explored through concrete empirical study of their social articulation. The next three chapters present one perspective of this sort, at the point of encounter between nature, technology and choice occasioned by the advent of assisted conception. In the conception narratives derivative of this encounter become clear both the power and the ambiguity of symbols and values often rendered more coherently from a distance. Close up, the 'biological facts' of reproduction themselves become complex signifiers of both change and continuity in the context of their technological instrumentalisation. The dilemmas and hopes expressed in the pursuit of a miracle baby, and the complex negotiations occasioning the encounter with high-tech conceptive success and failure, illustrate both the intensity and the distinctiveness of what it means literally to embody scientific progress as an expression of reproductive desire and consumer choice.

Chapter 3

The 'obstacle course': the reproductive work of IVF

It just takes over, there's no doubt about it.

(Jeanette Ives)

INTRODUCTION

In this and the subsequent three chapters, women's experience of IVF is investigated in terms of how women undergoing the procedure describe the experience of IVF as 'a way of life'. This perspective is informed by the phrase I encountered frequently during interviews, of 'Living IVF'. Conveyed by this expression is the sense of how IVF 'takes over' a woman's life, as is also expressed in the headnote to this chapter. I argue an ethnographic approach to IVF is one way to approach this intensity, in terms of how it is generated by various aspects of the technique. Although the accounts presented here can in no way be considered representative in a sociological sense, they are indicative of the way in which the experience of IVF is lived and embodied, and how this experience is described and narrated.

As with any ethnographic project, designed to elicit key terms or phrases through which people describe their own experience, certain condensed nodes of meaning emerge in descriptions of achieved conception. These can be considered points where several layers of meaning converge to produce an overdetermined effect. They are often to be found in phrases that are heard again and again across a range of different contexts and from a number of different sources. In re-analysing the interview material and fieldnotes, I discovered a number of phrases of this sort, which I then used to rework, organise and present the material.

Hence, this chapter is entitled 'The "obstacle course"', which is another phrase often used to describe the experience of undergoing IVF. The headnote describes the way in which IVF 'takes over',

which was another, related phrase that came up again and again. Both terms have the kind of overdetermined status which makes them useful for explicating a wide range of features of the IVF experience. In this chapter, then, the obstacle course metaphor is used to present the various stages of IVF and the physical, emotional and psychological difficulties they pose. These in turn explain why IVF 'takes over', and illustrate concretely what this expression means. A subtheme of the chapter is indicated by its subtitle, 'the reproductive work of IVF'.[1] This too provides a connecting thread, albeit an analytic one, linking a range of different features of the IVF experience, which, it is suggested here, together comprise a form of reproductive labour. In the final section, the tensions between women's paid work as part of the waged labour force is compared with their unpaid reproductive labour. This in turn provides the means for looking in another way at the most immediate demands of IVF, such as travelling, co-ordinating tasks, and general management of the 'regime' imposed by the treatment cycle.[2]

This chapter also introduces the description of IVF as a 'way of life'. The next chapter explores in more depth what is meant by this phrase, moving away from the immediate demands of treatment, to consider more broadly how IVF 'makes sense', or is made sense of, in a wider frame. The idea of a 'way of life', again, is multi-layered, referring both to IVF as a 'way of life', the lifestyles of individuals and couples, and the wider 'way of life' of the society they inhabit. Although the experience of achieved conception is not culturally bounded in a traditional anthropological sense, its description as a 'way of life' exemplifies a different kind of boundedness to this experience, providing the ethnographic frame for this research. Borrowing from cultural studies approaches to ethnography, informed by Raymond Williams's idea of 'whole ways of life' and 'whole ways of struggle', these chapters attempt to correlate the experience of 'living IVF' with broader questions about the social organisation of gender, kinship and the sexual division of labour.

