

UNIVERSITY OF CALIFORNIA, SAN DIEGO

Preconceived Notions: The Social Construction of Male Infertility

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by

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The dissertation of Liberty Elizabeth Walther Barnes is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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## ABSTRACT OF THE DISSERTATION

Preconceived Notions:  
The Social Construction of Male Infertility

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Gender scholars argue that in Western culture hegemonic gender beliefs are widespread and stable, and individuals' access to resources and power are contingent upon their ability to conform to these ideals (Ridgeway and Correll 2004; West and Zimmerman 2002). However, they also argue that gender is a fluid and dynamic aspect of identity, as demonstrated by

individuals' ability to revise personal notions of gender based on other salient features of identity, including, race, class, age, sexual orientation or physical (dis)abilities (Connell 1995; Fenstermaker and West 2002; Kimmel 2006; Ridgeway and Correll 2004; West and Zimmerman 2002). This dissertation uses male infertility as a case study for exploring what happens when the perceived foundations of masculinity are destabilized in the lives of heterosexual married men.

Male factor infertility is a clinical condition that affects nearly half of the more than seven million infertile couples in the United States. For this original research study, I employed mixed qualitative research methods, including ethnographic observation in male infertility clinics, in-depth interviews with male infertility specialists, clinic staff, infertile men and their wives, and content analysis of medical texts and conference addresses, in order to examine how medical institutions and individuals socially construct male infertility. I argue that the social processes of constructing gender and negotiating masculinity are tightly intertwined with the process of constructing disease.

Early in this dissertation I show that preconceived notions regarding women's responsibility for all aspects of reproduction have historically shaped popular understandings of male infertility and hindered the development and organization of male infertility as a medical specialty. I describe how medical practices are designed around preconceived notions of men as sexually knowledgeable and experienced, yet all the while strive to protect presumably fragile masculine identities. I detail the various ways infertile men work to

redefine their condition in terms that downplay infertility's threat to masculinity. Throughout this dissertation I argue that gender-constructing and disease-constructing processes are inextricable, because notions of gender inform understandings of disease. When disease presents a threat to gender identities, individuals create new understandings of disease in order to negotiate and stabilize their personal gender identities.

Chapter One:

CONSTRUCTING GENDER & DISEASE: Making Room for Male Infertility  
within the Sociological Imagination

Chapter outline:

***Introduction***

***Male Infertility in the ‘Reproductive Imaginary’***

***Literature Review***

*Infertility and Assisted Reproductive Technologies*

*Male Infertility*

*Gender Theories*

***Contributions of this Study***

***Methods***

*Research Questions*

*Mapping Out the Infertility Industry*

*Research Design: Mixed Qualitative Methods*

*Challenges to Research: Performance of Subjects, IRB Protocols, and*

*My Role as Researcher*

*The Trouble with Masculinities*

***Dissertation Chapter Outline***

Gender scholars argue that in Western culture hegemonic gender beliefs are widespread and stable, and individuals' access to resources and power are contingent upon their ability to conform to these ideals (Ridgeway and Correll 2004; West and Zimmerman 2002). However, they also argue that gender is a fluid and dynamic aspect of identity, as demonstrated by individuals' ability to revise personal notions of gender based on other salient features of identity, including, race, class and age (Connell 1995; Fenstermaker and West 2002; Kimmel 2006; Ridgeway and Correll 2004; West and Zimmerman 2002). This dissertation investigates how individuals respond when they realize they do not measure up to culturally dominant gender ideals. Concisely put, how do men deal with a crisis of masculinity?

This research study uses male infertility as a case study for exploring what happens when the perceived foundations of masculinity are destabilized in individuals' lives. As I discuss throughout this dissertation, cultural norms dictate a fundamental and fixed understanding about men and reproduction, specifically, that fertility is closely tied to virility. A man's masculinity is evidenced by his ability to impregnate his wife. Over the next several chapters, I describe how infertile men engage in 'gender work' to maintain their masculine identities when they cannot live up to the social expectations of their roles as men and husbands.

The American Society for Reproductive Medicine (ASRM) reports that 30% of infertile couples suffer from male factor infertility. While 30% are due to female factor infertility, 20% are due to both male and female factors, and

20% of couples have unexplained infertility.<sup>1</sup> In other words, men are responsible for heterosexual couples' inability to conceive in about 40% of all infertility cases. Internet sites, books, and magazines devoted to helping couples combat infertility provide long checklists for women: fertility signs she should watch for throughout her menstrual cycle, diets and vitamins that will improve her fertility, questions she should ask her doctor. Articles and books by psychologists, social workers and sociologists detail the grief, frustration, and depression suffered by infertile women. Infertility is an estimated three billion dollar industry, in which specialists who treat women dominate the business (Spar 2006). Despite statistics that indicate men are equally responsible for infertility, the notion that women are primarily responsible for infertility still prevails in contemporary society's collective consciousness. Have infertile men escaped the medical gaze and social scrutiny? Why, in light of scientific evidence showing that men are just as likely to be infertile, do women bear the brunt of reproduction and infertility treatments? Are infertile men invisible?

According to the National Center for Health Statistics (NCHS), there are 2.1 million infertile women in the United States of reproductive age, and 7.3 million American women have used infertility services.<sup>2</sup> The NCHS has closely monitored fertility rates, fertility status, and use of infertility services among women in the U.S. for the past several decades. No such statistics

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<sup>1</sup> ASRM web-site: <http://www.asrm.org/Patients/faqs.html#Q2>:

<sup>2</sup> NCHS web-site: <http://www.cdc.gov/nchs/fastats/fertile.htm>

exist for men. Where are all of the infertile men? Who are they? How do they cope? Where do they find help and support?

The goal of this research project is to better understand the lives of the millions of American men who live with infertility. This dissertation is the record of my journey to five male infertility clinics across the country where I spent over one-hundred hours observing clinical encounters between doctors and infertile male patients. Along the way I met twenty-four couples whom I interviewed in-depth and followed over time as they dealt with male infertility. What follows are the stories of men who are emotionally traumatized by their infertility, and stories of other men who downplay or outright deny their infertility. The men in this study chose to seek out information from medical authorities, and many pursued invasive and painful medical treatments to restore their fertility. The choices these patients made along their infertility journey illustrate how infertility forces men to consider society's preconceived notions of masculinity, and how individuals have the power to reformulate, revise, and reconstruct ideals of masculinity. I draw upon data from the field, including observations of medical practitioners and medical practices, to show the ways that medical institutions also actively engage in constructing and perpetuating popular ideas of masculinity and gender.

This research study straddles several fields of sociological inquiry: gender, medicine, infertility, assisted reproductive technologies, masculinities and men's health. Gender sociologists concur that while sex may be based on chromosomes, hormones, and anatomy, *gender* is socially constructed.

Similarly, research by medical sociologists has repeatedly demonstrated that though the biological reality of disease may be indisputable, the definitions and meanings of disease are socially constructed (Cockerham 1986; Freund and McGuire 1995). The findings from my research study as presented in this dissertation provide support for the main argument of this project. I argue that the social processes of constructing gender and negotiating masculinity are tightly intertwined with the process of constructing disease. As I show throughout the following chapters, gender-constructing and disease-constructing processes are inextricable, because notions of gender inform understandings of disease. When disease presents a threat to masculinity, individuals create new understandings of disease in order to negotiate and stabilize their personal gender identities.

### ***Male Infertility in the 'Reproductive Imaginary'***

In 2009 Barnard College hosted its 34<sup>th</sup> annual Scholar and Feminist conference. The theme for the conference was "The Politics of Reproduction: New Technologies of Life." The conference schedule was impressive, including social scientists, business professors, lawyers, physicians, activists, documentary filmmakers, and artists, with the keynote address given by renowned British anthropologist Sarah Franklin. The conference raised many important political and moral issues relating to infertility, assisted reproductive technologies (ART), and adoption, including, the commodification of eggs, sperm, and surrogacy; the health risks of ART for women, infants, and egg donors; the capabilities of and access to ART for homosexual couples; the

rights of donor offspring; class disparities regarding access to ART; state regulation of the infertility industry; legal rights of parents and surrogates; reproductive tourism; genetic selection and eugenics; and the experiences of transnational adopted children. The perspectives and ideas shared before a crowd of 200 feminist attendees were thought-provoking, compelling, and important.

The conference program illustrates the direction of feminist scholarship, which at present is focused on the various complex solutions to infertility. As technology advances, and markets for surrogacy and adoption expand, feminists are poised to follow and examine these solutions, critiquing the ethical issues they raise. This dissertation, however, challenges feminist scholarship to turn its locked gaze from the scientifically innovative and socially ingenuitive solutions of female infertility back to the infertile bodies trying to achieve pregnancy, including male bodies. While the conference speakers thoroughly covered the experiences of women (mothers, surrogate mothers and egg donors) and the technologies used to treat these women, the presentations demonstrated that the feminist imagination does not link men to reproduction, specifically infertility, its causes and solutions. Are men unconnected to the politics of reproduction or new technologies, as the conference theme and its contributors implicitly suggest?

One important argument foundational to this project is this: male infertility has been less prominent than female infertility in research, public discourse, media portrayals of infertility, and collective consciousness due to

preconceived notions about women's responsibility for reproduction. These notions, though often supported by biological facts, are socially constructed. In this chapter I show that the social sciences have ignored the reproductive experiences of men. I link this oversight to the preconceived notion that women are responsible for all aspects of reproduction, including infertility.

The time has come for scholars of reproduction and infertility to exercise their sociological imaginations, to question the pursuits of scientific research and medical markets. Inhorn et al challenge feminist scholarship to bring "men back into the reproductive imaginary, as reproductive partners, progenitors, fathers, nurturers, and decision makers" (2009:3). Expanding the sociological imagination to include male infertility is the first step toward raising public awareness, and creating a social environment that presses the scientific community to break down paradigms, and imagine new solutions to long-time problems. Channeling men toward medical interventions could potentially spare women some of the physical burdens of popular infertility treatments, and extend to men the charge to share responsibility for reproduction.

### ***Literature Review***

In the introduction to the edited volume, *Reconceiving the Second Sex: Men, Masculinity, and Reproduction* (2009), anthropologists Inhorn, Tjørnhøj-Thomsen, Goldberg and Mosegaard revise Simone de Beauvoir's historic declaration of women as "the second sex," claiming that when it comes to the study of reproduction, men are the second sex (2009:1). The authors argue that feminist scholars have thoroughly investigated the reproductive issues

affecting women. However, social studies of reproduction have overlooked the experiences of men. Men's conspicuous absence from this literature is presumably due to men's connection to the public sphere. As a result, "there are no ethnographic monographs on such major topics as male infertility," and many other reproductive issues, including, erectile dysfunction, men's use of contraceptive and assisted reproductive technologies, men's experiences of sexually transmitted infections, vasectomy, and prostate health (2009:2). De Beauvoir would likely argue that the exclusion of men from scholarship is due to their historically privileged status as the 'first sex,' which has protected them from academic analysis. Inhorn et al see this privilege as a double-edged sword. Men have historically avoided the overt scrutiny and painful medical regimens that women have been subjected to in the past. As a result, though, men today are the second sex when it comes to reproduction. They have less medical, social and emotional understanding about the medical issues they face compared to women.

### *Women's Health*

The Women's Movement of the 1960s and 1970s raised awareness regarding many issues central to the quality of women's lives. The inequality faced by girls and women in the education system, the workplace, the home, in politics and the media was brought to light by second-wave feminist activism. As awareness of these issues grew, women were also becoming more aware of the many ways that medical institutions were disadvantaging women. Barbara Ehrenreich and Deirdre English's book, *For Her Own Good:*

*Two Centuries of Experts Advice to Women* (2005), originally published in 1978 and based on an article presented in 1973, provided historical documentation of the medicalization of women's bodies. Women, they argued, served as the guinea pigs in the experimentation of radical treatments invented by medical doctors who enjoyed newfound authority in the nineteenth century. Women's bodies were subjected to leeching, injections, cauterization of their sexual parts, clitoridectomy, ovariectomy and hysterectomy, which were used to cure a variety of ailments, including headaches, sore throats, indigestion, backaches, diseases of the stomach, liver, kidneys, heart, lungs, tuberculosis, and mental illness -- all believed to be caused by the reproductive organs (2005:126).

The research of feminist scholars, like Ehrenreich and English, served as the impetus behind the Women's Health Movement of the 1970s. In 1970 twelve feminists published a brochure entitled, "Women and Their Bodies," which provided women with information about birth control, pregnancy, and nursing, which they believed "so-called experts" were failing to teach women. By 1973 this group of feminists came to be known as the Boston Women's Health Collective, an organization who has since published twelve editions of the women's health book, *Our Bodies, Ourselves*. In 1975 a group of feminist scholars and activists<sup>3</sup> founded the National Women's Health Network, an organization which has since been dedicated to researching and lobbying federal agencies on women's health issues. That same year one of the

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<sup>3</sup> This group included Barbara Seaman, Mary Howell, Alice Wolfson, Belita Cowas and Phyllis Chester.

founders, journalist Barbara Seaman, addressed Harvard Medical School. In her speech she called for greater representation of women in the practice of obstetrics and gynecology and in the decision-making regarding how money for female reproduction research should be spent. Due to the efforts of women's health advocates, the 1970s saw increased federal oversight regarding the safety of contraceptives, a rise in lay midwifery, and increased education among women regarding reproductive issues. In this climate of distrust toward the medical establishment, the first baby conceived through *in vitro* fertilization (IVF) was born.

#### *Infertility and ART Scholarship*

Social studies of infertility by feminist scholars emerged following the 1978 birth of Louise Brown, the first IVF baby. Infertility scholars Sandelowski and de Lacey argue that infertility as we now know it did not exist until IVF was invented (Sandelowski and de Lacey 2002:34-35). Before IVF scholars studied childlessness and sterility. However, the highly technologized medical protocols childless couples were enduring by the 1980s constructed a new type of social experience known as infertility. The emergence of assisted reproductive technologies in the late 1970s and its growing popularity in the 1980s presented a challenging puzzle to feminist scholarship. Otherwise healthy women were voluntarily subjecting themselves to invasive medical treatments for the pursuit of motherhood, a life role identified by some feminists as labor-intensive, socially undervalued, economically unrewarded,

and oppressive (Crittenden 2001; de Beauvoir 1951; Firestone 1970; Friedan 1963; Hays 1996; Hochschild and Machung 1989).

Sociologist Charis Thompson summarized that the first studies of infertility recognized ART as the triumphal achievement of patriarchal control over women's bodies (2002). The treatments were risky; the patients, uninformed; and 'success' only perpetuated the social order. ART was a luxury of the upper classes, and its use only emphasized race and class disparities and stratification within the medical system, and society. Some critics considered infertile women victims of "ideological duping," because they were willing to put their health and lives at risk in the face of social pressure (Arditti, Klein, and Minden 1984; Corea 1985; Crowe 1985; Solomon 1986 in Thompson 2002). The implication was that women ought to give up their desire for children in the name of feminist goals (Thompson 2002). In the 1980s feminist activist organizations and scholars called for more information about the risks of treatment for patients, and promoted adoption and child-free living as socially responsible options for infertile women (Birke, Himmelweit, and Vines 1990; Lasker and Borg 1989; Spallone and Steinberg 1987 in Thompson 2002).

In 1990 Margarete Sandelowski, a nursing professor and historical scholar, chastised feminist research for being unsympathetic to women's desire to have children, and called upon feminist researchers to validate infertile women by studying how they experienced their disease (1990). Critics contended that Sandelowski did not recognize the social and political forces

that influence the technological realm, or the economic circumstances that prevent some social groups from gaining access to treatment (Allen, Dietrich, Lutfiyya, and Theriot 1991:149). Amid the debate, philosopher Jana Sawicki pointed out that “although new reproductive technologies certainly threaten to reproduce and enhance existing power relations, they also introduce new possibilities for disruption and resistance” to the social system (1991:88). ART had the potential to break the paradigm of patriarchal marriage and family by introducing single and lesbian motherhood. Sawicki asserted that research should focus on the contradictory meanings of infertility, and pay close attention to the differences among women and the complex social relations in which they are situated (1991:87). Sawicki and others reframed infertility as a site for exploring social structures and power relations, and ushered in a new era of infertility research.

Over the past decade, infertility, involuntary childlessness, and assisted reproductive technologies (ART) have served as the empirical testing ground for social theories regarding culture, race, class, sexuality, technology, and gender. Cultural studies have used infertility as a site for examining the social meanings of natural conception, consumer and enterprise culture, risk, and everyday life (Becker 2000; Franklin 1997 in Thompson 2005). Race, class and sexuality studies within the context of infertility have considered what groups have access to medical care, and further analyzed the meanings of family, kinship, adoption, and surrogacy (Agigian 2004; Gailey 2000 in Thompson 2005; Ragone 1994; Ragone 2000; Strathern 1992). Within

science and technology studies (STS), infertility fits into a large body of research on many reproductive technologies, including contraception, prenatal screening, amniocentesis, ultrasound, paternity testing and fetal surgery. This body of research has explained how technologies are experienced by individuals, shown how medical practice serves as a form of surveillance, and elaborated larger political discussions of bioethics, eugenics and abortion (Franklin 1991; Franklin 1997; Rapp 1999; Sawicki 1991; Thompson 2005).

Thompson (2005), author of *Making Parents: The Ontological Choreography of Reproductive Technologies*, posited her 'agency through objectification' theory in contrast to the belabored feminist argument of medicalization as inherently oppressive. She argued that in many instances technology does not deprive individuals of agency, but offers greater agency. In the case of infertility, patients choose to submit to therapy for the long-term achievement of *selfhood*, which may include pregnancy and parenthood. Infertile women are not helpless patients in need of saving by medical technology, nor are they victims of social ideologies. Rather, the infertile "woman's objectification involves her active participation and is managed by herself as crucially as by the practitioners, procedures, and instruments" (Thompson, 2005:185). While many theorists consider objectification and agency as oppositional concepts, Thompson argues that in the achievement of the self, a long-range project that requires a major investment of money, time and energy, objectification and agency are co-constitutive principles.

The most prominent studies of infertility over the last twenty years emphasize that infertility is a medical problem, as well as a psychological, emotional and social problem (Becker 2000; Franklin 1997; Inhorn 1996; Sandelowski and de Lacey 2002; Thompson 2005). Infertile, childless women often suffer from feelings of personal failure, inadequacy, guilt, depression, powerlessness, and loss of control (Franklin 1997:137; Whiteford and Gonzalez 1994:31-32,34; Zucker 1999:771,782). Because having biological children is seen as a natural and normal step along the life course, childlessness leaves couples feeling stigmatized as not normal and unnatural (Becker 2000:33-34; Franklin 1997:134,137; Riessman 2000:111; Thompson 2005:121; Whiteford and Gonzalez 1994:30).

Infertility studies contribute to understandings of gender in a variety of ways, by exploring the social meanings of motherhood and the lived experiences of women. Infertility threatens women's own gender identity, particularly if they see motherhood as imperative to womanhood and kinship defined by genetic ties (Becker 2000:40-41; Franklin 1997:137; Thompson 2005). Women undergoing treatment shift from the patient role to the consumer role, when treatments become expensive and risky (Becker 2000:242; Benjamin and Ha'elyon 2002; Malin, Hemminki, Raikkonen, Sihvo, and Perala 2001). Ultimately, infertility is a life-defining disease for women, which forces them to renegotiate their gender identity, and motivates women to invest their bodies, time, emotion, and finances into resisting the stigma of childlessness (Becker 2000; Franklin 1997; Riessman 2000:115).

### *Men and Infertility*

Ehrenreich and English (2005) assert that male bodies, and particularly male reproductive organs, were spared the scrutiny, torment and torture endured by female bodies of the nineteenth century. The overt medicalization of women's bodies in Western medicine over the past two centuries, and specifically the attention paid to reproductive organs, has rendered men virtually invisible in the study of reproduction and infertility today.

Anthropologist Gay Becker and sociologist Charis Thompson recognize that men's bodily experiences with infertility tend to "elude the ethnographic gaze" simply because men are often absent from most medical procedures (Becker 2000:56; Thompson 2005:120). They call for more research on the experiences of men and infertility.

Social worker Mary-Claire Mason (1993) wrote a thorough account of men's feelings regarding their infertility in her work, *Male infertility – men talking*. This commendable work broke the silence for infertile men, as she delved into the psychological processes that men go through when they learn they are infertile. Missing from her work is any analysis of the medical institutions and practices that treat infertility, or the medical experiences of the infertile patients. This is not surprising, though, since her focus as a social worker was on mental health, and many of the innovations used to treat male infertility today were only created in the past fifteen years. Since Mason's study, social science books on infertility and ART have cast only sideways

glances at the husbands and partners -- fertile and infertile – of the women undergoing infertility treatments.

Charis Thompson devoted one chapter of her book comparing how ideas about infertility differ by gender. She argues that for women, womanhood and femininity are commonly associated with the achievement of motherhood; whereas, for men, manhood and masculinity are closely tied to sexuality, not necessarily fatherhood (Thompson 2005:136). In the IVF clinic where she conducted fieldwork she noticed that low sperm counts were often associated with impotence, feminization, and lack of sexual prowess (2005:126-129). She found that in discourse among patients and clinic staff, fertility was often conflated with virility. In reality, however, patients' fertility status is rarely related to rigidity of erections or sexual performance. In two observed cases of male infertility – one the result of a sports injury; the other one a result of a vasectomy – Thompson observed how men relied on histories of hypermasculinity to restore their threatened masculinity and differentiate themselves from other textbook cases of male infertility.

Philosopher and technology scholar Irma van der Ploeg (1995) labeled couples diagnosed with male infertility “hermaphrodite patients”. Van der Ploeg analyzed medical texts to compare the “permeability” of female and male bodies to medical technologies in the treatment of male infertility. She found that though the men’s bodies may be the cause of infertility, the woman’s body remains the object of medical intervention. Her research, published before the advent of the male treatments popular today, showed

that *in vitro* fertilization was often prescribed to treat male infertility. IVF is a highly invasive procedure for women (462). Van der Ploeg shows that male infertility becomes a property of the female body, and the male body is rendered invisible (465,473). As a result, the woman's body must bear the burden of man's infertility. Van der Ploeg's insightful work shows how the two bodies of couples meld into a single patient identity, and confirms that women's bodies do bear the brunt of technological treatments.

One study of couples with male factor infertility suggested that men have more bargaining power than women in the decision-making process regarding IVF (Lorber and Bandlamudi 1993:33). Lorber and Bandlamudi found that when women want to pursue infertility treatments, they have to rely on their husbands for a semen sample, giving men the power position in decision-making. In other cases wives bear the "burden of *his* infertility" and submit to assisted reproductive technologies even when they do not want to, in order to spare their husbands the stigma and humiliation of infertility and childlessness (1993:34). Lorber and Bandlamudi argue that gender inequality persists in the home and within marriages, and plays out as couples deal with infertility.

Psychologists Webb and Daniluk (1999) conducted in-depth interviews with six infertile men. They reported several common themes experienced by these men, including, a sense of profound grief and loss, powerlessness and loss of control, personal inadequacy, betrayal and isolation, threat and foreboding, a desire to overcome and survive, and a need to positively

reconstruct their experiences (1999:12). The authors echo the findings of research on female infertility, noting that infertility comes as a “tremendous blow” to gendered identities (21). Infertile men have to redefine for themselves what it means to be a husband and a man (22). The authors note that recruiting men for this study was incredibly difficult, suggesting that male infertility is a deeply private and humiliating experience. The six participants in the study were four to fourteen years past their initial diagnosis, and none of them had male-focused treatment options available to them.

Tine Tjørnhøj-Thomsen’s comparison of male and female infertility in Denmark reveals the different ways that Danish men and women experience infertility. Tjørnhøj-Thomsen notes that “men can separate infertility and childlessness from their social and working lives and their relationships with other men,” whereas, women are connected to communities for which procreative experiences are central (2009:237). Danish men tended to be more closed or “shy” about their infertility experiences with others, while women were more likely to talk about their experiences with friends and colleagues (238). The men in the study described the social experience of infertility as worse for their wives than for themselves (237).

The studies by van der Ploeg and Lorber and Bandlamudi stressed that women bear the burden of male infertility. Since the mid-1990s technological and surgical advancements for addressing male infertility, like intracytoplasmic sperm injection (ICSI) in combination with IVF, varicocele repair, and testicular

sperm extractions<sup>4</sup>, were developed and popularized. Earlier studies, including most of the research already mentioned, do not address how couples diagnosed with male infertility make decisions for treatment when female-focused and male-focused treatments are available. This study strives to shed light on the decision-making process and reveal how infertile men understand their diagnoses, negotiate masculinity, and engage with new medical technologies.

### *Gender Theories*

The purpose of this study is to demonstrate the interrelation between gender-constructing and disease-constructing processes. As I provide examples of the many ways that doctors, patients, and their wives construct gender, I draw upon the work of gender theorists including Connell (1995), West and Zimmerman (2002), and Ridgeway and Correll (2004). These theorists recognize gender as a fluid and dynamic social ideology or system with the potential to be reconstructed in everyday situations, and argue that notions of gender, masculinity, and femininity vary across cultures, over time, and over the life course. They reject the tradition of socialization theory, which claims that children are programmed in their earliest years to speak and behave according to their gender, and carry that fixed identity throughout life. Instead, social constructionists see boys and girls and men and women as active participants in the construction of their own gender identity.

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<sup>4</sup> Treatments such these are described in detail in Chapter 2.

West and Zimmerman (2002) argue that men and women are constantly engaged in the process of “doing gender,” by making choices in everyday situations to act in ways that shape and redefine gender ideology. Why, ask these scholars, would anyone choose to engage in behaviors that may perpetuate unhealthy, and potentially destructive, stereotypes of their own sex? Individuals, they note, are often compelled to act in gender-typical ways, because access to power and resources in all aspects of life depends upon it (24).

Drawing upon West and Zimmerman’s ‘doing gender’ theory, Ridgeway and Correll (2004) created the “gender system” model for understanding gender relations. The gender system is the invisible social system that perpetuates unequal power relations between men and women. The authors drew upon the theoretical contributions of several scholars, including West and Zimmerman’s ‘doing gender’ theory and Wagner and Berger’s expectation states theory, and provide a meta-analysis on a variety of studies examining gender performance. They argued that ‘hegemonic gender beliefs’ underscore the structure and practices of social institutions, and color all ‘social relational contexts.’ Hegemonic gender beliefs include the widespread cultural notions or stereotypes about men and women that perpetuate gender inequality. These include “hierarchical presumptions about men’s greater status and competence,” and “assumptions about men’s and women’s different traits and skills” (2004:517). Social relational contexts include the everyday situations in which people interact with each other and with

institutions (511). Ridgeway and Correll note that some social groups create and ascribe to nonhegemonic gender beliefs, or alternatives to hegemonic notions of gender, but that in most instances hegemonic gender beliefs serve as the background frame for social relational contexts.

According to Ridgeway and Correll, there are three levels to the gender system at which gender-constructing processes occur: first, the macro-level of cultural beliefs and the distribution of resources; second, the interactional level where social relational contexts occur between and among individuals and institutions; and third, the individual micro-level, where selves and identities are formed (2004:511). Cultural, institutional and individual notions of masculinity influence one another. More importantly, the constant interplay between the three levels contributes to the construction and perpetuation of hegemonic gender beliefs. As argued throughout this dissertation, gender-constructing processes occur simultaneously, and are enmeshed with, disease-constructing processes. Therefore, I posit that disease is also constructed at the three levels of culture, institutions, and individuals.

Ridgeway's and Correll's own research projects have examined the "devilish resilience" of the gender hierarchy, and specifically gender inequality in the workplace. They call for more research to examine how hegemonic gender beliefs result in discriminatory actions and gender inequality-producing practices (2004:523-524). This research study does not directly address if and how one sex is more or less advantaged by the institutional practices of infertility medicine. However, this project does examine the ubiquity of

hegemonic gender beliefs, and the social relational contexts in which such beliefs are most salient. Ridgeway and Correll conclude that “although changing socioeconomic conditions and personal and collective resistance do gradually modify cultural beliefs about gender, the core structure of the beliefs are not easy to erode” (528). This dissertation examines how individuals adopt or resist cultural beliefs about gender, investigates the resilience of the gender system, and sheds light on the potential for social change.

While West and Zimmerman and Ridgeway and Correll emphasize the power differences between men and women, R. W. Connell’s work on hegemonic masculinity analyzes the power relations among men (1995:35). The hierarchy of gender is more complex, argues Connell, than men-dominate-women models suggest, because men also strive to dominate other men. A hierarchy of men exists, in which salient aspects of identity, like race, class, sexual orientation, age and ability, grant men access to different forms of power and resources. This system of “hegemonic masculinities,” demonstrates that there are multiple forms of masculinities across cultures and social groups, and that men demonstrate masculinity to compete for access to power, resources, networks, and women. Though sex is a central theme in his work as he discusses heterosexuality and sexual pleasure, his work does not address the biological function of sex: reproduction. Missing from Connell’s discussion is how fatherhood and fertility position men within the hierarchy of hegemonic masculinity. By focusing on male infertility, this

research explores the meanings of fatherhood, reproduction, and fertility status to masculinity and social status.<sup>5</sup>

In his essay, "Masculinity as Homophobia: Fear, Shame, and Silence in the Construction of Gender Identity," Michael Kimmel argues that manhood is equated with power, and its achievement is only possible for a minority of men (1994:135-6). As a result, men suffer from feelings of powerlessness and inadequacy (129-130). Masculinity encompasses all that men say and do, and serves as "a defense against the perceived threat of humiliation in the eyes of other men" (135). Kimmel categorizes masculinity as a homosocial enactment, "fraught with danger, with the risk of failure, and with intense relentless competition" among men (129). Kimmel theorizes that homophobia is central to the enactment of masculinity. Homophobia entails more than fear of gay men, or fear of being perceived as gay. Homophobia, as defined by Kimmel, includes the fear of other men, the fear of being emasculated or humiliated by other men (131). Masculinity based on homophobia and motivated by a constant quest for power perpetuates gender inequality (133-134).

### ***Contributions of this Study***

Few scholars have examined the role of men in the construction of infertility or male infertility, and as Thompson points out, much work still needs to be done on the experiences of men within infertile couples (Thompson 2002:66). At the October 2007 annual meeting of the American Society of

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<sup>5</sup> Oudshoorn similarly notes that contraception use among men is also excluded from Connell's work (2003:17).

Reproductive Medicine, mental health experts gathered to discuss the mental and social experiences of infertile men. Speakers at the meeting included medical anthropologist Marcia Inhorn of Yale University, clinical psychologist William Petok, a private practitioner for infertile couples and leader in his field, and male infertility specialist Peter Chan, M.D., Director of Male Reproductive Medicine at McGill University. These speakers each expressed dismay at the “dearth” of social science research on male infertility, especially in light of new technological innovations and ever-evolving notions of masculinity. This study answers the call for more work on male infertility, serving as the first “ethnographic monograph” on the topic of male infertility. This research project brings fresh insight to two fields of social science literature: the study of infertility and ART, and the study of gender.

The study of male infertility infuses a new and provocative perspective into old debates on assisted reproductive technologies (ART). Feminists have long debated the effects of ART: does ART perpetuate the objectification of women or provide women with new opportunities and means for reproduction? Due to the intense focus of these debates on women’s fertility status and women’s bodies, this scholarship has failed to address why male bodies have been less permeable to medical intervention, or imagine new possibilities for infertility treatment on male bodies. It seems that the medical community and popular media have rendered men invisible in the discussion of infertility. Social scientists, too, have contributed to the perpetuation of the assumption that women are responsible for infertility by focusing their work on women’s

lives and bodies, despite new medical innovations and technologies for the treatment of male infertility (Inhorn, Tjornhoj-Thomsen, Goldberg, and Mosegaard 2009). The invisibility of men in reproduction scholarship does not suggest that men have been disenfranchised. In fact, quite the opposite might be said. Men's reproductive experiences have been ignored due to their privileged status. Women's subordinate status has held women responsible for all aspects of reproduction. By introducing men to the ART debates, this study connects men to the onus of reproduction.

The case of male infertility provides a unique site for exploring constructions of gender, because notions and social expectations of sex and gender are central to all interactions, decisions and actions. As sociologist and reproduction scholar Adele Clarke notes, "It is difficult to conceive of a more sex- and gender-constructing maintaining discipline and set of practices and discourses than those of the reproductive sciences" (1998:22). Within the broad field of feminist and gender studies, researchers explore abstract social concepts of power, ability, access, opportunity, femininity and masculinity in a variety of spheres, including the workplace, education, the media and sports. This study of medicine and infertility deals with these same concepts in relation to the concrete biological realities of penises, testicles, semen, sperm, erections, and ejaculation – objects and functions that are essentially, unavoidably and indisputably gendered. This research project is the first of its kind to be based on ethnographic fieldwork inside male infertility clinics and on interviews with male infertility doctors, male patients and their wives.

Within the study of gender this research project specifically analyzes the roles of institutions in constructing gender, and sheds light on our developing understanding of men and masculinities. Many studies of gender focus on the experiences of women. Judith Wajcman argues that much of our gender scholarship reinforces “the perception that gender is only an issue where the research subjects are female,” and points out that “both men and women have gender identities which structure their experiences and their beliefs” (Wajcman 2000:454). Unfortunately, one of the pitfalls of research that does include men is that it often compares traits of the sexes. Findings of such studies may only emphasize essentialist notions regarding the natures, abilities, and aptitudes of men versus women. However, as many feminist scholars argue, the differences between the genders are not as great as the differences among men or among women (Epstein 1988; Fausto-Sterling 1985; Kimmel 2008). Men and women are surprisingly similar: they have similar intellectual capacities, share interests, and have the same basic needs of shelter, food, water; intimacy, love and acceptance; and the need to learn, progress, grow, and be self actualized. So, why do we continue to study gender difference? Masculinities scholar Michael Kimmel argues that we study gender difference, because society is desperate to find inherent and innate differences between the genders, so we can excuse the gender inequality that persists (2008:20). He posits that throughout history and across cultures, societies have attributed gender inequality to essential gender differences. In other words, men have enjoyed higher status and greater

access to resources, because they are believed to be superior to women in intellect and physicality. Kimmel argues instead that perceived gender differences are actually the product of gender inequality. As a result, governments and private entities support research in all fields -- from biology, neurology, and cognitive science to psychology and sociology -- that investigates the differences between women and men, and confirms social ideas regarding gender differences. Academic and popular journals overlook research studies that find only similarities between the genders. My goal in designing this study was not to reveal the striking differences (or similarities) between women and men. Rather, I investigate how men negotiate their own masculinity. This study is unique as it answers Wajcman's call for more research on men's experiences, but is not a comparative study of men and women. Instead, I compare social notions of masculinity as constructed by individuals with notions of masculinity as constructed by institutions.

Sociologists have described gender as a social phenomenon using several different paradigms, including: a set of roles, a system, a process, an organizing principle for society, and an institution. As a social constructionist, I employ Cecilia Ridgeway and Shelley Correll's (2004) "Gender System" as the most helpful model for understanding how gender is constructed through institutional and individual level processes. As these scholars points out, constant interaction between institutions and individuals strengthen and perpetuate notions of gender. Throughout this dissertation I strive to develop new understandings of the gender system, which emerged from Ridgeway and

Correll's innovative research conducted in the workplace and school. In an original application of the gender system model, I incorporate qualitative mixed methods to examine the relationship between institutions and individuals in the medical sphere. This study strives to show how medical practices are constructed around masculine norms and how men engage with medical authorities and technologies.

