technological and drug "advances" — they are in receipt of IVF "treatment" which would not have been necessary had there been no Dalkon Shield and no cavalier ignorance of women's health rights and rights to well-being and safety. This cavalier attitude continues in LAACAP countries. Defective, inappropriate, or medically untried and untested methods of contraception are foisted upon so-called third world women by so-called first world corporations and governments. It continues in western countries with these devices and defective drugs being imposed on Kooris, Murris, Nungas, Yamagee and other Australian Aboriginal women, women of colour, north American Aborigines, minority ethnic groups in countries around the world, and women in the lower socioeconomic strata.

Infertility is also attributable to environmental causes, as where women (and men) have in the past, or continue to, come into contact with Agent Orange and various pesticides, or hazardous workplaces. These hazardous workplaces have not disappeared from so-called developed countries. They remain profitable to the industrialists and important to national economies. Women of color, Aboriginal women, and lower socio-economic strata women and men are the major participants. Yet these industries are being transferred more and more into LAACAP countries. Ironically, capitalists gaining from the low-paid labour of women and men in the so-called third world may be (by the production or perpetuation of occupations detrimental to reproductive health) contracting the market for capitalists who seek massive dollar returns from selling "legitimate" mechanisms of contraception. The "medical model" (pushed into countries at a conveyor belt rate) of creating infertility vies with the factory model of creating fertility through "natural" (environmental and work related) means.

When women enter IVF and other new reproductive technology programmes, it is not made clear that they are being "treated" by a hazardous and experimental procedure. Surgical hazards have led to at least 15 known deaths on IVF programmes, two in Perth, Western Australia (Scutt, 1988). In addition to surgical hazards, feminists have comprehensively surveyed writing in medical journals dealing with various drugs currently used on women in IVF programmes (Klein/ Rowland, 1988). Their research caused them alarm, and raised concern about the possible long-term effects of the drugs on the women. In Melbourne, Victoria, Australia, one IVF programme has now announced it will no longer use hormonal treatment to stimulate greater ovum production in women on the programme. However, it is problematic whether this announcement means women's health and safety are the real concerns. Have the drugs really been dropped from the programme? If so, is it because of some other agenda relating to the maturing of immature eggs? If the Australian "leaders" of IVF technology believe it is necessary to respond to the reality long described by feminists — that fertility drugs are hazardous to women's health —the work feminists have done, drawing attention to the problems of drugs in these programmes, must be acknowledged as powerful. Unfortunately, women previously treated with these drugs remain vulnerable, as do women on programmes where the drugs continue to be used.

SEX AND SEXUALITY

Why are women so vulnerable to medical and scientific interference? Why do women's bodies become the sites for medical dominance and domination, scientific exploitation, and experimentation? Despite the differences in women's social, economic, political, and cultural backgrounds and existence, women's sexuality (both the real and the imagined) play a significant part.

In western traditional culture, women are treated as sexual beings, as if our entire identity were synonymous with our sexuality. Of course, in one sense it is: our sense of ourselves as human, as women, is directly related to our female personhood;

our biology is directly relevant to how we live in this world; our anatomy — the physical being of ourselves as women — provides an important centering for us all. Yet ultimately, we operate in the world as human beings with a multiplicity of talents, abilities, capabilities. And it is not our sense of ourselves as women that provides the dominant culture with its picture of the sexuality of women, or women as sexual beings. Rather, women are viewed through a male lens: we "are" what men think we are; our sexuality "is" as men see it.

Women in LAACAP countries labour under the imposition of dominant views of female sex and sexuality. In some countries — for example, in Africa, laws *require* women to bear children: the requirement that women become mothers is legislatively prescribed.[5] In all countries, because of the intrusion of western culture and western ideology, the view of woman-as-sex-object is continually emphasized. Few communities are able to avoid totally the marketing tactics of transnational corporations and, thus, advertising.