Chapter 5 is entitled '"Having to try" and "Having to choose"', which are again phrases encountered often in the course of the interviews. The former statement, encountered in every interview, proved integral to the overall analysis. This statement is of particular importance because of its repeated centrality to women's descriptions of IVF. At the core of the experience of IVF is the pursuit of reproductive desire, often naturalised as an inherent human or parental drive, and therefore complicated by its realisation in the

context of high technology. In such a context, the seamlessness of interplay between 'social' and 'natural' facts becomes particularly apparent. In particular, the significance of individual choice in the context of both new technology and the 'enterprise culture' of Thatcherism are discussed.

To introduce the technique of IVF, I begin with a contrast between the representation of IVF in the standard clinical introductory pamphlets, and women's descriptions of the technique. This chapter then moves on to consider the immediate physical, psychological and emotional demands of undergoing the IVF procedure. All three chapters on IVF are concerned with how women make sense of this procedure. These ways of making sense are both determined by the experience of treatment, and determining of it, as the attitudes women develop towards the procedure inform the ways in which they learn to 'manage' it, in both senses of the term.

INTRODUCING IVF: THE STANDARD IVF DESCRIPTION

The introductory descriptions of IVF distributed by the clinics involved in this study consisted of short pamphlets, compiled either by the clinics themselves or by the drug companies who produce the pharmaceuticals used in the procedure. Two primary features characterised the representation of IVF in these leaflets: IVF was always described as a 'simple' procedure, and as a 'natural' one. The simplicity of IVF was conveyed by its description as a sequence of stages or procedures: removal of the egg, in vitro fertilisation, and reimplantation of the embryo. The naturalness of the technique was emphasised through phrases such as 'giving Nature a helping hand', conveying the idea that IVF is just helping nature to do what it would have done anyway. These two representations, of IVF as simple and as natural, were combined in the image of IVF as a 'bridge', or, as one pamphlet describes it, 'a bridge to a new life'. The mechanical image of a bridge, which stands for the 'helping hand' of technology, invokes the original use of IVF to bypass blocked Fallopian tubes. In this image are united the idea of conception as a natural flow or sequence of events, and the insertion of technological assistance into a naturalised event to close the gap, as it were. The closing of the gap in turn refers also to the amelioration of the yawning gulf between reproductive desire and inability to conceive. It is the seamlessness of this transition which is the important message

uniting nature, technology and reproductive desire in these accounts, as in the media accounts discussed earlier.

The following are extracts from introductory IVF pamphlets describing the technique:

> IVF involves collecting eggs from the ovary, putting them together with spermatozoa in a dish, and if those spermatozoa fertilise an egg, putting the embryo or embryos that result into the womb.
>
> (*In-Vitro Fertilization with Fertility Services*, n.d: 2)

> *In vitro* fertilisation is a technique in which the sperm and egg, instead of meeting in the fallopian tube, are made to meet literally 'in glass' – i.e. the test tube (or a dish).
>
> (Information Booklet: *In Vitro Fertilization and GIFT*, Infertility Advisory Centre, n.d.: 3)

> IVF or (IVF-ET) entails bringing the male sperm and the female egg together outside the body, so that fertilisation occurs. The tiny fertilised egg (now called an embryo) is then transferred back to the womb to develop normally.
>
> (*In-Vitro Fertilisation: Some Questions Answered*, Serono Laboratories (UK) Ltd, n.d.: 1)

> Since 1978, *in vitro* fertilisation has provided a positive solution to many couples' infertility. The principle is simple: the function of the defective fallopian tubes is assumed artificially under strict conditions in the laboratory. This takes scarcely 48 hours.
>
> (*When Nature Fails . . . A Modern View of In Vitro Fertilization*, Organon, n.d.: 27)

> Commonly referred to as the test-tube baby technique, IVF is the technique of mixing the woman's eggs (ova) with sperm from her partner in a small dish or test tube in the laboratory, to allow fertilisation to occur. Once the ova are fertilised and have divided, one or more of the fertilised eggs (pre-embryos) are replaced into the woman's uterus through the cervix.
>
> (*Fertility Services*, AMI Healthcare, n.d.: 2)

While technically accurate, descriptions such as these, which emphasise the simplicity of IVF treatment, fail to convey several important aspects of the procedure. For one, they fail to convey the amount of procedure involved in removal of eggs. For another, they do not convey the number of ways in which the procedure can fail, or, in IVF parlance, lead to the cycle being 'abandoned'. The conflation of technology and nature in these accounts is partly facilitated by the simultaneous conflation of 'IVF', the actual point at which the egg is fertilised in vitro, with the entire process of 'IVF', which involves much more than that. Finally, the naming of the technique as 'IVF', for the one component of it which occurs independently from a woman's body, precisely emphasises its technological dimension, very much in contrast to the way this is de-emphasised by describing it as 'natural'.