### ***Methods***

The basic purposes of this section are to present the research questions that inspired this study, and describe the research design and techniques employed to address those questions. I will map out the terrain of the vast and expanding infertility industry, and pinpoint what aspects of infertility and ART this study encompasses. I will also explain how Ridgeway and Correll's theory of the interdependent gender system serves as a nice framework for this research. After describing the methods used to conduct this study, I will explain the challenges I faced while carrying out the study, including IRB (Human Subjects) limitations, as well as the difficulty in creating tools for measuring masculinity.

### ***Research Questions***

My first introduction to infertility medicine was as a patient. There is a quality and skill that sociologists share, which is the ability to separate ourselves from the world around us, to cognitively step back and critique the taken-for-granted norms that shape our society. It is this quality that draws us to the discipline, and through our training we hone this skill. As an aspiring

sociologist, I could not help but be amazed, intrigued, and perplexed by what I witnessed in the clinic. In many ways, I was a perfect patient – young, healthy, easily treatable, and compliant. But I also felt as if I were having an out-of-body experience, as if I were watching my own body move down a factory conveyor belt amid the scream of whistles and hum of motors, while people in white coats peered and poked at my flesh. I met with practitioners who seemed freakishly obsessed with their power to make me conceive. There was a strict protocol I was to follow, and technologies I was expected to willingly submit to. Outside of the clinic my social life was becoming equally bizarre. Family members, friends, co-workers, neighbors, and complete strangers were offering fertility advice, asking personal questions, and often made insulting assumptions about me. At a superficial level, these medical and social interactions were about eggs and sperm and sex. At the heart of the issue we were talking about harnessing a unique form of power: the ability to create human life, to make people into parents, and to pass on genetic material.

I wondered, were any sociologists documenting the fascinating world of infertility? A quick library search led me to rows of shelves of books by psychologists, sociologists, anthropologists, social workers, and nursing professors. The sheer volume of research was astounding; and the work, rich and impressive. In fact, many of the scholars, including Thompson and Becker, described their own personal experiences with infertility. But there was something all of the work seemed to have in common: a focus on

women's experiences with infertility. Don't men experience infertility, too? I wondered. Early in my graduate school career I set out to explore the "field" of infertility. I attended an infertility support group, and found among dozens of infertile women, *one* infertile man. During the meeting he asked, "Where are all the other infertile guys?" Later I attended an infertility conference at UCLA, hosted by a national infertility advocacy organization, and sponsored by businesses in the infertility industry. There I attended a class on male infertility, taught by a male infertility specialist. Of the 200+ conference attendees, there were only four people in the class, including a married couple, a married man attending alone, and me. The specialist who taught the class<sup>6</sup> graciously agreed to do an interview with me.

This initial interview is what launched this project. During the interview I learned that male infertility is common, but obviously not something people talk about. I also heard stories of couples who spent years and thousands of dollars treating the woman, only to find out later that *he* was the infertile one. These stories inspired my original hypothesis: Women bear the brunt of infertility treatments even in cases of male infertility. I soon realized, however, that creating a research design to test this hypothesis was nearly impossible since it was based on the assumption that male infertility often goes undetected. I would have to find a random group of couples who met the clinical definition of infertility, follow them as they sought help to achieve pregnancy, and somehow, unbeknownst to them or their doctors, discover the

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<sup>6</sup> Dr. Aaron Spitz of Orange County Urology Associates

real etiology of their inability to conceive. My hypothesis was nothing more than an un-testable hunch.

This hunch, it turned out, was common knowledge. This scenario plays out in the lives of American couples of all walks of life and social classes every day. Similar stories were recounted time and again by other doctors I interviewed. When I tell friends, acquaintances and practical strangers that I am conducting a sociological study of male infertility, more often than not I hear about a brother, a friend, or a colleague whose wife underwent infertility treatments for what was *his* problem. The reasons for this are both practical and sociological. To begin with there are more methods available – pharmaceutical, technological, and procedural -- to treat women than men. Even in cases where male infertility is immediately detected, some means for achieving pregnancy focus on the female partner's body.<sup>7</sup> Furthermore, many women first seek help from their primary care provider (PCPs) or gynecologists (with no additional specialization in infertility). While infertility specialists (fellowship-trained, board-certified reproductive endocrinologists) are usually very careful to test the man's fertility status, sometimes PCPs and gynecologists provide quick remedies for women without checking the fertility status of the man or referring the couple to a specialist.<sup>8</sup>

There are also sociological reasons why women often endure infertility treatments, even in cases of male infertility. Sociologists understand that

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<sup>7</sup> A detailed description of treatments for male and female infertility is provided in Chapter Two.

<sup>8</sup> For example, I heard about one case in which the husband refused to see a doctor, and so the wife continued taking an infertility drug for years (highly not recommended) prescribed by her PCP.

technologies are not created in a vacuum, but are developed amid social forces – encouraged and constrained by political, religious, economic, and social ideologies. As argued, women often bear the brunt of infertility due to historical assumptions about women’s responsibility for all aspects of reproduction. If, for example, a couple is struggling to get pregnant, the couple most likely assumes it is *her* fault, and so the woman seeks medical help first. If reproduction is assumed to be women’s realm, then more doctors are trained to treat women, and doctors and scientists develop more technologies to treat female bodies. The institutions that evolve over time to administer these technologies become increasingly focused on the treatment of women. Not surprisingly, we now have more institutions and more technologies devoted to the treatment of infertile women than infertile men. In some cases of male infertility, couples have to choose between female and male treatment options. Examples of such cases are included in this study, and I explore this decision-making process later on.

Once I established that women are more likely to be treated for infertility than men, I considered exploring the following research question: How do male factor and female factor infertility specialists differ in their approaches to treating infertility, and how do patients differentially experience these two approaches? To answer this question I created a comparative research design where I set out to conduct ethnographic fieldwork in IVF clinics operated by reproductive endocrinologists, which focus primarily on the treatment of infertile women, and in urology offices devoted to the treatment of

male infertility. This type of comparison would provide insight into the different ways men and women experience infertility. While a significant chunk of infertility research has shown that women are often emotionally devastated by infertility (Becker 2000; Franklin 1997; Greil 1991; Riessman 2000; Whiteford and Gonzalez 1994; Zucker 1999), I could compare such findings with the emotional experiences of men. I was also curious to find out how men and women identified themselves as “infertile,” and how they differentially took on the “sick role”.

However, after spending two weeks shadowing two different doctors, it became clear that the story of male infertility was a compelling one, and this entire research study could be devoted to better understanding the experiences of infertile men. So, I abandoned the comparative study of men and women to focus solely on male infertility. Sufficient research already exists on the topic of female infertility, and there was no reason to repeat the study of a topic already well-documented and explored. I refined my research question to focus specifically on men. The research question that now drove the project was this: How do men negotiate their masculinity when diagnosed with infertility? Inspired by the theoretical work of Ridgeway and Correll, male infertility presented a unique site for exploring the relationship between institutions and individuals in the construction of gender. Using male infertility as a case study, this project also sought to answer the following questions: How do men construct notions of masculinity, and how do those compare with the notions of masculinity constructed by institutions? How are notions of

gender perpetuated or reconstructed through the everyday interactions between powerful institutions and individuals? The chapters that follow address these questions.

### *Mapping out the Infertility Industry*

In her book *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception*, Debora Spar (2006) estimates that the infertility industry generates \$3 billion in revenue annually. What services comprise this vast and growing industry? When a heterosexual couple<sup>9</sup> first has a difficult time trying to conceive, it is most often the woman who first visits her Primary Care Physician (PCP) or Obstetrician Gynecologist (OB, Ob/Gyn). Likely, she will receive some basic advice for improving her chances to get pregnant. She may be instructed to try gaining or losing weight, watch her diet, monitor her ovulation cycle closely, and time sexual intercourse accordingly. If she's under age 35, her doctor will suggest that she return to discuss more medical options after twelve months of unsuccessful attempts at pregnancy with timed intercourse; after just six months if she is over 35 years old. If after the prescribed number of months she still has no success, she will return to her PCP or OB who may prescribe infertility drugs for a few months, or refer her and her partner to an infertility clinic. The infertility clinic is an IVF

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<sup>9</sup> Gay and lesbian couples experience what is now called "social infertility," because the absence of appropriate genetic material, egg or sperm, makes conception impossible. PCPs and OBs will immediately refer these couples to infertility clinics where they will skip straight to the step of sperm donation or egg donation and surrogacy.

clinic,<sup>10</sup> operated by a team of reproductive endocrinologists (fellowship-trained OBGYN's). Once the couple enters the infertility clinic, both partners will undergo extensive diagnostic procedures. Some diagnostic procedures may be conducted in-house, depending upon the capabilities of the clinic, while others may be referred out to laboratories, ultrasound clinics, and hospitals for laparoscopic surgery. Based on the diagnosis or diagnoses, the couple may be given options for treatment including infertility drugs and/or artificial insemination or *in vitro* fertilization using their own eggs and sperm. If male factor infertility is detected the man may be referred to a male infertility clinic, run by a urologist specializing in male reproduction.

During the diagnostic process, the couple will be tested for genetic diseases. If they are found to be carriers for certain disorders, they will meet with a genetic counselor, and may hire a specialized laboratory to test specific egg and sperm cells to select healthy materials for *in vitro* fertilization. If eggs or sperm are absent or found to be inadequate for successful conception, or if the uterus is incapable of incubating a fetus, then the couple will receive options for using sperm donors, egg donors, and possibly surrogate mothers. These services may be available in-house, or the couple may be referred to outside agencies.

At any stage in this process, the couple may seek out or be referred to mental health professionals who will help them process their feelings and make decisions for treatment. At any point along the way the couple may

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<sup>10</sup> IVF clinics are referred to as "ART Centers" in the medical literature. I have chosen to use the term "IVF clinic," which is what most clinics call themselves, and is more popularly used by patients.

choose to step off the infertility track, and choose child-free living, the wait-and-see-if-we-get-pregnant-naturally route, or adoption. In sum, the landscape of the industry includes IVF clinics, male infertility clinics, basic diagnostic laboratories, highly specialized genetic laboratories, genetic counselors, mental health counselors, and agencies for donated genetic material, surrogacy, and adoption. Of the \$3 billion pumping through this industry<sup>11</sup>, an increasing amount of these funds come from health insurance companies, but the bulk of this money is paid for by patients out-of-pocket.

What parts of this expansive landscape fell under my lens? The locus of my study was male infertility clinics, including providers and patients. However, I followed the reports of my patients' journeys as they negotiated other terrain, including laboratories, IVF clinics, a sperm bank and an adoption agency. Only two couples in the study used donor sperm: one couple went to a sperm bank and purchased an anonymous donation; the other couple used sperm donated by the husband's identical twin brother.<sup>12</sup> Only one couple in the study contacted an adoption agency, though, in final interviews other couples said they planned to look into adoption. I also took a backstage tour of the infertility industry by visiting a sperm bank and a highly specialized sperm testing laboratory, attended three weeklong medical conferences, and did an extensive reading of medical journals on the topic of male infertility.

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<sup>11</sup> This figure does not include adoption services.

<sup>12</sup> The initial purpose of sperm banks was to provide donor sperm to infertile men. Thanks to major advances in technology using testicular sperm, few men need donor sperm. Today over half of the customers of donor sperm are single women and lesbian couples.

### *Research Design: Mixed Qualitative Methods*

In order to best address my research questions, I needed to locate infertile men and collect data regarding their medical and social experiences. Male infertility clinics were the logical starting point.<sup>13</sup> As a trained ethnographer, I employed mixed qualitative research methods to collect data, including: 1) ethnographic fieldwork in male infertility clinics; 2) informal and formal interviews with medical personnel and patients; 3) participant observation at professional meetings for male infertility doctors and therapists; and 4) text analysis of medical journals and popular media.

Five male infertility specialists graciously allowed me to shadow them in their clinics. These specialists operate clinics in five cities across the country: San Francisco, California; Ann Arbor, Michigan; St. Louis, Missouri; Boston, Massachusetts; and New York City, New York. Before selecting and contacting these physicians I researched their credentials, including specialization training, business practices, and notoriety (publications, speaking engagements, respect among peers) in the field of male infertility medicine. Four of the clinics were part of larger university hospitals; one was connected to a private medical system. I chose to include the private clinic, because I wanted to include a female practitioner in the study. In the specialty of urology women are a minority, and those practicing male infertility medicine

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<sup>13</sup> Goldberg attempted to study male infertility in an IVF clinic in Israel, which claimed to specialize in the treatment of male infertility. She writes: "I had come with the desire to learn about men's experiences but very often found that all that was left of the men in the clinic was their sperm" (2009:205). Though some solutions to male infertility are provided in IVF clinics, I found it necessary to go directly to male infertility clinics to find actual male patients to observe and interview.

are especially rare.<sup>14</sup> The female practitioner chosen for this study is highly renowned in the field and well-regarded by her peers. As each of these clinics was connected to a larger hospital system, I had to submit applications to each hospital's Institutional Review Board (IRB or Human Subjects committee) to gain access and permission to shadow the doctors.

I spent over one-hundred hours observing clinical encounters between male infertility specialists and their patients. The plan was to spend one week shadowing each doctor, which I roughly calculated would amount to forty hours of clinical interaction per clinic. However, I missed hours of observation when doctors had no appointments scheduled, had private meetings with hospital staff, met with patients for reasons other than infertility (e.g. erectile dysfunction, incontinence), or were in the operating room. Sometimes, depending upon the doctor and the IRB protocol, I was able to observe surgeries, other times I was not. I used downtime to conduct informal interviews with nurses and staff, tour facilities, follow-up with patients, and record field notes. At some point during each visit I tried to schedule a formal sit-down interview with each doctor. A few of the doctors I was able to interview formally over lunch or dinner in one seated session; other doctors were interviewed in small snippets -- a few questions at a time -- during random breaks. Interviews with doctors and most other medical personnel were recorded and transcribed.

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<sup>14</sup> For example, in 2009 there were 8,773 members registered with the American Urological Association in the United States. Only 525, or 6%, of those members were women. The AUA does not keep statistics on the number of men and women specializing in infertility (Lacey Dean, AUA Media Specialist, personal communication, Sept. 2009).

There was a strict IRB protocol the doctors and I were to follow at each clinic in order for me to observe appointments with patients. Here I present a brief overview of the general protocol we followed, although each IRB protocol had to be adjusted according to the particular guidelines and preferences of each hospital. The doctor was to enter the room alone, explain to the patient (and partner, if present) that a sociology graduate student was shadowing him/her for the week to conduct research for her dissertation on male infertility. Then, s/he would ask if he/they would feel comfortable if I observed the appointment. If the patient and spouse agreed that I could enter, then I was invited into the room. I was not to speak during the appointment or use any recording devices other than pen and paper. I was to avert my eyes or leave the room if a patient was asked to disrobe. (I devised a signal system with each doctor whereby they would notify me that it was time to leave. I would quietly slip out of the door, and they would reopen the door when it was okay to reenter the room. This system worked very smoothly.) At the conclusion of the appointment I could ask the patient and his partner, if present, if he/they would be interested in taking part in a one-hour phone interview. If he/they agreed, I would record their contact information to call or email them to set up an interview. For most interview participants, written consent forms were mailed to them and returned later. At one hospital, I could not record contact information until consent forms were signed.

Most of the data shared in this dissertation comes from clinical observations, interviews with doctors, and phone interviews with patients.

From the five clinics I made contact with 24 couples who wanted to participate in the study, and who met the IRB requirements to participate in the study. The response rate for this study was 83%.<sup>15</sup> I interviewed the 24 couples at least twice over the course of eighteen months. All of the couples in the study are married.<sup>16</sup> I preferred to interview the men and women separately, because I believed they would be apt to express themselves more freely, and I also appreciated hearing subjects' perspectives of their spouses' experiences. Despite my attempts to separate couples, I had to be sensitive to the subjects' preferences and time. For several couples that I interviewed it was apparent that the spouse was in the room with them, possibly listening to their end of the conversation, which may have inhibited them from answering questions fully and honestly. One couple preferred to be interviewed together on speaker phone. One woman preferred to conduct her first interview via email as opposed to phone. Due to the sensitive nature of the research topic, the Institutional Review Boards were all very emphatic that I be sensitive to the subjects' feelings and comfort levels at all times. Accommodating requests for

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<sup>15</sup> During the course of my fieldwork, doctors met with twenty-nine male patients who met the requirements for this study, twenty-four of whom participated in the study. Two men told their doctors they did not want to participate and I never met them. Three couples agreed that I could observe their appointments, and provided me with contact information. However, two of those couples were not reachable when I tried to line up interviews later, and one couple expressed via email that after giving it some thought they would not like to participate in the interviews. I only saw one African-American couple meet with a physician during the entire course of my fieldwork who I would have like to include in the study. Unfortunately, they were one of the couples who I was unable to reach for an interview.

<sup>16</sup> There was no intention to exclude unmarried couples from the study, as marriage was not requisite for participation. It just happened that nearly all of the couples seeing doctors were married, which may indicate a greater desire for fertility among married couples versus co-habiting couples. One couple was engaged the first time I interviewed them, but were married by the last time I contacted them.

a joint interview and an email interview were necessary to demonstrate sensitivity to the subjects.

The decision to interview by telephone was a practical one. The research subjects lived in eight different states, and travel was cost (and time) prohibitive. Telephone interviews were less desirable because I could not read the body language or emotional cues of the subjects. However, telephone interviews were beneficial for a few reasons. First, subjects could not see or read my gestures or expressions. At times, the interview responses brought me to tears or made me smile, which I was able to easily conceal since the respondents could not see me. I fear that if subjects had seen me become emotional, it would have caused them extra distress, and possibly inhibited them from sharing more. Secondly, in the digital age, people are quite accustomed to and more comfortable with a certain degree of anonymity. I think that men were particularly more willing to open up since the telephone granted some anonymity.

The interviews lasted between 20 to 100 minutes, while the average interview lasted roughly 45 minutes. As stated I conducted at least two interviews with each couple. The first and last rounds of interviews were based on formal interview questions, and were transcribed. The basic purpose of intermediary interviews was simply to maintain contact with subjects. These interviews were simply informal updates on their treatments. In the first round of interviews many patients did not yet understand their diagnosis, and did not believe many of the questions about infertility applied to

them. After conducting the first few interviews I learned that “infertility” was not a helpful word to use in questions, because many patients did not self identify as infertile. Often I would substitute phrases like “this experience you’re having,” or “trouble getting pregnant,” or “low sperm count” for the words “infertile” or “infertility”.

By the last round of interviews, patients were not particularly sensitive to the word infertile. Even patients who did not think of themselves as infertile, *per se*, understood that they were experiencing infertility as a broader medical and social phenomenon. In the final round of interviews patients recounted many of the medical options and treatments they had encountered over the previous months. Several infertility scholars describe infertility as a process. Greil et al. explain that infertility is not a static *condition*, but a socially conditioned *process* whereby couples come to understand their inability to have children as problematic (Greil, Leitko, and Porter 1988:175). For this reason I designed the study to include multiple interviews. As the final interviews demonstrated, infertility is a process, and I was grateful to have followed up with the patients. I had an 80% participation rate in the last round of interviews. I lost contact with one military couple who had relocated since the first interview, and one woman and two men did not participate in the last round of interviews. The woman said she was not interested in participating, a message she relayed through her husband. One man said he did not have time, but his wife suspected that he was embarrassed talking about his

infertility. I was unable to reach the other man by phone. I was able, though, to interview the spouses of the three subjects who declined the final interview.

A copy of the interview questions is available at the end of this document in Appendix I. Also available at the end of this document is a list of the study participants, including their cities of residence, races, ages, occupations, and diagnosis or cause of infertility (Appendix II). Of the five clinics, I recruited five couples each from San Francisco and Ann Arbor; four couples from St. Louis; seven couples from Boston; and three couples from New York. The couples reside in eight different states. At the time of the first round of interviews the male subjects ranged in age from 23 to 42; the average age was 33; the median age, 36. Women ranged in age from 21 to 39; the average age was 30; median age, 32. The subject population is overwhelmingly white, but does include a Filipino American woman, a Hispanic American man, a Japanese woman (U.S. resident). One white couple and a white man are U.S. residents and citizens of Ireland and Canada, respectively.<sup>17</sup> Because infertility cuts across all social classes, the occupations and education levels of the patients vary significantly.

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<sup>17</sup> Subjects did identify certain racial/religious aspects of their identities during interviews, including one American man (born and raised in the U.S.) who referred to himself as Italian more than once, a few couples in Boston based their decisions on the fact that they were Catholic or Irish Catholic, and one couple identified as Orthodox Jewish. The Jewish couple lived in a Jewish community, and involved a rabbi in all medical decisions. One Catholic woman, a former nun, sought help from a Catholic M.D. who developed alternative forms of reproductive treatments that did not run counter to the strict Catholic guidelines which oppose masturbation or conception outside of the womb.

Unfortunately, the representation of working class men was too small to draw conclusive class comparisons.<sup>18</sup>

Subjects included an airline pilot, an elementary school teacher, an electrician, a musician, a chemist, a state trooper, and a “house-husband,” just to name a few. Appendix I includes the occupations of all subjects. The causes of the men’s infertility vary, including spinal cord injury, cystic fibrosis, cancer, diabetes, congenital absence of the vas deferens (CAVD), obstruction of the vas deferens, varicoceles, chromosomal abnormalities, anejaculation, and unexplained low sperm counts.<sup>19</sup> Some of the couples in the study were diagnosed with both male and female infertility factors. A few women in the study were diagnosed with irregular menses and/or polycystic ovarian syndrome (PCOS), two women had uterine health issues, and a couple of women were told they had advanced maternal age (ages 38-40), which was complicating the treatment process.

Throughout the dissertation I recount stories of couples dealing with male infertility who fall into three categories: 1) couples I heard about through stories from interviews with doctors; 2) couples I observed in clinical encounters who chose not to be interviewed; and 3) couples I interviewed.

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<sup>18</sup> It was also difficult to identify couple’s class standings, because household incomes were unusually high. Since the couples had no children to care for, both husbands and wives were working. Subjects with typically working class jobs enjoyed “DINK” status (double income, no kids). All of the household incomes were over \$50K and many were close to \$100K.

<sup>19</sup> Vasectomy reversals are a major source of revenue for male infertility specialists; however, I chose not to include patients with past vasectomies seeking reversals in the study. I attempted to interview one patient who remarried after having a vasectomy, and wanted to have children with his second wife. The interview guide was not effective, as the patient repeatedly stated (and I had to agree) that the questions did not apply to him. He emphasized that he *chose* infertility, and the process for getting his wife pregnant was straightforward. I did not include him in this sample.

For the most part I was able to observe an appointment with each of the couples I interviewed. On a few occasions, though, doctors had to rush to see the next patient while I was still gaining written consent from the previous patient. By the time I caught up with the doctor, he had already completed the consultation or examination with the next patient, but the couple still wanted to participate in the interview portion of the study. According to IRB protocols I was not permitted to view any patient medical records. The medical information I have for the subjects is based on what was gleaned during appointment observations, oral explanations provided by doctors following appointments, and reports from patients.

No gay or lesbian couples were included in this study. This research was conducted in male infertility clinics, which generally do not provide services to gay or lesbian couples. Since lesbian and gay couples use reproductive technologies like intrauterine insemination (IUI) with donated sperm or *in vitro* fertilization (IVF) with donated eggs and a surrogate mother, respectively, they are referred to IVF clinics.<sup>20</sup> The focus of this study on heterosexual couples highlights the importance of male fertility status to masculinity in relationships between men and women where gender roles are tightly defined in relation to each other. Other researchers, including sociologist Amy Agigian, author of *Baby Steps: How Lesbian Alternative*

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<sup>20</sup> Hypothetically, if a gay man was trying to have a baby using an egg donor and surrogate mother, and was found to have infertility issues, he may be referred to a male infertility specialist, but I did not see or meet any infertile gay patients during my fieldwork. Also, if a gay man did learn he had infertility issues, he would likely have a partner whose sperm could be used for conception. The chances that both male partners would have infertility issues that could not be addressed with IVF innovations would be highly unlikely.

*Insemination is Changing the World* (2004), and Washington Post journalist Liza Mundy, author of *Everything Conceivable: How Reproductive Technologies are Changing Men, Women and the World* (2007), have written comprehensive accounts of lesbian motherhood and gay fatherhood in the age of assisted reproductive technologies.

In addition to ethnographic work in clinics and interviews with medical personnel and patients, I also conducted fieldwork at a sperm bank and sperm testing laboratory, conducted participant observation at medical meetings, and reviewed medical books and journals. In the preliminary stages of this research study I interviewed a long-time practitioner of male infertility, Dr. Cappy Rothman. Dr. Rothman helped found one of the country's oldest and most popular sperm banks, the California Cryobank.<sup>21</sup> On two occasions Dr. Rothman graciously allowed me to tour the Cryobank, and talk to his staff. Another informative experience I was fortunate enough to have was a visit to SCSA Diagnostics Center, a sperm testing laboratory in Brookings, South Dakota. Founded and operated by biochemist Donald Evenson, the center receives sperm samples from all over the country, and tests the integrity of the DNA within the sperm. Sperm with higher levels of DNA fragmentation is less likely to successfully fertilize an egg or make it possible for a fetus to grow to full term. During my visit to Brookings, I was able to interview staff, and learn

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<sup>21</sup> The California Cryobank provides anonymous sperm for infertile couples, lesbian women and single women. It also banks sperm for men who are about to undergo chemotherapy or vasectomy, or who may be deployed with the military. Just in the last decade the Cryobank has also started freezing and banking newborns' umbilical cord blood, rich in stem cells, for new parents.

about various scientific parameters for predicting the success of sperm.<sup>22</sup> In addition to visiting these facilities, I also joined the American Urological Association and the American Society for Reproductive Medicine. As a member of the AUA and ASRM, I received copies of their monthly journals, and was able to attend their national meetings. I attended the 2007 AUA annual meetings held in Anaheim, CA, and the 2007 ASRM annual meetings held in Washington, D.C. At these professional conferences, I attended sessions on medical advances and research in male infertility, and personally met doctors and mental health professionals working in the field of male infertility. These meetings were very advantageous for me, as I learned a lot about the science of male infertility, and had the opportunity to ask questions of leaders in the field. During the ASRM meetings, I attended a two-day seminar for mental health professionals, which focused on providing counseling and therapy for men dealing with infertility.

From April to September of 2007 I completed an internship at the Intel Corporation. I worked with the Health Practices Research Group (HPRG)<sup>23</sup>, a research team consisting of sociologists, anthropologists, and psychologists, who study the uses of information technology (not medical technology) among medical professionals and patients. During my internship the HPRG supported my research study, covering the costs of travel expenses, office

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<sup>22</sup> I am truly indebted to Drs. Rothman and Evenson (and their wives) who generously shared their time, and graciously offered standing invitations to return to their facilities any time, and even stay in their homes.

<sup>23</sup> Since the time of my internship this research group was dissolved. Some members of the group moved to the GE Corporation, which took over Intel's Digital Health Group.

supplies, and provided small compensation for the research participants.<sup>24</sup> At the conclusion of my internship I gave a preliminary report (oral report with PowerPoint slides) of my findings at Intel.

*Challenges to Research: Performance of Subjects, IRB Protocols, and My Role as Researcher*

There was some concern among IRB boards that due to the “sensitive” research topic of my study, most patients would not want me to be present during their doctor appointments, but would feel pressured to allow me to observe out of fear they would receive less effective care if they declined to participate in the study. From my perspective, albeit biased, this was not the case. The patients who did not want me to enter would simply answer ‘no,’ and the overwhelming majority of patients quickly responded “sure” or “I don’t care.” Since I was usually standing off to the side of the doctor-patient interactions, most patients did not even look at me during the appointments. I have been asked by other researchers if I observed any degree of patients “performing” for me, attempts to look or sound or act in an impressive way, because they knew they were being observed.<sup>25</sup> I do not think there was any

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<sup>24</sup> Doctors received \$200 gift cards; patients received \$50 gift cards for participating in a first interview.

<sup>25</sup> The concept of subjects “performing” is a term derived from Erving Goffman’s dramaturgical model of society (1959). According to Goffman, society is like a stage with actors performing roles using socially-prescribed scripts. The act of performing may be amplified when an actor becomes a research subject. In the 1920s and 30s in Hawthorne, Indiana researchers tried to gauge changes in factory worker productivity according to changes in light. Productivity increased significantly throughout the period of the study, then slumped afterwards. The increase in productivity was attributed to the extra motivation workers felt because they knew they were being studied, rather than variation in light exposure. This phenomenon has been termed the Hawthorne Effect (Landsberger 1958). Though I can’t say my subjects (the doctors) became any more productive, they definitely felt motivated to impress me.

evidence of performing, nor did patients blush or appear embarrassed in my presence.

However, I do believe I saw performance on the part of doctors. A few times doctors launched into mini-orations about their philosophies of medicine and the personal qualities that make them effective physicians, which they would follow up by motioning toward my notepad and asking me, “Did you get all that?” Other times, they appeared to overplay their bedside manner, demonstrating an exaggerated concern for the patients’ comfort level and feelings. This is not particularly surprising, since the patients were only told that I was studying male infertility, generally, whereas, the doctors were aware that I was recording observations, and planning to write about doctor-patient interactions. Over the course of the week, the novelty of my presence wore off and the doctors were less inclined to perform. I do not believe that the data presented in this dissertation are skewed as the result of “performance,” because I write about the well-rehearsed “spiels” doctors gave patients to explain diagnoses and options for treatment. Similar spiels were given by all doctors, and I believe they had been delivering the same spiels for years prior to my visits.

Working with IRBs was, perhaps, my first introduction to the participation of institutions in the social construction of male infertility. The first IRB I worked with was at my home institution, UCSD. My original IRB application proposed preliminary research, limited to interviews only, to investigate the experiences of couples diagnosed with male factor infertility.

The IRB committee's major concern was my "maturity level" and ability to deal with such a "sensitive topic." The importance of confidentiality was repeatedly stressed, and I was instructed to stop any interview if a subject demonstrated any signs that they felt uncomfortable. In a future revision of my application I expanded the project to include clinical observations.<sup>26</sup> The committee once again stressed the sensitive nature of such a study, the necessary maturity of the researcher,<sup>27</sup> and requested that the protocol specify that I would avert my eyes when men were asked by doctors to expose their private parts.<sup>28</sup> While countless studies have already been conducted on female infertility and in infertility clinics where women have openly shared deeply private information and private parts, freely cried and expressed emotions, the uneasy acceptance of a study of men and their fertility status seemed to illustrate the perception of the male body as an object too sacred to be studied, men's

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<sup>26</sup> My original application was reviewed by the social science research committee. The revised version, which included clinical observations, was forwarded to the medical research committee.

<sup>27</sup> In one letter the committee worried that as a sociology graduate student I had not received the same sensitivity training as medical students. During my fieldwork I heard countless penis jokes by medical professionals, saw dirty cartoons on office walls, watched a highly sexualized video clip mocking an infertile man shown at a medical conference for the sake of entertainment, and saw a doctor sexually harass a medical assistant. In one situation a doctor and patient discussed how "hot" I was in front of me. I also saw doctors yell at patients to be quiet and listen, and appear completely apathetic when patients became emotional. Perhaps it's time for a study of the effectiveness of sensitivity training among medical professionals.

<sup>28</sup> I had no qualms about including this point in the protocol. However, several doctors invited me to watch surgeries, requesting permission from their patients' ahead of time. From beneath the sterile operating room blankets the only body parts exposed were the genitals. This suggested an unarticulated social norm surrounding the exposure of men's bodies. If a man is conscious, and you can see his face and body, it is inappropriate to look at his genitals. However, if he is unconscious, and you cannot see his face, and his genitals are about to be sliced open, then it is perfectly fine to look.

emotions as too personal to be shared, and the social assumption that infertility must be a humiliating experience for men.<sup>29</sup>

Fortunately, the UCSD IRB approved this study as medical research without much objection to the methods of research. Though I presented myself as a social science researcher, any study that takes place within the walls of a medical establishment falls into the category of medical research. Other IRBs were less accepting of social science research in their hospitals and clinics. The first concern among review boards was that patients *and doctors* were listed as human subjects. I was informed repeatedly that doctors cannot be research subjects, and had to remove any reference to observations of or interviews with doctors. Also, because I was a guest at the other institutions, the physicians I shadowed had to serve as the Principal Investigators (PIs) of the study. I was listed as the Co-PI. The idea that doctors cannot be subjects should elicit some concern among researchers in the field of medical sociology. If sociologists are to study institutional power structures and the power relationships between healthcare providers and recipients of healthcare, shouldn't we be permitted to study the authorities in the medical field? Doctors, it seems, enjoy a status essentially beyond our scope of critique.

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<sup>29</sup> Likewise, Goldberg found in her study of infertility that the rooms and areas of clinics designated for the treatment of men were more "private," and she had a difficult time gaining access to those areas. She observed: "The easy access gained to those areas treating women suggests that female infertility was seen as less problematic than male infertility. Somehow, male infertility demanded more secrecy and privacy" (2009:208).

Fortunately, the physicians I worked with were all very supportive of my aspirations as a student, and understood that they would be subjects of discussion in the dissertation. Also, all of the doctors I worked with expressed no interest in conducting patient interviews themselves or reviewing interview transcripts. Yet, technically, the doctors as PIs have a right to see all of the interview transcripts of their patients, some of whom made disparaging remarks about their doctors.<sup>30</sup> Furthermore, the power given to doctors as PIs means that they could potentially try to prevent the publication of my work if they don't approve of or agree with it, or seek to attach their names to my work.

Another concern of the IRBs was that ethnographic fieldwork is not real research. Review committees seemed irritated that my research questions could not be more systematically and quantifiably measured. There was a general concern that I was there to ogle patients, and patient privacy was repeatedly stressed. In light of HIPAA patient privacy laws, I understand the liability concerns for patient privacy. However, journalists seem to work above HIPAA, as news reporters and reality television camera crews regularly enter medical clinics and hospitals with only short notice approval from hospital administration and patients, and no prior approval from IRBs. I repeatedly assured IRBs that I am a sensitive and mature researcher, I would keep the highest standards of confidentiality, and my written work would not bring

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<sup>30</sup> Some patients asked if their doctor would or could find out what they shared during interviews. I explained to patients that the digital audio and transcription files were stored on my computer, and no doctor had ever requested to see them, but that doctors had the right to see them.

humiliation to any of the research subjects. Miraculously, and after much persistence, I was granted access at every field site. The various challenges I encountered throughout the IRB approval process, not to mention the number of weeks and sometimes months required to get through the process, explain why few medical sociologists use medical establishments as field sites.