The male lens operates in numerous fields, numerous disciplines. Examples are replete in law. In criminal law, men are seen as basically human (apart from those few convicted of sex crimes, who are generally depicted as "lower-class," nonwhite, and subhuman). They may offend, and therefore be imprisoned or otherwise penalised. Yet no one suggests a man has committed a (nonsex) crime by reason of his sex and sexuality. For women, the story is different. If a woman shoplifts, it is "because" she is menopausal, pregnant, suffering premenstrual syndrome, premenopausal, postmenopausal. If a woman kills her child, it is because her hormones are "raging," or she is suffering from lactation, not because superhuman patience and childcare ability is demanded of her 24 hours a day. A man who shoplifts is not put into the menopausal category; his hormonal cycles are not seen as the cause. The man who kills is not seen as doing so because he is male. Many other everyday explanations are seized upon, all of which have nothing to do with his sexuality. The only criminological theory that raised the possibility that men are criminal because of their biology was the "double YY syndrome" theory, which had a pronounced run for a short time in the 1960s and early 1970s, then was swiftly abandoned (Burke, 1969; Wallach & Rubin, 1971). (Was it abandoned because if was found that numerous men had a YY genetic makeup and the notion of stigmatising them all with the appellation "criminal" was too sensitive an issue?)

A woman working as a prostitute does so (in dominant theory) because she loves it, that's what women's bodies are for; that she works because she, like men, needs money to buy food, to live to pay rent, to pay school fees and childcare expenses, for a roof over her head is ignored, or seen as secondary. Men travel from so-called developed countries to the so-called third world, on what are called "sex tours." They "buy" women through mail-order systems. Catalogues are produced with pictures of women on display and men "take their pick." The allegation is that women *choose* to be pictured here; they *choose* to work in bars (after all, it's not *really* work: it's buying — or being bought — drinks, having fun!); they *choose* to live in the vicinity of United States' and other imperialist navy bases and international seaports; that the "choice" is dictated by the need to live (which requires money), and that the man with the wallet calls the shots, is ignored. This ignorance or oversight is convenient for men, and for governments dependent on the tourist dollar and foreign government support.

Where women engage in paid employment, our sexuality is frequently seen as at the base of our engaging in paid work. The nurse works as a nurse because she typifies the caring, nurturant female role: her sexuality and job are interwoven. The woman works as a secretary, because her sex and sexuality "fit" her for the role of "second wife." The woman lawyer works in family law, because family law is a "fitting role" for a woman — if she must

at all enter into a nontraditional field such as law. Sexual harassment on the job is as prevalent as it is because where women seek to adopt a role which (to women) is unrelated to our sexual being (at least as men see us), it is translated into being *directly* related to it: ergo, women become targets of sexual abuse, attack, and exploitation albeit working in jobs that we consider have nothing to do with sex or sexuality. Women working in service industries are seen as legitimate sexual targets. If she's serving drinks or making hotel beds, then she's "fair game."

HEALTH, SEX, AND SEXUALITY

That women are viewed in the dominant culture as sexual beings is readily apparent in the health field. Our sexuality influences our treatment, our legal standing, and the regard in which we are held. This is so whether we enter the field as patients, nurses, doctors or other professionals, or as persons seeking preventative education in health.

A study by Robyn Holden of the Australian Nurses Federation (ANF) found nurses subjected to physical violence in hospitals, by patients (Holden, 1985). It is also notorious (at least amongst women and women working as nurses) that nurses are subjected to extreme sexual harassment by patients and by doctors. Women's caring role is seen as central to nursing and, it seems, our sexual availability as women is projected into the nursing role. In Australia (and no doubt elsewhere) it is not uncommon for young men at university to speak lasciviously about "the nurses" at the local hospital, publicising real (or imagined) sexual exploits with them, as if nurses are there to be used sexually; that nurses are engaged in *a job* is remote from the minds of these students, and appears to be equally remote from the minds of the doctors and patients who engage in sexual harassment of them. Or perhaps it is that the job is seen to encompass, even to signal, women's sexual availability.

Sexual harassment of women patients by male medical professionals is widespread. In a study currently being conducted in Australia, doctors take sexual advantage of women patients, as do psychiatrists, physiotherapists, and dentists (Scutt, in progress). In England a physiotherapist who sexually harassed a woman, to such an extent that the acts amounted to rape, had a civil action for damages taken against him by her. She brought the action in trespass: intended touching of her body in ways that were sexual and had as their object sexual "favours" and the exploitation of the power position in which the physiotherapist stood, vis-a-vis the patient. Just as police refuse to take action where a nurse has been criminally assaulted by a patient, on the spurious ground that "it's a civil matter, not a criminal matter" (reminiscent of the police approach to criminal assault at home), so the police refused to prosecute the physiotherapist for rape and sexual assault (P. Ambikapathy, personal communication, 1989; Scutt, 1983, 1990a). It was then that the woman patient launched her civil case. This was a "first" in British legal history — in tracing back, no case was recorded where a person had taken an action for civil trespass where she (or he) was victim of a sexually exploitative crime in such circumstances.