Other aspects of these representations of IVF are also notable. For example, they describe no agents. Or, it might be said the only agency in evidence is the 'invisible hand' of technology. Techno-scientific agency is consequently naturalised, as a force in and of itself: 'the function . . . is assumed . . . by the laboratory'. Conception here takes place through a union of technological and natural processes, consistently represented in the passive voice. The technique of IVF is positioned as a helpmate to nature: it 'allow[s] fertilisation to occur'. In so far as Euro-Americans imagine kinship as the 'social construction of natural facts', IVF is here described as materialising that equation: the natural facts of conception, the meeting of the egg and sperm, are facilitated by the 'helping hand' of technology. Conception is literally pieced together. Yet, this is no ordinary construction process. The building blocks are those of life itself. Hence, in so far as the unfolding of 'the facts of life' are both narrativised and naturalised as the biological sequence through which Euro-Americans understand coming into being, these representations of IVF embed technology into nature in a manner that makes perfect sense of this contradiction.

WOMEN'S DESCRIPTIONS OF IVF: THE 'OBSTACLE COURSE'

A useful contrast can be drawn between the preceding introductory accounts of IVF and a description of it by one of the women interviewed. As Kate Quigley[3] describes her experience:

> Um, on the first day of the cycle, the first day of my period, we start with a, I have a nasal spray, which I use four times a day, one spray up each nostril, and then I had, then you have I think they are steroids, somebody said they were steroids, and then you take two in the morning and one at night, that's two, to help to grow healthy eggs. On the fourth day of your cycle you start with

> Perganol injections and my GP gave those to me, so I just had to go up to the surgery and he did those for me. And also on the fourth day you have to collect your urine and collect for twenty-four hours and then you have to send a sample off so that they can measure your oestrogen that's in your urine so they can see what response your body is making to all the drugs. And then on the sixth day you go for the first scan, that's when they can see if any eggs are growing and how many. You go for a scan every other day, and then on both occasions they said that on the 11th day, they said that the eggs, the follicles were sort of large enough for me to be given the hCG injection which they give about thirty-five hours before they aspirate the eggs, the hCG injection, it makes you ovulate, because without that you wouldn't ovulate. And then thirty-five hours later you have the eggs aspirated and if they fertilise and divide then two days later you put the embryos back.

Noticeably, this account puts most emphasis on the process of ovulation induction, and least on the actual process of IVF, which is in fact not even mentioned. From the point of view of a woman who has experienced IVF, in other words, the technique is defined *most* by what is missing from the introductory descriptions, and *least* by what is actually in them.

Far from being described as a simple technique, women repeatedly described the unanticipated complexity of the IVF procedure. Even if they were well acquainted with the range of techniques involved, they were often unprepared for the extent to which the technique 'took over' their lives through its considerable demands upon them. As Jeanette Ives, who is quoted in the headnote to this chapter, put it:

> It's a very intense procedure and if you're up at the hospital every day virtually and you are being monitored all the time so obviously it's a very intense time and you do get very involved in it all. Much more so than you imagine you will do, it's not like having one injection, you know, it's really involved. . . . And it does sort of take over your life to quite a big extent.

In addition to finding the technique more complicated than expected, and suprisingly 'intense', the number of things that could go wrong during the cycle was not anticipated accurately. This too can be seen as a result of the difference between IVF as a clinical procedure and IVF from a woman's point of view. A frequent way in which this

discovery was represented was in terms of a series of hurdles or stages: an obstacle race. The analogy of the obstacle race was for many women the most effective way to describe their experience of the actual procedure of IVF.