According to my IRB protocols I was not to speak during appointments. Keeping quiet not only pleased IRB committees, but was also consistent with my fieldwork philosophy. My goal was to be a 'fly on the wall' to the extent possible. I did not want my presence in the field to impact the course of medical action. Sarah Franklin, an accomplished scholar of assisted reproductive technologies, is a self-described "scholar-activist" (1997). Though this dissertation may sound like the work of a scholar-activist, I tried to remain completely uninvolved in patients' decision-making throughout the data- collecting segment of this study. This was a challenge. In some cases I believed I knew what medical route was best for the couple based on their diagnosis and financial situation, and had to resist the temptation to make suggestions when they chose a different route. In one particular case I did not agree with a doctor's recommendation for treatment, because I believed the procedure was completely unnecessary, not to mention terribly invasive and expensive for the couple. I tried to gently press the doctor to consider more counseling with the couple who I believed did not understand the basic mechanics of sexual intercourse. The doctor brushed off my concerns, and proceeded with the highly invasive diagnostic procedure to the tune of

\$10,000 out of their pockets and into his. Later, in interviews with the couple, I learned that my suspicions were correct. After enduring intense medical procedures to locate sperm, the couple achieved pregnancy through regular intercourse. These situations presented real ethical dilemmas for me. I felt it was morally right to intercede, and prevent unnecessary medical interventions and expenses. On the other hand, I am not a medical authority, and could not justify inserting myself in private conversations between doctors and their patients. For the sake of my research, it was valuable to watch these situations play out without any meddling from me, but the data gathered from these cases left me feeling complicit at times in the overt and unnecessary medicalization of naïve patients.<sup>31</sup>

Most people don't know what a sociologist is or does. This proved to be a bit problematic in conducting research. A few patients assumed I was training to work in medicine. For example, in the first round of interviews when I asked questions using the words *infertile* or *infertility*, words I came to realize doctors avoid using, a few patients became alarmed. Apparently, they had not yet processed or did not understand their diagnosis. They wanted to know if I had been privy to some of their health information that they had not yet heard about, or asked if I could explain their diagnosis to them. As stated earlier, I

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<sup>31</sup> I should probably note that in final interviews with a few patients I did make recommendations for various diagnostic procedures and treatments, readily admitting that I am not a medical professional. Because I spent time with different physicians, and familiarized myself with the science through professional meetings and journals, I have an uncommonly broad knowledge of the field. At medical conferences I discovered that I know more about the diagnoses and treatments of male infertility than most reproductive endocrinologists or urologists not specializing in infertility medicine. I have also invested considerable time researching treatments for women and men, comparing success rates, costs, and potential risks. Therefore, I believe I have a more balanced and less biased perspective on preferable treatment options compared to either female or male specialists.

quickly revised the questions. This mix-up may have pushed some men to think of themselves as possibly infertile sooner than they otherwise would have. More commonly, other patients assumed I was training to be a social worker or therapist. During interviews I asked patients if they had ever seen a therapist or counselor to discuss any of the emotional, financial or medical aspects of infertility. One woman responded, "Only you." A few other patients responded that our interactions were the only opportunity they had had to really discuss their feelings, possibly implying that I was some type of mental health professional.<sup>32</sup> Each couple received copies of the IRB consent forms, which explained my role and the purposes of the study. However, there was obviously some confusion about sociology.

### *The Trouble with Masculinities*

One of the greatest challenges to designing a research study of masculinity is to create tools for tracking masculinity without reifying stereotypical notions of masculinity. In 1936 Stanford psychology professor Lewis Terman and his assistant, Catherine Cox Miles, created a tool to test gender identity acquisition. Terman and Miles (1936) devised a masculinity-to-femininity continuum of traits, knowledge and abilities. Their survey tool asked subjects questions on a range of topics, including history, geography,

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<sup>32</sup> The confusion surrounding the work of sociologists abounds. While traveling to the various clinics, passengers seated next to me on flights would often ask me about the purpose of my trip. I routinely introduced myself as a graduate student in sociology, and explained that I would be spending time shadowing a urologist for my dissertation research. One man proceeded to tell me the intimate details of how Viagra saved his marriage, another man talked about incontinence issues, and several people shared personal stories of erectile dysfunction and infertility. Based on the manner in which they openly shared and even asked for advice I presume these people thought I was some type of medical or mental health expert.

fashion, emotions, personal preferences and tastes, and everyday chores like cooking. The purpose of the survey tool was to determine if subjects were properly acquiring their appropriate gender identity. Not surprisingly, the tool defined gender in such rigid terms that men who liked cooking and fashion, and women who did not, were pathologized as having gender disorders. As social constructionists know, gender is fluid and dynamic, and there is great variation in capacities, abilities and interests among men and among women. In their attempt to create a tool that could measure gender traits, Terman and Miles only managed to perpetuate common stereotypes about the genders.

Stereotypical depictions of masculinity and femininity naturalize singular archetypal forms of masculinity and femininity. If we look across cultures we can see empirical evidence that masculine preferences, behaviors, hobbies and interests are not connected to the Y chromosome. Work that may be considered manly in one culture may be deemed women's work in another culture. Expressions of emotion or communication styles considered feminine in one culture may be masculine in another. Not only do notions of masculinity and femininity vary across culture, they also change over time within any given culture, and over the life course for any given person. As several gender scholars have argued, there are multiple forms of masculinities (Connell 1995; Kimmel 1994). And I would add that within any given culture, among any subgroup of men, each man may construct and enact his masculinity in a unique way. Behaviors that one man may engage in to demonstrate his manliness, another man may avoid for the same purpose.

If masculinity is so dynamic, how can researchers create tools for recognizing the processes by which individuals construct and enact notions of masculinity? The job of social constructionists is not to measure manliness, or tally up performances of stereotypical masculine behaviors, but to understand how men are “negotiating,” or working to define, masculinity within their own social framework. As these definitions are worked out by individuals, researchers strive to observe how they are enacted, performed, or played out in different social contexts. This is tricky work. First, men and women do not think of each action they engage in as a gender performance, and subjects find it difficult to articulate the motivations behind their actions in terms of masculinity and femininity. This would be okay for researchers to deal with if all men made the same choices, and all women made opposite choices. The gendered patterns would be evident in the data. However, different men make different choices, and choose to enact their masculinity in different ways; the same may be said of women and femininity. Performances of masculinity and femininity may also overlap. This makes the data terribly messy. With a fine-tooth comb researchers have to tease through the words and actions of each subject, connecting motivations to what is observed and reported.

In this research study, I struggled to create a research tool, specifically an interview guide, which could capture notions of masculinity and recognize situations in which individuals were negotiating and enacting masculinity. My original interview guide asked subjects several questions about masculinity, the first of which was to define it. Most subjects were confused by the

question, and after some hesitation would rattle off stereotypical masculine traits, like strong, aggressive, and athletic, then ask if they had answered correctly. When asked if they believed their experiences with infertility had had any impact or effect on their own sense of masculinity, several respondents shrugged, “Not really.” After the first several interviews I dropped some of the masculinity-related questions from the interview guide, because 1) I believed the questions were only contributing to the perpetuation of masculine stereotypes; and 2) I worried the questions were pushing men to think of their medical issues as emasculating when they had not already perceived them that way. Fortunately, final interviews proved to be more fruitful on the topic of masculinity. After having spent several months dealing with infertility, the patients seemed better able to communicate the relationship between their medical experiences and their personal masculine identities. It was through the practical experience of carrying out this study, particularly while conducting interviews, that I learned just how slippery the concept of masculinity is. Its ‘taken-for-granted-ness,’ meaning, the many unarticulated ways that notions of masculinity shape social norms and individuals’ choices, and its plural and constantly evolving forms, make masculinity a difficult concept to isolate and track.

Two professors familiar with my dissertation prospectus (not committee members) suggested that I add questions to my interview guide that could determine if infertile men were having a ‘crisis of masculinity’ due to their infertility, and if they were trying to compensate for this crisis. They suggested

asking the subjects if they had started engaging in more masculine types of activities, such as weight lifting or motorcycle riding; or if they were trying to compensate with symbols of masculinity, like purchasing a new truck or expensive electronics.<sup>33</sup> I purposely avoided asking questions such as these, as I believed they were a return to the Terman-Miles continuum, reifying stereotypical notions of masculinity. Instead, I wanted the patients' stories to serve as narratives of negotiating masculinity. The beauty of this study is the inherently gendered nature of the topic. We can argue about what hobbies or skills are masculine or feminine, or if certain sports, or disciplines, or careers, or art forms are masculine or feminine. But the ability to have an erection, penetrate a woman, produce sperm, ejaculate and fertilize an egg is an unarguably masculine act, even when performed by the most feminine of men. In other words, this can't *not* be a study of gender and masculinity. Notions of gender, sexuality, and masculinity are described in each patient's account. My aim in this dissertation is to explain how men – when unable to perform what is deemed the most quintessential of “masculine functions” – reassess their values, make sense of their world, and re-affirm their personal identities as compassionate and responsible husbands and fathers-to-be. This is what it means to negotiate masculinity.

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<sup>33</sup> Sociologist Robb Willer attempted a similar type of study in 2005. His unpublished paper, “Overdoing Gender,” reported that men who felt their masculinity was being threatened would overcompensate by showing greater support for the Iraq War, more negative attitudes toward homosexuals, and greater interest in buying a sport utility vehicle (Willer in Kimmel 2008:93).

### ***Dissertation Chapter Outline***

Throughout the following five chapters I draw upon data collected during ethnographic fieldwork in the arena of male infertility to show that the social processes of constructing gender norms and negotiating masculinity are tightly intertwined with the process of constructing disease. In the next chapter, "Claiming Jurisdiction: Urologists and the Practice of Male Infertility Medicine," I describe the genesis and history of male infertility medicine. I explain where male patients are actually, physically situated within the infertility industry, arguing that there are no clear entry points for men into the institutional structures designed to treat infertility. This is due to the competing jurisdictional claims over the male body by different types of medical specialists. This chapter also includes a detailed description of various causes of male infertility, and explains treatment options available for each of these causes.

The third chapter, "Masculinity in Culture and Medical Practice: How Institutions Take Part in Constructing Popular Notions of Gender," looks at how cultural depictions of male fertility, semen, sperm, virility and sexuality inform medical practices for infertility. I argue that medical institutions are powerful players in the social construction of gender, and that their practices perpetuate stereotypical ideals of masculinity. Chapter four, "Infertility and Identity: How Men Redefine Their Masculinity in Light of their Fertility Status," draws in quotes from subjects to illustrate how men redefine and downplay their infertility diagnoses. I argue that redefining infertility in seemingly less

threatening terms is a technique infertile men employ for negotiating and protecting masculinity.

In chapter five, "Men and Technology: How Infertile Men Construct Masculine Narratives Around Medical Interventions," I argue that in contrast to other medical research suggesting men are reluctant to receive medical help, infertile men willingly embrace medical technologies to restore fertility. The data suggest that when masculinity hangs in the balance, men are quick to seek medical treatment. I also show that infertile men construct personal narratives which valorize their own efforts to engage with medical technologies, illustrating the power of individuals to revise masculine norms. The concluding chapter reviews the major contributions of this study. I also consider the questions raised by this study, which invite new opportunities for future research.

## Chapter Two:

### CLAIMING JURISDICTION: Urologists and the Practice of Male Infertility Medicine

#### Chapter Outline:

#### ***The Male Body in Tug-of-War***

#### ***Assisted Reproductive Technologies and the Role of Men***

#### ***The Male Infertility Clinic***

*Assessment of the Male Patient*

*Etiologies of and Treatments for Male Infertility*

#### ***Why Treat Male Infertility?***

#### ***Confusion in Decision-Making***

*Calculating Cost, Risk and Success*

*Conflicting Information*

*The Management of Information*

#### ***Discrepancies in Treatment Practices Among Male Infertility Specialists***

#### ***Making Space for Men***

**Notice to Patients**

*In this new era of IVF, some gynecologists have begun treating both male and female infertility by using IVF only. In many instances the male partner's condition is ignored and the male partner is not offered any evaluation or examination. In some instances gynecologists are even operating on male patients without having any formal training or certification.*

*We feel that this approach is dangerous for several reasons. First off, couples may not be informed of all their options so as to make an educated decision regarding their treatment. Secondly, male infertility is often the result of an underlying and usually treatable condition. Male fertility problems usually don't arise without reason. In some cases male infertility is the first sign of testicular cancer and should not be neglected. For many couples, the problem can be corrected and expensive treatments can be avoided.*

--From the web-site of a prominent male infertility specialist<sup>34</sup>

**The Male Body in Tug-of-War**

Since the 1970s sociologists have examined the far-reaching expansion of medicalization, and the ways that Western medicine has continuously enveloped new jurisdictions (Brown 1995; Conrad 1992; Conrad 2005; Conrad and Leiter 2004; Ehrenreich and Ehrenreich 1978; Ehrenreich and English 1978; Loe 2004; Zola 1978). Psychological disorders, alcoholism, and erectile dysfunction are just a few of the numerous examples of popular social issues of the past half century that now fall under the jurisdiction of medical authorities. In his 2005 article, "The Shifting Engines of Medicalization," Peter Conrad argues that recent changes in the organization of medical knowledge and practice are reshaping how and why medicine expands to incorporate new jurisdictions. Originally, medicalization was theorized to be a process driven by moral entrepreneurs or power-seeking professionals. But in the new millennium, argues Conrad, biotechnology, consumers, and managed care serve as major driving forces in the expansion of medicine (2005:3). At one

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<sup>34</sup> [http://www.malereproduction.com/07\\_maleinfertility.html](http://www.malereproduction.com/07_maleinfertility.html)

time social scientists argued that patient-consumers were victims of medicalization, but Conrad clarifies that today patients play a more powerful role because “health care is more commodified and subject to market forces,” and “health care institutions must compete for patients as consumers”(8).

As discussed in the first chapter of this dissertation, infertility has been a slippery topic for social scientists who oppose the extreme medicalization of women’s bodies, but want to embrace the new social realities that assisted reproductive technologies make possible for women and families. Infertility follows the description of past and present models of medicalization outlined by Conrad. Thirty years ago there were so many risks, associated with infertility treatments, including death (Klein 1989:231), it appeared that women were being victimized, subsumed by medical authority. Today infertility is a lucrative industry driven by market forces and consumer demands for commodities, like medical services, donor gametes (egg and sperm), and surrogate mothers. Advertisements in glossy magazines and over the airwaves, quite similar to the direct-to-consumer marketing campaigns of pharmaceutical companies, seek to lure baby-hungry couples into infertility clinics. IVF clinics must compete with each other for the business of infertile couples, and male infertility clinics must compete with IVF clinics for infertile male patients. Amid the clamor for business, the male body has become the object of a medical jurisdiction tug-of-war between male infertility specialists and highly specialized gynecologists, namely reproductive endocrinologists/infertility specialists, who both claim they can effectively solve

the problem of male infertility. As the “Notice to Patients” above demonstrates, male infertility specialists make claims of expertise to undermine competition and create boundaries of jurisdiction between medical specialties.

In Chapter One I argued that preconceived notions regarding women and reproduction have rendered men nearly invisible in both popular and academic discussions of infertility. In this chapter we step into the medical institutions that treat infertility, and look at where men fit in the system. I show that innovative medical procedures do exist to treat the uncooperative reproductive systems of aspiring fathers, but there are no clear entry points or medical paths for male patients who venture into the current medical system. Male patients often must navigate a labyrinth of conflicting and tightly controlled information. I draw upon interviews and observations at clinics and medical conferences to describe how male infertility specialists are waging a war against REs for jurisdiction of male infertility. As a result of the medical debates and disorganization of the field, patients may be subjected to unnecessary or unnecessarily invasive treatments. In this chapter I show that the failure of urologists to unify and organize male infertility medicine into a board certified sub-specialty has generated confusion among patients and led to the improper management of male infertility in some cases, and has ultimately cost urologists ground in the fight for medical jurisdiction of male infertility medicine. In the following chapters of this dissertation I use the information presented here to complete a gendered analysis of male infertility.

The lack of organization of male infertility medicine compared to the well-established board certified sub-specialty of female infertility is an example of culture lag, where popular assumptions about women and reproduction have hindered the development and establishment of technologies and institutions to treat male reproductive issues.

A *jurisdiction* is defined as a claim over a specific kind of knowledge, and a particular kind of work (Abbott 1988). Generally, no two professions can occupy the same jurisdiction simultaneously, as “one profession’s jurisdiction preempts another’s,” or the dominant profession engulfs the subordinate (1988:87). In the ‘system of professions,’ as analyzed by Andrew Abbott, medicine is one general profession inside a larger constellation of professions that includes law, architecture, journalism, etc. On a micro-scale, within the field of medicine there also exists a division of labor, a system mapped out by jurisdictions, in which boundaries delineate kinds of knowledge and work to be controlled and performed by different types of specialists. At present the jurisdictional boundary between reproductive endocrinologists and male infertility specialists is blurred, falling somewhere across the male body. Reproductive endocrinologists are able to practice infertility treatments on the female body, a right legitimized by their board certification with the American Board of Obstetrics and Gynecology. Often, all they need to conduct their work is sperm, a product of the male body. Male infertility specialists, as certified by the American Board of Urology, are qualified to assess, palpate,

incise, and splay open the male body and its parts. Male factor infertility, as a clinical condition, is a territory where both professions stake their claim.

In the first two sections of this chapter I describe the actual locations where men's bodies intersect with medical technologies, including male infertility clinics. I describe how male infertility is assessed, review the various etiologies of male infertility, and outline some of the medical treatment options for addressing these problems. In the subsequent sections of this chapter, I draw upon fieldwork to describe and analyze a field of medicine claimed by two types of specialists. I discuss the claims of superior knowledge and capabilities made by male infertility specialists, and show how these claims complicate the patient decision-making process. I also provide examples of cases I observed which illustrate that the lack of organization around infertility medicine has resulted in medical errors. Finally, I consider how a reorganization of the field of male infertility might be beneficial to patients.

From a sociological perspective, I recognize that science and medicine are constructed within a social context, but that there are physical and biological realities that cannot be disputed. For the male patients who seek medical help, the biological reality is that they cannot achieve pregnancy with their significant other within a desired timeframe. At the same time, I recognize that institutions and technologies shape our biological experiences. Medical practices are informed by a Western model of disease, and business practices are designed within a capitalist free market. In other words, how and where male patients find themselves is a socially constructed space where

technologies, information, and business practices are highly managed by a body of social actors each with independent interests. In this chapter, I do not advocate any one *true* definition of male infertility or any *best* practices for its treatment. I do, however, challenge medical institutions to work responsibly to ensure quality care for patients, and provide patients with valuable information throughout the treatment process so they may be empowered to make informed decisions regarding their own bodies and health. Furthermore, as a feminist scholar, I see how making space for infertile men in the medical sphere could potentially spare women some of the physical burdens of popular infertility treatments, and extend to men the charge to share responsibility for reproduction.

### ***Assisted Reproductive Technologies and the Role of Men***

As scholars like Inhorn (2009) and Thompson (2005; 2002) repeatedly suggest,<sup>35</sup> the social science research and discussion surrounding reproduction overlooks the experiences of men. However, men are not just missing from discourse. Men are quite literally physically absent from most aspects of the infertility industry. Scholars' attempts to include men in infertility research are often frustrated (and frustrating), because infertile men are hard to find. Young anthropologist Helene Goldberg set off for Israel in 2002 to conduct research on infertility. She began her ethnographic work in IVF clinics that claimed to specialize in male infertility. She writes: "As I entered Israeli clinics, I found that men had not only been missing from writing and debates

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<sup>35</sup> Detailed in Chapter One.

about infertility, but that they were often also missing in the clinics” (2009:205). In the earliest stages of my own research I, too, found that men were missing from support groups, on-line help sites, and infertility education conferences for patients. So, where are all the infertile men? Goldberg could not find men, and to her chagrin, found only their sperm (205), because she was looking for men in IVF clinics. The procedures performed in IVF clinics, including artificial insemination, also known as intrauterine insemination (IUI), and *in vitro* fertilization (IVF), do not require interventions into men’s bodies; indeed, only their sperm is needed. Semen for these procedures is provided by masturbation, which men may do in private rooms at clinics, or more commonly, at home. As one male infertility specialist described to me, the technology has reduced the role of fathers to merely sperm donors.

The advents of IUI and IVF have been great boons for infertile couples. Old medical texts suggest doctors have been administering artificial insemination since at least as early as 1915 (Huhner 1937:39).<sup>36</sup> IUI, as practiced today in infertility clinics, involves taking a semen sample, “washing” the sperm (separating the healthy sperm from the seminal fluid and weak or dead sperm via centrifugation, followed by combining healthy sperm with a prepared solution), and inserting the sperm into the uterus vaginally using a long syringe. Prior to IUI women are often prescribed a drug to stimulate

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<sup>36</sup> The concept of IUI may have been practiced prior to 1915. According to an oral history of male infertility medical practices provided by Dr. Cappy Rothman, a medical school professor in Philadelphia in the 1800s used the sperm of one of his students to impregnate a woman with an infertile husband. It is highly likely variations of artificial insemination technology have been used in other societies throughout human history.

ovulation. IUI is considered an effective method for treating women with irregular menstrual cycles or unpredictable ovulation.<sup>37</sup> However, it may also be used for women with male partners with low sperm counts.

IVF is a process whereby women are administered hormones to stimulate the production of multiple eggs in the ovaries. As many eggs as reach maturation are harvested using a laparoscopic sucking device. Semen is collected from the male partner and washed. Eggs and sperm are put together in a petrie dish or test tube – hence, the name ‘test tube baby’ – where fertilization takes place. After a few days, the developed embryo is placed into the uterus, where ideally, it will implant, and begin normal fetal gestation. From the time of its inception in the late 1970s, IVF was used to treat infertile women. However, it also proved to be helpful in cases of men with low sperm counts, as it ensured the contact of sperm with egg more systematically than intercourse or the simpler IUI technology. Since much of the IVF process, including the hormone therapy, egg harvest, and embryo transfer take place in the woman’s body, men are understandably absent from some clinic activity.<sup>38</sup>

The exciting innovation of intracytoplasmic sperm injection in 1992, also known as ICSI (pronounced “icksy”) or IVF-ICSI, created dramatically new

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<sup>37</sup> IUI is also used when patients choose to use an anonymous sperm donor. In cases where single or lesbian women use donor sperm and know they have healthy ovulation cycles, the women forgo the ovulation stimulating drugs. In fact, women using sperm donors can insert the sperm themselves (vaginally, depositing sperm near the cervix) in the privacy of their own homes, using syringes (or “basters”) provided by sperm banks.

<sup>38</sup> Many studies do show that male partners play a special social role in supporting their wives through the various steps of treatment. However, once the sperm is submitted to the clinic, the man’s presence is not needed.

options for couples with male factor infertility. In this process, a single microscopic sperm is manually sucked into a needle and injected into an egg. The process was originally created to help along fertilization for men who had extremely low sperm counts, or who had very few properly developed sperm, because the process only requires one single healthy sperm per harvested egg. But the most remarkable aspect of this technology was developed in the late 1990s when researchers discovered they could fertilize an egg using not only ejaculated sperm but sperm from the testicles or epididymes. Even immature sperm cells found in the testicles were proven capable of fertilizing eggs, resulting in live births. Two decades ago men diagnosed with “azoospermia,” meaning a zero sperm count or not one sperm found in the ejaculate, were told they would never have biological children. Today, thanks to biopsy and surgical techniques used to remove sperm from the testicles or epididymes, in combination with IVF-ICSI, azoospermic men regularly father children. One of the earliest concerns and criticisms, from both the scientific and lay communities, regarding ICSI using the less-developed or immature sperm found in the testicles, was that the offspring would presumably be more likely to have birth defects or developmental disorders than children created from fully developed sperm. To date, the data show that IVF children are twice as likely to have birth and developmental anomalies than non-IVF children (Chen, Sun, Li, Yin, Xiong, and He 2007; El-Chaar, Yang, Gao, Bottomley, Leader, Wen, and Walker 2009; Goel, Sreenivas, Bhatnagar, Lodha, and Bhatla 2009; Olivennes 2005; Olson, Keppler-Noreuil, Romitti,

Budelier, Ryan, Sparks, and Voorhis 2005; Schieve, Rasmussen, and Reefhuis 2005).<sup>39</sup> However, the research comparing IVF children with IVF-ICSI children has been less conclusive, and much more controversial. Some studies show a slight increase in developmental anomalies, particularly among children of fathers with chromosomal defects, but no findings have been dramatic enough to discourage the use of IVF-ICSI (Alukal and Lamb 2008; Christianson, Yates, Hubayter, Reigart, Zhao, and Wallach 2009; Hawkins, Barratt, Sutcliffe, and Cooke 1999; Squires, Carter, and Kaplan 2001).

### ***The Male Infertility Clinic***

IVF-ICSI using testicular sperm launched men's bodies into the medical sphere. The role of azoospermic men is more involved than just masturbating "sperm donors," since they must be physically present in the clinic, and willing to submit to medical intervention for the processes and technology to work. Other men, including some with varicose veins in the scrotum, men who cannot ejaculate, men with extremely high or low hormone levels, men with obstructed ducts in the genitals, and various other fertility problems may also be directed toward or search out male infertility specialists to upgrade their fertility status.

Male infertility specialists have been around for decades, long before the innovation of IVF-ICSI using aspirated sperm, but they were few in number, and they offered fewer treatment options than today. Nellie Oudshoorn, author of *The Male Pill*, argues that the historical orientation of

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<sup>39</sup> Data vary by study, but most studies conclude that birth defects are found in about 3% of IVF infants compared with under 2% in the general population.

medical practice toward female reproduction has resulted in more practitioners in female reproductive science today versus male reproductive science. The differing organization of the male and female reproductive medical specialties has further discouraged the development of male infertility science. As Oudshoorn explains, clinicians of female reproduction are unified and better organized within the single field of gynecology. The few male reproductive practitioners trained in the 1960s and 1970s were fragmented into various sub-specialties including urology, the study of the urinary tract and prostate gland; and endocrinology, the study of the testes, testosterone and hormones. The practical treatment of infertility has been delegated to gynecologists, specifically, specialists within gynecology, reproductive endocrinologists (RE's) promoting a focus on women's reproductive systems over men's (2003:26).

Early medical texts show that a handful of medical doctors practiced some form of male "sterility" medicine in Europe and the United States in the early nineteenth century (Mondat 1844). As mentioned in chapter one, female reproduction was highly medicalized in the nineteenth century, often to the detriment of women. As historian Ornella Moscucci notes, during that time period male bodies and male reproduction were far less medicalized or categorically understood by medical professionals compared to women's bodies (1990). Some documents indicate an attempt by physicians to create a section of andrology within the American Medical Association as early as 1891 whose intended focus was the genito-urinary tract of men. However, the history and fate of the section are unknown (Niemi 1987).

The male infertility sub-specialty of urology practiced today took root in the second half of the twentieth century,<sup>40</sup> and has grown significantly in numbers of practices, practitioners, and patients with each new technological innovation.<sup>41</sup> Today many male infertility specialists operate male infertility clinics which often have on-site laboratories where highly trained technicians conduct semen analyses. These practices may be private, relying on referrals from outside physicians, or they may be part of larger medical systems, affiliated with IVF clinics within the same medical system. Unlike female infertility specialists, male infertility specialists are not board certified within their sub-specialty. To elaborate, female infertility specialists are board certified gynecologists who sub-specialize in reproductive endocrinology. At the end of a board approved fellowship, they must take a second board exam with the American Board of Obstetrics and Gynecology to certify as reproductive endocrinologist/infertility specialists (also known as RE/I's or RE's). In preparation for their RE/I board examinations, fellows are advised that they "should be able to evaluate a woman for infertility and be able to develop and carry out an appropriate plan for management of the infertile woman" (ABOG 2004:26). On the subject of male infertility, fellows are expected to "be able to evaluate the male partner and diagnose sub-fertility and absolute infertility and evaluate and discuss patients with these problems"

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<sup>40</sup> The American Association of Andrology was formed in 1974.

<sup>41</sup> Based on personal communication with Dr. Cappy Rothman, founder of the Center for Male Reproductive Medicine, and co-director and co-founder of the IVF Center at Century City Hospital.

(2004:28).<sup>42</sup> The main focus of treatment for the RE is the infertile female partner for whom the RE develops a management plan; management of the male patient is beyond their scope of expertise. Though REs are qualified to conduct a physical examination of male patients, they typically do not.<sup>43</sup> Once certified, REs may open their own private clinics or join teams of REs at existing IVF clinics.

In contrast, male infertility specialists are medical doctors board certified within the specialty of urology, all of whom study and receive basic training of male infertility during their residencies (AUA 2009:13).<sup>44</sup> There is no additional board certification available for the sub-specialty of male infertility, sometimes referred to as andrology. Male infertility practitioners most often receive highly specialized training during a fellowship following their urology residency. Some long-time practitioners of general urology may opt to train for a few weeks or months with a male infertility specialist to learn the

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<sup>42</sup> I spoke with representatives from the American Board of Obstetrics and Gynecology and the American Board of Urology who both explained that there are no “official documents” which state specifically what an RE or urologist are actually qualified to treat, upon completion of their board certification. Both representatives directed me to guide books created to help residents and fellows prepare for board examinations. The ABOG representative also explained that any medical doctor could possibly practice infertility medicine without board certification, and would have no reason to fear legal recourse from patients for doing so. The main purposes of board certification, as explained, was simply as a credential to enable doctors to demonstrate they had attained a certain level of expertise within a specific field, and to make doctors more marketable, particularly in urban job markets.

<sup>43</sup> None of the male patients in this study was physically examined by an RE at any time. When patients come to male infertility clinics, it is presumed they have never received a physical examination for infertility.

<sup>44</sup> Board examinations test the expertise of urologists in the following categories: “ethics, professionalism, epidemiology, andrology (including **infertility**), calculous disease (including endourology and shock-wave lithotripsy), congenital anomalies, pediatric urology, urologic disorders of females, infectious diseases, neurourology and urodynamics, obstructive diseases, renovascular hypertension and renal transplantation, sexuality and impotence, adrenal diseases and endocrinology, trauma, urologic pathology, urologic imaging and interventional radiology, urologic oncology, and geriatric oncology.” Source: AUA. 2009. *2010 Information for Applicants and Candidates, Fifty-seventh Edition*. Charlottesville, VA: American Board of Urology, Inc., p. 13. Boldface added.

microsurgical skills of the trade. Other urologists, often reputed as less committed to and less knowledgeable in the treatment of male infertility, may attend workshops or continuing education courses to brush up on new innovations and techniques in male infertility medicine.

Why is male infertility not a board certified sub-specialty? Doctors I interviewed described their field and urology generally as a disorganized specialty of medicine. On occasion groups of doctors within the American Urological Association (AUA) have attempted to organize male infertility into a certifiable sub-specialty, but there is always enough resistance by other urologists to stall organization efforts. Most urologists seem to appreciate the lack of bureaucratic involvement from organizations like the American Board of Urology (ABU), valuing the autonomy that they enjoy in their practices. To their detriment, the lack of an organized sub-specialty has resulted in poor patient awareness of the medical help available to infertile men.

Unfortunately, the inadequate training of some urologists attempting to practice infertility medicine has resulted in the ineffective and even harmful treatment of male patients, which I discuss in-depth later in this chapter.

Most men diagnosed with some form of infertility never find their way to a male infertility clinic. Of the small fraction who do, nearly half of these male patients are referred to a male infertility clinic by an obstetrician gynecologist (Ob/Gyn), just under a quarter are referred by RE's, another quarter from their primary care physician (PCP), and the remainder are referred by other

urologists (Rosenberg and Honig 2007).<sup>45</sup> Couples who are trying to achieve pregnancy most likely begin a battery of diagnostic tests with their physician, the PCP, Ob/Gyn, or RE.<sup>46</sup><sup>47</sup> The first step for men is to provide a semen sample for analysis. In some cases, men who are found to have insufficient semen quality may receive an immediate referral to a male infertility specialist. In most cases, REs will recommend the couple use some form of assisted reproductive technology (IUI, IVF, IVF-ICSI), bypassing the need for any additional assessments or medical opinions. Though male infertility specialists accuse REs of being greedy with their male patients by not referring them out to male infertility clinics, in truth, the ratio of IVF clinics to male infertility clinics is overwhelmingly lop-sided. There are many major cities, and even some entire states, that do not have one practicing male infertility specialist (Nangia, Likosky, and Wang 2007).<sup>48</sup> Understandably, the sheer lack of male infertility clinics in some geographic areas discourages doctors from referring infertile male patients to specialists.

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<sup>45</sup> This data comes from an unpublished paper by Rosenberg and Honig. These figures are comparable to those given by the doctors I interviewed regarding their own practices.

<sup>46</sup> Several infertility scholars note that women begin and lead the process of infertility work-ups (Greil 2002:112).

<sup>47</sup> Some couples are required to complete diagnostic tests with their PCP or the woman's OBGYN before they can schedule an initial consultation with an RE. In other cases, RE's are the first to conduct the tests.

<sup>48</sup> Because male infertility is not a board certified practice it is difficult to calculate the exact ratio of female infertility practitioners to male infertility practitioners. Numbers of female infertility practitioners (RE's) are kept by the ABSM and AMA; no figures are kept for urologists who have fellowship-trained in male infertility. Membership figures provided by the American Society for Reproductive Medicine shed some light on the numbers. There are 852 RE's compared with only 227 urologists (personal communication, Eleanor Nicholl, ASRM, 10/1/09).

### *Assessment of the Male Patient*

Male patients who are referred to a qualified male infertility specialist will likely receive a comprehensive assessment which will include another semen analysis, and a physical examination of the genitals, as prescribed by the World Health Organization (Rowe, Comhaire, Hargreave, and Mahmoud 2000). The semen analysis examines several parameters of the semen and sperm, including ejaculate volume, concentration of sperm per milliliter, sperm count, and the motility and morphology of the sperm. The WHO has set the “gold standard” for sperm counts at 20 million sperm per milliliter and at least 40 million sperm per ejaculate<sup>49</sup>, based on data showing that lower figures may decrease chances of conception, while higher numbers do not increase the likelihood of conception.<sup>50</sup> Low ejaculate volume ( $\leq 2$  ml) may indicate a blockage in the vasa deferentia or a misguided flow of seminal fluid from the seminal vesicles (see Figure 2.1). Sperm with poor motility are not likely to “find” and fertilize an egg. Sperm with poor morphology, including sperm with misshapen or small heads, missing tails or two tails, are incapable of properly fertilizing an egg. If a grossly malformed or incompetent sperm were to fertilize an egg, the pregnancy would result in spontaneous miscarriage.

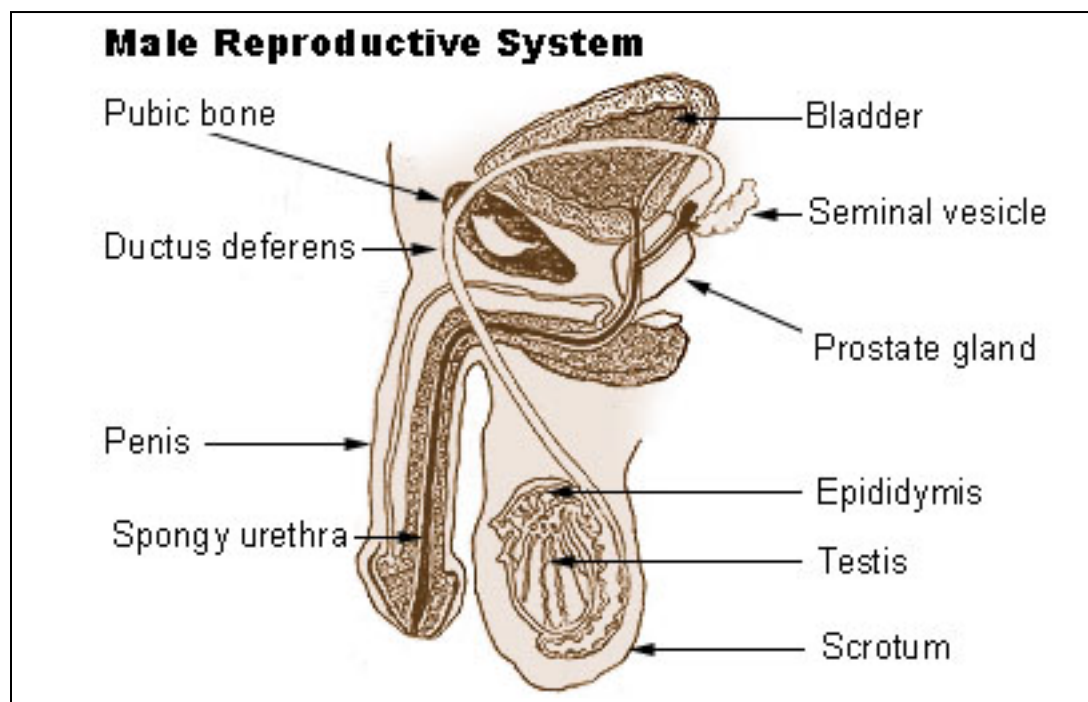
Male infertility specialists stress that poor motility or morphology are incredibly important factors in a couple’s ability to achieve pregnancy, but are often overlooked where there is a high sperm count. Hypothetically, a PCP,

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<sup>49</sup> This is known as “total sperm count,” calculated as number of sperm per milliliter multiplied by volume (number of milliliters).

