

CHAPTER 3

TREATMENTS FOR MEN AND CHILDREN

1. INTRODUCTION

Crucial to the analysis of reproductive technologies is the recognition that these practices do not only involve the blending of nature and technology, but also that they constitute discourses on the production of *individuality*.²⁰² This is one of the reasons why "reproductive politics" has been and still is central to women's emancipatory struggles. Pregnancy is about the making of new individuals, about processes of individuation, about two bodies becoming one, one body becoming two.²⁰³ Individuality, however, whether understood psychologically, morally, legally, or even biologically, is not a pregiven ontological category, but always a contingent achievement.²⁰⁴ At the same time, it is fundamental to most of our notions that invoke normative issues in medicine, such as patient autonomy and bodily integrity; it underlies patient rights and informed consent procedures in medicine. With respect to bodily self determination, for example, it is obviously required that it be clear what counts as self, and what as other, where the boundaries of the individual body are drawn. In contemporary reproductive technologies, however, it is precisely these boundaries that are at stake and being redefined.

By focusing on two fields within reproductive medicine and technology, infertility (in vitro fertilization) and congenital disease (fetal surgery), the emergence of two new, extraordinary types of patients was analyzed in the previous chapter. Extraordinary, because they depart from conventional notions of what can count as an individual patient. 'The couple' in infertility treatment (male infertility in particular) and 'the fetus' in fetal surgery have come to be considered independently identifiable and treatable, single patients. Significantly, they have emerged as such in contexts where women now are being medically treated for problems that used to belong to others, that is, for problems that used to be their children's and male partners'. Moreover, this development challenges any self-explanatory use of the notion of a patient's bodily self-determination in medicine, because it occurs

in technologically induced clinical contexts where it is no longer clear *which* selves or *whose* bodies precisely are involved and to what extent, nor is it even always possible to say *how many* selves and bodies exactly are involved.

Both couples and fetuses are construed as patients in the very process of defining and transforming the problem from which they are said to suffer, and of which technology is supposed to relieve them. They thus constitute two highly consequential instances of the way reflexivity helps us see how “an attribute previously considered to have emerged from a set of preexisting conditions is in fact used to generate the conditions,”²⁰⁵ In the process of shifting the problem of male infertility spatially in and out of bodies, body parts, laboratories, and Petri dishes, ‘the couple’ appears as the new bearer of the problem thus conceived. Similarly, congenital disease can be seen to transform according to changing temporal designations of the occurrence of the problem. From being a problem of born children, congenital disease has shifted into the prenatal period, where a ‘fetus’ is now considered a patient indicated for therapy. These transformations are achieved through elaborate medical procedures, consisting mainly of interventions in female bodies. Again, it is the scientific experiments themselves, that “produce the nature whose existence they predicate as their condition of possibility.”²⁰⁶

In this chapter, the analysis of ‘the fetus’ and ‘the couple’ as ‘hybrids’ produced in technological practices, is taken one step further. I describe how the notion that fetuses and couples *are* patients is sustained and made durable through scientific accounts that present the construction and transformation processes described in the previous chapter in reversed order. Instead of considering medical interventions as the material preconditions from which new problem definitions and new patients emerge, these texts retrospectively present the medically defined problems of fetuses and couples, as well as these patients themselves, as pre-given phenomena. The problems and the patients are thus seen as the unproblematic starting points from which interventions follow, rather than the other way around. In order to achieve this reversal, the traces of the interventional work necessary to establish male infertility as a couples’ problem, and congenital disease as a fetus’ problem, are erased from the accounts. I will show how the ambiguous status of these new patients with respect to both naturalness and individuality is resolved by specific discursive patterns.

The first section describes a type of pattern that, following Star (1992), is referred to as ‘deletion’. It concerns a class of discursive mechanisms that accomplish the *erasure of interventions* on female bodies, and, by implication, their constitutive role in establishing new patients and new problem definitions. The second section deals with another pattern that

further enhances the idea that these technological practices are not about 'women' or 'female bodies'. This 'purification' pattern, as Latour (1993) has called it, reduces the duplicity of fetal patients and infertile couples. Instead of being about women and men as couples, and about women and future children as in fetal surgery, this pattern shifts the tenuous balance by suggesting that these practices are actually still, above all, about *men* and *children*. This makes recognition of the shift of medical problems between 'individuals' significantly more difficult (for, as will be taken up in chapter four, it diminishes the possibilities of seeing individual female bodies being involved in these technological practices at all). A further illustration of the working of the mechanisms involved in these two patterns is given in the third section on scientific evaluations of the technologies. Finally, the chapter concludes with some remarks on the possible effects of these patterns on the changing position of the female body in medico-technological reconfigurations of reproduction and the potential for contesting these changes.