Descriptions of IVF as an obstacle race or a set of hurdles to be overcome were very common. Several women used this analogy to describe their experience of the technique:

> It's like, to me, when I think about it, it's like running the Grand National without a horse and with your legs tied together and with a blindfold on. I don't know how long the Grand National is . . . it feels like that . . . but with all the brooks and everything else, and you've got to get over every single hurdle and you can still fall at the finish line.
>
> (Meg Flowers)

> And you think the first time, oh yes, it's going to work, even though they say the first time doesn't usually work . . . and the reason the disappointment is stronger than you'd expect is because it's like a set of hurdles, and each one that you're successful you build your hope a bit more.
>
> (Karen Clarke)

> Well, just reading in an article and coming to the treatment I didn't realise that there were so many obstacles that you've got to get over, you've got to get over each obstacle one at a time before you can carry on to the next, you know there may be a problem where you just don't ovulate for one reason or another, so that cycle has to be abandoned, and then try again the next cycle and then the problem is whether they fertilise, and then the problem of whether they will divide.
>
> (Susan Doyle)

Far from describing a simple technique, these descriptions address the difference between IVF in theory and IVF in practice. In theory, each stage leads to the next stage, but in practice each stage becomes a potential source of failure, and thus an 'obstacle'. In descriptions such as these, the emphasis is not only on the unexpected difficulties encountered, but on the high risk of failure at each stage, a fact for which most women, despite being well informed beforehand, were emotionally unprepared. As is also noted in the latter two descriptions, one from a woman who was a trained nurse and very knowledgeable about IVF, appreciating beforehand the high

likelihood of failure, or the number of ways in which the technique can fail, is difficult both because of the reluctance not to believe it will succeed, and simply because not enough information is conveyed. These are only some of the difficulties of conveying an accurate description of what the technique involves. Ellen Brown explains how easily IVF can be underestimated:

> There's a lot more to it than you're thinking [at the outset]. As I say, it all sounds wonderful but you don't realise the small percentage that works and the lot that doesn't work. When I first went up there I was thinking oh, if there's nothing wrong with it, it's going to work. And obviously it doesn't, you know. [But] you can't help but think you are going to be one of the successful ones, and that if nothing goes wrong you are going to get pregnant.

There is both an initial reluctance not to believe 'you are going to be one of the successful ones'[4] and an underestimation of the number of things that can go wrong during the cycle.

Yet another consequence of the obstacle race element in the experience of IVF is its impact on definitions of success and failure. Initially, women define success and failure simply in terms of whether the technique results in a 'take home baby', the ultimate success of IVF. This changes as the obstacle race element of the technique comes to be better appreciated. Coming to see IVF as a series of hurdles has the effect of a treatment being seen as successful if it progresses beyond some of these obstacles, *even if it later fails*. But failure is also much harder to accept the further along the cycle it comes. Failure is absolute, and is described as 'the cycle being abandoned' or, simply, 'abandonment'. Success, on the other hand, is measured in terms of degrees of success, or relative success, more often than in terms of complete success, which is the exception.[5]

To appreciate more fully the series of stages or hurdles involved in IVF, a schematic representation of the serial components of the procedure is provided below. This sequence also includes a brief indication of the demands of the technique in terms of the work that is required at each stage.