What has to be remarked on, in looking at these three areas, is that the triggering factor in the sexual harassment and abuse is that the victim/survivor is FEMALE. In each situation, she plays a different outward role: in one, she is the nurse, the worker who cares for the patient who exploits and abuses her; in the second, she is a patient who is exploited and abused by the person in the "caring" role — doctor, physiotherapist, psychiatrist; in the third, she is a worker and work colleague — a person ostensibly on an equal level, or at least a level where the hierarchy is between professionals (doctor to nurse) — who is exploited and abused by a colleague. The common factor in each scenario is that the victim/survivor is a woman; the sexual exploiter and abuser is a man. Whatever her position or role, he relates to her as a sexual being who is

useful to him in that role: he acts as if he believes he has a right to her person, to her sexuality (which are seen as identical; as one and the same thing); that (if she has any "independent" part to play at all) she must/will respond to his imprecations.

Ironically, the traditional professionals whom women attend for help, treatment, and preventative education are the persons who frequently create or add to women's illhealth. Having added to that illhealth, doctors and other professionals are they who profit: women are obliged to continue treatment with that individual, or seek help from some other professional. Psychiatry is one example. The Freudian approach — of regarding women "patients" seeking help, having been sexually abused in childhood, as "liars", women with unmet desires to engage in sexual intercourse or sexual activity with a father, uncle, family friend, etc. — is one which guarantees the profession a continuing source of "patients." If a woman is told her reality — of being sexually abused as a child, by her father — is a fantasy, she is being told that her reality does not exist. In such circumstances little wonder she thinks she is mad, or sick, requiring continuing treatment for her illness. And she can never recover her equilibrium, until she has her reality confirmed. This professional will never confirm it. Ergo, he has a patient for life.

Infertility provides another such example. Doctors providing substandard or even actively harmful contraception, or treating women's bodies without care during surgery, provide generation upon generation of doctors with generation upon generation of patients. Women rendered infertile by doctors return to doctors to have themselves "made whole" again. The "answer": yet more damaging "treatment."

When a woman is not a patient but, rather, a carer — as is the case for nurses — her health is also at risk. The woman, placed in the role of sexual being despite her work role, is at risk of her health and wellbeing. Sexual harassment on the job is a work hazard. She suffers psychologically and sometimes physically as a consequence of the sexual harassment. She becomes a (genuine) candidate for treatment. Her work (literally) makes her sick.

WOMEN'S SEXUALITY TODAY

Yet although we rightly rail at the way dominant patriarchal culture has seen women either as sex objects or as the perfect mother — the woman who gives her all to her children and has no identity beyond this role—developments in reproductive technology hail a new way of looking at women. In the past, it was woman's sexuality which was objectified. Today, woman's sexual role as mother is being objectified, too.

New reproductive technologies are removing from women our mothering role. Medical scientists are promoting the notion that women's bodies are vessels only—providers of a womb in which a child may be carried, a child produced by artificial means. This occurs in popular culture, as in the advertisement for a Volvo car appearing on billboards and in the print media (Koval, 1988, p. 125):

> There's only one safer place than a Volvo to carry young children. Up to the age of nine months Mother Nature does a magnificent job providing for the transportation and protection of the very very young. After that, unfortunately, she runs out of room.