<sup>50</sup> Sperm counts may reach upwards of hundreds of million sperm per milliliter.

Ob/Gyn, or RE who orders the initial semen analysis for a patient might see a high count of 50 million sperm, assume the patient has a healthy fertility status, and overlook a male factor, like poor motility or morphology. Such cases illustrate a typical situation where the woman is presumed to be unable to conceive and proceeds with therapy, while the man is assumed to be fertile, and goes untreated.



**Figure 2.1:** Diagram entitled “Male Reproductive System.” Source: U.S. Government.

The main purposes of the physical examination are to inspect and palpate the penis, testes, and scrotum, and the palpation of epididymes and vasa deferentia (see Figure 2.1). Doctors may also assess the genitals for scrotal swelling and scarring, and examine the prostate gland and seminal

vesicles if there is any history or signs of disease of the sex glands. During the examination of the penis, the physician looks for a condition known as hypospadias, or the abnormal placement of the meatus or opening normally located at the tip of the penis; surgical or traumatic scars or any deformities. Any abnormalities or deformities may cause erectile problems or ejaculatory dysfunction, preventing proper intercourse or delivery of semen into the vagina and conception. During the examination of the testes, the physician checks that the testicles have descended properly into the scrotum, and palpates the testicles to check their proper size and shape. The testicles are the factories where germ cells develop into sperm. Undescended, maldescended, small or malformed testicles may indicate a problem in the factory, inhibiting sperm production. While examining the scrotum, the doctor will feel for any palpable veins, or varicoceles, which may have developed alongside the testicles. Varicoceles facilitate unnecessary blood flow through the genitals, potentially raising the temperature of the testicles, and inhibiting sperm production or killing sperm.

The epididymes and vasa deferentia, located inside the scrotum, are not easily visible to the eye. It is only by palpating the scrotum that a physician can feel for their proper placement and form. Nodules, swelling, or cysts detected in the epididymes, which are attached to the testicles and serve as reservoirs for sperm, might indicate inflammation or infection, preventing proper ejaculation of sperm. Distention of the epididymes may indicate a “back-up” of sperm, due to the absence of the vasa deferentia. The doctor will

palpate to locate the vasa deferentia, cord-like tubes running from the epididymes to the seminal vesicles. During male orgasm the epididymes thrust sperm through the vasa deferentia to the seminal vesicles.<sup>51</sup> There the sperm are combined with seminal fluid, and the semen propels through the penile duct to complete ejaculation. Absence of the vasa deferentia is a congenital defect which prevents the travel of sperm from the testicles to the penis. Patients with congenital bilateral absence of the vasa deferentia (CBAVD) will never achieve pregnancy through regular intercourse and will have zero sperm counts. Nodules, swelling or pain upon pressure of the vasa deferentia may indicate inflammation. The entire physical examination takes only a few minutes. During my fieldwork I left exam rooms during the physical exam, and routinely reentered the room less than five minutes later following the exam.

#### *Etiologies of and Treatments for Male Infertility*

Infertility is defined as the inability to achieve pregnancy after one year of unprotected sex, or the inability to carry a pregnancy to live birth (Chandra 1994).<sup>52</sup> Although infertility is defined by the ASRM as a single disease, it is a disease caused by a plethora of various etiologies. In women, infertility may be caused by hormonal or ovulatory issues, or any number of physical problems evident in the ovaries, fallopian tubes, or uterus. When a male

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<sup>51</sup> Vasa deferentia are the same tubes “snipped” or cauterized in vasectomy, the common surgical procedure used to prevent pregnancy.

<sup>52</sup> This is the definition adopted by the ASRM, the CDC, and most health insurance companies that cover infertility services. The WHO uses “two years of exposure to pregnancy” (or unprotected sex) to determine infertility. Some infertility specialists will shorten the length of inability to conceive to six months for women over the age of 35.

factor is present, first established by poor semen parameters, doctors explain they are primarily looking for a problem in the “factory” (the testicles) or the “bridge” (vasa deferentia and urethra via the prostate) needed for proper delivery of seminal fluid and sperm.

Factory production of sperm may be inhibited by a number of issues, including: common other diseases like diabetes, obesity, and prostate and testicular cancers; illicit drug or steroid use; excessive exposure of the testicles to heat, toxins, or chemotherapy and radiation; and heat from varicoceles. Major trauma to the testicles, including torsion or twisting of the testicles, can stop sperm production. Hormone imbalances also deter sperm production, including hypogonadism, where levels of FSH (follicle-stimulating hormone) and LH (leutenizing hormone) are too low, and testicular failure due to excessively high levels of FSH and LH. Some chromosomal genetic disorders, including Klinefelter’s Syndrome<sup>53</sup> (also known by its chromosomal indicator: ‘47, XXY’), and micro-deletions of the Y-chromosome also result in reduced production of sperm.

Bridge problems include issues like anejaculation and retrograde ejaculation, which hamper the delivery of sperm from the testicles. Anejaculation, or the inability to ejaculate, is relatively common in men with spinal cord injuries, multiple sclerosis, or psychological disorders. Retrograde ejaculation occurs when semen is directed toward the bladder instead of being

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<sup>53</sup> Commonly, men are born with two sex chromosomes: X and Y; women with XX. One in 500 men is born with an extra X chromosome, and half of those patients exhibit symptoms of Klinefelter’s syndrome.

emitted through the urethra. Obstructions in the ducts due to infection, trauma or scar tissue block the passage of sperm. Also, as previously mentioned, detection of congenital bilateral absence of the vasa deferentia (CBAVD) indicates the patient was born without the necessary tubules for transporting sperm. CBAVD is common in men with Cystic Fibrosis.

In addition to the semen analysis and physical examination already described, male infertility specialists may employ other diagnostic procedures for assessing etiologies, like genetic screening for chromosomal disorders, trans-rectal ultrasound to determine prostate health, and urine analysis to check for retrograde ejaculation of sperm into the bladder. Vasography, an X-ray process which entails flushing dye through the vas deferens, is conducted to check for obstructions. Surgical exploration may be conducted to investigate an obstruction, but is generally avoided. Testicular biopsies used to detect the presence of sperm are both diagnostic and therapeutic. During this procedure, testicular tissue is removed and placed under a microscope for detection of live sperm. If sperm are present, the sperm may be frozen for future use with IVF-ICSI.

The most common treatment methods offered by male infertility specialists include hormone prescriptions; surgical varicocele repair, also known as varicocelectomy; surgeries to clear obstructions; electroejaculation, a process of applying an electric shock producing instrument to the seminal vesicles via the rectum or to the penis to stimulate ejaculation; and a variety of techniques for finding and removing sperm from genital organs, including

testicular mapping, percutaneous epididymal sperm aspiration (PESA), testicular sperm extraction (TESE), testicular sperm aspiration (TESA), and microsurgical epididymal sperm aspiration (MESA). PESA and MESA both entail the removal of sperm from the epididymis. During a PESA procedure, the specialist inserts a needle and syringe into the epididymis to remove sperm, using a local anesthetic in the genital area. MESA, on the other hand, requires the patient to be under general anesthesia, the scrotum incised, and the physician removes sperm using microsurgical instruments. PESA and MESA are preferable to TESE and TESA, because epididymal sperm is more mature than testicular sperm, and therefore believed to be more effective at fertilizing an egg, which can appropriately develop to a live birth. TESA is very similar to PESA, only the needle is inserted into the testicle rather than the epididymis. It is also performed under local anesthesia. TESE is a more sophisticated technique that involves general anesthesia, incision in the scrotum and removal of larger deposits of testicular tissue using an angiocatheter

### ***Why Treat Male Infertility?***

Gynecologists, and specifically reproductive endocrinologists, help couples with male factor infertility achieve pregnancy every day. If a couple's dream is to have a healthy baby, and an RE can promise to fulfill that wish even in cases of male infertility, then why involve a male infertility specialist? This is *the* hotly debated question among REs and male infertility specialists, and a tough question faced by the many childless couples who simply want

the least expensive, least invasive, and least risky treatment with the quickest result. An RE may lead an infertile couple with a male factor through the processes of IUI, IVF or IVF-ICSI using ejaculated sperm to achieve pregnancy. If all goes well, the couple will be pregnant within a couple of months, and welcome a new baby within a year from their initial consultation. Involving a male infertility specialist often means marked delays along the path toward parenthood. Unlike REs, the work of male infertility specialists is to discover the specific etiology of the male factor and address it. Male infertility specialists persuasively argue that male treatments are less expensive than IUI and IVF, less invasive and risky, and enable the couple to get pregnant “the old-fashioned way.” If all goes well, the husband will receive treatment within a month, improve his semen parameters within six months, the couple will be pregnant within the year, and have as many babies in the future *naturally* as they could ever hope for. Unfortunately, infertility practice is “more of an art than a science,” as several doctors explained to me. IUI and IVF treatments routinely fail, and even when they work, mothers and infants may suffer health complications as a result of the technologies employed. Likewise, male infertility treatments do not always deliver what they promise -- improved semen parameters – and some male patients discover their painful surgical procedures were for naught.

If there is no known female factor, recommendations for assisted reproductive technologies are based on the sperm count of the male partner. If the man has a count of at least 10 million sperm, the couple is eligible for

IUI, a less expensive and less invasive option than IVF. If the man has a count of less than 10 million and more than 1 million sperm, the couple is candidate for IVF. If the couple has fewer than 1 million sperm, they are directed to IVF-ICSI, which requires only one sperm per harvested egg. In extreme cases of azoospermia that warrant IVF-ICSI using testicular or epididymal sperm the roles of the RE and male infertility specialist are fairly straightforward. The RE oversees the egg harvest, the fertilization process, and the egg transfer. The male infertility specialist is responsible for extracting the sperm, freezing it, and transporting it to the laboratory. But what are the roles of the two specialists in routine cases of IUI and IVF? What happens when the male infertility specialist gathers information during an examination that sheds more light on the diagnosis, opening up new possibilities for treatment options? For example, a male infertility specialist may recommend surgery to clear an obstructed duct or remove a varicocele believed to be inhibiting sperm production in lieu of IUI or IVF, offering hope that the couple will have their natural fertility restored. In these types of situations, the roles of the RE and male infertility specialist are less clear, and the two specialists may vie for control over management of the couple's infertility.

Dr. Peter Chan, a renowned male infertility specialist, teaches continuing education courses to urologists. He raises the rhetorical question, "If all we need is only one living sperm, why do we bother treating and

evaluating male infertility?”<sup>54</sup> Male infertility specialists, argues Chan, are uniquely qualified to upgrade the fertility status of the male patient by identifying and treating the underlying cause of the infertility, something that REs and the technologies they employ do not do. If a patient’s fertility status is upgraded, the couple may be able to opt for IUI in lieu of IVF, or IVF in lieu of IVF-ICSI. Each step down the technology hierarchy saves patients time and money, and may reduce health risks to mother or baby. Depending upon the underlying cause of the infertility, in some cases male infertility specialists claim they can move patients entirely away from technology, and help them achieve pregnancy through “IBF,” a term coined by male infertility pioneer Dr. Cappy Rothman to refer to “in bed fertilization” or spontaneous conception through sexual intercourse – a method most couples would favor over IVF. Ultimately, argues Dr. Rothman, proper assessment of the infertile male patient is about “putting a question to rest.” He argues that men should not be left to wonder why they have a low sperm count for the rest of their lives, which may happen when couples opt for high-tech reproductive solutions without discovering the specific etiologies of poor semen parameters.

Dr. Chan encourages urologists to “claim your territory” when working with REs, but also promotes a cooperative team approach to treating infertility by male and female specialists. In my own observation I found this was only possible when a urologist spent clinical hours working inside an IVF clinic, as

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<sup>54</sup> From a course taught at the AUA 2007 Annual Meetings. Dr. Chan raised the same question at a presentation given to mental health professionals on male infertility medicine at the ASRM Annual Meetings the same year. I heard Dr. Chan speak at both meetings, and have had brief personal communication with him, but he was not interviewed or shadowed for this research study.

was the case in one university hospital. In most cases, the practices are separate, and when there is big money on the line (and even bigger professional egos), competition for business can turn nasty. One male infertility specialist reported that after seeing a male patient and recommending surgery, he received an irate phone call from the referring RE who informed him, "I wanted you to extract his sperm. I didn't ask for your *opinion!*" As a result of the competition between specialists, couples receive conflicting information regarding the best course of action they should pursue for their particular diagnosis(es).

### ***Confusion in Decision-Making***

In my own fieldwork and interviews, many patients sensed the tension between the wives' and the husbands' doctors. Faced with conflicting information, and feeling caught in the middle of a strained rivalry between specialists, how do couples make decisions for treatment? Couples base their decisions for treatment on medical, financial, and social factors. Couples compare specialists' success rates for their respective male or female treatments, costs for treatment, and the perceived potential health risks characteristic of some treatments. Some couples choose to include several IVF or male infertility clinics in their comparative analysis. Clearly, all of this calculation requires a taxing amount of legwork and research, not to mention a fairly sophisticated understanding of mathematics and statistics!

Couples also rely on the Internet, books and doctors for information regarding their condition. However, information about male infertility from

different sources often conflicts, and information is tightly managed by practitioners. In this section I discuss how patients attempt to choose treatment plans based on the information available to them, and I also provide examples of conflicting information dispensed to patients, and the ways that practitioners control the dispersal of information.

### *Calculating Cost, Risk and Success*

In the age of evidence-based medicine one would expect best practices for treatment to be clear. Unfortunately, in the field of infertility complicated pricing schemes, incomplete information regarding insurance coverage, insufficient and conflicting information regarding treatment success rates, and conflicting research findings regarding the health risks and effects of different treatment options make it challenging for couples to make informed decisions for treatment. A basic price comparison of ART services with male infertility treatments seems relatively simple. According to the Society for Assisted Reproductive Technologies (SART), the average cost of an IVF cycle in the United States is \$12,500. IUI ranges in price from several hundred dollars to roughly \$6000 depending upon the clinic, and the type of pharmaceutical drugs used to induce ovulation. A male infertility procedure, like varicocele repair or clearing an obstructed duct runs about \$5-10,000. Assuming a couple were to base their decision solely on price, then IUI would likely be the first choice, their second choice would be surgical repair for the man, and the third choice would be IVF. But, what if insurance will cover some treatments, but not others? What if insurance covers some steps of some treatments, but

not entire treatment processes? What if the couple hopes to have multiples, like twins or triplets common to IUI and IVF, or is adamant about avoiding multiples? What if the couple hopes to have more children in the future? What if the couple has ethical concerns regarding discarding extra embryos? Each of these questions complicates calculations. Furthermore, there may be a female factor adding costs to some steps of treatment, or complicating success rates. Advanced maternal age may push the couple toward the quickest treatments. Comparing costs of basic services is not easy, as many factors, including insurance coverage, success rates, chances of multiples, plans for future siblings, ethical issues, female factors and maternal age are all weighed in the decision.

Many REs recommend patients plan and prepare for a few cycles of IUI or IVF, since success rates are relatively low. Conducting a price comparison of IVF services among IVF clinics is difficult when services are packaged differently. Some centers may charge per egg harvest, promising up to three transfers; other centers charge per transfer. More private practices now offer a cost-sharing plan, which charges patients more for IVF upfront, but promises a money-back guarantee after so many rounds of failed IVF. Health insurance rarely covers female treatments in most states, Massachusetts being the celebrated exception to this rule.<sup>55</sup> Some couples have a limited number of cycles covered by insurance, or have a high deductible for infertility services

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<sup>55</sup> Massachusetts state law requires insurance companies to cover infertility treatments. Other states, like California, require some insurance coverage, which usually have high deductibles or low caps on coverage. In some states where no such laws exist, some companies cover some aspects of infertility, while most do not.

(approx. \$10,000). Predicting insurance coverage for male infertility treatments is nearly impossible.<sup>56</sup> While the insurance codes for “infertility,” *per se*, are regularly not covered, some aspects of treatment may be covered. For example, some diagnostic procedures or prescription medications may be covered. If the doctor codes for etiologies, like hormonal issues, pain, anatomical problems, anything found to be damaging to quality of life, sexual pleasure or ability to work, treatments may be covered. As several doctors explained, some insurance companies are unaware that certain services are infertility-related. If the doctors choose insurance codes carefully, everything will be covered. Obviously, it is difficult for couples to estimate costs as they begin the treatment process, since different doctors code services differently, and insurance coverage varies. If insurance claims are denied, couples may be ill-prepared for the medical bills they have incurred.

In 2006 the CDC reported that only 41,343 live births resulted from the 138,198 attempted cycles of IVF (CDC 2008); the CDC collects no data on IUI success rates. Similarly, only about 33% of couples in which the male partner undergoes varicocelectomy will achieve pregnancy (ASRM 2008). As these statistics show, many couples spend thousands of dollars on treatments each year and never realize their dreams of parenthood. Not only do couples drain savings accounts, rack up credit card bills, and take out second mortgages on

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<sup>56</sup> In my own study, patients’ predictions of cost, including out-of-pocket expenses and health insurance coverage, were inaccurate. Some patients spent much more out of pocket than they had anticipated, while others were happily surprised by unexpected insurance coverage.

their homes, they also spend countless costly hours away from work pursuing medical treatments.

Many patients endure painful and uncomfortable procedures, risking their personal health. Women undergoing treatments are particularly vulnerable to minor discomforts like hot flashes, nausea, mood swings, and bruising from daily hormonal injections, as well as more severe life-threatening issues like ovarian hyperstimulation syndrome (OHSS) and complications during pregnancy due to sets of multiples (Elster 2000; Gera, Allemand, Tatpati, Session, Wentworth, and Coddington 2006; Wang, Kwan, Davies, Kirby, Judd, and Norman 2003). Women I spoke with also worried that the high consumption of synthetic hormones would put them at greater risk for other conditions not scientifically substantiated, like irregularities in their natural hormone levels or cancer.

Men are reassured by doctors that the outpatient surgeries they undergo are not particularly invasive or risky, and that they can expect to be fully recovered and back at work within 48 hours. In my interviews with patients, men reported tremendous pain during and following procedures, extreme swelling and bruising of the genitals, and many days required for full recuperation. Patients are warned that due to the trauma of surgery, improvements in semen parameters are not evident for at least three to six months; some men never see improvements.

Perhaps the most disturbing risks to health that the latest research shows are the risks associated with pre-term labor. Since many IUI and IVF

treatments result in multiples, and multiples are at higher risk for prematurity than singletons, a relatively high proportion of offspring of IUI and IVF suffer physical and mental developmental problems. Couples in this study tried to consider all of these potential risks to the wife, husband and infant(s), as they made plans for treatment.

### *Conflicting Information*

Throughout my fieldwork I became increasingly aware of the conflicting information patients receive regarding general facts about conception and male infertility. As discussed, REs and male infertility specialists often do not agree about treatment plans. In fieldwork I found that these two types of specialists also had conflicting ideas about other reproduction issues. For example, couples are routinely advised by PCPs, Ob/Gyns, REs, as well as popular books and web-sites to abstain from sex just prior to the woman's fertile peak, or the 24-hour period during the menstrual cycle when women ovulate. The conventional wisdom has always been that if a man avoids ejaculation (intercourse or masturbation) he can strategically "save up" his sperm for his big chance during intercourse at ovulation. By charting basal body temperature, noting changes in cervical mucus, and using over-the-counter ovulation test kits, which have become increasingly popular and less expensive over the past decade, women can gauge their fertile period with relative accuracy. However, during my observation in clinics, male infertility specialists advised couples to have "as much sex as possible" in the week leading up to ovulation. Confused, many women would explain that they had

received contradictory advice from their own doctors. Seemingly unaware of the popular theory regarding timing intercourse, male infertility specialists would explain that 1) sheer numbers of sperm emitted from multiple ejaculations were more important than the concentration of one ejaculation; 2) sperm can live up to five days; and 3) sperm “saved up” in the genitals are believed to weaken or malform; meanwhile, sperm freshly produced in the testicles are believed to be most potent. Couples had to decide on their own which specialists’ advice they would choose to follow.

The fact that information dispensed by the two types of specialists conflicts should not be too surprising, but does demonstrate how patient confusion is generated. More surprising is the conflicting information dispensed by different male infertility specialists. During my multi-sited fieldwork I observed many inconsistencies in the information given to patients, particularly in regard to the personal habits that impact fertility. For example, it is widely accepted knowledge that heat inhibits sperm production. This explains why the male genitals hang in the scrotum removed from the body: to keep the testicles (sperm factories) cooler than normal body temperature. Several theories regarding excessive heat and decreased sperm production abound, including ideas that hot tubs, Jacuzzis, laptop computers, and restrictive underwear (tight briefs opposed to boxer shorts) inhibit sperm production. The scientific research on these various theories is scant, but a small unpublished study of public awareness found that restrictive underwear and stress were believed to be the two most common causes of male infertility

among patients (Rosenberg and Honig 2007), a fact that male infertility specialists find amusing in light of the multitudinous possible clinical etiologies for male factor infertility. We might expect male infertility specialists to set the record straight on these topics, but they cannot seem to agree.

One doctor I shadowed was working on a paper and had done some guest interviews with the media discussing the negative effects of hot tub and Jacuzzi usage on sperm counts. He advised all of his patients to avoid such warm environments, along with restrictive underwear, and exhorted patients to keep their laptop computers off their laps. Another doctor I shadowed actually scoffed at patients who mentioned that they were trying to avoid hot tubs, laptops and restrictive underwear, saying that such theories were unsubstantiated, and the heat sources were not significant enough to impact patients' semen parameters.

Another theory more common outside of the United States hypothesizes that the radiofrequency electromagnetic waves (EMW) emitted by cell phones damage male fertility. In 2008 the leading journal of infertility medicine, *Fertility and Sterility*, published an article from a university laboratory closely affiliated with one of the leading male infertility clinics confirming that cell phone usage decreases sperm count, motility, viability, and morphology (Agarwal, Deepinder, Sharma, Ranga, and Li 2008). However, the findings were never picked up by the popular press, and the study has been ignored by medical professionals.

Male infertility specialists also do not agree on the effectiveness of nutraceuticals. Nutraceuticals (or neutraceuticals) are vitamin and antioxidant supplements derived from natural foods believed to have medicinal benefits. Nutraceuticals are available without a prescription in pill, capsule, powder or shake form. Some scientists and doctors theorize that antioxidants, like Vitamin E, help with sperm development and motility. In continuing education courses sponsored by the AUA, urologists were encouraged to recommend them to patients. Nutraceutical products, like Proxeed®, claim to improve sperm count, motility and concentration. When patients inquired about the effectiveness of antioxidants or Proxeed®, which they had learned about on the Internet, some doctors I observed were very encouraging, while most shrugged and told patients that they could take them if they wanted to, but expressed little confidence in their effectiveness. The lack of consensus on each of these topics reflects the general lack of unity among practitioners.

#### *The Management of Information*

Male infertility specialists often accuse REs of withholding information from patients by not being forthcoming about all of the treatment options available for couples with male factor infertility. Likewise, I found in fieldwork that male infertility specialists also tightly manage information, carefully choosing what information to share, and how it will be shared with patients. For example, in the “Notice to Patients” cited at the beginning of this chapter patients are warned that, “In some cases male infertility is the first sign of testicular cancer and should not be neglected.” Presumably, this claim was

used to motivate (or threaten) patients to seek out help from a male infertility specialist. I heard this claim about cancer many times in interviews with doctors to explain why REs should refer male patients with poor semen parameters to a male infertility specialist for a complete physical examination. There is a statistical correlation between testicular cancer and poor semen quality, but the research repeatedly shows that the causal relationship only points one direction: testicular cancer causes poor semen quality. Infertility is a poor predictor of cancer, but this is never clearly stated.<sup>57</sup>

Another demonstration of how practitioners manage information is the example of the ‘phenotypic time bomb theory.’ There is a scientific argument that infertility may be hereditary, but historically did not pass on genetically because people who could not reproduce were unable to pass on any traits, including infertility. (Simply put, if your parents were infertile, you wouldn’t exist.) The logic follows that enabling infertile people to reproduce runs contrary to the evolutionary purposes of natural selection, and only facilitates the passing on of infertility-related conditions. One specialist described the increasing usage of IVF-ICSI as a “phenotypic time bomb,”<sup>58</sup> a term critics of IVF-ICSI coined to describe a future world where all men must rely on technology to reproduce. In other words, if men with poor fertility status use

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<sup>57</sup> No patients in this study were discovered to have testicular cancer, and no doctors reported ever finding cancer in infertility patients.

<sup>58</sup> Phenotypes are defined as the observable characteristics of a species based on genotypes, or genes.

technology today to reproduce, their sons will likely inherit poor fertility.<sup>59</sup>

Increasing usage across generations would result in a growing population of infertile men (Hawkins, Barratt, Sutcliffe, and Cooke 1999).

In interviews several specialists relayed some variation of the phenotypic time bomb theory to me, but not surprisingly, evolutionary theories about infertility and survival of the fittest were never shared during clinical encounters with patients. In one clinical interaction a couple who had been contemplating treatment options for some time asked the doctor if a male child could possibly inherit his father's infertility issues. The doctor diplomatically explained that not much data is available since the offspring of most new infertility treatments are still young, but that, yes, it was conceivable that male offspring could inherit infertility issues. The couple explained that after considering their options, they had decided they could not bear to see a child of theirs experience the anguish of infertility like they had and so they would live child-free or consider adoption. Initially upbeat, the doctor encouraged them to pursue some promising treatment options that would put an end to their emotional suffering, and if need be, could certainly be used by any son years from now. No, the couple insisted, they felt their decision was the right thing to do. The doctor's irritation and disapproval was soon evident in the conversation and when the couple left he sharply criticized their decision. Incidents like these, where doctors try to downplay the possible risks of the

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<sup>59</sup> Couples with a male factor due to genetic conditions like cystic fibrosis, for which infertility is common, are referred to genetic counselors to ensure that the wife is not a carrier. Precautions are taken to ensure that the disease is not be passed on to male offspring.

treatments they offer, illustrate doctors' strong desire to remedy couples' childlessness.

Information regarding risks associated with paternal age was also carefully managed by practitioners. The broad consensus among medical professionals is that women's fertility status declines sharply at age thirty-five,<sup>60</sup> and advanced maternal age increases the likelihood of complications, such as miscarriage, hypertension, or incompetent cervix, and pregnancy outcomes, such as Down syndrome and Edwards syndrome (de La Rochebrochard and Thonneau 2002; Luke and Brown 2007; Nicolaidis and Petersen 1998). This information is fairly common knowledge among the lay public, particularly among women who are socialized in routine medical exams to be conscientious about their reproductive health.

Research conducted on paternal age suggests male fertility also declines, but the facts surrounding the male biological clock are less widely known. Though fertility (ability to achieve pregnancy) may not drop as drastically, advanced age in men correlates with declining sperm quality, and greater risk for pregnancy loss, birth defects, neurological disorders, clinical syndromes and genetic diseases (Kidd, Eskenazi, and Wyrobek 2001; Slotter, Marchetti, Eskenazi, Weldon, Nath, Cabrerros, and Wyrobek 2007;

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<sup>60</sup> One male infertility specialist (a man) who taught reproduction courses at the medical school connected to the university hospital where he worked reported getting booed and having objects thrown at him by female medical students during lecture when he said that women serious about having children should consider having them before they reached their mid-30s. A female M.D. who spoke at the Barnard Scholar and Feminist Conference 2009 reported that her graduate students in public health and medical residents "hate it" when she teaches about declining fertility with maternal age. She explains, "Our social and biological realities are out of sync."

Snajderova, Petrak, Mardesic, Havlovicova, and Zemkova 2009; Williams, Land, Han, Sutton, and Brannigan 2004). These risks are even more pronounced in cases of ART (Rochebrochard, Mouzon, Thepot, and Thonneau 2006). Statistically, the risks for infertility and pregnancy complications increase for women in their mid-thirties. Problems associated with paternal age do not become apparent until fathers reach their forties or fifties.

In nearly every appointment I observed the female's age was a major point of discussion. Women in their twenties and early thirties were congratulated for pursuing motherhood while they were still young. Women in their late thirties were advised not to procrastinate pursuing treatment, and to consider the duration of treatment protocols as they selected treatment options. Women over 39 were gravely informed that due to their advanced age the likelihood of achieving pregnancy with any treatments was low. On the other hand, I never heard a male patient's age discussed during an appointment. The oldest male patients seen by doctors were men in their fifties, often in second marriages, seeking vasectomy reversals to restore fertility, and enable their much younger second wives to get pregnant. These were generally considered high-revenue patients for clinics, since vasectomy reversal runs about \$10-15,000. Even in these cases the effects of paternal age were never discussed.

At one university hospital I had the opportunity to observe a case management meeting, which included several REs, the male infertility

specialist I was shadowing, his nurse, a genetic counselor, a psychologist, and the IVF laboratory technicians. One case on the agenda involved a patient in his seventies and his wife, fifty years his junior. The patient was suffering erectile dysfunction and anejaculation, both attributed to his age. His wife was believed to be healthy and fertile, and the plan was made to move forward with IUI or IVF, using sperm acquired through electro-ejaculation, with the patient under general anesthesia. The major concern of the meeting was whether or not it was ethical to facilitate this oddly-matched couple's desire to procreate. The foreign-born man had returned to his native village just a couple of years earlier and married the daughter of an old friend. The non-English speaking wife had no employment or marketable skills. It was unclear if she had been forced into the marriage and the move to the United States. His age put her at high risk of becoming a young widow. At no point were the risks associated with his elderly age discussed and no plans were made to inform the couple of the possible risks due to paternal age. Instead, the electro-ejaculation and IVF were added to the monthly schedule.

In each of these examples, including claims about testicular cancer, the phenotypic time bomb theory, and the male biological clock, information was tightly managed by practitioners for the sake of attracting and securing business. The issue of paternal age versus maternal age also illustrates how easily popular notions about gender and aging (e.g., men as ever-virile, women as beautiful in youth) enable authorities to withhold information.

### ***Discrepancies in Treatment Practices Among Male Infertility Specialists***

Some male infertility specialists I interviewed spoke venomously of reproductive endocrinologists who attempt to manage male infertility with ART. When asked why some RE's do not refer male patients to male specialists, they gave curt responses, like, "Greed," or, "The RE has a mortgage to pay." Others complained that REs were not held accountable for their actions. As one doctor explained to me, REs just help women get pregnant, and then pass them off to OB/GYNs for regular prenatal care and delivery. REs do not have to address the complications that result from multiples, for example, so they have no incentive (and there are no laws in place) to restrict the number of embryos they transfer. "What other type of specialist can get away with performing procedures and not following up?" asked one doctor rhetorically. For example, he explained, if an orthopedic surgeon performs surgery on a patient's shoulder, and complications follow, then the orthopedist is responsible for fixing it. Likewise, male infertility specialists have to follow up with their patients, but not REs. Also, in interviews male infertility specialists frequently described female infertility treatments as excessively and needlessly invasive and harmful compared to "simpler" and "less invasive" male treatments. Whichever types of treatment are more invasive – cutting into the male genitals or pumping women full of hormones and sticking foreign objects into their genitals – is debatable.

Data from interviews with doctors alone would suggest that REs do not have the patients' best interests at heart. However, data from my fieldwork

observations reveal that male infertility specialists do not always act in the best interest of patients either. On occasion, urologists conducted procedures that had no known benefits, were harmful to patients' fertility, or unnecessarily subjected patients to particularly expensive and invasive treatments when simpler procedures were sufficient. Here I describe varicocele repair, testosterone supplements, and sperm extraction procedures as examples where doctors possibly harm or "up-sell" their patients.

Varicoceles are often culpable in low sperm production and low sperm counts.<sup>61</sup> When an RE discovers a low sperm count, he or she may direct the couple to IUI or IVF. If a male infertility specialist detects a varicocele, he or she will recommend a varicocelectomy to cut off the blood running near the testicles believed to be causing the low count. There are four grades or levels of varicoceles, based on the size or distention of the veins. The most severe type is grade III; less severe is grade II; next, grade I; and the least severe form is "subclinical," which is only detectable with Doppler ultrasonography. Grades I, II and III are detectable during palpation by a well-trained specialist. Multiple studies show that repairing a subclinical varicocele shows no improvement in sperm production (ASRM 2008), because they are likely too small and insignificant to impact sperm count.

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<sup>61</sup> Because the varicocele transports blood along the testicles, the heat from the blood presumably inhibits sperm production. In some cases, men have low sperm counts, but evidence of normal sperm production. For example, a large number of dead sperm found in the ejaculate would indicate healthy production, but a low count. In these types of cases, varicoceles are thought to raise the temperature of the scrotum, killing sperm in transit from the testes.

Several of the doctors I interviewed reported seeing patients who had undergone varicocelectomies for subclinical varicoceles performed by other urologists. The male infertility specialists criticized these doctors, but were also chagrined to admit that most mistakes they see are caused by other urologists, not PCPs or REs. When the sperm count showed no improvement, the urologists referred them to the more highly trained specialists I shadowed.

Nonetheless, in clinics male infertility specialists routinely see patients who have undergone a varicocele repair for a subclinical varicocele. Why do urologists perform surgery on subclinical varicoceles? Most likely, the urologists were not properly trained to treat male infertility. They were familiar with varicocelectomy as a treatment option, but not knowledgeable of the medical literature advising against it for subclinical varicoceles. It is also possible that with less expertise or experience with male infertility they did not trust their own ability to palpate the varicocele.<sup>62</sup> When they did not detect a varicocele with their hand, they worried they may have missed one, and decided to check again with a Doppler ultrasound device. When the Doppler revealed a blood-pumping varicocele, the urologists second-guessed their initial instincts, presumed it to be larger than it actually was, and moved forward with surgery. In other cases, it is possible that doctors simply wanted to offer patients hope by doing something, anything, to attempt to improve fertility. They go in to the surgery with the attitude that, so long as the patient is infertile, there's nothing to lose. Other doctors may simply be trying to drum

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<sup>62</sup> Specialists I shadowed reported getting referrals from other urologists who had not detected obvious varicoceles in physical examinations.

up business, knowing that the chances for improving sperm quality are extremely slim.

In one clinic I observed an appointment with a couple<sup>63</sup> being treated for non-obstructive azoospermia, or a 'zero sperm count.' The husband had undergone a varicocele repair surgery with another urologist, who told him there were no more treatments available for him. The couple aggressively sought out a male infertility specialist for a second opinion. The appointment I observed was their first time meeting with a fellowship-trained urologist, who provided them with more treatment options. After the couple left, I asked the doctor why the urologist seen previously by the couple had performed surgery for a zero sperm count. The varicocele was not subclinical, meaning it was large enough to necessitate surgery. However, varicocele repair is found to be ineffective, and therefore not recommended, for azoospermic patients. The doctor responded bluntly,

In theory, it was to improve his testosterone production...[The patient] had a little bit of pain related to [the varicocele]. But you need to make a decision about the benefits [surgery is] going to provide or don't do it... Then, giving him a whiff of a chance that sperm would return to the ejaculate -- in the outcome of that case, it's sort of silly. You could build a case that it's to optimize sperm production, but the evidence in that case is really poor...Shame on Dr. Sheldon<sup>64</sup> -- who attends these meetings, *should* read the literature, *should* be knowledgeable about what is possible – to not know what the results are of potential treatment...It's unfortunate. It's disappointing.