The stages of IVF

1 Previous infertility investigations diagnosing, or not, source of obstacle to conception (if necessary).

2 Choosing an IVF programme (investigation, selection, referral, initial consultation, admission onto programme).
3 Initial work-up (updating of infertility tests, etc.).
4 Preparation for first cycle (getting drugs from GP, arranging time off work, arranging transport, financial arrangements, etc.).
5 Ovulation induction (two- to three-week period of daily injections, tablets, hormonal nasal spray, ultra-sound scans, urine collection and sampling, blood tests).
6 Egg aspiration (hCG (human chorionic gonadotrophin) injection thirty-five hours before removal of eggs, valium/pethadine twelve hours beforehand, aspiration – surgical removal of up to thirty ova (general anaesthetic in some cases)).
7 Embryo transfer (ET) (if eggs have fertilised and divided successfully, up to three are selected and transferred into the cervix through a catheter after twenty-four to forty-eight hours).
8 Pregnancy testing (following a two-week waiting period, blood tests are performed to establish whether pregnancy has occurred).
9 Prenatal monitoring (if pregnancy has commenced a programme of prenatal monitoring is followed until completion of pregnancy by either miscarriage or birth). In some cases, 'selective termination' of one or more fetuses is indicated, due to a multiple pregnancy. This procedure is, however, controversial and is not widely used.[6]
10 Birth (when they continue to term, IVF pregnancies are more likely to involve caesarian section, and are also more likely to result in pre-mature birth and congenital abnormality, due to the higher incidence of multiple pregnancies).

Again, as is evident from this list, in vitro fertilisation itself is one of the few aspects of treatment in which neither the woman nor her partner are involved. It is also notable that this stage, for which the technique is named, occurs well along in the cycle and is not always achieved by couples undergoing treatment. During the first two weeks of treatment, the main aim is to induce successful ovulation. Successful egg maturation must then be followed by successful egg removal. The ova must then fertilise and divide. Finally, the fertilised ova must successfully implant in the uterine lining in order for the pregnancy to 'take', and it must then continue to term in order for IVF to be a success and result in a 'take-home baby' – the bottom line of IVF success or failure.[7]

In addition to there being more potential sources of failure during

an IVF programme than many women realised, it is often equally difficult to appreciate the extent to which IVF can be too 'successful'. In other words, if too many embryos implant, the woman may experience a multiple pregnancy. Such a prospect may not initially appear alarming, indeed it may even appear desirable to women and couples who have been trying for many years to conceive. However, even with twins there is a greater risk of perinatal complications or permanent congenital disabilities. With higher-order births of three or more, the risk factors increase considerably. In addition, even if there are no congenital or peri-natal complications, simply caring for three newborns can produce tremendous strain, effectively creating for a woman who keenly desired a baby a cruelly inverted scenario of 'overbirth', in which she finds herself in the previously unimaginable situation of having too many babies.

In addition to being unaware of the number of stages at which the technique can fail, the obstacle race analogy is also used to describe the nature of the demands of treatment, the work involved in meeting each new stage afresh, always with an awareness of the risk of failure, yet equally with a reservoir of hope for success. All of the interviews contain references to the unanticipated demands of 'the regime', of which the following are accounts indicative:

> I think it's always easier to read about something than to actually do it. . . . But until you've experienced [IVF], you know, you say oh we do this and we collect the eggs and we do this and it all sounds quite easy.
>
> (Sylvia Newton)

> [We just thought] that it would be an administration of a drug and a recovery of an egg and then fertilisation, test-tube fertilisation, and re-implant, and essentially that *is* the procedure, but that is very much an oversimplification of the procedure.
>
> (Meg Flowers)

> I think it's more complicated than I thought it would be. . . . They just went through the basics of what exactly they did, which basically meant taking the eggs out, fertilising them outside the body, and putting them back in and that sounded quite straightforward to me, I thought it was something you could do in an afternoon.
>
> (Mavis Norton)

In addition to being more complicated than many women initially thought, IVF is often more emotionally traumatic as well. In part, it is the unanticipated demands of treatment which make of IVF such an 'intense' experience. Likewise, it is often the first procedure that is the most overwhelming. Other factors also contribute to this sensation, however, in particular the anticipation inevitably generated at each stage of treatment, and the number of stages which must be successfully completed in order to succeed in realising 'the ultimate goal' of a take-home baby. Finally, and most obviously, there is the basic underlying stress of IVF being a woman's 'only hope' to have a child. Frances Keating, a child-minder with an adopted daughter, explains the impact of this 'last chance' quality of IVF:

> I think unless you've actually been on an IVF programme you don't really know what's involved. Because it is, I mean I must admit I went there for the IVF programme thinking you go in, you have these injections, it is all, I mean I knew it took a few days, but I didn't think it would be as traumatic as it was. I think it was the way that emotionally, the way it upset me. I found one minute I was high and the next minute I was down. Going for the injections didn't bother me, taking the tablets and all the collections, that part of it never bothered me, but it was the fact that it was my last chance, I suppose, my only hope.