But it is not only advertisers who see women in this way. So do so-called professional health carers, as well as members of the judiciary. As Klein and Rowland state (1990, p. 5–6)

> . . . masculinist and misogynist science and medical technology is . . . characterised by its focus on DISMEMBERING, FRAGMENTING AND DISSECTING real live women into their body parts in what Janice Raymond has called 'Rambo-technology' (Raymond, 1988): women are depersonalised and reduced to wombs, eggs, ovaries — to body parts

> disconnected from the women and their lives. Dr. Robert Winston, a British IVF practitioner, describes so-called surrogate mothers as 'endrocrinological environments'; Judge Harvey Sorkow, who heard the Mary Beth Whitehead case, called surrogates 'alternative reproduction vehicles'; and the American Fertility Society described them as 'therapeutic modalities' (in Corea, 1988). Losing their identity and personality, women are also seen by researchers as research animals. As Drs John McBain and Alan Trounson put it, 'the human female is capable of having substantial litters. . . . ' (McBain & Trounson, 1984, p. 54)

This distancing of women from our role of "mother" is equally as dangerous as seeing women ONLY as mothers. The problem is that we as women globally have not been able to establish our own vision of ourselves as fully human, with a unique quality of giving birth to life, a capacity which is wholly female and which we may, or may not, determine to use. The countervailing strength of the dominant culture interposes. It is destructive both to women who do physically bear children and to those of us who, for whatever reason, do not. The interests of women, whether classed by the dominant culture as "fertile" or "infertile," are intimately linked.

THE FEMINIST "NEW WORLD"

The creation of a "new world" that is not of masculine making but of feminist understanding, devotion and care — a feminist "new world" will come about only when the sexuality of women and our personhood ceases to be seen through a male lens. This can only occur when the male version of our sexuality ceases to be central to what we are as women, and to dictate the way the world reacts and relates to us.

The dominant approach to infertility and to fecundity reveals an "old world" problem. Why are infertile women seen as "patients", candidates for medical science and technology? Where doctors create the infertility it is they, not the women rendered infertile, who require treatment: reeducation into caring, considerate human beings capable of doing their job correctly and without damage to women, women's bodies and women's psychic health. Where scientists have rendered women infertile through their experimentation and ignorance of women's bodies and women's humanity, it is they who require treatment, not women: reeducation into feminist science, not the scientific reductionism in which they engage.

Motherhood is not the apotheosis of being female, human, alive as a woman on this earth. That we have a maternal or a sexual capacity is not the sole reason for living. But because the dominant culture sees the mothering capacity and the sexual capacity of women as all encompassing, "treatment" modules are designed with that in mind; solely in mind.

Where a white middle-class woman is diagnosed "infertile" (and what does that truly *mean!)* the "treatment" in the "developed" world (as well as for middle-class women in LAACAP countries) is to "make her pregnant" by whatever means possible — and where it is not possible, to manufacture a climate where other women will "stand in" for her. The economic and sociopolitical condition of women ensures a steady stream of women who will fill the "surrogate" mother role. And it is often too late that these women realise they are not "surrogates" at all, but *mothers.*

Women from the so-called third world are not generally diagnosed "infertile" when they attend sterilisation camps or other purveyors of enforced contraceptive measures. The infertility rates of women in LAACAP countries are high.[6] Nonetheless, fertile or infertile women who are poor and who are of nondominant ethnicity, whether in LAACAP or western countries, are seen as candidates for population control. International conferences are held to determine the "best" way to control LAACAP women's fecundity. Programmes are devised (with minimal publicity) in "developed"

countries to control the fertility of women in lower socio-economic or minority ethnic groups. Often, there is no overt organisation of such control, but racist and white supremacist notions are so firmly entrenched that individual doctors and other health professionals implement techniques for "holding down" the reproductive capacity of women in these groups (Corea, 1988, p. 148).

An enormous industry has been built up around the sexualisation of women's bodies. In the medical and scientific field, the leaders are associated with new reproductive technology programmes, and cosmetic surgery. In the so-called third world, or for poor, ethnic minority women in "developed" countries, the target remains population control, or the provision of "fertility" for infertile western women (and men). In the so-called "leisure" industry, it is pornography and advertising, and mainstream soap opera, that use women's bodies and feed back into the sexualisation of women's bodies and women's lives. Another aspect of "leisure" industry is tourism and the hotel industry, and "sex tours" — where women's bodies provide the central core of "pleasure — making" (for whom? for what?).