2. THE DELETION PATTERN

An often observed characteristic of scientific discourse is that it produces a sense of neutrality, objectivity, and naturalness for the facts and objects it describes through what can be called "cleaned up accounts".²⁰⁷ In the first chapter several arguments and examples were given in order to highlight this function of style in scientific writing. Here, I want to focus in more detail on one form of such stylization that is specifically relevant to the politics of science and technology. The standardized formats and economic use of language so typical of technical, scientific writing accomplish effects that go beyond verbal parsimony. Purporting to give only scientifically relevant results, a highly stylized rendering of the work is achieved by leaving out most of the practicalities, day to day contingencies, and details that constitute the larger part of doing scientific research. Thus, in its representational practices,²⁰⁸ science - and experimental medicine is no exception here - produces its results, its discovered facts and objects, through inevitable selection of relevant details from a sea of irrelevant ones, by making distinctions between trivial practicalities of the experimental set up and significant theoretical or methodological advancements and results, and so on. Of course, any writing or reporting must necessarily be selective and make distinctions between what is relevant and what is not. Therefore, this selectiveness as such is productive: without it the very possibility of giving informative accounts would be lost.

However, this inevitable selectivity also means that there is no such thing as neutrality in writing. The criteria according to which one distinguishes between the relevant and the irrelevant, between information and noise, constitute a specific perspective, one that inevitably excludes others. From such other standpoints, particular selections of what is to be deleted and rendered invisible may come to look far less innocent than mere practical detail. Star (1992), for instance, convincingly argues that it is also the entire social and political constellation (divisions of labor, distributions of resources, and so on) from which the scientific pursuit of natural facts proceeds, which is erased in this selection. Thus the purity of scientific result can be seen to stem from an unavoidably partial selection of what will be related, from an inevitable complex configuration that is anything but pure or power-neutral.

In this section I focus on some of the 'deletions' involved in constructing couples and fetuses as patients in high-tech experimental reproductive medicine. I focus in particular on practical and material 'details' concerning the way in which female bodies are implicated in these practices.

A first point in this respect is the close interrelationship between the all-pervasiveness of the deletion pattern and the fact that 'couples' and 'fetuses' are considered the patient (in IVF and fetal surgery respectively). This translates into an immediate pattern in which interventions are not described as interventions on female bodies, but instead as interventions on said couples and fetuses. Referring to the fetus as the one undergoing procedures in fetal surgery is by now the standard way of describing things, despite the fact that women are physically involved here. Similarly, in IVF it is couples who are said to undergo the various invasive procedures involved in the technique, a way of speaking that replaces descriptions of women as the patient undergoing procedures. Especially in procedures that involve female bodies only, however one may define 'others involved', it is at first sight puzzling why the interventions should be referred to as follows:

Intratubal embryo transfer was carried out in 95 *couples* in whom male disorder was the main reason for infertility. All patients had had at least three intrauterine inseminations before they entered the IVF programme.[...] Four main schemes of ovarian stimulation were used in these *couples*.²⁰⁹

Obviously, both stimulating ovaries and transferring embryos into fallopian tubes is carried out on female bodies, something which seems unnecessarily obfuscated by ascribing it to 'couples'. But this pattern of redescribing interventions on women as interventions on 'other' patients, does not stand alone. It is accompanied by other, less obvious versions of the same mechanism that, together, produce a consistent, cumulative effect. This

effect, that probably was never consciously intended by anyone, may nevertheless be quite consequential.

The several varieties in which the pattern occurs have something in common. They achieve the deletion of the involvement of female bodies through *reconceptualizing intervention*: the actual interventions are redescribed and transformed into something else. This concerns less the fact that it is female bodies that are involved, as in the first example of the pattern given above, but rather the interventional character of the procedures themselves so that they are no longer visible as (part of) the therapeutic efforts proper.

A phenomenon constituting a major reconceptualization of therapy is the conceptualization of (major) surgery on pregnant women for congenital disease of future children as "*prevention*",²¹⁰ as is unambiguously stated in the following quote:

Advances in diagnostic and surgical techniques have provided a new basis for prevention of certain congenital defects by intrauterine therapy.²¹¹

Since the term 'prevention' signifies taking early action in order to avoid the occurrence of more serious problems that need more drastic interventions later, its appropriateness in this context is rather questionable.²¹² However, the point here is not to evaluate the appropriateness of conceptualizing surgery as prevention, by weighing the preventive measures against the harm prevented, but to consider the effect of a conceptualization as prevention in itself. This effect can be described as pulling attention away from the intervention as intervention and redirecting it elsewhere. 'Prevention' invokes an image of something prevented which tends to overshadow and downplay the means of prevention itself; as Ulrich Beck writes: "The center of risk consciousness lies not in the present but in the future"²¹³ Thus, the projected dangers of the future, the images of potential harm, are highlighted in a way that makes the interventions in the present become relatively shaded: preventive fetal surgery is primarily about some future damage avoided. The preventive measures in the present have, as a consequence, become secondary.

In this way the pervasiveness of the vocabulary of prevention in the discourse on fetal surgery suggests serious questions about its limits as an endeavor with a distinctly positive ring to it. Prevention relies on an estimation of risks, it involves the prediction of a future course of events that may then be altered and improved. In the case of pregnancy, establishing the required prognosis or diagnosis is a meticulous process of reducing the uncertainties inherent to every prediction by a growing series of increasingly invasive and risky procedures. Closely connected to the deleting effects of

Prosthetic Bodies

The Construction of the Fetus and the Couple as
Patients in Reproductive Technologies

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2001, VI, 172 p., Hardcover

ISBN: 978-1-4020-0116-1