The potential for failure is always, and understandably, underestimated by most women – the need to believe in the potential for success of treatment outweighing the need to recognise failure as the most likely outcome. Referring to the kinds of media accounts described in the last chapter, Meg Flowers describes how difficult it is to anticipate the number of stages at which an IVF cycle can 'go wrong':

> To say that's the procedure, which it is, sort of a, b, c, d, that's what happens, there don't seem to be that many, not as many people as I imagined actually got to the end result of even having the egg retrieved, the eggs or whatever. The insinuation seemed to be from the media I suppose that if you embark on IVF it's almost as if you are going to get there in the end, but it may take two or three times. Whereas it just seems to be incredibly more difficult than that, that almost as if the intimation is that there is definitely going to be a positive end result in it so you get from the media[8], to me, all of the positive sides of it, of the women who

> are having the babies, but you don't hear an awful lot about the women who start doing tests for IVF and don't get accepted onto it or get accepted onto it and fall at different hurdles.

It is on their first cycle of IVF that women encounter most forcefully the unanticipated demands of treatment. Subsequent cycles are then undertaken with greater confidence and assurance, even satisfaction in having acquired sufficient experience to 'have a programme of it', as Patricia Evans recounts:

> The first time 'round the IVF programme itself is hard, because you don't know what you're doing. You don't know, you don't know what they're doing. You don't know, you're thinking to yourself have I got my drug regime right, have I made a mess of it, when have I got to take my next tablet, when have I got to go for my next injection, or – you're not sure what you have to do, but when you've done it once, you know, you soon remember what you have to do, and then you're thinking 'oh, I know what I have to do' and then you have a programme of it.

The repetition of certain phrases in this extract, concerning the unknown dimensions of the programme, underscores the urgency often experienced on the first cycle about 'getting it right'. Familiarity with the treatment cycle gained on the 'first time 'round' enables a greater sense of control, and the confidence required to feel 'you have a programme of it'.

The initial sense of disorientation and uncertainty is not surprising given the number of procedures to be coordinated. Again, it must be remembered both that medical matters can be more daunting than more ordinary tasks, and that there is a tremendous amount riding on a successful outcome. Both of these factors can make what would otherwise be comparatively simple tasks into an anxiety-producing test of organisational and coordinating skills.

Keeping track of the drug schedule requires integrating several courses of different hormonal preparations, including injections, tablets and nasal spray. Sara Yates, a factory worker, explains:

> You can't neglect it, you can't say like all last week you'd taken your tablets and you'd taken your spray and you think, oh, I'll leave it off tomorrow and the next, you can't do that, you've got to work it for yourself the times that you are taking it. Like me, I work mine, I take it at nine, twelve, three, six, nine, twelve, between and you know where you are, you know, you've got to work yourself to a pattern as you know when you look at that clock, when you like three o'clock time when you are sitting there about quarter to, you know you've got another fifteen minutes and you've got to take your spray like, you know.

Learning how 'to work yourself to a pattern' requires some adjustment and can initially feel like a constant preoccupation. On later cycles, it is easier to integrate self-treatment programmes into normal daily schedules.

Many women also expressed surprise at the extent to which the programme came to dominate their lives as soon as they commenced the cycle. Pauline Harding, a doctor's wife who also worked as his secretary and looked after their young child at home, describes her busy schedule:

> The only trouble is that I find is that once I start going over to the clinic, on day six of the cycle, that tends to take over. Going there, it seems to be the only thing that I think about. [My husband] will come home with loads of typing for me and I'll say 'just leave it for the moment', you know what I mean, it just sort of takes over everything. And, um . . . I don't know if that should do or not [but] it takes an hour getting there, and an hour back, and you're there for an hour and a half, it seems to take up most of the day. You come back and you're absolutely shattered. . . . As soon as you start then it seems to take over everything. I keep on thinking about the scans, and working the dates out, roughly when there will be the aspiration, and hoping that [my husband] will be able to take me, and sort of thinking, well, if it's going to be late in the afternoon I'll have to arrange for someone to have [my child], sort of trying to work out everything, I have to have everything settled in my own mind.

