelihood of infertility and less time to do anything about it.

> infertility . . . forces us to ask how far we are prepared to go to get a child

There are a limited number of ways of dealing with infertility. We can come to accept childlessness and do nothing about it, we can attempt to adopt, or we can seek medical help to overcome or bypass the physical source of the problem, if it can be identified. In the past, people could not choose to seek medical help because there were no medical solutions. It was assumed that those people who could not have their own children would either accept their childlessness or adopt. Before contraception became widely available and before single parenthood was even minimally socially acceptable, adoption was easier. But today there are 250,000 people per year applying to adopt 1,000 newborn babies and 29,000 older children. The majority of them obviously have no chance of succeeding, and even those who do may wait up to five years.

Problems of adoption

If we want to understand why those who can afford it are going abroad to adopt, and why others are exploring the possibility of surrogate motherhood, in spite of attendant problems, the answer lies here. Many of those who try to adopt have also gone to their doctors for medical help. The infertility clinic at Kings College Hospital in London reports an increase from about 4,000 patients in 1982 to about 6,000 in 1984 attending for investigation and treatment, precisely because techniques for helping them have improved in such a short space of time. Medical understanding of the causes of infertility has grown to the point where only in 10% or less of cases can the problems not be identified. Unfortunately, knowing the source of the problems and overcoming them are two different matters. At Kings for example, only 25% of people seen will eventually achieve a successful pregnancy at the moment because some of the techniques are still in the early stages of development and simply don't work for everyone.

Infertility invariably raises the question of why people want children in the first place, because it forces us to ask how far we are prepared to go to get a child. It is a bitter irony for a woman who has conscientiously used birth control for a number of years, and perhaps even had an abortion, not to be able to get pregnant when she tries to.

Most women at some point become mothers. Those who decide not to have children at all need a lot of courage to carry out that decision because of pressure put on them by family and friends. However, this is completely different to being childless against our wishes. We are certainly socialised to have children, but we cannot ignore or underestimate the positive aspects of having children or the immense power of the desire to have them, though many in the women's movement and on the Left have tried.

What has been the response of the Left and the women's mo'vement to this issue so

far? The Right are calling for a ban on research into embryos. In reality many of the issues are far from straightforward. In the last year I have heard all of the following arguments in discussions about infertility, and I dwell on them at length because they touch on the central issues in this debate.

Firstly, some feminists argue that infertile women are lucky to have escaped the 'oppression of motherhood'. And while it might be easy to reject this statement out of hand, important points lie behind it. Motherhood is oppressive to women, and if the desire to have children remains unquestioned, as is often the case for fertile people, then we will not work for the changes needed to remove that oppression. The failure to envisage a viable personal and political solution to this problem has made many feminists anti-children, ie, if you can't find a way to remove the oppression, then remove its source, don't get pregnant. But this is a false solution, proven by the fact, if nothing else, that many of the feminists who espoused it are now having children themselves. So awareness of oppression has not stopped people from wanting and having children, and never will.

Secondly, it is often assumed that women are infertile because 'they weren't meant to have children'. This is essentially a religious attitude which mystifies pregnancy as well as infertility as acts of God. This attitude underlies anti-abortionist thinking, along with the belief that sex outside marriage is a sin, and explains why anti-abortionists oppose *in vitro* fertilisation, artificial insemination and other alternatives to married sexual intercourse in reproduction. It is both insulting and degrading to people with fertility problems to condemn them in this way.

An anti-child position

Thirdly, in the past, many on the Left have argued that if you can't have your own children you could look after other people's children. But glorified babysitting is not a substitute for parenthood. Children are often locked away at home or school in our society. They are never welcome in our workplaces, and often not in our social lives when they don't belong to us. Those who have children find it hard to get away from them, and whose who don't can go quite happily for years without so much as seeing a child outside family gatherings unless they make a special effort to do so. At the same time, the possessiveness of those with children is fierce and almost unchallengeable. Most people do not actually want to share raising them with other adults, as many attempts at shared parenting have shown. Parents move away and take their children with them, or if the adults fall out access to the children is often cut off along with the friendship. Shared parenting is not just about sharing the work and the fun, but also about sharing decisions about the child. In no sense do children belong to the community, and the lack of childcare facilities is only a surface manifestation'of this fact.

Fourthly, it is argued that whilst we still don't have adequate NHS abortion facilities infertility treatment is too expensive. Based on an anti-child position this assumes that prevention of pregnancy should have a higher priority than making it possible for those with problems. It also assumes, in line with government thinking, that only a fixed amount of money should be made available for particular forms of health care, in this case reproductive health care. Such thinking forces us to create competition between different needs, where the strongest lobby or the preferences of individual health authority members win out and everyone else can suffer in silence or seek private treatment, which is precisely what is happening in the NHS today. Reproductive services are expensive, taken together, but some of them could be provided more cheaply and better than they are and some could be de-medicalised.