Several specialists complained to me about the consequences of a common myth in medicine: that testosterone increases sperm production. In

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<sup>63</sup> I was able to observe this couple's appointment, but they declined to be interviewed.

<sup>64</sup> Name has been changed.

practice, prescribing men testosterone actually shuts down the body's natural release of testosterone, and interrupts the natural relay of hormone signals necessary for sperm production. I observed a handful of cases in the clinic where unknowledgeable doctors previously seen by patients had prescribed testosterone to men with low sperm counts. As a result, the men's sperm production dropped to extremely low levels or altogether ceased. In conversations with me, male infertility specialists blamed PCPs and REs for irresponsibly prescribing the testosterone. In actuality, in every case I observed it was another urologist who had made the error.

Conflicting opinions regarding best practices for extracting sperm needed for IVF-ICSI illustrate how information is tightly managed and business interests drive practitioners toward procedures with the highest price tags. In cases of azoospermia, or a zero sperm count, male infertility specialists must establish if sperm production is occurring. If any sperm – even just one -- is found in the testicles or epididymes, sperm production is confirmed.<sup>65</sup> As described earlier, PESA, TESE, MESA and TESA are procedures for finding and removing sperm from the genitals. PESA and TESE are less invasive techniques that may be conducted in the clinic setting. MESA and TESE, on the other hand, require the use of general anesthesia, microsurgical

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<sup>65</sup> Once confirmed, patients may opt for IVF-ICSI using testicular or epididymal sperm, or they may choose exploratory surgery to find out if a blockage or obstruction causing the unsuccessful transportation of sperm during ejaculation may be corrected. If it is correctable, and the couple opts for surgery to repair the obstruction, then the couple may be able to achieve pregnancy through regular intercourse. Generally, if sperm is found in the initial investigation of the testes and epididymes, it is frozen. Ideally, fresh sperm is preferred for IVF-ICSI, but the frozen sperm is banked as a precaution, in case no sperm is found when the woman's eggs are ready to be harvested and fertilized.

instruments and technology, and are therefore, conducted in highly-equipped operating rooms. Consequently, PESA and TESE do not cost more than a few hundred dollars, and have quick recovery times, requiring little time off work for patients. Conversely, MESA and TESE can cost patients up to \$15,000 out of pocket, and have slower recovery rates.

In one clinic where I conducted fieldwork, azoospermic patients were advised to move directly to MESA, and were required to pay in cash upfront prior to the procedure. A specialist at another clinic commented that he could not understand the need to move all patients straight to MESA, explaining that he finds sperm quickly using the much simpler PESA or TESE techniques in his office in at least half of his azoospermic patients. MESA is a much more involved and invasive step than may be necessary. In their own defense, regular MESA practitioners argue PESA and TESE techniques have higher complication rates, due to risks like puncturing sensitive tissue. But the discrepancy in treatment costs raises eyebrows. Why not provide patients with information regarding all of the procedures available, the potential for complications associated with each procedure, and allow patients to choose for themselves which sperm removal option to pursue? Another defense of MESA as a first line of action is that PESA and TESE do not provide as large of a sample or as many sperm and they are more likely to find no sperm compared to microsurgical options. If so, then PESA and TESE would be a reasonable first step, especially if IVF-ICSI only requires one sperm per egg.

If an insufficient number of healthy sperm were found, then patients could move to the more cost-prohibitive MESA option.

The use of MESA demonstrates some of the questionable business practices of specialists. It also highlights specialists' attempts to set boundaries of expertise between general urologists and those with specialized training in male infertility. General urologists are often not trained in the microsurgical techniques required for MESA, but would likely feel comfortable attempting simpler techniques like PESA and TESE in their offices. The advocacy of MESA as the ideal sperm procurement method may be an attempt to discourage or intimidate general urologists from infringing upon medical territory claimed by those with special training in male infertility.

Surgery for subclinical varicoceles, testosterone prescriptions, and the use of microsurgery over simpler treatments illustrate a few important points about the male infertility industry. First, despite claims of superior expertise regarding the infertile male body, some urologists have caused harm to some patients. Secondly, in light of the poor track record of some urologists, it is no wonder that REs see little value in referring infertile men to them. Finally, urologists derive deep satisfaction in being involved in the technological processes that help couples achieve pregnancy.

Urologists accuse REs of being motivated by "greed" or money. The data presented here would suggest that urologists' are equally motivated by money. However, I would argue that economic interests were actually secondary to doctors' desires to fix male infertility. Doctors seemed intent on

employing the most cutting edge technologies to demonstrate the power of their medical knowledge and skills. Solving couples' problems, ending their emotional struggle, and creating new life are the thrilling rewards of a urologists' career. As one doctor explained to me, "Two things make my day – three things. Having a baby named after me. Getting a spinal cord injury patient to have a family. And having the wife come up to you and say thank you. It's awesome." Doctors derive great satisfaction and pride in helping men overcome their infertility using the best technologies available. It is their life work.

### ***Making Space for Men***

In this chapter I have shown that the current medical system does not provide a clear path toward resolving couples' desires for a biological baby in cases of male factor infertility. Most infertility institutions are arranged to deal with women first or women only. Some systems discourage the participation of male bodies in clinical treatment options, while others usher men into a realm of confusing and controversial treatment options. As shown in Chapter One, women are held accountable for infertility, even when a male factor exists. In this chapter I have shown that even when male patients actively pursue medical help for their infertility, they may face obstacles to the proper assessment of their diagnosis, conflicting information regarding treatment options, and may be manipulated by questionable business practices.

Infertile men are scattered throughout the infertility industry without a clearly designated space and place due to the general disorganization of male

infertility medicine. So, where in the infertility industry is there room for men? Typically, only the sperm of infertile men are found in IVF clinics. However, some men are found there, too, consulting with a physician, providing a semen sample, or encouraging a female partner along through the treatment process. Without fail, men are found in male infertility clinics. However, the patients who actually land in male infertility clinics represent only a small subset of the actual infertile male population. These patients are likely part of sophisticated medical systems that have referred them to the clinic, or they (or their wives) have searched on the internet and, perhaps, travelled far distances to locate a male infertility specialist.

Despite the examples presented in this chapter of patients receiving conflicting information or being manipulated into unnecessarily invasive treatments, male infertility medicine as practiced by highly trained urologists is a promising field for patients. The fertility of many couples in this study improved after being treated by a male infertility specialist, resulting in natural conception; others were able to have sperm extracted by a male infertility specialist for IVF-ICSI resulting in pregnancy. Unfortunately, the war of jurisdiction waged against female infertility specialists and the disorganization of the male infertility specialty has resulted in 1) the lack of consensus among practitioners regarding best practices for male factor infertility and conflicting ideas regarding general facts about male reproductive health; leading to 2) poor public awareness and frustration for couples in search of help for the infertile male partner. If the discipline of male infertility hopes to flourish as a

field of medical specialization, male infertility specialists might more thoughtfully consider organizing male infertility into a board-certified sub-specialty of urology. This may alleviate many of the problems and confusion discussed in this chapter.

If male infertility was a board certified sub-specialty of urology, board examinations would presumably weed out incompetent practitioners, thereby eliminating useless and harmful practices, like varicocelectomy for subclinical varicoceles and testosterone prescriptions. Structured guidelines and training in the field would likely eliminate some of the inconsistent and conflicting information received by patients. Board certification may also reduce the perceived threat of non-specialized urologists and reproductive endocrinologists staking claim in male infertility territory, which has contributed to hostility between male and female specialties and resulted in unnecessary upgrades in infertility services (e.g. MESA). If the specialty were better organized, public awareness of male infertility medicine would likely increase meaning more business for male infertility clinics. Also, as the public becomes more knowledgeable of the etiologies and treatments of male infertility, the specialty would be held to higher standards of accountability.

The lack of organization within the field of male infertility medicine does not prove that women are more likely to be infertile. As I argue throughout this dissertation, preconceived notions regarding gender shape medical understandings of disease. More than likely, the disorganization of the male infertility medical specialty has stemmed from the historical emphasis on

women's bodies in the study of reproduction. The development of male reproductive medicine as a scientific discipline has lagged behind female reproductive medicine. This lag reflects broader cultural ideas about the presumed fundamental link between male fertility and masculinity, which I address in the next chapter, and the role of medical institutions in protecting men's sense of masculinity.

## Chapter Three:

### MASCULINITY IN CULTURE AND MEDICAL PRACTICE: How Institutions Take Part in Constructing Popular Notions of Gender

#### Chapter Outline:

#### ***Ridgeway and Correll's Gender System***

#### ***Cultural Representations of Masculinity and Fertility***

#### ***Masculinity Embedded in Medical Practice***

*Challenging Masculinity: Testing Sperm, Testing Men*

*Protecting Masculinity in the Clinic*

The Physical Examination

Genital Appearance

The Diagnosis

#### ***Doctors Do Gender***

#### ***Conclusion***

### ***Ridgeway and Correll's Gender System***

According to Ridgeway and Correll (2004), cultural beliefs about gender serve as the backdrop to all 'social relational contexts,' or the everyday situations in which people interact with each other and with institutions (511). Cultural ideas about gender are widely accepted, taken for granted, remarkably stable, and are present in everyday interactions between people (513). Unfortunately, popular gender beliefs often favor men's aptitudes and abilities over women's, generating unequal power relations between the sexes and resulting in reinforced stereotypical notions of masculinity and femininity (517). What makes our culturally pervasive stereotypes about men and women, masculinity and femininity, so stubbornly resilient? Ridgeway and Correll argue that as new industries and organizations develop, social practices are created in light of the existing gender beliefs (523). In other words, institutions are shaped by culturally popular notions of gender, and institutional practices perpetuate these notions.

Institutional practices and the interactions between institutions and individuals constitute and sustain what Ridgeway and Correll call 'the gender system,' an invisible social system that preserves gender inequality. There are three levels to the gender system: first, the macro-level of cultural beliefs and the distribution of resources; second, the interactional level, where individuals interact with each other and with institutions; and third, the individual micro-level, where selves and identities are privately formed (2004:511). Gender beliefs are constructed and reified at all three levels.

Plus, an on-going and dynamic interplay transpires between culture, institutions and individuals, whereby the three levels influence each other. Widespread cultural beliefs underscore institutional practices, which in turn color the personal beliefs and attitudes of individuals.

How do preconceived notions about virility and masculinity shape medical practices in the diagnosis and treatment of male infertility? The gender system model provides a helpful framework for analyzing male infertility medicine. In this chapter I examine the relationship between the first two levels of the gender system, culture and institutional practice, in regard to masculinity and fertility. I begin by reviewing the existing social science literature on male fertility, semen and sperm, to show that societies around the globe and throughout history have strong ideas about male fertility as an indicator of masculinity. I follow with data from the field to illustrate how prevalent cultural ideas about fertility, virility, and male sexuality have shaped basic medical practices, including diagnostic procedures and clinical interactions between doctors and patients. I argue that medical institutions are powerful players in the social construction of gender and disease, as they employ practices rooted in stereotypical and static gender beliefs. The implementation of such practices perpetuates popular notions of gender, and shapes how male infertility is defined and understood.

### ***Cultural Representations of Masculinity and Fertility***

Sociologist Meika Loe, author of *The Rise of Viagra: How the Little Blue Pill Changed Sex in America*, shows that men suffering from erectile

dysfunction report lower self confidence and a diminished sense of masculinity (Loe 2004:78-79). Annie Potts, another feminist scholar who has studied erection difficulties, argues that the penis is believed to be a small representation of the man. If the penis is weak, so is the man (2000:85-86). In the hierarchy of hegemonic masculinities the man who can sustain a solid and long-lasting erection can presumably successfully compete against other men for women, can pass on genes, and “be counted as a ‘real’ man” (2000:90). From the performance of one (modestly sized) organ emerges an entire narrative of masculinity. On the other hand, men who struggle with erectile dysfunction see their bodies as weak, feminized, broken and in need of repair. Pharmaceutical solutions, like Viagra®, do not simply improve sexual function. They are believed to restore masculinity (Loe 2004:82). Scholarship on erectile dysfunction documents the culturally-defined relationship between sexual performance and masculinity. If sex is so central to masculinity, how important is reproduction? In this section I consider the connection between fertility and masculinity, and discuss how cultural representations of semen and sperm reinforce this relationship.

Sexual performance is described in terms of virility. One who is virile is capable of a) copulating, and b) fathering children. Virility is synonymous with both fertility and masculinity (Becker 2000; Thompson 2005). Throughout history and across cultures fertility status and masculinity have been tightly linked. Sociologist Lisa Jean Moore (2007), author of *Sperm Counts: Overcome By Man’s Most Precious Fluid*, points out that the value of men’s

fertility and genetic material traces back to ancient times. In the Bible men are blessed with biological offspring for their righteousness, obedience, and favor with God. Religious and cultural texts over the past several centuries have stressed the sinfulness and wastefulness of “spilling of the seed” by way of masturbation or withdrawal during intercourse, emphasizing the sacred nature of sperm (Moore 2007:20-21).

In the present day Western scientific texts anthropomorphosize sperm, reflecting traditional notions of men and masculinity (Martin 1996; Moore 2002; 2007). In her popular essay “The Egg and the Sperm: How Science Has Constructed a Romance Based on Male-Female Roles,” anthropologist Emily Martin analyzes the language used to describe the nature and functions of human gametes in medical literature. While the human egg has historically been typified as ‘a damsel in distress,’ sperm in contrast are painted as heroic warriors, productive, strong, and powerful, charged with the important mission to journey, deliver, and ‘activate’ the egg (Martin 1996:34). Martin argues that sperm represent the masculine traits deemed most valuable by the dominant culture. Human reproduction depends upon strong and powerful sperm. The men who produce these sperm ensure the survival of the species!

In a similar analysis, Moore looked at the use of language and imagery in books intended to educate children on sexuality and reproduction. As Moore explains, children’s books present human reproduction as occurring in loving heterosexual families, and the sperm cell is the protagonist, “a character children can root for” (56). Cartoon representations of sperm are always male;

eggs, complete with long eyelashes and makeup, are female. Sperm and egg are as romantically in love as the man and woman who produced them.

Competition among sperm is central to these stories. Sperm race to the finish line where the prize, the egg, awaits the victor. As representations of little men,

“...sperm are portrayed as having consciousness, self-reflexivity, and the ability to communicate with each other. Sperm are good workers, they are happy and willing to do what they are programmed to do, and they can learn through training and persistence. . . [Sperm] have desire; sperm are in a race; sperm are competitive; among sperm, there will be only one winner; sperm have a sense of entitlement and fairness; sperm can be powerful; and speedy, active sperm are good, while fatigue and slowness are bad (Moore 2007,64-65).”

Sperm have been endowed with a wide array of human and masculine traits.

Beyond scientific and literary texts, Moore (2007) also shows that in the pornography and sperm banking industries sperm and semen are represented “through ideas about masculinity as a way of mirroring back some measure of the man. . .The more masculine the man, the more manly his semen, and vice versa” (2007:148). For example, in the sperm donation business she notes that if a donor is found to be healthy, his sperm is assumed to be healthy. In the sperm banking and pornography industries, when sperm are recognized as healthy, sexy or powerful, so are the men who produced it (149). These industries are not advancing a new idea of sperm and semen as representative of their male producers; rather, they are reflecting and perpetuating broader cultural notions regarding male virility, potency and masculinity.

If healthy sperm tell a story about virile men, what story do weak sperm reveal? In her book, *Exposing Men: The Science and Politics of Male Reproduction*, political scientist Cynthia Daniels (2006) recounts how notions of masculinity were threatened by discoveries of decreasing male fertility rates around the globe in the 1990s. In 1992 Danish researchers announced a fertility crisis: over the previous fifty years, sperm counts had dropped more than 40% worldwide (Daniels 2006:31). Declining male reproductive health challenged the long held “presumption of reproductive masculinity – the idea that men are less vulnerable than women to the harms of the outside world” (2006:68). The report was met with panic and denial, both in the scientific community, as well as in the news media. Over the next decade smaller studies of male fertility among specific populations proliferated. Sperm counts were believed to provide a window into the health of nations, and a measure of male populations’ masculinity.

News coverage of sperm counts depicted sperm as tiny soldiers or rockets at war with toxic threats (Daniels 2006:53).<sup>66</sup> One editorial facetiously argued that an assault on sperm was the latest development in the battle of the sexes. Another report suggested a link between the increase of women in workplaces and colleges, and decreasing sperm counts (54-55). As geographically-specific studies of sperm counts were published, media coverage compared “the sperm counts of various nations in Olympic

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<sup>66</sup> Helene Goldberg (2009) described similar militaristic depictions of sperm in Israel. A sperm bank ad targeting soldiers depicted sperm in military helmets and berets. During her fieldwork, a doctor described sperm as “missiles.”

competition terms” (59). Some countries flaunted the masculinity of their men: “the mighty men of Finland are walking tall these days.” Other reports, like one from Scotland, worried about declining sperm counts producing a “lack of national virility” (60). The media discussions surrounding sperm count research highlighted the social value of male potency and its centrality to masculinity.

As presented, Moore (2007), Martin (1996) and Daniels (2006) use scientific, literary and news media texts as windows into culture, in order to explore the hegemonic gender beliefs about male fertility prevalent in dominant culture. Culture cannot be easily pinpointed, procured, and analyzed under a microscope; it is ubiquitous, abstract, and is represented by a combination of elements, including language, norms, beliefs, and values. Culture is best understood by examining the artifacts produced within it, in this case scientific language and popular media representations. While scholars of erectile dysfunction have convincingly argued that sexual performance is a reflection of masculinity, Moore, Martin and Daniels show that a man’s (and nation’s) masculinity is reflected in his sperm count. In fact, the number of sperm one has is possibly more important to his masculinity than the number of children he has.<sup>67</sup> Sperm represent inherent virility, the potential to impregnate multiple women, and have as many children as one desires.<sup>68</sup>

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<sup>67</sup> Nowhere in Daniels’ (2006) thorough analysis of media reactions to declining sperm counts is the issue of birthrates addressed. This omission suggests that there was more concern about masculinity than about the end of the human race.

<sup>68</sup> In her book, Moore (2007) quotes a science writer who ponders the glorious fact that in just two weeks one man produces enough sperm to provide one for every fertile woman on the planet (p. 40).

Moore (2007) and Daniels (2006) recognize that we live in a culture which promotes the belief that the true measure of a man is his sperm count and semen quality.

### ***Masculinities Embedded in Medical Practices***

Moore (2007) and Daniels (2006) point out that healthy sperm and sperm counts serve as indices of the strength of men and the health of nations, respectively. The male infertility specialists included in this study subscribed to this notion. As one doctor explained to me:

[Infertility is] the ultimate disease, in my opinion. It's the ultimate disease. You were on this earth to eat and reproduce, and if you can't reproduce, someone's telling you something... There's something going on, and it's bigger than you can imagine. And we have some science to show that. It's bigger than that. It's the ultimate medical disease of the species.

Infertility here is depicted as the forewarning of terrible things to come, and must be treated. As I observed doctors and medical practices in the field I became acutely aware of the ways that cultural ideas about fertility status and masculinity were rooted in everyday clinical practices.

As Ridgeway and Correll observe, gender beliefs are easily embedded in organizational structures, rules and procedures (2004:324). The scholars' research on women in the workplace reveals that hegemonic gender beliefs about male superiority become institutionalized and result in discriminatory practices (Ridgeway 1997; Ridgeway and Correll 2004:524-5). This project does not address if one sex is more or less advantaged by institutional practices than another. However, it does reveal the very specific ways that

gender beliefs about masculinity become embedded in institutional practices. In this section I draw upon observations in medical clinics to show how stereotypical beliefs about masculinity and male sexuality have shaped the creation of medical practices for male infertility. In turn, the medical practices that are employed everyday in clinics across the country reproduce and legitimize popular ideas about masculinity.

This section entails two parts. First, I describe the first diagnostic step patients must submit to: the semen analysis. Here I argue that cultural ideas about men as hypersexual beings provide the framework for the development of this diagnostic protocol. Medical staff presumes that any man can “perform” anytime, anywhere, under any conditions. The routine of semen collection is intended to test semen quality, but in fact, becomes a test of men wherein they must prove their masculinity. In the second half of this section I discuss what happens once patients are diagnosed with infertility issues. Infertility is assumed to be humiliating for men, and so medical practitioners strive to protect and bolster their patients’ sense of masculinity in clinical interactions and treatments.

#### *Challenging Masculinity: Testing Semen, Testing Men*

In final interviews patients were asked if any aspects of infertility were embarrassing for them. Several men looked back to their earliest encounters with the medical system, and recounted “providing a sample,” or semen collection, as the most embarrassing part of the entire experience. Being asked to provide a semen analysis on a specific day at a specific time, and

sometimes in a specific location, came as a literal challenge to *perform* and prove their masculinity.

In her analysis of scientific literature on the sexes, feminist scholar Susan Bordo (1999) argues that cultural ideas about male sexuality inform the work of brain scientists, biologists and psychologists. Popular science leads us to believe that “men are testosterone-driven, promiscuous brutes whom nature won’t permit to keep their peckers in their pants” (1999:229). According to the prevailing “hot man” thesis, a term coined by Bordo, male sexuality is aggressive, uncontrollable, and animalistic. In the same vein, anthropologist and masculinities scholar Matthew Gutmann (2009) argues that men have inherited a “sexual destiny,” one which entails a “rapacious” sexual appetite, heterosexual desire and homophobia, and has no room for love. As Gutmann so astutely notes, while penises may be the erotic and conspicuous sites of sexual pleasure, “the fact remains that for the vast majority of men’s lives, penises and testicles are not in high states of excitation. The erect penis is not the default” (28).

Perhaps at no time are men more painfully aware of this fact than when they have to perform by providing a semen sample for analysis. Ideas about masculinity and male sexual performance are evident in the expectations incorporated into the institutional practices of medical clinics. Men in this study were often given exact times and dates for collection, e.g. “Tuesday morning between 8 and 9 a.m.” Most men had the option to produce the sample at home, and then drive it to the clinic or laboratory. However, if they

lived more than a one-hour drive from the drop-off facility, they had to produce the sample on-site. In some cases, if the first semen analysis results reviewed during the initial consultation were poor, the patient was asked to leave another sample “on [his] way out.”

A few men complained that no instructions were given; they were simply handed an empty cup and told where to leave it once they had collected their sample. One patient reported that the medical assistant told him to “Have fun!” and giggled as she left him alone with the cup. The assumptions about men built into the institutional practices of the clinics include the idea that, first, men are well-experienced when it comes to masturbation; second, that they can masturbate under any conditions; third, that they will enjoy providing the sample; and fourth, that they will be able to aim their ejaculation appropriately in order to catch the whole sample in the cup. Medical personnel often remarked that infertility work-ups were difficult for women<sup>69</sup>, and “fun” for men. More often, the experience was confusing for men. Were the patients supposed to stand up or lie down? If the erect penis angles upward, how could they possibly catch all of the semen inside the cup with gravity working against them? These questions went unanswered since no instruction was provided and patients did not ask, possibly out of fear of being seen as sexually unknowledgeable and concomitantly less masculine. Furthermore, the simple technology of the small plastic specimen cup also

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<sup>69</sup> Most women are required to provide blood samples. Depending upon the clinic, some women have to undergo what’s known as a “chomid challenge,” which entails testing hormone levels while on the drug chlomiphene, and some women have to go through laparoscopic procedures prior to diagnosis.

reflects the general lack of attention, innovation, and design given to semen collection, as well as assumptions about men's inherent, all-knowing, sexual abilities to perform.

Like many of the patients I interviewed, Bruce received his first order for a semen analysis from his wife's doctor. Because he lived more than an hour away from the clinic where he was to have the semen analysis done, the doctor directed him to masturbate when he arrived. However, upon arrival the staff there explained that that particular center was not prepared to have patients provide semen samples on-site. Nonetheless, they offered to find him a private space for providing the sample. Bruce recounts,

They take me and this guy comes over and he hands me this cup and he says to follow him. Then he takes me around the corner and down this hallway and he's just looking around just randomly for something like some open area. And he tries to put me behind a curtain in this I guess like a recovery room for outpatient surgery, which I was not comfortable with sitting behind this curtain. I couldn't even believe it. I said, "Are you serious?" As I told my friend, people can see my feet under the curtain. I don't know if I'm gonna—what if all of a sudden I was on my toes?

After Bruce protested about the location, he was moved to another room. He continues,

Then they put me in this room with no lock on the door. It's just this quiet room in the corner of this hallway that has a chair and a stretcher type bed and a clock that is the loudest clock you've ever heard in your life that hums and ticks. And he says, "Okay, come back down that hallway and make a left and bring me the cup when you're done." I didn't know what to expect. It was...miserable...You have you and your imagination, which is running thin on my end. . .I checked the whole room thinking I've seen the Internet. They've got these stupid voyeur cameras all over the place. So, I'm like listing things up and thinking, "My, God, is there any—?" And this clock is just tick, tick, tick. I looked at the clock. It was 8:30 in the morning. So, then it became this mind

game because then I thought I didn't want to show up at 8:33 and hand him this cup and it got to where it's 8:50 and I'm still standing in this room.

The norms around masculinity are tricky to navigate. Bruce explained that when he first arrived and told the staff he wanted to provide the sample on-site, he thought they were looking at him like "some pervert." He worried again that if he returned the sample after only three minutes, at 8:33, they would think he was too hypersexual, but if he delayed masturbation too long, they might think there was something wrong with him. At one point, Bruce recalls, a woman tried to walk into the room. He caught the door with his hand before she saw him, and then had to keep his left foot planted against the door to prevent it from opening again. Once he had his collection, he wandered the halls with the cup in his hand, trying to find the man who gave him the cup.

Bruce explains,

After, you have to fill a form out with the time that this happened. So, you have to kind of watch the clock, and then it says, "How did you do this? Masturbation or other?" And so, I sat there for a while thinking, "What in the hell is 'other'?" I've never had an option. I almost put "other" just to see what the look on their face. I don't know.

'Other' applies to medical techniques for procuring fresh sperm, like electro-ejaculation. However, Bruce's reaction to the question captures some of the pressure men feel to intuitively know and understand all things sexual.

Bruce's experience was unusual, because the center was ill-prepared for him to provide a sample on-site. However, even clinics that routinely ask men to collect semen on-site are not much better. At one clinic all of the patient rooms had large windows overlooking a major freeway. A couple of

patients commented that they felt like everyone passing on the freeway was watching them. After trying for several minutes to perform, all the while distracted by the traffic below, one man gave up and promised the doctor he would bring in a sample later in the week.

Providing samples in more private settings was equally challenging for some men. Due to his diabetes, Andrew suffered erectile dysfunction and found it very difficult to masturbate. Furthermore, he and his wife were devout Catholics, a religion that deems masturbation a sin. As a compromise with their faith, they felt that the best way to collect semen would be to engage in intercourse, and then Andrew would withdraw just prior to ejaculation. Since the couple lived more than an hour from the male infertility clinic, Andrew and his wife rented a hotel room near the clinic the night before he was to bring in his semen sample. Andrew hoped being away from home and work would allow him to relax and enjoy the experience. Alas, the morning his sample was due (at 9 a.m. sharp!), Andrew could not perform. Frustrated and embarrassed, the couple packed up and went home.

Donald, a radio announcer, compared the pressure of having to masturbate with the pressure he faced at work to meet deadlines. Here he recounts trying to ejaculate at home with his wife's help:

...You got this cute wife rubbing it, and it's like it just doesn't work right, so that's kinda challenging to your masculinity. . .Come on. You're [his wife] sitting there looking all cute. You've even got your black fishnet-- or, no those are regular stockings... And it's still a very, you know, like not able to take care of business really on time. . .But it's like when you're working on a project for work, and they say, it's gotta be done by 11:59 and 59 seconds, so we can get it in for 12:03 news, and the next

thing you know, you're trying to read, you know, two and a half minutes of news copies, and you keep stumbling over your words.

As Donald describes, providing a semen sample is challenging, especially when you are up against the clock and people around you have very specific expectations.

While visiting one clinic, the specialist I was shadowing took me to show off his newly furnished "collection room." He confessed that a few years earlier a journalist from a men's health magazine had come to visit the clinic, and in his column facetiously described the collection room as, as cozy as a public restroom with *Good Housekeeping* magazines. The doctor proudly showed me the new leather loveseat, the coffee table with pornographic magazines, and the television set and DVD player with a collection of adult videos. Despite the upgrades, the tiny room with fluorescent lighting was still cold, sparse and chamber-like.

In contrast to medical facilities, I toured a sperm bank during my fieldwork that had three rooms dedicated to semen collection. Each collection room had soft, plush furniture with high-end entertainment systems. The rooms were wall-papered with pornographic images; the overhead fluorescent lights were off, and soft lamps provided a home-like atmosphere. The lucrative sperm banking industry likely has more cash to create and furnish collection rooms than cost-saving medical clinics. They are also more dedicated to creating a comfortable experience for men, one that will encourage donors to return again and again.

In clinics semen collections were not only used for diagnostic purposes, but were also necessary for some treatment protocols, like IVF and IUI. While shadowing one male infertility specialist, he received a phone call from the medical staff at the IVF clinic located in the same hospital. The IVF team had just completed an egg retrieval on a female patient and were supposed to move forward with IVF-ICSI due to the husband's low sperm count. To do so, they needed the husband to masturbate so they could use fresh sperm. Unfortunately, presumably due to all of the pressure of the moment, the husband could not perform. The male infertility specialist agreed to extract sperm from the testicles, and the couple was sent to the male infertility clinic. The specialist described the situation to his staff (all women) so they could prepare a room for the procedure. The staff made a weak attempt to muffle their laughing and snickering, which was only exacerbated by the frantic wailing and carrying-on of the patient's wife in the waiting room. From all appearances, the staff was enormously amused and entertained by the man's inability to perform and his wife's angst. At a deeper level, their laughter also revealed the embarrassment and discomfort -- and perhaps even irritation -- people feel when witnessing the violation of strong social norms. What kind of man, after all, would prefer being stabbed in the testicle with a wide needle over the presumed pleasure of masturbation?

After describing his harrowing experience at the laboratory, Bruce aptly observed, "These people become so callous to it, they don't realize how traumatic it is for the person standing there holding the cup." I would argue

that some of the patients in this study found providing a sample to be a major affront to their masculinity, in some cases, more so than actually hearing the bad news of their semen analysis results. I often wondered how institutional practices may have differed if at any stage in the diagnostic or treatment process women were expected to orgasm on command. Would women be given more time, more space, more privacy, more comfort? Would women be expected to find the experience “fun”? This question cannot be tested, but the preposterousness of women being expected to orgasm for medical purposes highlights differing social norms regarding masculinity and femininity. Andrew captured the norms of masculinity when he so vividly interpreted his failure to perform: “For a man, you feel obviously less than a man. Men should be able to gush sperm all over the place.” The fact that every day new patients to the system continue to face such expectations to perform only preserves and perpetuates norms regarding male sexual prowess.

### *Protecting Masculinity in the Clinic*

Most men in this study completed at least one semen analysis prior to meeting with a male infertility specialist. Upon meeting with a specialist, patients undergo a physical examination and are asked to provide a second semen sample. Though some doctors seem oblivious to the discomfort and humiliation semen collection may cause patients<sup>70</sup>, doctors are extremely conscientious and deliberate about protecting their patients’ masculinity during

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<sup>70</sup> The one female doctor included in this study was in the process of creating a new center for male reproduction while I shadowed her. To her credit, the new clinic was designed with a special sperm collection room, where couples could be together in a very home-like atmosphere.

clinical interactions. Doctors carefully manage how information gleaned from the physical exam and the semen analysis is disseminated to patients, so as not to offend, embarrass or devastate patients with bad news. As stated, semen collection procedures are designed around assumptions that men can ejaculate anytime, anywhere. When semen analyses confirm poor fertility, doctors assume their patients will be devastated, humiliated and emasculated by their fertility status. These assumptions are not based on personal insights into the values, goals or beliefs of individual patients; rather, they stem from broader cultural beliefs about men, virility and fertility discussed earlier in this chapter.

#### The Physical Examination

A few patients told me that the most embarrassing part of their infertility experience was having their bodies examined. All of the doctors I shadowed stressed that the physical examination must be kept brief and business-like to avoid distressing or embarrassing patients. At the first clinic I visited, the specialist, a man, asked that I not be present during physical exams. I assured him that I would not, and that to do so would violate the IRB protocol of my study. Relieved, he explained that my presence (presumably, as a woman) might cause a patient to have an erection, which would be embarrassing for everyone in the room. A few months later I shadowed a male infertility specialist who is a woman. I relayed to her my conversation with the first doctor, and asked her if she ever worried that her presence as a woman would cause her patients to have an erection. The woman doctor

assured me that the first doctor was being ridiculous, and there was no cause for concern. Whether or not the first doctor was right, his request demonstrates concern for patients' comfort. In the case of male infertility, managing comfort is about managing masculinity, including masculine performances like erection. His concern also reflects assumptions about the strong, uncontrollable heterosexual drives of men.

### Genital Appearance

Aesthetics of the body are fundamental to cultural beliefs about masculinity and femininity. In our image-obsessed culture, asserts Bordo, the size of genitals really does matter (1999:72-73). Studies note men's insecurities about penis size in a culture that equates size with manliness (70). In most cases of infertility, the genitals appear properly formed and average in size. However, in some cases infertility is caused by deformed genitals, or a lack of sperm production results in small testicles. When the genitals do appear normal, doctors are diligent about reassuring patients that everything looks fine.

One doctor I interviewed<sup>71</sup> told me, "I tell my patients they have big balls." He claimed patients loved to hear this, and it was his method for protecting their sense of masculinity. In another clinic, I observed a doctor who regularly told patients following the physical exam, "Other than your really small penis, everything looks fine!" Then, he would wink at the wives, if present, and laugh heartily. He told me privately that using this kind of humor

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<sup>71</sup> I did not shadow this particular doctor. I shadowed his partner in the same clinic.

helped diffuse the situation, and reassure patients that they were still manly and normal. Unfortunately, many patients appeared confused by his jabs, and it took them a moment to grasp his sarcasm.

One interview in particular revealed that the proper appearance of the genitals may be more culturally valuable than actual proper functioning of them. Bruce was diagnosed with a zero sperm count due to congenital absence of the vas deferens. In other words, Bruce was born without the internal ducts that transport sperm from the testicles to the penis, which are not externally visible. When asked if his experience with infertility had had any impact on his sense of masculinity, he responded:

No. Not when I had the ultrasound and everything came back and they said, "Yeah, no, it's all in order. The rest of everything's fine." I can handle the thought of some tube not being connected. If they'd have come back and said, "Hey, you've got extremely small testicles," then I would have questioned my masculinity...

Bruce claims he did not connect the zero sperm or the missing vasa deferentia to his masculinity. Instead, Bruce clings to the fact that all external parts of his genitals appear normal to maintain his sense of masculinity. In the case of male genitals, it may be said that form is more important than function.

In contrast, another patient, Marshall, described an appointment with the initial doctor that referred him to the male infertility specialist. He recalled, "...she looked at my testicles and said, you know, 'One is maybe not descended and it's like soft and it's not quite right'. . . It made me look at it kind of differently." As I recount in the next chapter, Marshall's entire experience

with infertility caused profound suffering. Seeing his body “differently” may have only exacerbated the situation.