This is a typical description of 'women's work' in the way it describes the coordination of childcare, secretarial responsibilities and the demands of treatment having to be integrated not only on a daily basis but in the longer term. It thus presents a picture of household management which is characteristic of the ways in which several different kinds of work must be integrated, and the difficulties this can present.[9]

Both the intensity of the programme and the momentum which is generated by it were frequently commented upon aspects of the experience of IVF. In the description above, the demands of the IVF

programme are described as seeming 'to take over everything'. In several interviews, IVF was similarly described as becoming a 'way of life':

> I didn't know what hit me, I honestly didn't know what hit me, I couldn't believe the intensity of the programme. . . . *All you do is eat, drink and talk IVF*, your dinner conversation revolves around how big your follicles were that day, which side you had your injection in and that sort of thing, you just do, *you just live and die IVF.*
>
> (Mary Chadwick)

> Because you go into it one hundred percent, you see, it's not something you go into half sort of. . . . You throw everything in and everything else gets pushed by, *I mean . . . you live, eat, drink – everything is IVF.* Nothing else exists . . . I wasn't interested in anything else. I felt guilty, because all I was thinking about was this like, but you can't, like it takes over everything really, because it's your chance.
>
> (Frances Keating)

In both of these descriptions, IVF is described as something you 'live, eat and drink'. It is a measure of the extent to which it is felt to 'take over' a woman's life, and the life of the entire household, that it is described in this language. That IVF becomes like the food you eat indicates the degree to which it becomes a 'way of lfe'.[10]

This feeling of 'living IVF' is similarly described in the following exchange between Sara and Kevin Yates concerning the logistics of urine collection:

H: It's something you both live, I mean it's not something you just do once. It's things like . . . I've always got a jug in a plastic bag in the car.

W: Yes, you have to take your jugs, just in case. . . . You've got to feel committed first, you've got to be prepared for that.

H: You've got to be totally dedicated. You can't go nowhere without that bloody jug in the bag, you need two or three.

W: That's it, it's become a way of life to us now, you know what I mean, I think we've got about six of these damn jugs, spread one here there and everywhere.

There is the feeling that the programme becomes inescapable, pervading every aspect of a couples' life, and requiring that they show both dedication and commitment to succeed at meeting the demands of treatment.

Part of the intensity of the programme can be explained by the amount of attention it requires to coordinate urine collection, hormone injections, travel to the clinic for scans, and so forth. There is also a forcefulness to the build-up effect of the ovulation induction period, during which egg follicles are being monitored for their rate of growth: 'I felt as if I'd gone all the way up to ninety-nine and then I've had to come all the way back down to zero again', as one woman put it. Whilst there was quite a large degree of variation in the extent to which women became involved in the technical side of IVF, a sense of having ones life taken over by the waiting, the worry, the activity and the stress was consistent. Clearly, one of the most important sources of the intensity of the programme is the potential outcome of successful treatment – a baby. This aspect of the experience of IVF, the balancing of hope for success against a realistic recognition of the likelihood of failure, was often described as a major preoccupation, and is discussed in the next chapter.