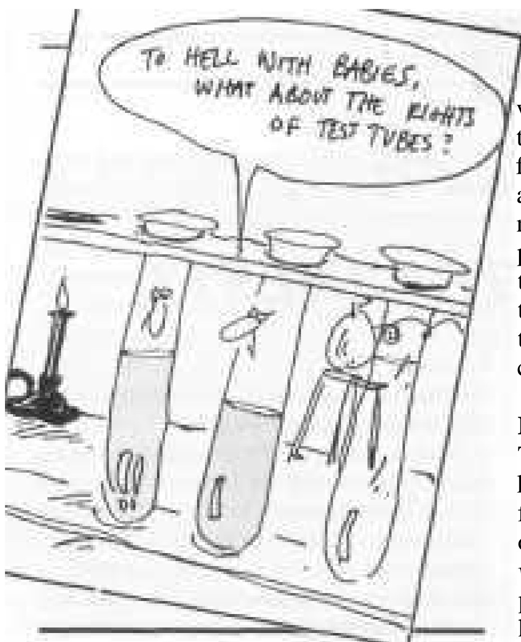
Preventive health care would reduce the need for cure in this, as in other, areas of health care. For example, both sex education and health education should cover the subject of infertility when reproduction is discussed, including some consideration of when people should try for children and why. More resources are needed to combat the epidemic of sexually transmitted diseases, and research on cures for pelvic diseases in women should have higher priority. In addition the working conditions of both men and women should be improved so that they don't adversely affect fertility as well. But curative medicine is still necessary because not all infertility will ever be prevented. A balance of responses is required so that current forms of treatment are substantially improved, which would both increase their success rate and make them less costly.

Lastly, it is sometimes claimed that the knowledge gained in research to improve infertility treatment is too dangerous. It will give doctors too much control over our bodies and over childbearing and will lead to attempts to create only perfect children: 'the needs of the infertile should be sacrificed and the research stopped for the greater good of all of us.'

In response it must be said that the means to control who has children already exists in the form of contraception, abortion and sterilisation, all of which are both forced on women or withheld from them in line with population policies, religious ideologies, etc. Secondly, techniques for intervening in women's bodies, whether to prevent pregnancy or assist it, have much in common, because they are based on the same information. The logical result of a ban on infertility technology is a ban on all reproductive technology, which in turn raises questions about medical technology as a whole. Third, it is simply not good enough to say that the needs of the infertile should be sacrificed from a political point of view. A politics based on being able to make choices, by having both the power and the means to do so, means the same thing for infertility as it does for abortion.

Reproductive medicine v genetic research

The issues relating to reproductive medicine are further complicated by the development of genetic research. A different dilemma arises where research and technology relate to embryos, foetuses and babies rather than women and men. Re-



glorified babysitting is not a substitute for parenthood

productive medicine and genetic research used to be two separate disciplines but they are coming together in a number of ways, in that many of the causes of miscarriage appear to be linked to genetic disorder, and research on miscarriage is closely linked to infertility research. Much of current infertility research depends on the study of conceptuses (the cluster of cells which divide following fertilisation and before they differentiate into embryo and placenta). This is important for understanding which sperm are fertile, why growth stops or goes wrong, and to ensure that sperm, eggs and conceptuses survive *in vitro* or during freezing. Medical treatment of infertility depends on this work.

There are about 1,000 known types of genetic disorder. Some cause miscarriage. Others cause disablement which may be mild, severe or fatal, and affect about 5% of children born in Britain. Many children with genetic disorders did not survive in the past, and it is medical technology which now saves and prolongs some of their lives, as is the case with cystic fibrosis for example. But the knowledge which allows lives to be saved and prolonged is now also being used and sought both to prevent and correct the disorders as well as to screen for them before birth (amniocentesis and chorionic biopsy), after fertilisation *in vitro* and in adults at risk of having children with disorders.

Medical intervention

There is both a value and a danger in this knowledge and how it might be used. In a few countries screening is available for only about 20 known disorders. If the *in vitro* fertilisation procedure is greatly improved and the success rate in terms of healthy, live births becomes high, screening of adults whose children may be at risk could lead to *in vitro* fertilisation being offered as an alternative to sexual intercourse so that the conceptus can be screened *in vitro* and only transferred to the mother if the disorder is not present. In many ways this would be an improvement over screening during pregnancy where prevention of the disorder currently means abortion, but where it may soon also mean attempts to correct the disorder in the womb and after birth. No matter which path is taken there are risks involved.

We can perhaps take a lead from the guidelines in the 1972 Peel Report on what constitutes ethical research on aborted foetuses, namely that the purpose had to be shown to be therapeutic, ie, to prevent or cure disease. But we need to be very sure that genetic research is not eugenic in nature, that is, that it is not done in order to 'inject' certain characteristics into people and remove others, because we can never trust scientists or the state with that kind of control.

Most people cringe when they hear the word 'science' because they are convinced they cannot possibly understand the medical world. The effectiveness of the NHS depends on its ability to respond to peoples' needs. The research side of it is essential in this context since it determines so many of the services offered. Widespread ignorance of embryology, genetic and infertility research encouraged two million people to sign petitions in support of the Powell Bill and the power of the fear of science which lay behind those signatures meant that only a handful of MPs were prepared to work for its defeat - only 88 voted against it. Public opposition, with few exceptions, was only kindled because the Bill threatened infertility treatment and legal abortion: awareness of the scientific issues stayed at the level of how specific techniques worked and what their immediate value was, at best.

Scientists, of course, understand the scientific issues and spend a good deal of time discussing the ethical issues involved - among themselves. But few take account of the political consequences of their work or consider it a priority to explain themselves to the world of non-scientists. Having commissioned the Warnock Report to raise these issues publicly, the Government has promised comprehensive legislation on infertility treatment, donor insemination, *in vitro* fertilisation, embryology, surrogacy and related issues. The Powell Bill will influence the tenor of that legislation, having come out of one of the minority reports in the Warnock Report. We are lucky, given the lack of discussion of these issues on the Left and in the women's movement, that the complications of writing so much legislation will give us a breathing space of perhaps a year to bring our own perspective to what that legislation ought to contain and ask whether legislation is in fact the best way to cope with research and technology. But first, however, we will have to come to some consensus as to what a socialist and feminist perspective is. E

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"YES"
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