### The Diagnosis

The clinical definition of infertility, as used in patient literature and adopted from the World Health Organization, is “no conception after at least 12 months of unprotected intercourse” (Rowe, Comhaire, Hargreave, and Mahmoud 2000). The American Society for Reproductive Medicine (ASRM) created the following definition: “Infertility is a disease or condition of the reproductive system often diagnosed after a couple has one year of unprotected, well-timed intercourse, or if the woman suffers from multiple miscarriages. Infertility can be male or female related.” The use of the word *disease* is controversial<sup>72</sup>, but something leaders in the ASRM believed was important when they instituted the definition, in order to help patients get insurance coverage for their infertility conditions.<sup>73</sup> However, infertility is a broad label used to describe an entire range of possible physical ailments, conditions, diseases, and congenital disorders, which could make conception difficult.

In the United States, clinicians, patient advocacy groups, literature and web-sites advise couples to see a doctor if they have not conceived after “one year of unprotected sex.” As one WHO manual states: “The time limit of 12 months is arbitrary, but corresponds with the fact that the majority

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<sup>72</sup> Anthropologist Sarah Franklin asserts that infertility is “not necessarily a disease, or caused by a disease” (1997:146). For the purposes of this study, I define infertility as a disease.

<sup>73</sup> Based on email dialogue generated within a listserve for ASRM members.

(approximately 85%) of couples who achieve pregnancy spontaneously will do so within 12 months” (2000:5). There is no research demonstrating declining chances of conception following a year of unprotected sex. In fact, many couples do spontaneously conceive after years of unprotected sex without medical intervention. The main purpose of the time limit is to alert patients to seek medical help. The incorporation of an “arbitrary” time limit within the definition demonstrates that disease is, indeed, socially constructed.

In interviews doctors rattled off the WHO definition when asked to define infertility. They refer to themselves as “infertility specialists” in interviews, on web-sites, in brochures and on business cards. When discussing patient cases, doctors refer to patients as infertile. Yet, in clinical encounters I never heard a doctor tell a patient, “You are infertile,” “You have infertility,” or “You won’t be able to have children.” The word *infertility* is used in the abstract, as in, “Sometimes in infertility patients, we see...” Or, “Infertility may be a result of...” Instead, doctors offer diagnoses in terms of semen analysis results. They approach patients with information such as, “Your count was 10 million; we want to see 20 million,” or, “During the exam I felt a grade three varicocele, which could explain your low sperm count.”

While the information is straightforward, patients usually have no frame of reference for interpreting the gravity of results, and look to the doctors to tell them how serious their situation is. Doctors methodically explain the next step in diagnostic tests or treatment options. For example, a doctor might say, “Looks like you had a zero sperm count on your last semen analysis. Let’s try

another one. If it's still zero, we can't really know if you're producing sperm until we get in there and poke around a little bit." Or, "Based on your sperm count, we can do a varicocele repair, or you can try IUI or IVF." Often charts with success rates and prices are pulled out for patients. As discussed in Chapter Two, statistics and dollar figures do not clarify for couples when they can expect to get pregnant. In fact, they often generate more confusion than clarity. Unless a couple is working closely with a reproductive endocrinologist who steers them away from varicocele repair, or a couple has moral objections to IVF, they most often follow the male infertility specialist's recommendation for the first line of treatment.

Why don't doctors tell patients they are infertile? Doctors described infertility to me as "devastating" for men<sup>74</sup>, and believed they played an important role in managing and protecting men's masculinity. Doctors also had a strong business interest in not using the terms infertile or infertility. In final interviews patients were asked to define infertility. Most described infertility as the inability to ever have children, even with medical intervention. Had doctors given patients the diagnosis of infertile, patients may have believed they were out of medical options, dictating the end of business for the doctors. When patients hear medical options (even with unclear success rates), hope is restored.

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<sup>74</sup> The word "devastating" was tossed around by doctors, nurses, and a psychologist in the clinics I visited.

### ***Doctors Do Gender***

Ridgeway and Correll contend that gender is constructed in the everyday interactions between individuals and institutions, and among individuals. Likewise, Fenstermaker, West and Zimmerman argue that gender is “not simply something one ‘is,’ but rather that it is something one does in interaction with others” (2002:29). West and Zimmerman’s ‘doing gender’ theory posits that constructing gender is a process of creating differences between women and men that are not natural or biological, but lead us to believe that differences are essential (2002:13). In interactions with patients and with myself, doctors actively participated in the process of doing gender. Doctors construct gender by making blanket declarations about the natures of men and women, and more subtly, through their use of language with patients and in their differential treatment of men and women in clinical interactions.

During a phone call prior to my visit, one doctor told me, “Men just don’t take care of themselves. They’re like wild animals.” All of the doctors I shadowed lamented men’s perceived resistance to medical care or laziness when it came to health. At least three doctors described their infertile male patients as being “drug in” by their wives, a word choice suggesting men are not only unmotivated to seek medical help, but they are controlled by their wives. In fact, as I discuss in the next two chapters, the men I interviewed were quite willing to see a doctor, and highly motivated to participate in medical treatments. The metaphor of men as “wild animals” illustrates how aspects of gender which may result from socialization are believed to stem

from innate, natural gender differences. In reality, women in this country are socialized as early as adolescence by the media, schools, family, and medical institutions to schedule annual examinations for pap smears and breast exams, and to discuss birth control. Men, on the other hand, are arguably not socialized to the same extent to be as responsible for their reproductive health.

In clinical interactions some doctors explained medical conditions in terms they believe are better suited to men. One doctor I shadowed uses “mechanical” metaphors about cars, planes, and motorcycles to explain diagnoses to patients. For example, he tells patients:

“The tests show engine needs fuel. Fuel is hormones, LH and SH. I’m trying to figure out if your engine’s running and your exhaust is blocked or whether your engine’s not running and your exhaust is open... I can fix exhaust, but it’s hard to fix engines.”

This metaphor depicts the male body as a machine with mechanical parts and an energy source. Another doctor uses baseball analogies to describe diagnoses to patients. Both doctors claim patients “love” these analogies, which engender stereotypical notions that all men are interested in cars and sports.<sup>75</sup> As the first doctor explained to me, “Guys are car people...I think I come out with metaphors that they can relate to...Then they’ll understand and will be more empowered and less weak.” Men with compromised fertility, especially those being “drug in” by domineering wives, are in a vulnerable place and are perceived to need empowering.

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<sup>75</sup> In contrast, as a woman, I can say from personal experiences with infertility and childbirth, no doctor I have seen has ever used a car or sports analogy to describe my body or health status to me.

A third doctor I shadowed warned patients who were prescribed drugs to improve their testosterone production that side effects would include the urge “to hit a ball really hard or drive really fast.” The doctor and his patients always shared big grins when he said this, as if it made the drug therapy sound more appealing, as if it could actually increase masculinity. References to cars and sports are intended to make men more comfortable and protect them from a potentially emasculating experience.

Two of the five doctors I shadowed did not use masculine metaphors to explain medical matters. One of these doctors was simply more reserved and taciturn in clinical encounters. The other doctor, the only woman I shadowed, replaced scientific language with layman terms when talking to patients, but did not speak in metaphors. The doctors who relied on metaphors about cars and sports were all male, suggesting that masculine metaphors serve as catalysts in ‘male bonding’ between male doctors and patients. Their usage expedites the development of friendship and trust by establishing “sameness” between doctors and patients. When doctors talk about cars and sports, they are essentially communicating, “We are both men. We are alike. We understand each other. You can trust me.”

Male infertility specialists not only participate in constructing men and masculinity, but also create and perpetuate ideas about women. Prior to appointments male infertility specialists request that wives be present at patients’ first appointments with medical records in hand. The wives’ medical histories and infertility work-ups provide important information for making

treatment plans.<sup>76</sup> At one clinic a genetic counselor on staff emphasized to me the important role wives play as “the keepers of medical information.” She explained that wives were responsible for everything from scheduling husbands’ appointments<sup>77</sup> to keeping track of their husbands’ family medical histories. During appointments patients are asked an array of questions, such as: How many months have you been trying to get pregnant? What is the quality of the ejaculate? What genetic diseases run in your family? Patients regularly turn to their wives to answer these questions, which is not surprising to doctors.

As a specific example, in one case I observed a male infertility specialist meeting with a couple, previously seen by a general urologist, for the first time. Here I relate the conversation that transpired between the doctor and couple, in which the doctor was gathering information about the husband’s medical history and health status. The doctor and husband had to rely on the wife to provide the needed information.

Doctor: No sperm seen...in semen analysis?

Husband: No.

Doctor: Who suggested you come here?

Wife: We did. [His] urologist basically said, ‘You’re done.’

Doctor: (to husband) Based on your – (turns to wife) his – FSH?

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<sup>76</sup> If wives had no infertility issues, then couples would be encouraged to pursue male-focused treatments, like surgery. However, if wives did have infertility issues, couples were given options that entailed treatment for both partners or were encouraged to move directly to female-focused treatments, like IUI or IVF.

<sup>77</sup> Several patients in this study credited their wives with seeking out a specialist and setting up the initial appointment.

Wife: Yes.

Doctor: (to husband) Did you have any genetic testing?

Wife: No.

Doctor: No other medical problems? How much Vitamin E do you take?

Husband: Ask her.

Wife: Whatever is in a multi-vitamin plus 400 mg.

From all appearances the husband seemed quite intent on being there and grateful for his wife's knowledge. When he said "Ask her," he did not sound resentful or facetious, but rather embarrassed, recognizing his own ignorance and reliance on his wife. The wife did not provide information that the husband did not have access to. She simply served as "the keeper of the information."

If patients arrive alone, doctors chastise them for not bringing their wives. Yet, ironically, wives are often ignored or even treated with contempt during appointments. Doctors maintain eye contact with male patients, and occasionally roll their eyes, sigh, or cringe when patients' wives ask questions or make comments. One doctor told me, "If the wife talks, I tell her to let him talk." In an appointment, I observed a doctor tell an inquisitive wife, "Be quiet! I'll tell you everything you need to know." Wives were described to me as "impatient," because "they want to get pregnant yesterday (sic)." Doctors invoked stereotypes of women, specifically wives, as overbearing, meddling, and overly concerned about reproduction. At least one doctor I worked with

believed women were less likely to understand infertility than their husbands, because men are more apt to understand science.

Serving as “the keepers of medical information” puts women in an awkward position. Husbands and doctors rely on wives for information, but the role makes women look like “overbearing wives” when they ask questions. The work of ‘keeping information’ is overlooked and disregarded as real labor. Scheduling appointments, keeping track of medical histories and records, conducting medical research, and contacting health insurance companies requires time, diligence, organization, attentiveness and background knowledge. It is indeed work: an aspect of household management relegated to women as part of what Arlie Hochschild called women’s “second shift” (Hochschild and Machung 1989). When couples enjoy good health, this work goes unrecognized, unappreciated and unrewarded, demonstrating the unequal power relations and division of labor between men and women within marriage. Yet, I would argue that this labor entitles women to an influential role in decision making when disease is present. As I discuss in Chapter Five, couples in this study generally made decisions together, and men were amenable to their wives’ desires to try male-focused treatments before female-focused treatments.

What doctors do not seem to realize or appreciate is that wives are often their greatest allies. Patients and wives arrive at appointments anxious to get a professional opinion with a healthy dose of deference for and trust in their doctor’s advice. Patients look to their wives for information, feedback,

support and advice. Not only are women “the keepers of medical information,” but they are also the ones who research infertility, seek out male infertility specialists, and support their husbands during treatment. Husbands routinely reported in interviews that their wives were much more knowledgeable on the topic of infertility than they were, and had conducted more research than they had.

Why don't doctors appreciate the role of wives? Male infertility specialists only had the duration of their appointments with patients (approximately fifteen minutes) to influence their patients' plans for treatment and secure business. Male infertility specialists see themselves in competition with gynecologists and reproductive endocrinologists who are likely being consulted by the wives of their patients. At one level the wives symbolized and embodied the business competition between male and female infertility specialists. Possibly doctors worried the wives had already been indoctrinated by their own female specialists to pursue strictly female-focused treatments, and so they believed they needed to convince their patients of the benefits of more male-focused treatment plans. At a deeper level, doctors perceived wives as competing authority figures who had already earned the loyalty of their patients and had the power to dissuade their patients from the doctors' good recommendations. What doctors did not realize, and a fact that came to light in private interviews with patients, is that women often encourage their husbands to pursue male-focused treatments before they submit to more female-focused regimens, which I address in Chapter Five.

## ***Conclusion***

Within the existing 'gender system,' cultural beliefs about gender shape and inform the creation of institutions and institutional practices. What are the prevailing cultural beliefs about men and reproduction? First, men are supposed to be effective, in control, and highly motivated sexual creatures. Second, masculinity is proven through a man's ability to impregnate a woman. These preconceived notions about masculinity are the basis of other cultural beliefs about masculinity, such as, men enjoy masturbation any time, men like to hear they have large genitals, sperm counts are a measure of masculinity, and infertility must be humiliating for men.

Cultural beliefs not only shape the creation of institutional practices, but more importantly, the constant repetition of such practices sustain and perpetuate gender beliefs. Institutions serve as conduits of culture. As the example of semen collection so colorfully illustrates, social norms about men's raging sexuality inform how diagnostic procedures are designed and carried out. What was presumed to be an enjoyable experience for men was actually grueling and embarrassing for some. Masculinity is defined by strength, but ironically, is also understood to be a fragile component of the male self. Diagnoses of genital malformation and infertility are believed to be devastating for men and medical institutions strive to employ practices that protect and preserve patients' masculinity. Doctors reassure patients when their genitals appear normal, and are careful not to throw around words like "infertile" and "infertility," relying instead on euphemisms and masculine metaphors.

Because cultural ideas about men and masculinity determine the institutional practices of infertility medicine, the gender system endures.

## Chapter Four:

### INFERTILITY AND IDENTITY: How Men Define their Masculinity in Light of their Fertility Status

#### **Chapter Outline:**

***Introduction***

***Reprise: Where are all the Infertile Men?***

***Infertility and Masculine Identities***

***The Emotional Experience of Infertility***

***Denying Infertility's Impact on Masculinity***

***Focusing on the Etiology***

***"Just a Medical Condition"***

*Coping with Guilt*

***Infertility: A Symptom of a Larger Problem***

***Anticipating Fatherhood***

*Stepfatherhood*

***Conclusion***

In Chapter Three I examined the first two levels of Ridgeway and Correll's gender system: culture and institutions. Cultural beliefs about gender are embedded in institutional practices, illustrating the key role institutions play in constructing gender and disease. In this chapter, I focus on the third level of the three-tiered gender system, the micro-level of private individuals, where personal identities and conceptions of the self are formed. According to Ridgeway and Correll (2004), gendered identities are shaped by regular interactions with institutions. In the case of male infertility, patients' identities are influenced by the medical sphere in two ways: first, in the ways that medical practitioners define infertility; and secondly, through the availability and use of medical technologies that treat infertility. In this chapter I focus on patients' definitions of infertility, how patients construct their own identities as infertile men, and how personal definitions of infertility impact masculinity.

Throughout this dissertation I have argued that the processes of constructing gender and disease occur simultaneously and are inextricable. In this chapter I argue that infertility presents a major threat to masculinity. In order to preserve their own sense of masculinity, infertile men are constantly engaged in the work of defining and redefining masculinity and infertility. In interviews men explained to me what it means to be a 'real' man, a good husband and a capable father. Many men also verbalized how and why something like infertility should not be damaging to one's masculinity. Some men redefine 'infertile' and 'infertility' in ways that feel less emasculating. The patient accounts presented in this chapter share a common theme: patients

categorize their infertility as a treatable medical condition and cling to the promises of medical technology. In the next chapter I explore how and why infertile men embrace medical technologies.

***Reprise: Where are all the Infertile Men?***

At the 2007 meetings of the American Society for Reproductive Medicine, a group of mental health professionals held a two-day seminar entitled, “Men and ART: the Missing Voice,” which focused on men’s experiences with infertility. Speakers<sup>78</sup> repeatedly took the mental health community to task for not conducting more research on men’s emotional and social experiences with infertility. During one question and answer period, a clinical therapist in the audience rose to the microphone and declared with some exasperation, “We are *trying* to study male infertility, but it is impossible to recruit men for our studies. Men don’t want to talk about their infertility.”

In the late 1990s Canadian scholars Russell Webb and Judith Daniluk encountered similar problems when they attempted to study men’s experiences with infertility. They report that the recruiting process, which entailed advertisements in newsletters and newspapers and through doctors and medical clinics, took several months, required expansion into another major city, and only resulted in six male subjects (Webb and Daniluk 1999:22). The subjects had all experienced infertility several years earlier, and by the time they were interviewed five of them had adopted children and one had used donor sperm. The authors of the study acknowledge that the subjects

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<sup>78</sup> Speakers included several clinical psychologists, an anthropologist, an M.D., and an attorney. Details of the conference are included in chapter one.

may have been very unique in their willingness to discuss such an intimate aspect of their lives, and their stories likely do not reflect the early experiences of men dealing with infertility (20).

Based on my own research, I would argue that many men who qualify for infertility research studies do not participate in part because they do not identify themselves as infertile. This not only makes research difficult, but is also an important finding regarding the social experiences of infertile men. Among infertile men who do not participate in research, some simply do not want to openly discuss a very private and intimate matter like infertility. Other infertility patients do not realize they qualify for research studies, because they do not understand that they are infertile, and some blatantly deny that they are infertile. Furthermore, technological advances in the past fifteen years have changed how men experience infertility. At the time of Webb and Daniluk's study, infertile men had few medical options available to them and so coping with male infertility was primarily a psychological process. Today, dealing with infertility is also a physical and medical process. Patients like the ones in this study who consulted male infertility specialists are swept into treatment protocols immediately upon diagnosis.

Recruiting materials for this study, namely IRB consent forms, did not recruit "infertile couples" or "infertile men." Instead, subjects were asked to participate because they had "been evaluated for or diagnosed with

infertility,”<sup>79</sup> or “because [they had] some questions and concerns about [their] fertility.”<sup>80</sup> In other words, couples did not have to self-identify as “infertile” to participate, they only had to be consulting with a male infertility specialist to qualify for the study. The qualifications for participation in this study helped create a research sample of men who all fit the clinical definition of infertile, but not all perceived themselves as infertile.

Recruiting techniques used to attract subjects for infertility research in the past have arguably created biased research samples for study. For example, psychologists and mental health professionals who write about infertility often rely on the narratives of their own patients, specifically, people who have sought professional help to overcome the psychological and emotional trauma they attach to infertility. Other studies recruit primarily from infertility social support groups, again resulting in a self-selected group of subjects.<sup>81</sup> Most studies recruit “infertile” women and men (Letherby 1999:177), which immediately disqualifies infertile individuals who do not identify themselves as infertile. This research study avoided the pitfalls of a biased sample by recruiting couples inside infertility medical clinics, rather than through support groups or mental health clinics.

In this study some subjects with zero sperm counts responded “no” when asked if they had ever thought of themselves as infertile, while others

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<sup>79</sup> From the UCSD IRB Informed Consent form.

<sup>80</sup> From the Boston University Medical Center IRB Informed Consent form.

<sup>81</sup> See: Lorber, Judith and Lakshmi Bandlamudi. 1993. "The dynamics of marital bargaining in male infertility." *Gender and Society* 7:32-49.

Webb, Russell E. and Judith C. Daniluk. 1999. "The end of the line: Infertile men's experiences of being unable to produce a child." *Men and Masculinities* 2:6-25.

with much more promising semen parameters reported feelings of depression due to their “infertility.” Some men view their bodies and themselves as infertile, and experience the heart-wrenching emotions associated with loss and grief. They feel devastated and emasculated by their diagnosis, and struggle to restore their personal sense of masculinity amid circumstances beyond their control. Other men resist the stigma of “infertile” by reconceptualizing their impaired fertility in terms that feel less threatening to masculinity.

To some degree the research subjects in this study constitute a self-selected research sample because they all consulted a specialist regarding their fertility issues. This research sample primarily includes men at the earliest stages of the infertility journey, as most were interviewed after their first consultation with a male infertility specialist. Mostly likely, this sample represents men who generally trust medical professionals and have generous health insurance coverage or the financial resources to pursue infertility treatments. I was surprised at the willingness of the participants to embrace any and all medical technologies available for treating male infertility before considering alternatives, such as donor sperm, adoption, or child-free living. Anthropologist Tine Tjørnhøj-Thømsen, who conducted in-depth interviews with infertile couples in Denmark, noted that she often heard couples ask the question, “Who will I be, then, if I won’t be a parent?” (2009:233). This question is central to most social studies of infertility, because research participants commonly experience medical interventions prior to participating

in the studies. For example, most of the women and men in Gay Becker's study of infertility had undergone three or more years of medical treatment prior to being interviewed (2000:23). In Throsby and Gill's study of infertility, all participants had undergone at least one unsuccessful round of IVF in the five years prior to being interviewed and had since quit treatments (2004:330). Webb and Daniluk's study of male infertility included subjects who had resolved their infertility through adoption and sperm donation, prior to the advent of IVF-ICSI (1999:10).

In contrast to these studies, I often met and recruited my subjects at their first consultation with a male infertility specialist. Perhaps, participants did not raise questions about life without children because they were rushed into treatment protocols quickly and with a good dose of optimism. Couples were set on exhausting every possible medical option, (not to mention, draining their bank accounts), before trying other alternatives or imagining life without children. When I asked men and women their thoughts about sperm donation, adoption, or child-free living, the overwhelming majority of subjects responded that these were not options they had ever considered or discussed with their spouse. When pressed, many subjects said they would love to one day adopt a child, they just were not yet at a point where they needed to consider it. Such responses highlight a strong taken-for-granted social norm about the process and journey of infertility, which is that infertile couples should exhaust all medical options, before moving on to other alternatives

(Becker 2000:17).<sup>82</sup> It also demonstrates a strong belief in the value of being biological parents, and the unwavering faith couples have in medical technology to help them conceive. It is not surprising, then, that so many men in this study did not consider themselves infertile. The promises of medical treatment options allowed many men to stave off the stigma of infertility for some time.

### ***Infertility and Masculine Identities***

Long before they meet with specialists, infertile couples feel confused and frustrated when the “old-fashioned way,” or timed sexual intercourse, does not bring the desired result of pregnancy. Infertility is a biological mystery, but it presents itself first as a social problem, where desired social roles – like motherhood and fatherhood -- are not easily attainable. For men who envision themselves as loyal and dependable husbands and aspiring fathers, poor semen analysis results render their perceptions of themselves and the future unclear. As anthropologist Gay Becker, author of *The Elusive Embryo*, points out, infertility forces men and women to recognize and reconsider social norms regarding gender, fertility, and parenthood, which were taken for granted before they learned they were infertile (Becker 2000:34-35).

Nearly all of the men in this study reported feeling surprised when they first heard their semen analysis results. The only exceptions to this were men who had other physical diseases or disabilities which they knew might impair

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<sup>82</sup> On a personal note, my husband and I are adoptive parents. Since we adopted our daughter eight years ago, we have been asked repeatedly about our experiences with IVF. We never pursued IVF, but others' assumptions that we tried IVF and it failed, reflect this social norm about the proper course of action for infertile couples.

their fertility. Most of the men in this study reported that they had either planned their whole lives to one day become fathers or had desired fatherhood ever since marriage. Twenty-three year-old Luke, a navy seaman and the youngest male subject in the study, summed up his desire for fatherhood by saying, "It's kind of the only purpose of life, to have a child and pass along things to your child." Luke's description of the purpose of life captures the social norm of parenthood, kinship, and family life central to contemporary American culture. As other scholars have noted, the two primary procreative norms married couples face are that 1) they should reproduce; and 2) they should want to reproduce (Whiteford and Gonzalez 1994:28). Poor fertility forces men to reconsider their social roles as reliable husbands and potential fathers, major life roles through which men construct, perform, and prove masculinity.

Infertility research over the past thirty years has captured the devastation, depression, grief, alienation, hopelessness, isolation and stigmatization experienced by infertile people, particularly women (Becker 2000; Benjamin and Ha'elyon 2002; Greil 1991; Letherby 1999; Malin et al. 2001; Marsh and Ronner 1996; Miall 1986; Riessman 2000:111; Sandelowski 1990; Whiteford and Gonzalez 1994:30; Zucker 1999:771). The emphasis on emotional suffering has helped draw attention to infertility as an important topic of study. This emphasis has also played into preconceived notions about infertility as any woman's greatest heartbreak and any man's deepest humiliation. To be sure, many couples are deeply affected by infertility. For

some men and women, “infertile” serves as their master status, or the most salient identity by which they define themselves and their lives within their social world (Becker 2000; Greil, Leitko, and Porter 1988; Sandelowski 1993). Some men and women resist “infertile” as a master status, as Becker found during her ethnographic work in infertility clinics, and many patients work to re-define social norms, or what is “normal,” amid challenging life circumstances (2000:35). Infertility may not always be traumatic. Still, it disrupt individuals’ cognitive framework, forcing them to meld new feelings with prior assumptions about life and life roles (Zucker 1999:772).

Infertility is clinically defined as the inability to conceive after one year of unprotected sex. This definition is found on informational web-sites for couples, and in all of the patient literature. Despite the fact that the patients in this study fit the clinical definition of infertile, and their semen analyses showed poor results, it was apparent in some of the first interviews I conducted that many men in the study did not identify themselves as infertile. After the first several interviews I added the question, “Have you ever thought of yourself as infertile?” to the interview guide. In final interviews eight of the twenty-four men in this study answered yes. Of the remaining two-thirds of the male subjects, one man answered “almost,” and the rest said “No.”

Why did the majority of men not see themselves as infertile? As discussed in Chapter Three, specialists are not always straightforward and clear with patients about their fertility status. Because doctors seem upbeat and hopeful about potential treatment options, patients often feel hopeful, too.

No patient ever hears the words, “You are infertile.” Instead, patients hear numbers: number of sperm per milliliter of semen, percent of motile sperm, and statistical probabilities for success with various treatments. Once patients leave doctors’ offices, they return to their homes and work, where they are left to interpret the severity of their infertility issues for themselves. Beyond that, they have to figure out what infertility says about them as men, and what impact infertility has on their masculinity.

Michael Kimmel explains that, “The hegemonic definition of manhood is a man in power, a man with power, and a man of power. We equate manhood with being strong, successful, capable, reliable, in control” (1994:125). The dominant hegemonic form of masculinity becomes the standard against which other men are measured and, more often than not, found wanting (125). However, men who do not measure up to the hegemonic ideals of masculinity, in particular, must work to recreate gender in terms that protects their masculinity or defines masculinity in alternative ways.

Gender scholars often use the term “renegotiate” to capture the process of gender work, and describe how men try to maintain, repair, or restore their personal sense of masculinity when they face a crisis of masculinity (Gray, Fitch, Fergus, Mykhalovsky, and Church 2002:58). In common parlance the verb, *negotiate*, has two primary definitions: first, it is used when two or more parties attempt to come to an agreement through discussion or compromise; and secondly, it means to navigate some hazard or obstacle successfully. It is the second definition of negotiate, “to successfully navigate an obstacle,” that

scholars invoke in their research on men and masculinities, and best captures the gender-constructing processes I observed among the men in this study. Over the life course, men face various circumstances that challenge their own preconceived notions about what it means to be a man, a father, a husband, and even what it means to be socially “normal” and valuable within society. Renegotiating masculinity is the process whereby men work to restore or repair their masculinity. Power, resources, achieving “normalness,” restoring self worth, and overcoming feelings of inadequacy are the ultimate objective of negotiating masculinity. The process of negotiation entails the variety of ways that men choose to deal with perceived threats.

Men in this study on the path toward parenthood faced the obstacle of not being able conceive a child with their wives. At a superficial level this obstacle entails not having adequate sperm. At a deeper level this obstacle means being less of a man, an inadequate husband, and an unrealized father. In a culture where virility and potency are synonymous with masculinity, what infertility says about one’s masculinity is the most threatening aspect of this obstacle. As Becker recognizes, “when men learn they are infertile, they analyze their situation in the context of cultural expectations about manhood” (2000:29).

Infertility is a journey marked by highs and lows, hope and hopelessness, small victories and repeated setbacks. Over time patients come to understand that their inability to have children is problematic, as it complicates their social and emotional lives (Becker 2000:31; Greil, Leitko,

and Porter 1988:175). Because I had contact with patients more than once over the course of twelve to eighteen months, I was able to witness the personal transformations patients experienced over time in coming to terms with infertility. Infertility is caused by a variety of physical disorders, diseases, disabilities and deformations. There is no one stereotype of or path for 'the infertile man.' Infertile men's experiences are as unique as their diagnoses. The men in this study were diagnosed with a number of conditions, from erectile dysfunction to cystic fibrosis, unexplained low sperm counts to traumatic injury. They learned about their diagnoses in different ways, and at different stages of the life course. They had different perspectives of their infertility based on their health histories and the treatment options available to them.

The twenty-four men in this study represent twenty-four different stories about the ways that men come to understand and define their infertility and make choices to deal with it. What follows are a variety of stories about men's different experiences with infertility. Some men in this study openly described the emotional suffering they experienced due to their infertility. Some employed strategies for deflecting the stigma of infertility. Most of the men initially responded to their infertility emotionally, and then cognitively reconceptualized their experiences in ways that salvaged their masculinity. What is consistently illustrated throughout these diverse accounts is that how men choose to interpret, construct, and define infertility is central to renegotiating masculinity.

## **The Emotional Experience of Infertility**

Twenty-nine-year-old Jordan, a self-employed carpenter, discovered he was “sterile” during his first marriage. Now in his second marriage he has pursued several diagnostic tests and procedures to establish the cause of his infertility. A “mapping” of his testicles, a procedure that entails seventeen tissue biopsies in each testicle, showed the absence of any sperm. His specialist speculated that major trauma to the testicles during an automobile accident years ago stopped sperm production. Jordan was by far the most anguished patient I interviewed for this study. During both interviews he was overcome with emotion, moved to tears, and expressed deep heartache over his inability to help his wife conceive.

Jordan grew up in a small town in the Midwest, and came from a working class background. While many men in this study relied on scientific and medical explanations to make sense of their inability to achieve pregnancy, Jordan explained that he was not able to have children because God was punishing him:

For me, I feel like I'm getting punished. That's the way I feel about it. That's the way I look at it is, I'm getting punished. God is punishing me for not being able to have kids of my own because of everything that I've went through in my life. You know what I mean? I've been punished in some way. I've had some kind of accident or injury where all I do is suffer in pain. I hurt literally seven days a week, 24 hours a day. It's like another part of the pain. Instead of it being a physical pain it's an internal pain.

Jordan described a whole life of pain and disappointments, “punishments from God,” beginning with when he was molested as a child, followed by his life-threatening car accident, failed first marriage, and now his infertility.

Jordan described dropping the phone and crying when he first heard the results of his sperm analysis. He and his wife opted for IVF using donor sperm from Jordan’s identical twin brother. When he learned the first IVF treatment did not work, Jordan openly admitted his reaction: “Cried my butt off.” By our final interview, Jordan and his wife had accepted loans from family members and incurred major credit card debt to pay for travel and medical expenses for several failed IVF treatments. In the months prior to our final interview Jordan and Karen took in a young boy as a foster child. Though Jordan was still upset about his infertility, he expressed sincere joy about his new role as a father.

Contrary to masculine stereotypes of men as emotionally sober, Jordan described the range of emotions infertility incited and poured out his feelings during interviews. Another patient, Marshall, a musician and coffee shop waiter in his late thirties, sounded exhausted and crushed by his experiences with infertility. In our final interview Marshall described some of the feelings associated with infertility:

Learning that I was infertile and dealing with the emotions that come with that, like the fears and the sense of...worthlessness and inadequacy...the sadness...the suffering, feeling inadequate and feeling kind of helpless.

Though Marshall admitted to feeling worthless, inadequate, and helpless, he explained that there are differences between what he “believes” about infertility and how he “feels” about infertility. He elaborated, “I believe that [infertility] has no impact over masculinity whatsoever...I don’t believe it makes you less of a man. You’re [upset] just because it’s like an irrational, emotional kind of response.”

Manhood is about power, and power is about controlling unruly emotions (Kaufman 1994:145,148; Kimmel 1994:133). Marshall strived to be more rational in his thinking about infertility, and argued that infertility does not make one less of a man. At times, though, his emotions got the better of him, and he succumbed to an “irrational, emotional kind of response.”

In private interviews doctors told me that a diagnosis of male infertility could ruin marriages and lead men to commit suicide.<sup>83</sup> In clinical interactions, doctors believed they had to tread lightly to protect their patients from imminent devastation.<sup>84</sup> As a result, the severity of patients’ infertility issues was not always presented to them clearly, and not surprisingly, many patients did not perceive themselves as infertile. In some cases, patients deliberately

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<sup>83</sup> I have not found any published data on increased rates of divorce or suicide among infertile men. Becker argues that divorce rates are low among infertile couples, but there are no statistics to support this observation (38). One doctor claimed that published data show Hispanic men are highly likely to commit suicide if they are diagnosed infertile. He could not cite the source, and my own searches for such a reference were fruitless. Infertility aside, Kimmel points out that men commit suicide three times as often as women, and psychiatrists chalk this up to perceived social humiliation (133). Doctors’ assumption that infertile men are more likely to commit suicide illustrates just how humiliating doctors believe infertility must be for their patients.

<sup>84</sup> I sensed that doctors’ explanations of the seriousness of male infertility were not just a show of sympathy for patients. This rhetoric also helped construct the importance of their chosen field of medicine. These doctors did not want to be perceived as specialists who simply provide elective procedures to upper class patients. Instead, they wanted me to understand that the work they did was saving families and saving lives, and was no less important than other medical specialties.

resisted the diagnosis of “infertile” to avoid stigmatization and preserve their threatened masculinity. Other patients were upset by their diagnosis, and worked to downplay their infertility in terms that felt less emasculating. Several techniques were employed by patients to reconceptualize infertility and restore masculinity. These included: 1) denying infertility’s impact on one’s own masculinity; 2) concentrating on the specific etiology of the infertility and accentuating the positive aspects of their diagnostic test results (e.g. some healthy sperm); 3) defining infertility as a simple medical condition, emphasizing the promises of medical technology and distinguishing the self from the body; and 4) recognizing infertility as a symptom of larger health problems.

### ***Denying Infertility’s Impact on Masculinity***

Thirty-eight-year-old Max, a carpenter, was ambivalent about divulging his feelings regarding infertility. He said,

At times I felt like it was all my problem...I wasn’t good enough...to become a father, but it’s not necessarily exactly like that. I didn’t really feel that negative, but *almost*.

LW: ...If I heard you right, you said you felt *almost* not good enough.

Max: Correct...I’d *almost* get to the point where I felt like I wasn’t good enough of a husband and partner to...provide the necessary ability to become a father.

In this exchange, Max acknowledged the potential for infertility to generate negative feelings, but denied that he had ever actually reached that “point.”

Infertile men reach crucial moments where they question their masculinity, and

must engage in the mental work of figuring out what infertility means to them about their own masculinity.

Dennis, a thirty-nine-year-old special education teacher, described feelings of inadequacy regarding his infertility. He explained, "I just feel like I'm not holding up my end of the bargain... If she'd married somebody else, she'd probably be pregnant by now and have kids and stuff like that..." A taken-for-granted aspect of the marital partnership is that each party brings his or her procreative abilities to the relationship, and men often feel guilty when they default on their marital commitment (Webb and Daniluk 1999:21). Dennis compares himself to "somebody else," an imagined 'Other,' a man who is fertile and can give his wife children. Masculinity is a process that entails "intense relentless competition" with other men (Kimmel 1994:129). Since "somebody else" is capable of something Dennis is not, Dennis feels inadequate.