Women must continue to articulate our demand that women the world over have rights to high standards of maternal and infant health care. It is only when women in LAACAP countries or living in "third world" conditions in industrialised nations do not need to give birth to many children, in the hope that two or three will survive, that a new world will emerge. Women must continue to demand a right to define our own sexuality, free of dominant cultural views of women and womanhood. It is only when women are not forced, by economic and sociopolitical circumstances, into selling sexuality as a commodity that our sexual autonomy will be gained.

It is vital that we continue to appreciate our unique capacity for childbearing, whilst riot falling into the trap of romanticising motherhood and maternity. The maternal approach taken by a world that places motherhood on a pedestal whilst depriving women of autonomy, and childbearers and carers of substantial (or any) supports must be critiqued continually. This critique must ensure, however, that we do not fall into the trap of providing an argument for those who wish to "assist" us by providing mechanical and experimental means of creating children — through IVF and other new reproductive technologies. Similarly in renouncing male-imposed "visions" of female sex and sexuality we must provide a positive female expression of our own sexual autonomy.

Women's sex, sexuality, health, and economics are closely intertwined. It is imperative that in any moves to create a new world, we recognise this vital link. Any approach which denies women's independence and autonomy, and our rightful place as human beings rather than sex objects or mother-icons, cannot be appropriate. Any approach which adopts unthinking resort to the rhetoric of "choices" in a world where women are limited by the very essence of male dominance, male power, white supremacist governments, and multinational corporations spells further colonisation of women's bodies. Women have a responsibility to act with integrity in our own lives. We cannot support the use of other women's bodies for scientific and medical experimentation and exploitation. We cannot support the use of other women's bodies to give us the "choice" to "have" a biological child. We must be wary of a medical profession and scientific community that, in the guise of "help" creates, recreates, condones, or continues the prominence of (the male vision of) women's sexuality in the place of women in the world, and that seeks to utilise women's bodies as alternatively playgrounds and experimental sites. Whether it be the leisure industry or the medical industry, we must be wary of "solutions" that bring to women misery and further "health problems," and to the (male) proponents of the "solutions" fame and further economic and charismatic power.

END NOTES

1. The expression "LAACAP countries" was coined at the 6th International Women and Health Meeting in the Philippines from 3–9 November 1990. The acronym stands for Latin American, Asian, Caribbean and Pacific, and was formulated to overcome the inadequacy of expressions such as "third world" and "first world"; "developed" and "undeveloped" countries; "North-South" nations.

2. Women from LAACAP countries attending the 6th International Women and Health Meeting gave graphic examples of the foisting upon women of sterilisation and tubal ligation operations, as well as the use of such long-term contraceptives as Norplant, by their own governments or imposed from outside, by governments of "first world" countries, particularly the United States of America (see also Akhter, 1988).

3. RU486 is promoted as a "boon" drug to be used as an abortifacient by women in LAACAP countries as well as in "developed" countries. Klein, 1990; and Raymond, Klein, and Dumble, in progress, point out the absence of any long-term testing of RU486 and the negative short-term effects of RU486 on women's bodies.

4. Civil litigation is mainly engaged in by corporations and individuals who have sufficient financial standing and personal status to bear the expense and personal stress associated with participation in the legal system. Although rates of litigation in medical negligence cases differ between countries (for example, the United States of America is generally recognised as the most litigious nation regarding medical negligence) it is nonetheless true that women, being more often in the lower socioeconomic strata and having other characteristics which render them less likely to participate in the legal system as civil litigants (minority ethnic status, minority racial status) will relatively rarely appear in court-room battles for redress. However, due to the very nature of the doctor-patient relationship and the position of women (as patients) vis a vis men (as medical practitioners) it is likely that many women would have cause for complaint in the nature of medical negligence, etc.

5. At the 6th International Women and Health Meeting in the Philippines a woman from Nigeria spoke of laws existing in African countries which require women to reproduce.

6. At the 6th International Women and Health Meeting it was reported that women from LAACAP countries suffer high levels of infertility as a consequence of poor sanitary and hygiene conditions. Sexually transmitted diseases exacerbated by tourism and other external impositions, is also the base of a significant part of infertility rates. Contraceptive measures "gone wrong" as a consequence of initial rough treatment by medical practitioners, or failure to adequately "follow up" also causes infertility among women in LAACAP countries.

REFERENCES

Akhter, Farida (1988). The Norplant trial: An investigative study on methodology and ethical issues. *Hygeia* 3(1 and 2), pp. 19–34.