THE PHYSICAL DEMANDS OF IVF

In addition to the work of managing the various tasks involved in an IVF programme, there are also physical demands. On top of scheduling the demands of treatment into the rest of her daily routine, women have to manage their own bodies and undergo physically quite demanding procedures. This is another way in which the demands of IVF can be seen as having literally to be embodied by women undergoing the procedure. This is another way in which IVF can be seen as 'taking over' or becoming a 'way of life'.[10]

Scanning procedures

In terms of physical discomfort, many women described the scanning process as one of the most demanding aspects of the programme. The purpose of scanning with an ultrasound monitor is to evaluate the effects of the hormone injections upon the rate of follicular growth. In order for the scan to reveal a clear picture, the bladder must be full, indeed bursting. This has to be achieved in coordination with travel, and the following are typical descriptions of what many women found to be the most physically demanding component of the cycle:

> Mind you, the hardest part about all this treatment is just being able to gauge your bladder right. It really is, because, honestly, you can just be right one time and another time you go, you can feel right, and you ain't got enough liquid in you. . . . And yet you can be too full for it, you can never gauge it, that's the hardest part, and some people, well, I like, you can't just let a little drop out, you know what I mean, it's ever so hard to control down there, and then you have a little top up, like you know, them are the things in with treatment, I think they are more awkward, them little things like that.
>
> (Sara Yates)

> When you are travelling every other day, then it's every day, and you have to have a full bladder, and that's discomforting in itself. You know what it is like if you are absolutely bursting, I mean I'm talking about bursting to go to the toilet, and then they are pressing something on you [the scanner], all you can think of, you are not thinking about follicles, you are just thinking 'I'm dying to go to the toilet', you know, and that's all you can think of, you see. It sounds silly, doesn't it, I don't know.
>
> (Catharine Lewis)

A definitive feature of the ultrasound scanning procedure, then, is the requirement that women exercise physical control over a physiological process that is difficult to gauge accurately. Indeed, in conjunction with travel and the vagaries of appointment schedules characteristic of even the most well-organised clinics, 'gauging' the bladder correctly might be described as an impossible task. It is perhaps because of the standard amount of hilarity connected to anything 'down there' that such difficulties are dismissed as 'silly' in the second extract. This trivialisation of their own physical discomfort is very typical of the self-descriptions provided by many women in the study, with the exception of the aspiration procedure, as is discussed below.

The aspiration procedure

While the scans are the most demanding physical aspect of the cycle from one day to the next, the operation to remove the eggs once they have matured is the most physically traumatic single event involved in IVF. At the clinic attended by women in this study, aspiration was performed as an out-patient procedure whenever possible. This

meant the avoidance of the use of general anaesthetic, which is more complicated, and was often considered undesirable by women undergoing IVF because of its after-effects. However, it is not possible to use a local anaesthetic for the entire abdominal region, and therefore women were only mildly sedated with drugs such as valium or pethadin before aspiration. As a result, women were conscious during aspiration, during which a long needle is inserted into their lower abdominal cavity to puncture the egg follicles and remove as many ova as possible with the aid of an ultrasound scanner. Anticipation of this procedure was often anxiety-producing, and an understandable amount of trepidation was often expressed concerning this component of the programme. Again, while there was some variation, with some women not finding aspiration unduly traumatic, many women described egg removal as acutely painful, as the following descriptions indicate:

> I wasn't prepared for how painful the aspiration was going to be. I mean they give you a pain barrier form, and I just went off the page. . . . I don't remember anything about the aspiration at all except the pain. . . . I was in agony.
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> (Mary Chadwick)

> I mean the first time I went and had the eggs, what do they call it, the aspiration, it bloomin' hurt and in the leaflet it said there may be some slight discomfort, but this will be perfectly bearable, and it must have been a man that wrote that, because you have a needle straight through your bladder and it does hurt, apart from the fact as well that I was wide awake. . . . And I made sure that they knew that I, you know, I was aware of what was going on and it I know it hurt. I couldn't tell you how long I was in there, and I couldn't tell you how many eggs they'd taken out. . . . Put it [the pain] extreme, it was, and especially you bear in mind you are lying there, and your bladder is full, and you can't move an inch, you know . . . you are just lying there, and I've got my nurse's hand in mine, and she must have nail ridges in her hand half an inch deep because it was, and I was crying, and all the other things I'd been through it never got to me like that!
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> (Mavis Norton)

> They say they just put the tube in and suck out the eggs and that, and that's it, you know. . . . It was quite painful, I nearly jumped off the table.
>
> (Jeanette Ives)