Dennis took an interesting approach to 'gender work' as he attempted to renegotiate his masculinity. He explained that within society "if you're infertile...that isn't considered very masculine." But then clarified, "I'm forty now. I think that if I was twenty, I would definitely feel [less masculine], but now that I'm older, I really don't care what other people say." Here Dennis admits that infertility is potentially emasculating, and admits that there may have been a time when he was younger that infertility might have made him feel less masculine. However, now at the age of forty, he claims he feels

empowered to deflect social ideas about fertility and masculinity, and chooses not to care “what other people say.”

The story of Dennis illustrates the fluidity of masculinity over the life course. Social norms about masculinity change with age. Dennis not only recognizes this, but counts on it as a way to protect his masculinity. He also recognizes that as one ages it is less important to subscribe to social norms. Dennis’s technique for renegotiating masculinity in the face of infertility is to deny that infertility has any impact on him personally. He gives himself permission not to care what society dictates about masculinity.

In Chapter One I assert that masculinity is a slippery topic of study. People have a difficult time seeing their life experiences within the context of gender and masculinity. Several subjects in this study openly recounted feeling “incomplete” or “less of a man” in their answers to questions about fatherhood, marriage, emotions, or their self perception. To my surprise, however, many of these same men responded, ‘no,’ when asked directly if their experiences with infertility impacted their own sense of masculinity or manliness. My job as a researcher is to connect subjects’ insights about themselves as people, men, husbands and fathers to notions of masculinity, even when subjects do not see the connections.

Abe, a thirty-one-year-old real estate planner, explained that the poor results from multiple semen analyses brought “an increasing level of sadness.” However, in our final interview he talked about a novel he had been reading about a working class Dominican family living in New Jersey. He described

how the male protagonist in the story had to live up to very stereotypical ideals of masculinity. The book made Abe think about his own social class and culture and he noted that due to his own cultural background (as a white educated man), he did not “feel a lot of pressure to be masculine.” Abe claimed that for “the upper class there is less masculine requirement,” and that his experiences with infertility had not really impacted his own sense of masculinity.<sup>85</sup> Is there “less masculine requirement” for the upper class? More likely, upper class men already enjoy the privileges of hegemonic masculinity, e.g. power, money, education. Abe outright denies that upper class men have to live up to the ideal of biological fatherhood.

Abe and his wife were hopeful about medical options and prepared to pay for any treatments necessary. Masculinities scholar Michael Kaufman observes that while working-class manhood “stresses physical skill and the ability to physically manipulate one’s environment,” upper-middle class manhood “stresses verbal skills and the ability to manipulate one’s environment through economic, social, and political means” (1994:145). Middle and upper-middle class men with good health insurance and economic resources are able to manipulate their fertility status through economic means. By Kaufman’s definition, pursuing expensive medical treatments is actually a way for upper-middle class men to enact their masculinity.

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<sup>85</sup> A white middle-class male subject in Becker’s infertility study made a similar observation. He explained that he was willing to talk about his infertility with his friends, but he would not discuss his infertility at work, “a fairly blue-collar environment,” for fear of being ridiculed. These examples reflect “class differences associated with cultural dialogues on masculinity” and infertility (Becker:200:47).

### ***Focusing on Etiologies***

By all definitions, Dale, a thirty-year-old graduate student, is infertile. He has a zero sperm count, and his wife did not conceive after more than a year of unprotected sex. When I first met Dale, he and his wife, Alice, had travelled from out of state to meet with a specialist for a second opinion about his infertility. The specialist, regarded by many in the field as the world's leading expert on male infertility, offered more services than their previous doctor. Dale said that the doctor "gave [them] some hope" with the "methodical, thoughtful plan" he recommended for them. While the treatment plan seemed "methodical," Dale described his journey with infertility "as a roller coaster," explaining:

We get our hopes up and then, even when that test shows pretty much exactly what we were expecting, it's upsetting...There are a lot of ups and downs, and I think it's harder, because...it is something we want a lot...People ask if...we really wanna have children all that much...Something natural is what [we] really do want, so that makes it...even more sort of higher up and lower down.

Previous scholars of female factor infertility have invoked the analogy of a roller coaster to describe the experience couples go through each month as they wait in anticipation to find out if the wife is pregnant (Becker 2000:165). Dale shows that male factor infertility feels like a roller coaster, too, as he and his wife anxiously await the results of repeat semen analyses. As Dale explains, the path of infertility is loaded with highs and lows, ups and downs. Even when they know they should expect "upsetting" results, hope springs

eternal. The anticipation and hope for good news only makes bad news more disappointing and leaves them feeling “lower down.”

Despite his zero sperm count, when I asked Dale if he had ever thought of himself as infertile, he responded:

I don't know. Well, yes, but not using that term...I guess it's really just a matter of semantics...I guess I focus more on the...‘zero sperm.’ So, if I focus more on that, that puts a broader label of ‘fertile.’

Dale believed he could still apply a “broader label of *fertile*” to himself. He refused to identify as infertile to avoid stigmatizing himself, and to maintain hope that medical procedures would find sperm in his testicles. Dale was fortunate that his parents and wife's parents had offered to help pay for medical treatments. Dale clung to the promises of treatment, and was able to stave off much of the emotional suffering experienced by other patients.

Dale admitted that when he first learned about his sperm count, he worried that his wife, Alice, would have regrets about marrying him. He shared his insecurities with Alice, who reassured him that she had no regrets, and was mainly worried about his feelings. Dale believed that his zero sperm count had little impact on his sense of masculinity. He explained:

I think in general society defines masculinity by...a lot of those stereotypical traits, you know. Things like...sports and...being aggressive in the different fields...I guess that my definition of that would differ in that...I don't see it necessary to...be so assertive, so externally...aggressive, or like trying to be macho or things of that nature.

LW: Do you think that this experience with zero sperm has had an impact on your sense of masculinity?

Dale: Not all that much. I mean, I've never been like...a big macho guy, so...no. I don't really feel that it has on that level.

Dale claimed that he did not believe one had to be athletic or aggressive or macho to be masculine. As an unspoken extension of this logic, Dale implies that a man does not have to have a high sperm count, either, to be masculine. Dale could not see or refused to admit that infertility affected his sense of masculinity.

In my first interview with Robert, an instructional technology developer in his early thirties, I asked if he had ever thought of himself as infertile. He explained:

No. I don't think of myself as infertile. I think of myself as below the averages to make natural pregnancy easy. I don't think it couldn't happen, and I don't think it might not happen over time. I just think the statistics are sort of against us...I'm in a range, as well, which I do have sperm. I do have some that are healthy. I do have some that are normal. So, I guess I don't think of myself as infertile. I just think of myself as below average, I guess.

Though Robert did describe himself as "below average," he resisted defining himself as infertile by accentuating some positive aspects of his semen parameters: the presence of some healthy, normal sperm.

Like Dale, Robert focused on the etiology of his issues. When asked if his infertility experiences had been challenging to his sense of masculinity, Robert responded:

Not really...I think of it all...as medical. I mean, clearly, I don't like to know that my sperm quality is not where it needs to be ...Years ago that would have determined that I would not have been a father, and that makes me at times sort of question, and be like, is that the way it's meant to be? . . .On the other side, I feel so strongly that [having a baby is] something I want, and that it's something I'm meant to do, and

something that Jane and I are meant to do together, that I sort of live on the other half of just feeling lucky that we have some options.

Robert recognized the historical period in which he lives and that he is lucky to have technology to help him. Like Dale, Robert created a distinction between “sperm quality” and “infertility.”

***“Just a Medical Condition”***

Robert defined infertility “as medical,” an issue which should have no bearing on his masculinity. The availability and accessibility of medical treatments allowed patients to redefine infertility as “just a medical condition.” Interestingly, there were no questions in the interview guide (see Appendix I) that asked patients if they perceived or focused on infertility as simply a medical condition. (I would not know how to phrase such a question clearly and objectively.) Instead, ideas about infertility issues as nothing more than a medical condition were a common theme in answers to questions about masculinity, emotions, marriage, fatherhood, reflections on the self, perceptions of the self as “infertile,” and the definition of infertility. After hearing repeatedly from subjects that infertility is “just a medical condition,” it became clear that couching infertility this way is an important step in renegotiating masculinity. Asserting that infertility is just like any other medical condition is to say that infertility has no more bearing on masculinity than any other disorder, injury or illness.

Other medical sociologists have shown that any condition that requires medical attention, e.g. heart disease or cancer, may be emasculating for men

even if the condition is not gender-specific (Courtenay 2000a; Emslie and Hunt 2009; Nicholas 2000). However, of all of the medical problems men face, there are few that hit at the heart of masculinity like male infertility. The determined way men repeatedly told me that infertility is just like any other medical issue seemed to be an attempt to convince me – and perhaps themselves, too – that infertility is not a big deal. Defining infertility as just a medical issue was one way to negate the unique impact infertility has on masculinity compared to other disorders.

The well-researched example of erectile dysfunction sheds some light on why some infertile men want to define infertility as just a medical condition. Erectile dysfunction, known as “impotence” just two decades ago, was long considered a psychogenic disorder within the tradition of Western medicine. Impotent men were advised to participate in psychotherapy to overcome the mental and emotional issues that prevented them from having satisfying erections. The development of new medical technologies in the 1980s and 1990s, including penile prosthetic implants and medication, changed impotence from a psychogenic disorder into “erectile dysfunction” or “ED,” a medical disorder, which could be treated by medical doctors (Loe 2004:39-40; Nicholas 2000). Impotence was once a taboo for discussion, and a medical condition few men admitted to suffering from. Today an estimated 20 million American men have sought medical help for their erectile dysfunction.<sup>86</sup>

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<sup>86</sup> [www.viagra.com](http://www.viagra.com)

Characterizing erectile dysfunction as a medical condition rather than a psychogenic disorder liberated men from some of the emasculating assumptions associated with impotence. In contrast to ED, most causes of infertility are not psychogenic.<sup>87</sup> Yet similar to ED, popular beliefs about the causes of infertility are especially emasculating for men. These beliefs include ideas that infertile men are sexually inferior, do not understand how to have sex properly for conception, or have a sexual disorder (Goldberg 2009:215; Tjørnhøj-Thomsen 2009). Another popular belief is that infertile men have lower testosterone levels, and are therefore, less manly. In most cases, these beliefs are simply myths. Most infertile men have very fulfilling sex lives and have normal hormone levels. When patients say that infertility is just a medical condition they are working to dissolve these myths, and defend themselves as normal, masculine men. Redefining infertility as a simple medical issue was a process that allowed patients to untangle fertility status from personal and social worth, and even disconnect the self (how individuals' define and perceive who they are) from the body.

Thirty-one-year-old Kurt, an industrial chemist, was initially plagued by feelings of shock, sadness, anger, and embarrassment associated with infertility. When asked if infertility had ever caused him to question himself as a good husband, Kurt replied,

Yeah. Oh God. The one time I think that I was probably at my lowest was when I was thinking there wasn't any real need for me, really, 'cause I can't provide [sperm]. I didn't think I was going to be able to be

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<sup>87</sup>The only exception would be some cases of anejaculation, or the inability to ejaculate during sexual intercourse.

a father, so I was going to be not much use to Rebecca if she wanted to have a family. So, I began to question why she really needed to have me around, you know? It was something that I really felt at the time. Was I really a good husband? Because I can't entertain the thought that maybe I would not be the father of her children.

Kurt was a loving husband, and a great economic provider, but couldn't "provide" adequate sperm. He worried that his wife, Rebecca, would find him useless in her quest to have a family. Kurt also reported feeling depressed for some time after he received his initial diagnosis. He believed his depression was affecting his marriage and his work, and he admitted that in quiet moments of reflection he shed tears thinking about his infertility.

When I asked Kurt if he believed infertility had impacted his sense of masculinity. He responded:

Yeah, it has. I obviously felt like less of a man, and sometimes it still can hit me down again, but I'm trying to come to terms with that... Hopefully, that's not the case -- that I just have some sort of medical condition that means I don't produce quite as much as I should have, and it's just something that we're going to have to deal with. I did feel -- I did have some problems with it, though.

Kurt hoped that he just had a "medical condition," which he interpreted to mean he was not "less of a man." By conceptualizing infertility as a medical condition, Kurt reminds himself that infertility cannot be a reflection of his manhood; rather, infertility just reflects a treatable biological condition.

Over a year later when I interviewed Kurt again, he and his wife were expecting their first child conceived through IVF. When asked if he ever felt that infertility had reflected anything about him as a person, he replied:

I tried not to go down that route... I felt myself as leaning toward that kind of thoughts, but I quickly stopped that one. I just realized that it's a

medical issue. It's just unfortunate that that's the case. Like I said before, there's not an awful lot I can do about it. It doesn't change who I am, it's just a medical issue. I have confidence that it doesn't make me any different.

For Kurt, recognizing his infertility as a medical issue was a battle. Kurt saw more than one "route" available to him. He could choose to perceive infertility as a poor reflection of himself as a man, but "stopped" that thought process whenever he caught himself going that direction. Instead he resolved to conceptualize infertility as a "medical issue," which had no power to change his self identity.

Leonard, an investigator with a Midwest police department in his late thirties, fathered one son before being diagnosed with a pituitary tumor.<sup>88</sup> Following delicate brain surgery and years of hormone therapy, Leonard's fertility was compromised. The hormone depletion caused by the tumor necessitated Leonard take testosterone supplements, arresting sperm production. His infertility became evident when he and his wife decided to have a second child. In our initial interview, when asked if he felt that infertility reflected anything about him as a person, Leonard explained:

It doesn't change my personality, or -- you have to forgive me because I'm really getting literal. Yes, it says that I'm a...infertile person, you know, and it's not good in a kind of way, but as far as changing my personality or anything like that, no.

By taking a very "literal" approach to understanding his condition, Leonard defended himself, claiming infertility could not change his personality or who

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<sup>88</sup> Most likely, he fathered the first son prior to the development of the tumor.

he was. In the same interview Leonard answered “No” when asked if infertility had ever threatened his sense of masculinity.

Under the direction of both his oncologist and male infertility specialist, Leonard quit taking the steroids to boost sperm production, but then suffered from erectile dysfunction from a lack of testosterone, making sexual intercourse nearly impossible. Over the course of several months and various attempts to restore his sexual function and fertility simultaneously, Leonard watched his semen counts bounce up and down between zero and normal. In our concluding interview, when asked if this experience had ever affected his own sense of masculinity, Leonard confidently answered “No.”

LW: Okay. And why is that?

Leonard: I look at it as having a broken arm or something like that. It's just a physical limitation. . . Like a broken arm or missing finger or something like that.

By defining infertility as a basic “physical limitation,” Leonard disconnected fertility status from masculinity. More broadly stated, he disconnected his bodily experience from his perception of his own self. Leonard’s analogy of infertility being like a broken finger also indicates a lack of personal responsibility for fertility status.

### *Coping with Guilt*

Masculinity is about staying in control (Kaufman 1994:148; Kimmel 1994; Tjørnhøj-Thomsen 2009). A disease like infertility generates a profound sense of powerlessness and loss of control, which is particularly threatening to masculinity (Webb and Daniluk 1999:14). Previous scholars who have

explored this theme attribute feelings of powerlessness and loss of control among men to the lack of medical options that existed less than two decades ago for male factor infertility (15). Medical treatments available today, however, help to restore some sense of control. In this study control issues were often thematically tied to a language of guilt, blame and fault.<sup>89</sup> Some men link their fertility status to personal life choices and feel personally responsible for their infertility. Other men create distinctions between the body and the self. They present bodily experience as something beyond their control, and for which they are not to be blamed.

One doctor recognized guilt as a common emotion experienced by his patients, and saw managing patients' guilt as part of his job. He described his role in helping to reassure patients they are not at fault for their infertility:

First thing I tell [patients] is that sperm production is a very sensitive process to overall body health. So, if you're taking good care of yourself, that's all you can do. I try to 'de-guilt' the trip<sup>90</sup> by saying "I don't think this has anything to do with your lifestyle. You're taking really good care of yourself and you need to continue that and treat your body like a temple." So, I try to empower them a little bit and get the blame thing out of there, 'cause men just basically internalize guilt. There's guilt in most of these guys.

This doctor hoped that "de-guiling" patients would "empower" them not to blame themselves. Patients receive mixed messages from explanations like

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<sup>89</sup> Guilt is a relatively unexplored theme in most social studies of infertility, which may indicate a gender discrepancy. Since most studies are about women's emotional experiences, this may indicate that infertile men are more likely to experience guilt compared to infertile women. Webb and Daniluk's study of six infertile men identifies seven common themes in the narratives of their experiences. Guilt is not one of them.

<sup>90</sup> The word choice "trip" used by the doctor is a play on the phrase "guilt trip" but also captures the experience of infertility as a journey.

these. On the one hand, they are told infertility is not their fault. On the other hand, they are also told infertility corresponds with “overall body health” and lifestyle choices. Is it any wonder that patients feel guilty when everyday choices about diet and exercise, not to mention histories of sexual activity, drug and alcohol use, traumatic accidents, using cell phones and laptops, sitting in hot tubs and wearing tight underwear, are all believed to impact male fertility?

During appointments I often heard patients ask doctors if they did something to cause their poor fertility. Patients feel relieved when doctors assure them they are not at fault for their fertility issues. Several patients emphasized in interviews that because they cannot control their fertility, or are not at fault for their infertility, their fertility status was no reflection of them as a person. Whether or not men are responsible for their infertility (a debate medical science has yet to sort out), resolving guilt and establishing blamelessness is an important step in renegotiating masculinity.

When Bruce, a twenty-nine-year-old pilot, first found out he had a zero sperm count, he kept it a secret from his wife. He explained,

I had no idea how I was going to tell Lacey, because I...thought there was...really no chance [to get pregnant]...I felt awful because I know that she not only wanted to have a child, but a child that was ours. And I kind of felt like I wasn't holding up my end of the bargain. I was scared also. Who knows? Was it something that I've done? I had no idea. I have been a pretty, pretty straight and narrow guy, but still in growing up and all experimented with things, and I was just thinking -- worst case -- “My God, if I've done something to myself that's causing this.”

Bruce called his best friend from childhood, now a trained physician, to find out what the results might mean. His friend reassured him that he most likely had a birth defect that prevented sperm from passing in the ejaculate, but informed him that he and Lacy could still get pregnant using assisted reproductive technologies. Finding out that his zero sperm count was not his fault allayed Bruce's feelings of guilt, and he was able to tell his wife about his infertility.

In another case, Shaun, a diamond wholesaler in his mid-thirties, had an unexplained zero sperm count. During exploratory surgery his specialist found that his vas deferens appeared -- quite mysteriously -- to have been snipped apart. After reviewing Shaun's medical history the specialist concluded that the only possible explanation was that the vas deferens was inadvertently severed during a hernia operation Shaun had as a small child.<sup>91</sup> Shaun described how his zero sperm count initially made him question his masculinity:

I'm a pretty strong, confident guy. Of course, you start thinking to yourself, 'Here I am shooting blanks.'...You kind of question yourself, your masculinity or your manliness, I guess. But after actually thinking about it intelligently for a few days, no, I would say...I'm definitely a man. Just because my plumbing got messed up...doesn't make me any less of a man, because I had absolutely nothing to do with it, nothing to do with why I'm going through all this.

Finding out that he was "shooting blanks" forced Shaun to question his masculinity. In time he learned that his "plumbing got messed" due to another

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<sup>91</sup> The specialist reported that as soon as he saw the ruptured vas deferens he knew it had been severed by surgical instruments. Such a clean break could not have been caused by trauma. In our private discussion, the specialist explained that there was no reason for the doctor who performed the hernia surgery to be "poking around" in the area of the vas deferens. If Shaun's family had known what had happened at the time, they ought to have filed a malpractice lawsuit.

doctor's error. This allowed Shaun to absolve himself of any responsibility for his infertility. He argued that because it wasn't his fault, because he "had absolutely nothing to do with it" he was "no less of a man."

Shaun's story is unique because he could actually pinpoint the event that rendered him infertile. He surely could not be held accountable for something that occurred when he was very young at the hand of another physician. Men with other conditions also worked to exonerate themselves of their infertility. Marshall, whose story is shared earlier in this chapter, admitted that his experience with infertility caused "low self esteem," and made him feel "inadequate" and "helpless." Marshall worried that he was not a good husband, "like not worthy" or "not exactly a great catch." When asked if he ever felt that infertility reflected something about him as a person, Marshall surprised me with his answer: "No, because it's not something I can control. So, no."

Tim, a technical support specialist in his late thirties, echoed Marshall when asked if he felt that his low sperm count reflected anything about him. "No," Tim replied. "You can't control it, no." When I asked James, a twenty-nine-year-old salesman, if his low sperm count had had any impact on his masculinity, he replied, "Probably not, because...there's other people who have had that problem, and there's nothing you can do about it." Marshall, Tim and James all stressed infertility as a medical issue beyond their control, which had no power to define them as people.

Infertility scholar Arthur Greil observed that most infertile women view the body as an emblem of the self. When their bodies fail, women see themselves as failures (2002:106). However, Greil identified one woman in his sample of twenty-two who drew a “clear distinction between her body and her self,” when she described herself as “a victim of a lousy package” (105). This unique viewpoint among infertile women was a common technique for preserving personal worth and masculinity among infertile men, a technique used to avoid the stigma of personal failure. Quotes from Shaun, Tim and James describe the body as beyond the control of the self. I would argue that the representations of infertility as “just a medical condition” discussed earlier serve a similar purpose. Most medical conditions, like the example of a broken finger raised by Leonard, are not reflections of one’s social worth. Many men in this study discuss the infertile body as an object which presents certain physical characteristics. The self, on the other hand, makes decisions, chooses to engage in certain behaviors, and can control itself. The self cannot always control the body, and for this reason, the self is not culpable for the deficiencies of the body.

Feminist scholar Annie Potts came to a similar conclusion in her research on erectile dysfunction. She points out that within the medical model of understanding impotence, the body is at fault, and “there is nothing a man can do or think to change the condition” (Potts 2000:93). Though men initially experience powerlessness, they are eventually liberated by the Western model for understanding illness. The body and its “plumbing” are to blame,

and the self remains intact and innocent. Though the body may present less masculine characteristics, ultimately, the self is the real seat of masculinity.

In her study of male infertility in Israel, Helene Goldberg recounts the experiences of one subject who, like the men in this study, was able to separate his self-image from his sperm quality (2009:214). However, Goldberg notes, he was not able to do this until after he learned that other men suffer from fertility problems, too. James, quoted above, similarly claimed that infertility did not affect his sense of masculinity, because “there’s other people who have had that problem...” As I discuss in Chapters One and Two, infertile men have been rendered nearly invisible by pervasive cultural ideas about women being at fault for infertility. Infertility support groups are predominantly female and focus on the experience of female infertility, and infertile men struggle to find a support network of other men experiencing infertility (Webb and Daniluk 1999).<sup>92</sup> At the conclusion of interviews male subjects routinely asked me how many men were participating in this study. Men often remarked how surprised they were to learn how common male infertility is. When I thanked men for their participation, I often heard comments like, “I’m happy to do this if sharing my experience will help someone else. Sometimes you feel like you’re the only one going through this.” The silence surrounding male infertility creates feelings of isolation for men. That isolation generates fear and shame when one’s masculinity is

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<sup>92</sup> In this study a few wives and only one man had ever attended a support group, and only one woman attended a support group on a regular basis. The one man who had attended the support group with his wife noted that they were the only couple dealing with male factor infertility in attendance.

constantly defined in relation to other men (Connell 1995; Kaufman 1994; Kimmel 1994). For men like James, just knowing that there are other infertile men in the world, makes it easier to relinquish responsibility for fertility status and separate the body from the self.

***Infertility: A Symptom of a Larger Problem***

A handful of patients in this study dealt with serious chronic health issues, including cancer, spinal cord injury, diabetes and cystic fibrosis, which impaired their fertility. They explained to me that infertility was simply a symptom of a larger problem. Emphasizing the more serious root cause of their infertility helped to assuage some guilt, resist the “infertile” label, deny that infertility impacts masculinity, and avoid emotional suffering. Some of these patients also had a unique perspective on infertility, because they were grateful just to be alive. They described infertility as a minor hiccup along the life course after surviving a life-threatening disease or accident. Gray et al, who conducted a study of prostate cancer patients, note that “current crises are linked to past personal history” (2002:46). Illnesses that threaten masculinity are perceived through the lens of past illness experiences.

Thirty-six-year-old Martin, a clerk for the city government, battled cancer in early adulthood and his zero sperm count is attributed to the chemotherapy and radiation he underwent during those years. Martin says that at the time his only concern was overcoming the cancer, and the possible negative effects of treatments on his fertility never crossed his mind. Some days he gets mad at the oncologists who he claims failed to inform him to

bank sperm prior to treatments, but most of the time he does not feel justified getting angry with the professionals who saved his life.

During both our first and final interviews, Martin seemed very conflicted about his feelings regarding infertility. He defined infertility as “somebody who can’t have kids,” and since he is raising a stepson, said he does not think of himself as infertile. However, he feels a lot of turmoil about his inability to provide better financially for his family or afford infertility treatments, and wished he “could be there in a more better way” for his wife. When asked if infertility had ever caused him to question himself as a good husband, Martin replied, “No. Not really. Because...I just put all the blame on cancer.” Martin developed a coping strategy that enabled him to categorize infertility with the more serious life-threatening medical issue of cancer, which victimized him at a young age. He avoided guilt by blaming his infertility on his cancer. Since cancer was no reflection of him as a person, he can rationalize that infertility is not either.

Andrew, a thirty-nine-year-old business owner, was diagnosed with diabetes in adulthood. The diabetes resulted in erectile dysfunction (ED), which made it difficult to provide a semen sample for analysis.<sup>93</sup> Andrew also had poor semen parameters, and identified himself as “almost” infertile. Andrew admitted that ED and infertility were both challenging to his sense of masculinity at times, but ED was more difficult to deal with because it would affect him for the rest of his life, whereas, infertility could be solved with

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<sup>93</sup> Andrew’s experience trying to provide a semen sample is recounted in Chapter Three.

medical intervention or adoption. When I asked Andrew if infertility had been an emotional struggle for him, he responded,

Not really. It can get you down from time to time, but for me, it's just a medical disease...It's just like me getting all depressed with my diabetes. I just haven't. I have a cross I was given to bear, you know?

Like other patients, Andrew stressed that infertility is “just a medical disease.”

Andrew pointed out that diabetes has not made him depressed, suggesting there is no reason why infertility should be an emotional struggle for him.

Thirty-eight-year-old Sam, a self-described “house husband,” incurred a spinal cord injury at age 19, which left him paralyzed from the waist down. Sam's semen analysis showed a high count of sperm, but poor motility, which likely means that his testicles continue to produce sperm, but the sperm weaken and die before ejaculation. Sam uses an injectible medication to create erections and a vibrating device to stimulate ejaculation. Prior to marriage Sam was very forthcoming with his wife about the fact that having children would require medical intervention due to his paralysis.

During my first interview with Sam, I asked if he had ever thought of himself as infertile, he replied, “No.” When I probed deeper, Sam explained,

Being a paraplegic myself is a little different. It wasn't so much the fact of being infertile, but the method of trying to ejaculate is a lot different than your average person. So, the fertility is definitely there. [The doctor] perceives no problems with us getting pregnant.

When Sam says “the fertility is definitely there,” he presumably means the sperm are there, highlighting the importance of the presence of sperm in defining fertility. Even though Sam and Miriam can only get pregnant using

assisted reproductive technologies, Sam reports “no problems” with getting pregnant.

Sam stressed that dealing with infertility does not even compare with the accident that left him in the hospital for three months, and caused internal injuries, broken bones, and paralysis. “This [infertility treatment] doesn’t really seem much different than an ordinary doctor’s appointment, honestly,” said Sam, describing meetings with his infertility specialist. Sam’s infertility issues are dwarfed by the life-threatening health issues he faced decades ago. He does not believe infertility has any impact on his masculinity or reflects anything about him as a person. By our final interview Sam and Miriam had gone through two failed rounds of IVF, and were preparing for another round. Again, I asked Sam if he had ever thought of himself as infertile. “No, I don’t,” answered Sam, “I think it’s just due to...the circumstances that have happened medically.”

Carl, a forty-year-old business consultant, suffered from cystic fibrosis his entire life, which had necessitated many doctors’ appointments in childhood, and a lifelong dependency on medications. At age seventeen Carl was told that he would never father a biological child due to congenital bilateral absence of the vas deferens (CBAVD), common in males with cystic fibrosis. Because he found out he was infertile at a point in his life when he was not interested in having children, Carl reported in our first interview that he took the news much easier than other men. He shared:

It was kind of a nice thing for a long time. . .I didn’t wear condoms for a

long time -- until AIDS came out. So, it was actually...kind of nice. You tell women there's nothing to worry about there, and they relaxed, and it was good.

Carl's experience illustrates how notions of masculinity change over the life course. There was a time when Carl's infertility was a boon to his sex life, because he was able to have sex without the threat of unwanted pregnancy. Carl admits now that his infertility affects him, "Only in the sense that I can't do everything another man can do." Carl's story emphasizes two key aspects of masculinity: the centrality of sexuality and sexual activity to masculinity, and the fact that men define masculinity in relation to other men (Connell 1995; Gutmann 2009; Kimmel 2006).

Carl always believed he would one day have children through adoption or using a sperm donor, but his first wife did not want children and so they did not discuss these options. After his first marriage Carl found out that new technological innovations were helping men with cystic fibrosis father children. I first met Carl and his fiancé, Rita, at a male infertility clinic where they were seeking information regarding available treatment options. In our first interview Carl claimed that his infertility had never caused him sadness, grief, anger, guilt or embarrassment. He explained,

I thought all my life, since seventeen, I could never have a biological child. About five years ago I was told by a doctor that actually now it was possible. That was a giant, exciting, totally new development for me. . . Now Rita and I are together and...having this possibility, even watching how the science, what it's done...making this possible, it all does seem somewhat miraculous to me. So I guess I'm on that side of grateful for the process.

Carl had accepted early on that he would not be able to have children. In fact, at the time he was diagnosed with cystic fibrosis, he was told it was not likely he would even live beyond his twenties. The possibility of having a child was nothing short of “miraculous” for Carl.

Technological innovation instilled Carl with new hope and a new sense of longing to be a biological father. After they married, Carl and Rita chose to try IVF-ICSI with sperm extracted from Carl’s testicles. Only a couple of days before our scheduled final interview Carl and Rita learned that their third IVF attempt had failed. Their male and female fertility specialists, working in concert, attributed the failures to Rita’s age, forty. In our final interview Carl admitted that for the first time he was dealing with feelings of disappointment and sadness. He sincerely hoped that Rita would try one more round of IVF, but knew that would require some convincing since she detested the hormone shots and procedures IVF entailed and had qualms about the physical toll pregnancy would take on her body. Rita was ready to move on to adoption, and Carl was willing to support that pursuit. After spending over \$30,000 on treatments, their journey ended right where it began. Carl still thought of himself as “functionally sterile,” as he called it, but now he thought of Rita as infertile, too.

Carl’s health history had given him an interesting perspective on his infertility and masculinity. Due to his cystic fibrosis, as a child Carl had always been physically smaller than other boys in school. He was not athletic and never perceived himself as a particularly masculine guy. When he got to

college he learned that he had strong leadership skills, which he considered to be his most masculine traits. Later, he honed his skills to become a very successful businessman. Even though infertility means that he cannot do “something other men can do,” it does not affect the leadership skills he values most about himself. Carl’s method for negotiating masculinity is to emphasize his non-physical masculine traits.

For Martin, Andrew, Sam and Carl life dealt them some serious challenges. Infertility was only one of many medical issues they faced. Andrew found his untreatable erectile dysfunction more distressing than his infertility. Martin, Sam and Carl were just grateful to be alive. In many ways their previous experiences with the medical system had already socialized them as patients.<sup>94</sup> As Sam described, infertility felt like any “ordinary doctor’s appointment.” All four of these men had doctors who they had to meet with on a regular basis. They were familiar with the medical system, and had likely already mentally processed some aspects of the medical experience that other patients in this study found emasculating. Neither Martin nor Sam thought of themselves as infertile, because they believed that if they could reverse their other health issues, at their core was a fertile man.

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<sup>94</sup> Becker observed that women and men with preexisting health issues were more likely to raise questions about risks associated with IVF than others. She argues that “prior experiences with medical care socialized them to think in such terms” (83). My point here is not that patients were more risk-oriented, but just that, as Becker says, prior experience with medical care socialized them to all aspects of patienthood: willingness to visit doctors regularly, compliance with doctors’ orders, etc.

### ***Anticipating Fatherhood***

In her book *Infertility: Medical, Emotional, and Social Considerations*, psychiatrist Miriam Mazor (1985) notes that everyone has fears and ambivalence about parenthood, but that “the infertile person must struggle harder with them” (31-32). However, Greil et al (1988) argue that women are more likely to experience infertility as “role failure” than men (182). In this study patients were asked if infertility had ever caused them to question their ability to be a good father. Marshall wondered in “a weird, superstitious way” if his zero sperm count indicated he was “just not meant to be a father.” Martin worried that he was not a good father to his stepson, and did not feel completely confident about his parenting skills. Max worried he was “almost” not good enough to be a husband and father. Aside from these examples, other men in this study reported that infertility had not caused them to question their ability to be a good father.

Why are infertile men less likely to report insecurities about parenthood than infertile women? Previous studies suggest that women’s social world is centered on reproduction, pregnancy and motherhood, which provide constant reminders that the infertile woman is not fulfilling her appropriate social role (Greil, Leitko, and Porter 1988; Tjørnhøj-Thomsen 2009). Infertile women may take this one step further and internalize that they are not fit for motherhood. Whereas, men are better able to “separate infertility and childlessness from their social and working lives and their relationships with other men” (Tjørnhøj-Thomsen 2009:237). Also, motherhood begins at the moment of conception

(Davis-Floyd 1992; Martin 1987). Women are expected to make lifestyle changes during pregnancy that ensure a safe and healthy environment for the fetus to grow and develop properly. Pregnant women must forgo alcohol and tobacco, engage in continuous light exercise, take prenatal vitamins, watch their diets, get plenty of rest, and meet with medical professionals regularly. Expectant mothers are encouraged to begin prenatal bonding with their babies by singing songs and reading books aloud. Motherhood requires a cooperative, healthy body to raise healthy, intelligent, happy babies. When women cannot get pregnant they perceive their bodies as uncooperative, genderless, and inadequate for motherhood (Becker 2000; Greil 2002; Letherby 1999). Fathers, on the other hand, have fewer expectations placed on their bodies and lifestyles during the gestation period of the baby (Han 2009). Most responsibilities of fatherhood do not begin until the baby is born. The span of nine months between conception and birth makes it easier for infertile men to mentally disconnect the ability to conceive a child from the ability to rear a child.

*Father*, as a verb, means both impregnation and rearing a child. Yet, some subjects claimed they did not see any relationship between the ability to conceive children with the ability to raise them. When I asked Robert if infertility had ever caused him to question his ability to be a good father, he replied:

Never. Never put the two together.

LW: Why do you think you didn't connect them?

Robert: I just really don't feel like my ability or my sperm count has anything to do...with my ability to be a father.

Robert claims not to see the connection between his fertility status and his parenting ability. Another subject, Dennis, echoed Robert's thoughts, explaining, "Your actions once the child is born make a good father and mother, whether or not you're fertile or infertile."

Kurt's poor fertility status caused him much anguish, but his experience with infertility made him realize how much he valued fatherhood. In his first interview, prior to his wife conceiving, Kurt explained:

I think it's made me realize how much I want to be a father and if we are successful, it may be that I think I would try that much harder to be a good father, because it's been so difficult to get there.