Burke, Kenneth J. (1969). The XYY Syndrome: Genetics, Behaviour and the Law, 46, *Denver Law Journal* 261–293.

Corea, Gena (1985). *The mother machine: Reproductive technologies from artificial insemination to artificial wombs.* New York: Harper & Row.

Corea, Gena (1988). Women, class and genetic engineering — The effect of new reproductive technologies on all women. In J. A. Scutt (Ed.), *The baby machine,* Carlton, Victoria, Australia: McCulloch Publishing; pp. 135–156.

Holden, Robin (1985). Aggression against nurses. *Australian Nurses Journal, 15(3),* 44–47.

Klein, Renate (1990). RU486: A New Miracle Drug? *WEL Newsletter,* Canberra, A.C.T., Australia (December).

Klein, Renate & Rowland, Robyn (1990). *Women as body parts in the era of reproductive and genetic engineering.*

Keynote Address, 4th International Conference on Women's Health Issues, Nov. 1990. Massey University, Palmerston North, New Zealand.

Klein, Renate & Rowland, Robyn (1988). Women as test-sites for fertility drugs: Clomiphene citrate and hormonal cocktails. *Reproductive and Genetic Engineering: Journal of International Feminist Analysis*, 7(3), 251–275.

Koval, Ramona (1988). The commercialisation of reproductive technology. In J. A. Scutt (Ed.), *The baby machine.* Carlton, Victoria, Australia: McCulloch Publishing, pp. 108–134.

McBain, John & Trounson, Alan (1984). Patient management-treatment cycle. In C. Wood & A. Trounson (Eds.), *Clinical in vitro fertilisation,* Berlin: Springer Verlag.

Mink v. *University of Chicago* (1978). Cited Cynthia Orenberg, (1981). *DES: The Complete Story.* New York: St. Martin's Press.

Mintz, Morton (1985). *At any cost: Corporate greed, women and the Dalkon shield.* New York: Pantheon Books.

New South Wales Anti-Discrimination Board (1986). *Annual Report.* Sydney, N.S.W., Australia: Government Printer.

Raymond, Janice (1988). At issue: Of eggs, embryos and altruism *Reproductive and Genetic Engineering: Journal of International Feminist Analysis,* 7(3), 281–285.

Raymond, Janice, Klein, Renate, & Dumble, Lynette (1991). *Broadening the RU486/PG debate: A non-aligned feminist report.* Boston: Institute on Women and Technology, forthcoming.

Rich, Adrienne (1977). *Of woman born.* London: Virago Press.

Scutt, Jocelynne A. *White Collar Rape: Sexual Exploitation of Clients by Professionals,* (in progress).

Scutt, Jocelynne A. (1983/1990a). *Even in the best of homes: Violence in the family.* Ringwood, Victoria, Australia: Penguin Books; Carl ton, Victoria, Australia: McCulloch Publishing.

Scutt, Jocelynne A. (1988). *The baby machine: The commercialisation of motherhood.* Carlton, Victoria, Australia: McCulloch Publishing.

Scutt, Jocelynne A. (1990b). *Women and the law: Commentary and materials.* Sydney, N.S.W.: Law Book Company.

Wallach, Alta & Rubin, Larry (1971). The premenstrual syndrome and criminal responsibility. *U.C.L.A. Law Review, 19,* 210–254.

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IVF-BABIES BY NUMBERS

MARIE HUGHES*

In this talk I will describe my IVF experience. I'll begin with some background information. I have a child from a previous relationship and my husband has two. He then had a vasectomy. We hoped to have a child together so my husband underwent a reversal.

After 12 years since the vasectomy, the reversal was a difficult and painful operation. Recuperation required 2 months of light duties, no lifting, no running, no driving for 2 weeks, no intercourse. After 12 months it was deemed to be unsuccessful and his surgeon tried to persuade a repeat operation. It was obvious that we were extremely unlikely to take that course but he insisted that we take 3 days to think about it. After 2 days he phoned to tell us of this magical new alternative. He had a real sales pitch, it was literally "only one space left, on the wonderful, all-new, miracle program. If you don't get in now you'll never have another chance." We bought it.

We went along to the information night which was something Jimmy and Tammy Bakker would have been envious of:[1] glossy videos, glossy publications, smooth talk. This was only the second time this particular program had been conducted; the first time resulting in 1 pregnancy out of 20 couples. A 5% success rate. A woman who had been on the first program sang the praises of the vaginal egg pick up with no pain, no anaesthetic, no side effects. A vaginal egg pick up is performed with ultrasound guidance through the vagina. The ultrasound probe is inserted painlessly into the vagina and a needle passed through the vaginal wall into the follicles on the ovaries. Each follicle is punctured, aspirated, and flushed out several times with fluid.

It was a good package, well sold, and we were made to feel very privileged, very fortunate to have the opportunity to use this wonderful technology designed especially for us very special people and that was how they wanted us to feel. Very, very special.

It became obvious that many people on the program were almost obsessed with the aim of having a child. We believed we weren't as troubled. We thought we would have this last try. For us it meant that if it failed, we could get on with the rest of our lives. The main reservation we had was that it didn't seem right that the woman's cycle had to be altered to fit in with the timing of the program by the use of powerful hormonal drugs when the infertility problem lay with the male. I was advised to undergo a laparoscopy some months prior to my husband's reversal to ensure that I would have no problems becoming pregnant. I had no history of infertility problems and I had already had one child. I went ahead and had the operation. My husband was also deeply concerned as I suffer extreme PMS and he was concerned as to the long-term effects of interfering with my body. He likened

*Marie Hughes is a pseudonym. The events she is describing took place on an IVF program in Melbourne, Australia. This is an edited version of a talk she presented at the Women and Surgery Conference, organised by Healthsharing Women, September 26–29, 1990 in Melbourne, Australia. It is published in the Conference Proceedings.

the scene from the film *The Exorcist* with the woman's head spinning around as typical scenes in our home at PMS time.

All 20 women on the program were regulated to ovulate within 5 days of each other regardless of what their natural cycle was. This entailed commencing Clomiphene Citrate (Clomid) tablets from day 4 to 8 of the cycle, one in the morning and one at night. On the 2nd day of taking Clomid tablets, daily injections 150ml of Human Menopausal Gonadotrophin (hMG) began. After 2 days of injections twice daily blood samples to measure the Estradiol, LH, and Progesterone hormone levels are taken and an ultrasound scan is performed to observe the growth of the follicles. Within the next few days another ultrasound is performed and on the last day or so before the anticipated egg collection a 5000ml dose of Human Chorionic Gonodotrophin (hCG) is given to trigger ovulation.

We felt really prepared. I had been to the library and got out everything I could find on IVF. But there was *nothing* on this procedure as it was so new. However, I bought books by Jocelynne Scutt[2] and other opponents of IVF so that I could be well informed and have a balanced view. I talked to women who had been through the program and I believe we went into it well informed, prepared to ask questions and not be manipulated. How wrong we were. The counselling is a farce. It is there as a legal requirement to enter the program (Victoria is the only State in Australia with this law) but is used as a massive P.R. (public relations) exercise.

I will now talk of the weeks leading up to the procedure. I was told to attend the clinic at 7:00 each morning for blood tests, injections of hMG, and a talk with the doctor. What I hadn't been told was that not only the 20 women on the same program as I, but the 100 or so other women on different programs, were also required to be there at 7:00 A.M. On day 1 I arrived bright as a button at 6:55 to find I was about number 30. I even had to take a number. No one told me the queues would be 1 hour long. No one told me that there would be queues. Queues for blood, queues for the doctor, queues for the injection.

When I tried to question the system I received no satisfactory answer. Already I was becoming just another number, just another bum to prick, just another chart to read. The special treatment promised by my special medicos was fading fast.

Communication was starting to break down. One doctor gave one date for my egg pick up and when I mentioned this to the next doctor I was told to forget it, the first doctor had no right to say that. It wasn't important anyway. Maybe not to him, but it certainly was to me. So much was going on at the time that it was crucial to know exactly where I stood. We were to ring at a certain time for my blood test results. What we hadn't been told was that 100 other women were also ringing at that time and it turned into Repetitive Strain Injury of the dialing finger for an hour or so to get through. Yet more frustration. The frustration was becoming unbearable. Here I was. Where was the woman who wasn't going to be flustered? Wasn't going to become obsessed? Was going to be forthright and insist on being treated properly? She got lost in the number system along with the other 99 women, probably all feeling much the same way.

On the final week of the program my husband was admitted to hospital. He had a plush private room and we thought it wonderful to have privacy. By lunchtime of that day I had really bad pain in the abdomen, and knew, not from the IVF literature but other research I had read that I was ovulating. By late afternoon I had great difficulty walking and I told a nurse. She told me not to worry as it would all be over soon. I was also admitted to hospital later that day. However, I was admitted to the rundown section of the hospital: a ward with six beds, peeling wallpaper, and vinyl floors. I can laugh now at the irony of the men in the plush private rooms and the women, like chickens, herded into the hatchery, ready for processing. By this time I was really concerned about the extreme pain I was in and called sister again as the pain was getting worse. I asked to be put up the queue as I knew I

was ovulating. But I was told that as my husband's surgery was not till the evening I would have to wait.

After my husband had been through surgery a nurse advised me that his operation had been a success. He was now fertile and the blockage had been cleared. She indicated that they took a good batch of sperm. Even the terminology gets to me now. A good batch of sperm, I wonder if that's like a good batch of scones from the oven. My first reaction was happiness. Though in a split second it dawned on me that they had carried out the procedure they were told not to do. From the nurses description I realised that they had done another complete reversal. Not a sperm collection as we had agreed upon. As this started to sink in I became quietly hysterical and sobbed for an hour or so. The realisation of what they had done hit me. Together we had agreed on the "first" operation. This was the only way my husband had agreed to the procedure and they had not done this. Some-' how I felt responsible. I felt I had disappointed him and let him down. I don't know why I felt this way but I was quite distressed. I then became very angry with the doctors.

My turn came for the surgery and up until this time I hadn't seen the anaesthetist. I met him as I was being wheeled into surgery. I told him of my pain and he said it would all be over soon. As if that made it alright. It didn't click that I was going to have a general. I react very badly to them. Every post-op (post-operative) nurse's nightmare. Not pleasant at all. I didn't want a general but I wasn't given a choice. By the time I was put on the table it was all being organised and I got an injection which knocked me out before I could protest.

When I came to in the ward some hours later, I knew something was wrong, as I was in more pain than I had been in before I went into surgery. They had performed an egg pick up via laparoscopy. I hadn't been warned I would have surgery. They certainly hadn't asked me. I was furious. They later claimed that they had commenced a vaginal egg pick up but as I had ovulated they needed to do a laparoscopy. Funny that. However, that didn't account for the general anaesthetic nor the fact that I wasn't told there was a possibility of a laparoscopy. I was still furious. I can only surmise now that it was quicker, easier, and more beneficial for them. Not for me, but for them.

It took until the next day to find out how many eggs had been collected. There was no ward round as they claimed there would be. My husband hobbled up to visit me and bumped into my gynecologist in the corridor. He was told, not me, what procedure they had used. They had tried a vaginal pick up, and realised it was too late. They then proceeded with a laparoscopy. They took six eggs and then the surgeon, without having requested permission, injected my tubes with my husband's sperm. Just in case.

Meanwhile, we were unprepared to be so incapacitated and this again caused massive logistical problems. In simply getting both of us home. We had not made long-term arrangements for anyone to look after our son. My husband was told not to drive but had no choice. He discharged himself from the hospital to collect our son, returned to the hospital to collect me when I was able to be discharged and then back home again. A round trip of approximately 120 kilometres. In a gear shift car that he was not supposed to drive. We were also in the middle of packing house and had to hire someone to finish the job for us as neither of us was capable.

We were told that the results of our egg fertilisation would be ready by 3:00 PM the next day. We didn't find out till 3 days later as they were trying to cope with so many results. Our hope was quickly fading and we were eventually advised that no eggs reached fertilisation stage.

I was due to have a pregnancy test 2 weeks later to find out if the procedure they had performed on me had worked. On the day my period was due and about 3 days before my pregnancy test I started to exhibit strange behaviour. Every hour or so I would go to the toilet, insert a tampon, remove it and inspect it minutely for any sign of colouring. Within two days I had gone through near four packets of tampons