Rather than causing him to question his fathering ability, infertility had nearly the opposite effect. Kurt had a stronger resolve to be a good father.

Most men I interviewed did not admit to ever having doubts or fears associated with fatherhood. I suspect many did have some anxiety, but denying it was an easy way to defend their masculinity. I also suspect it was a question that floated in the backs of their minds, but they had never been forced to formulate and articulate their thoughts on the subject. Interviews challenged men to re-evaluate their ability to be good fathers and, for the first time, express their ideas. Interviews also provided men with an opportunity to reconsider preconceived notions about fertility and fatherhood, and rebuild and redefine masculinity. While infertility was often described as a situation beyond patients' control, how men raise their children is something they can

control. Surely, some of these men had qualms or anxiety about fatherhood, but as they talked and shared their ideas about what makes a good father they sounded more empowered.

In final interviews patients were asked to briefly describe what makes a good father. The most common response was the importance of fathers “spending time” with and “being there” for their children. Jordan’s and Bruce’s responses typify what many subjects shared:

A father is somebody that’s there to give children a shoulder to cry on, listen to, play with and be there as much as possible. And even though you got to work and everything, you still have to be there to support. You can’t just let the kid raise himself. (Jordan)

Being there...I think it’s a lot of the same qualities of being a good husband. Listening, talking, communicating...not just talking but listening and communicating back. I think the biggest thing is freeing up some time to spend, because all the time you spend with your child is time that they’re not spending doing something they shouldn’t be. (Bruce)

Both Jordan and Bruce emphasized the importance of fathers listening to and communicating with their children. They described the important role fathers play in supervising and guiding children. A child cannot be left to “raise himself,” and should be prevented from “doing something they shouldn’t be” doing. Jordan also acknowledged the traditional role of men as breadwinners, stating that fathers “got to work.”

Carl and Kurt, likewise, explained that they looked forward to spending time with their children and providing their children with opportunities to learn and develop. They also recognized their own fathers as good role models.

I try to remember how my father was to me, try to remember all the good things he did for me, still does for me. And I'd try to provide just as much as possible for my son so he can do what he wants to do, he can be what he wants to be, and give him every opportunity that he wants emotionally, financially, whatever, whatever he wants to do or be. The basic thing that I can do is be there for him for what he needs. And I would say that's the heart of what I'm trying, what I would like to be as a father. (Kurt)

Being able to have them know that they're loved. Being able to give them good educational opportunities. Spending time and interacting with them a lot, as did mine by the way. (Carl)

Kurt and Carl emphasize their masculinity by identifying with the most influential male figures in their lives, their fathers. Drawing upon the work of psychoanalysts,<sup>95</sup> sociologist Michael Kaufman points out that manhood is learned in the home beginning in childhood, and masculinity is represented by fathers (1994:146-147). Fathers serve as reliable examples of masculinity that infertile men can identify with, relate to, and strive to be more like, as they construct their own ideas of masculinity.

These descriptions of good fathers and good fathering demonstrate the fluidity of masculinity, and the power of individuals to construct their own notions of masculinity. Good fathers are portrayed in traditional roles as breadwinners and disciplinarians. However, some responses also resembled traditional nurturing ideals of motherhood. Men explained that fathers need to "be there," "listen to," and "love" their children, and, as Jordan said, provide "a shoulder to cry on." Men listed positive characteristics which they believed they could embody and exemplify. Traits of good fathers are self-constructed

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<sup>95</sup> Kaufman draws upon the works of Sigmund Freud, Nancy Chodorow, Dorothy Dinnerstein, and Jessica Benjamin.

markers for achieving masculinity, and are independent of fertility status. By describing the types of fathers they would like to become, men in this study were able to portray themselves as capable, worthy, masculine men.

### *Stepfatherhood*

Two men in this study were stepfathers. Stepfatherhood was a double-edged sword for these men as they dealt with infertility. On the one hand, it provided them with fathering experience, which legitimated them as capable fathers. However, being a stepfather generated other insecurities. For example, Craig, a thirty-three-year-old state trooper, confidently responded that infertility did not cause him to question his ability to be a good father. Yet, when asked if the experience had ever caused him to question himself as a good husband, he replied,

Yeah, a little bit. . . I just look at it from a point, you know, Jessica was never married when she had her first child. Here's this guy that she said she didn't -- the way she talks about him isn't the best, and yet they had a child together. I'm just thinking, 'Well, here I am trying to be a good guy and stuff, and I can't even help produce a child.'

Craig could not help but to compare himself to his wife's previous boyfriend, the father of his stepdaughter. The comparison left him feeling discouraged and inadequate.

Martin also felt conflicted by his role as a stepfather. When I asked Martin if infertility had ever caused him to question his ability to be a good father, he paused. He replied thoughtfully,

That's a good question, because...I wanna be better than my dad...I want the best for [my stepson], but sometimes I feel like because I haven't fully experienced...my wife being pregnant -- I haven't

fully...experienced all of that, I feel that I put a lot of pressure on myself. And that's how sometimes...I mess everything up.

Martin believed he was a good father to his stepson and he wanted what was best for him, but he also wanted to “better” than his own father. He felt a twinge of inadequacy because he had not experienced pregnancy with his wife. This lack of experience translated into extra pressure he put on himself and “messaging everything up.”

Kimmel asserts that the “great secret of American manhood” is that men “*are afraid of other men*” (1994:131). Most infertile men compare themselves to a faceless crowd of presumably fertile men and are struck with feelings of inadequacy. Stepfatherhood, however, creates particularly threatening circumstances where infertile men define their masculinity in relation to specific fertile men, who they know by name and who were once loved by their wives. Craig believed he was a good father, but worried he was not measuring up as a husband. Martin worried that his inexperience with pregnancy was translating into poor fathering skills.

### **Conclusion**

The narratives of infertile men demonstrate that infertility and masculinity may be defined in myriad unique and nuanced ways. But what these narratives collectively show is that defining and redefining infertility and masculinity is a requisite cognitive process for infertile men. Men cannot escape infertility completely unscathed, but they can renegotiate masculinity by reconsidering social meanings attached to fertility, and define for

themselves what it means to be a man, a husband and a father. Most importantly, these accounts show that the process of negotiating masculinity is not optional.

Individuals have the power to define gender in personal ways that may deviate from or go against broader cultural and institutional notions of masculinity and femininity (Ridgeway and Correll 2004). Dale claimed that because he had never been a “macho guy,” infertility was less threatening to his masculinity. Dennis explained that as he aged he had more freedom to disregard stereotypical norms of masculinity. Abe believed his class status spared him the stigma of infertility. Several scholars of gender recognize that notions of masculinity (and femininity) differ across lines of class, race, age, sexual orientation and able-bodiedness (Connell 1995; Fenstermaker and West 2002; Hearn and Collinson 1994). In this chapter I have argued that working class men are harder hit by infertility, due to a limited scope of knowledge regarding biology and medical science, fewer economic resources for pursuing medical treatments, and excessive pressure from their wives to have children. I have also shown that men with histories of chronic illness or severe injuries interpret their infertility as less emasculating than other men. These cases exemplify the variations of masculinity.

A common theme throughout these stories is men’s reliance on medical technologies to restore fertility and masculinity. The promises of medical technologies were recalled when men defined their particular diagnoses as different than infertility, when men defined infertility as “just a medical

condition,” and when men worked to separate the body from the self. Medical interventions were perceived as a logical, normal and even natural solution to infertility. In the next chapter I analyze how men made decisions for medical treatments and how they regarded these experiences.

## Chapter Five:

### MEN AND TECHNOLOGY: How Infertile Men Construct Masculine Narratives Around Medical Interventions

#### Chapter Outline:

***Introduction***

***Men and Medicalization***

***Male-focused Treatments as “Natural”***

***ART is Normal***

***“Tough it Out”: Enduring Treatments as a Display of Masculinity***

***The Role of Wives in Decision-Making***

***Sperm Donation***

***Treating Infertility, Treating Grief***

***Conclusion***

*"If I was on an island with one million girls we would all be dead within the next one hundred years and there would be no one left on the island... I couldn't reproduce at all without medical intervention."*

--Bruce, a 29-year-old pilot with a zero sperm count

Feminist scholars have long argued that men enjoy a privileged relationship with technology (Lohan and Faulkner 2004; Wajcman 2000). Historically, men have been the designers and producers of various technologies, have enjoyed greater access to technologies, and have occupied the positions of authority, as doctors, politicians, business and military leaders, that oversee the administration of technologies (Wajcman 2000). Women are also users of technology, but more often than men, they are subordinated by technologies as recipients (or victims) of technological interventions (Cockburn and Ormrod 1993; Davis-Floyd 1992; Davis-Floyd and Dumit 1998; Ehrenreich and Ehrenreich 1978; Ehrenreich and English 2005; Lohan and Faulkner 2004).

Several scholars have explored the relationship between women and medical technologies. Ehrenreich and English's (2005) historical work shows that women have been subjected to dangerous medical experimentation since the nineteenth century. Anthropologist Emily Martin (1987) argues that the technologies employed in modern medical practices for menstruation, childbirth, and menopause have alienated women from their own bodies. Similarly, anthropologist Robbie Davis-Floyd (1992) argues that women in labor are treated as broken machines, unable to deliver without the expertise

of professionals and the implementation of technologies. These scholars assert that women often have little say regarding the technologies they are subjected to, and medical practitioners tend to neglect the overall well-being and to disregard the feelings and knowledge of their female patients.

In the works of Ehrenreich and English (2005), Martin (1987), and Davis-Floyd (1992), the medical practitioners are primarily male, and the patients are female. The paradigm inherited from these studies is straightforward: the practitioners who manage medical technologies are powerful, and their patients are often rendered powerless. What happens to this paradigm when the practitioners are male and female, and the patients are male? If masculinity equals power (Kaufman 1994; Kimmel 1994), how do male patients maintain their sense of masculinity at the hands of medical authorities and when subjected to invasive medical interventions? Male infertility provides an intriguing case study for exploring these questions.

In the last chapter I examined how men come to understand their fertility status, and how diagnoses impact personal masculinity. In this chapter I explore how men move through medical decision-making and treatment protocols. I argue that rather than feeling emasculated and disempowered by technology, or vulnerable to the hazards of technology, men's historical affinity with technology enables infertile men to embrace medical technologies. Men in this study did not relate to medical interventions as technologies of subjugation, but rather as tools for harnessing power and maintaining control. I found that the technologies used to repair fractured masculine identities were

seen as both natural and normal steps toward parenthood, and their usage was central to patients' stories of masculinity.

Numerous scholars have demonstrated the close association between masculinity and technology, or between "boys and their toys" (Cockburn and Ormrod 1993; Oudshoorn 2003; Wajcman 2000). Infertile men who seek medical treatment reconceptualize medical technologies as normal, natural, and their use as a noble display of masculinity. I argue that men construct narratives about their infertility medical experiences that emphasize their masculinity, presenting themselves as heroic husbands and fathers-to-be, and engaging with technologies in ways that reflect the close-knit relationship between masculinity and technology. These masculine narratives demonstrate the fluidity of gender and the power of individuals to construct their own gender ideals.

Until the mid-1990s infertile men had very few options for medical treatment. Anthropologist Gay Becker observed that often "men feel left out" of the medical process for overcoming infertility (2000:56). Today, new innovations for treating male infertility provide men with an opportunity to restore fertility, as well as masculinity. Medical resources help men to define their infertility as "just a medical condition," instilling them with hope that pregnancy is likely to occur. The availability and promises of treatments for male infertility allow men to postpone facing the biological reality of their fertility status and having to consider other alternatives like adoption, sperm

donation or childlessness. The stories shared in the last chapter touch upon the hope that medical technologies bring to men with poor semen parameters.

In her study of male infertility in Egypt and Lebanon, anthropologist Marcia Inhorn identified two main reasons why the middle- and upper-class men in her study chose to undergo varicocele repair surgeries: “to bolster marriage through shared suffering and to bolster masculinity through fertility” (2009:269). Indeed, men in this study readily pursued treatments which demonstrated to their wives their willingness to endure pain and suffering. The men were certainly motivated by the promises of medical technologies to restore fertility. In addition, men in this study often sought treatments that would altogether prevent their wives from having to undergo uncomfortable procedures. For example, some men boasted how they had endured tremendous pain to protect their wives from the risks of *in vitro* fertilization (IVF). The decisions couples made reflected men’s long held affinity with technology, and the perceived “valiant charge” given to men to protect their wives from the threats of technology.

In her book *The Male Pill*, Nellie Oudshoorn argues that in the context of contraception, the idea of men taking responsibility for their reproductive bodies was “excluded from hegemonic masculinity” and constituted a subordinate form of masculinity (2003:16). Gender scholars Cecilia Ridgeway and Shelley Correll remind us, however, that individuals are capable of constructing and holding nonhegemonic, or alternative, gender beliefs (2004:520). Other gender scholars argue that notions of gender are fluid and

dynamic. West and Zimmerman argue that gender is not simply a role we fill, but something we accomplish and do. Gender is an “emergent feature of social situations” (2002:4). This chapter presents an illustration of how men reformulate masculinity when their bodies do not cooperate with cultural ideals of hegemonic masculinity. The men in this study understood at some level that they were having difficulty impregnating their wives. In order to repair masculinity they readily participated in treatments that could restore fertility. In the process they revised traditional notions of hegemonic masculinity to emphasize that good husbands do care about reproduction, and real men take responsibility for their reproductive bodies.

### ***Men and Medicalization***

Medicalization is the process of identifying or categorizing conditions, behaviors, social action or social problems as medical disorders. Most research on the medicalization of disorders has revealed who has the power to medicalize social groups, and what groups are most vulnerable to medicalization (Conrad 1992; Conrad and Schneider 1980; Freidson 1970; Zola 1972). Medical sociological research recognizes the power of medical institutions, medical authorities, mental health professionals, and pharmaceutical corporations to construct new disorders and subject vulnerable populations to medical intervention.

This present study of male infertility took root at the intersection of two sub-fields of medicalization scholarship, namely, infertility research and the study of medicine and masculinity. In the early 1980s feminist scholarship

identified the many medical risks associated with infertility medicine, and argued that strong social norms about requisite motherhood pushed women to unnecessarily engage in dangerous treatment regimens (Arditti, Klein, and Minden 1984; Klein 1989; Solomon 1986). In the subsequent decades infertility scholars analyzed the power relationship between patriarchal Western medicine and female infertility patients (Sandelowski 1990). Infertile women, it seemed, were “dupes,” easily manipulated into participating in harmful medical practices. Meanwhile, “scholar-activists” fought for less painful and risky treatments for infertile women, and for better access to treatments for lower class and minority women.<sup>96</sup> The most recent infertility research reveals that infertile women are not passive victims of medical intervention, but are active social agents and informed consumers who learn to “work the system” to their advantage (Cussins 1996; Greil 2002:103; Thompson 2005).

Like the social study of infertility, the study of men’s experiences with Western medicine is a fairly new field of inquiry. Although medical sociology scholarship took root in the 1950s, the study of men’s gendered experiences with disease and medicine has been mostly ignored. Rosenfeld and Faircloth argue that sociologists’ emphasis on the distribution of disease and access to healthcare among historically oppressed groups left white men’s relationship and experiences with Western medicine relatively unexplored (2006:3).

Rosenfeld and Faircloth surmised that medicalization research of the last three

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<sup>96</sup> The infertility literature is reviewed in detail in Chapter One. For a detailed history of social activism regarding infertility, see Sarah Franklin’s work, *Embodied Progress*, 1997.

decades of the twentieth century focused entirely on women or “genderless” bodies, patients whose sex was not taken into consideration. Research ignored men’s bodies, and “the medicalization of masculinity evaded the sociological imagination altogether” (Courtenay 2000b; Rosenfeld and Faircloth 2006:1, 18-19).

Scholars have pointed to epidemiological statistics showing men avoid doctors and medical intervention to illustrate that hegemonic masculinity is defined by strength and independence, and that sickness and reliance on medical help are viewed by men as emasculating and signs of weakness (Courtenay 2000a; Watson 2000). Men make fewer visits to the doctor than women, are less likely to comply with medical direction, and are more likely to engage in high risk behaviors and have unhealthy lifestyles. Men are believed to be more likely than women to suffer from heart disease, obesity, diabetes, and cancer, and have shorter life spans than women (Courtenay 2000a). Watson, Gray and others argue that the study of men’s health “relies on epidemiological data and ignores specific men’s experiences” (Gray et al. 2002:44; Watson 2000). Upon closer inspection, we see that the lack of concern regarding personal health matters has been linked to men’s socialization and social norms about how ‘real men’ should act (Courtenay 2000a; Watson 2000). The most powerful forms of masculinity, it seems, are “defined *against* positive health beliefs and behaviors” (Gray et al. 2002:57). One might conclude that “masculinity itself is a cause of ill health” (Rosenfeld and Faircloth 2006:15).

More recent social studies of male-specific medical disorders, like erectile dysfunction, prostate cancer, and andropause, suggest a growing acceptance of medical technologies among men (Gray et al. 2002; Loe 2004; Potts 2000; Szymczak and Conrad 2006). This research demonstrates that when masculinity hangs in the balance, men willingly submit to medical interventions to restore aspects of their appearance, health status, bodily functions, and identity that are key to their masculinity. Based on her work among men with impotence and sexual dysfunction, cultural studies scholar Annie Potts observed among her subjects “a certain desperation...to fight back against the perils of an insecure masculinity” (2000:97).

Although these two sub-fields of medicalization scholarship, the study of infertility and the study of men and medicine, have taken different historical trajectories, they have arrived at the same point of discovery: men and women willingly submit to medical intervention to restore threatened gender identities. Infertile women who seek medical services are no longer portrayed as victims of medical science, but rather as informed consumers who intelligently engage with medical technologies for personal gain, to achieve normalcy, and to reaffirm their female identity (Becker 2000:240; Greil 2002; Thompson 2005; Whiteford and Gonzalez 1994:36). Similarly, studies of men and medicine have concluded that men perceive medical intervention as the means whereby they can restore and repair their fractured masculinity (Loe 2004; Potts 2000).

### ***Male Infertility Treatments as “Natural”***

Scholars have long argued that all aspects of modern life, even seemingly natural things, like food, language, and our bodies, are the products of highly technologized processes (Davis-Floyd and Dumit 1998; Giddens 1990; Haraway 1990). Technologies, like the ones developed and employed for conception, gestation and childbirth, become so commonplace that in time people perceive them as natural and normal facets of everyday life.

Sociologists Joseph Dumit and Robbie Davis-Floyd argue that society has “moved so far into the cyborg realm that only those technological transfusions we call ‘assisted reproduction’ – safe, monitored, controlled – are considered ‘natural’ in this post-modern world. It has become unnatural to give birth at home, without the body-altering safety net of high technology. Instead, our culture has naturalized technobirth” (Davis-Floyd and Dumit 1998)

Infertility scholars, including Becker, Franklin, Thompson, and Throsby and Gill, have similarly explored the ways that infertility patients and doctors construct their experiences with assisted reproductive technologies as natural and normal. No parent wants to believe that their baby is the artificial product of scientific experimentation. Doctors emphasize to patients that their decision to use medical technologies is a natural and normal one. Patients adopt this attitude. In infertility medicine, as in most aspects of life, people place the greatest value on processes and products that may be described as “natural.”

*In vitro* fertilization (IVF) is the crowning achievement of biotechnology.<sup>97</sup> IVF is a technological procedure that produces healthy children using natural, organic, biological and genetic materials.<sup>98</sup> Infertile couples see IVF in contradictory terms – it is technological and natural, scientific and organic, extraordinary and common. Anthropologist Gay Becker reported that when the infertile couples in her study first resorted to reproductive technologies they believed they were unnatural. However, if conception “did occur because of technological intervention, the parents often made a concerted effort to treat the process as *if* it were natural” (2000:6-7).

Franklin, a British anthropologist and infertility scholar, was surprised to find in interviews that many infertile women perceive IVF as a ‘natural’ solution to achieving pregnancy (1997:188). Many of the subjects viewed their bodies and themselves as not normal and going against nature (1997:137). Yet, some women described IVF as a “natural process” (188). Others recognized IVF as a miracle, conflating it with the miracles of spontaneous conception and pregnancy. IVF technology was described as “just doing what nature does anyway” (189). Franklin writes: “This affirmation of the ‘naturalness’ of IVF is consistent with the infamous plasticity of ideas about ‘the natural’, and their

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<sup>97</sup> Robert G. Edwards who invented IVF received the 2010 Nobel Prize for Medicine. An estimated 4 million children have been conceived through IVF.

<sup>98</sup> At an infertility support group I attended one couple who had conceived through IVF was presenting to the group their experiences. The husband recalled that after explaining to a friend that they had used IVF, his friend asked, “So, what’s the difference between a ‘test tube baby’ and your baby?” He replied, “Nothing.” His friend seemed shocked that common IVF is the same thing as “test tube babies.” The term “test tube babies” is a stigmatizing label that conjures images of mad scientists creating artificial life.

ability to be readjusted even to circumstances which patently contradict this claim” (1997:188).

In Throsby and Gill’s study of men’s experiences with IVF(2004), they note that men “repeatedly disavowed that IVF is a technological procedure,” and described the process as “natural” (2004:336). At the same time, however, the men in the study celebrated IVF as the best option science had to offer (336-7). The contradictory descriptions of IVF as both “natural” and “scientific” among Throsby and Gill’s study, as well as the efforts by Becker’s subjects to naturalize their experiences with reproductive technologies, demonstrate what Sarah Franklin called the “infamous plasticity of ideas about ‘the natural’.” Technology is ubiquitous to every aspect of life. Individuals have the power to emphasize or downplay its usage, to celebrate its potential or render it invisible or even natural.

Male infertility specialists understand the value couples place on a “natural” reproductive experience, and define male-focused treatments as *more* natural than female-focused treatments. The doctors I shadowed stressed to me and their patients the importance of restoring male fertility so that conception could occur at home, “naturally.” One doctor cleverly advocated “IBF,” or “in-bed fertilization,” over IVF. The rhetoric of making natural conception possible was embraced by men and women, and resonated with masculine norms regarding a husband’s duty to impregnate his wife. In the terms of Erving Goffman’s dramaturgical model, this rhetoric moved the medical technologies of infertility treatments backstage, so that a

natural story of conception – spontaneous pregnancy through sexual intercourse -- could play out onstage (albeit private).

*ART*, or ‘assisted reproductive technology(ies)’, is an all-encompassing medical term used to refer to intra-uterine insemination, *in vitro* fertilization (IVF), and IVF with intracytoplasmic sperm injection (IVF-ICSI). *ART* generally entails the entire constellation of technologies, from hormone prescriptions to laparoscopic instruments to test tubes, utilized to make IUI and IVF possible. Based on my observations in clinics and at medical conferences, male infertility treatments other than IVF-ICSI fall outside the definition of *ART*. Male infertility specialists, in medical publications and on their web-sites, use ‘*ART*’ to describe treatments that take place in the female body, while male treatments are described by their particular names, e.g. varicocelectomy, testicular sperm extraction, hormone therapy, etc.

Male treatments epitomize medical technology at its most sophisticated. Exploratory and reconstructive surgeries utilize cutting edge instruments for micro-surgery, and incorporate all of the technologies of fully-equipped operating rooms, including computers for monitoring vital signs, and for magnifying, recording, and televising procedures. Patients use pharmaceutical technologies for regulating hormones, managing pain, and for general anesthesia. Specialists are highly skilled, and accompanied by highly trained staff. Surgical procedures that target male organs, are invasive, painful, and require long recovery periods. Yet these highly technologized solutions enable sperm to eventually fertilize an egg inside the womb in the

privacy of one's own home, and therefore, are not perceived as 'technologies' like other forms of ART categorically are.<sup>99</sup> The omission of male-focused treatments from the umbrella term, 'assisted reproductive technologies,' facilitates the perception among patients that male-focused treatments are less technological and more "natural" solutions.

Of the twenty-four couples in this study, fourteen were given the choice to pursue a male treatment, e.g. surgery, electro-ejaculation, or drug therapy, in lieu of a more female-focused treatment like IUI, IVF, or IVF-ICSI.<sup>100</sup> Thirteen of those fourteen couples chose to try the male treatment first; if it failed, they would move on to the more female-focused treatments. The only couple who chose to move directly to IVF-ICSI based their decision on the unanimous recommendations of their male and female infertility specialists.<sup>101</sup> Another three couples were given the option to pursue IVF-ICSI using sperm surgically extracted from the husband's testicles, which they pursued without hesitation. One couple was advised to go directly to IVF, which they did. Two couples were directed to IUI, which they did. Of the remaining four couples,

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<sup>99</sup> As discussed in Chapters One and Two, many scholars have asked why men are missing from the social science literature on ART. The fact that male treatments are not considered ART, answers this question in part. However, many feminist scholars use the term "NRT," or new reproductive technologies, to expand the study of ART to include surveillance technologies like ultrasound and amniocentesis, as well as birth control technologies. There is room for male infertility treatments in NRT studies.

<sup>100</sup> As explained in Chapter Two, female-focused treatments can be used to overcome male infertility issues.

<sup>101</sup> The wife was 39-years-old, and diagnosed with adenomyosis, a rare infertility disorder. Both specialists agreed that improving the husband's semen parameters would not be enough to get her pregnant. The couple did pursue IVF-ICSI, which failed.

one applied to adopt a child,<sup>102</sup> one couple was undecided on treatment due to the wife's unique infertility diagnosis,<sup>103</sup> one couple dropped out of medical care because they could not afford treatments, and one very young couple was postponing treatments until they were older. Nearly all male patients who were candidates for treatment made the male-focused treatment their first choice and priority.

James, a thirty-year-old salesman, chose varicocele repair surgery to improve his substandard semen parameters, rather than jumping to IUI or IVF. Varicocele repair surgery entails tying off or cauterizing veins in the testicles, which are believed to raise the temperature of the testicles and impair sperm production. James expressed some concern that his semen sample could possibly get "mixed up" with the wrong eggs if they were to pursue IVF. Varicocele repair seemed risk-free to James, giving him a sense of control over conception. James admitted he also had some ethical concerns with IVF, explaining:

We chose to do [varicocele repair] before...jumping ahead to the other non-conventional ways, you might say. So, [our religious views] probably had a little bit to do with it there. . . You know, try to have a child the natural way if at all possible.

James describes IVF as "non-conventional," and surgery followed by intercourse as "the natural way." After James's surgery, his wife, Laura,

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<sup>102</sup> Andrew and Sue never received a clear diagnosis, because he was unable to produce a proper sample for testing (as recounted in Chapter Three), so they never found out if male treatments were available to them. They also worried that IVF would be their only option, which they opposed on religious grounds (discussed later in this chapter), so they quit seeing their specialist and chose to adopt a baby instead.

<sup>103</sup> The wife had a bicornate uterus, for which she was seeing a specialist to help determine her chances for success with any treatment.

conceived through sexual intercourse. In our final interview James joyfully explained, “We were hoping we could do it naturally, and we did!” Conception by sex enabled James to quickly forget all of the technological intervention that lead up to that point, rendering the entire experience “natural.”

Couples generally had no moral concerns with male treatments<sup>104</sup>, e.g. surgeries, sperm extractions, while IVF did raise ethical questions for some patients. Andrew and Sue, a Catholic couple whose story appears in Chapter Three, opposed IVF because they believed it was unethical for conception to occur outside of the body, and they did not want to be faced with the decision of what to do with any unused embryos.<sup>105</sup> When they first sought out a specialist they hoped that a male treatment for Andrew, and possibly hormones or surgery to improve Sue’s fertility, would allow them to conceive through regular intercourse at home. When they learned IVF was the only option available to them, they quit seeing their specialists and contacted Catholic Social Services to pursue adoption.

Another couple in the study, Leonard and Janet, shared some of the same concerns about IVF regarding the possibility of having to discard unused embryos. Furthermore, Janet explained that she was worried about pursuing IVF, because she had heard on a news program that the hormone shots

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<sup>104</sup> Two couples initially had reservations about masturbating for the semen analysis on religious/moral grounds, but chose to participate, anyway.

<sup>105</sup> For IVF women’s ovaries are stimulated to produce multiple eggs in one cycle. Some women produce as many as ten or even twenty eggs. All or most of the eggs are removed and fertilized as embryos, though not all embryos will survive. Technicians select the healthiest embryo(s) to transfer into the uterus. The remaining embryos are frozen for future use. Couples who eventually choose not to use all of their embryos may donate the remainder to other infertile couples or discard them.

required for IVF may cause cancer in female reproductive organs. Ironically, when I asked Janet if she had any similar concerns about Leonard's therapy which entailed daily hormone injections, she did not. Later in our interview Janet described her husband as a very masculine guy, who wears t-shirts and jeans, has a deep voice, watches football, and works as a "rescue hero" (police officer). Janet sees herself as vulnerable to the dangers of pharmaceutical technologies, to which her masculine husband is immune.

The case of Leonard and Janet captures a running theme in couples' decision-making. Men are portrayed as less threatened by and vulnerable to the risks of technology, an idea stemming from men's longstanding relationship with technology. Science studies and feminist scholar Judith Wajcman asserts, "Men's affinity with technology is now seen as integral to the constitutions of male gender identity and the culture of technology" (2000:454). She notes that early feminist approaches to technology "dismissed technoscience as inherently patriarchal and malignant" and were "pessimistic about the possibilities of redesigning technologies for gender equality" (2000:449). In the treatment of male infertility, however, women do benefit from the close association of masculinity and technology. Several men in this study sought to protect their wives from the risks of technology. For example, Abe, a real estate planner, and his wife, Katie, opted for varicocele repair surgery first, because, as they each explained, they needed time to consider the risks of IVF. As a pediatrician, Katie admitted that several of her young patients were conceived through IVF and displayed no birth defects or

problems, but she still needed time to consider all of the potential risks to herself and any children. Abe deferred to Katie, because he believed that her profession qualified her to make the most educated decision. He preferred pursuing surgery first so they “could conceive naturally.” Neither Abe nor Katie had any qualms about varicocele repair, and did not need time to consider the risks associated with the surgery. As this case illustrates, men’s affinity with technology makes medical intervention for men appear to be a “natural” solution. It also encourages men’s involvement in reproductive technologies, which promotes shared responsibility for reproduction and gender equality. Furthermore, this also repairs any damage to men’s sense of masculinity by allowing them to be the “protectors” of their wives.

In Chapter Three I discussed the extreme emotional distress of one particular subject, Kurt. Kurt shared that his infertility caused him to feel depressed and question whether he was a good husband, brought him to tears, and made him feel like “less of a man.” Due to his particular diagnosis, Kurt was not given any male treatment options. He and his wife, Rebecca, were advised to go directly to IVF or IVF-ICSI. Kurt openly expressed his willingness to take part in medical interventions, and regretfully explained,

I would have happily taken as much treatment as required... if it would have helped. So, if hormone replacement therapy was the option, I would have done it. If surgical extraction was the option, I would have done that. But, as it turned out, there wasn’t an awful lot I could do other than supply my sample as an option... So, unfortunately, most of the procedures were left to Rebecca.

Kurt's situation illustrates how powerless and out of control men may feel when the technology is beyond their realm of participation. Other men were able to demonstrate their masculinity by participating in treatments. In contrast, Kurt had to rely on his wife to endure treatments in his behalf to make conception possible.

### ***ART is Normal***

While most couples preferred male-focused treatments, many couples in this study eventually turned to IUI and IVF. Sociologist and infertility scholar Charis Thompson, who conducted ethnographic fieldwork in IVF clinics, observed that when patients met certain social norms of sexual orientation, socioeconomics, and civility, the use of reproductive technologies was more easily perceived by both practitioners and patients as a normal step on the road to parenthood. According to Thompson's observations, IVF clinics were most welcoming of heterosexual couples who were easily able to afford treatments, and demonstrated civility and warmth toward one another and medical staff (Thompson 2005). These patient-couples formed an idyllic picture of a "normal," loving family for a child. Thompson observed that lesbian and lower class couples were not as welcomed by clinics.<sup>106107</sup>

Couples who appeared less stable in their relationships, e.g. argued publicly,

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<sup>106</sup> For example, in initial screening calls, lesbians were referred to commercial sperm banks. Prices were quoted to couples upfront to deter people who were unable to pay. Thompson recognized that by the end of her fieldwork practitioners became more open to homosexual couples, a clientele base that is widely accepted today.

<sup>107</sup> Thompson points out that the 'socioeconomic norm' for patients was replaced by biological norms, due to the 1992 Fertility Clinic Success Rate and Certification Act, which required IVF clinics to report their success rates to the public. As a result, doctors became more interested in serving clients who could pass a series of biological tests, which predict better outcomes for IVF, than those with the most financial resources (90).

were not well regarded by clinic staff. In summary, Thompson argues that medical technologies can be more easily embraced by patients, practitioners, and even the general public, as “normal” when all other patient variables appear to meet social criteria of a “normal,” happy, healthy family.

As clinics construct patient norms, patients who meet these norms are better able to see themselves as having a valuable, normal reproductive experience. After being told that their fertility status is abnormal, infertile patients want to know that they are on the road to normalcy. The patient population in this study met the clinical norms outlined by Thompson: they were all heterosexual, in loving monogamous relationships, and the majority had the financial resources to afford treatments. I would also argue that the ways men in this study chose to define their own fertility status made reproductive technologies seem like a normal step toward achieving biological parenthood.

Most men in this study defined infertility as “the inability to conceive” or “the inability to have a biological child.” While ‘infertility’ was often defined as a permanent condition, men interpreted their own diagnoses as temporary medical conditions that could be easily remedied. The focus on a “biological” child normalizes the technological processes that join sperm and egg, making conception and pregnancy possible. One patient who defined infertility as “the inability to create a baby,” explained that “you can’t really say you’re infertile if you can do something through IVF.” By creating a very broad definition of infertility, as in “the inability to conceive” (notably minus the clinical standard

timeline of ‘within one year’), these men could reaffirm their fertility through conception by any means over any length of time. They could also reaffirm their sense of masculinity, and avoid feeling inadequate.

Robert’s story, recounted in chapter four, exemplifies the welcome role technology plays in the lives of infertile men. Recall that Robert acknowledged that at a “different time” in history his poor sperm quality might have meant he would never become a father. He felt strongly that having children is something he was meant to do. Thanks to some healthy, normal sperm in his semen, and lots of technological assistance, conception was possible. Robert chose to undergo varicocele repair surgery to improve his semen parameters. Four months after surgery, a semen analysis showed no improvements in Robert’s sperm count so he and his wife Jane, feeling impatient, pursued IVF-ICSI. A few months after conceiving through IVF-ICSI, Robert’s doctor conducted another semen analysis, which established that Robert’s sperm count had increased to a normal fertile level.<sup>108</sup> Neither Robert nor Jane reported any regrets about choosing both the varicocelectomy and IVF-ICSI, even though either therapy alone would likely have been sufficient to achieve pregnancy. Within a span of a few short months Robert and Jane had

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<sup>108</sup> Due to the trauma of surgery, sperm counts generally go down just after surgery. Patients are told that their sperm count will dip down after surgery, and then, hopefully, rise higher than pre-surgery levels within 4-12 months.

participated in the most high-tech, cutting edge services available for treating male and female infertility.<sup>109</sup>

Despite the rigorous physical toll of IVF-ICSI, particularly for Jane, Robert and Jane quite willingly participated in all of the medical options available to them. The accessibility and abundance of technologies and procedures provided constant hope and likely relieved some amount of anxiety. In our final interview I asked Robert again if he had ever thought of himself as infertile. He replied,

No, because I think with the levels I have, I wasn't completely infertile. I knew I would always be able to...do IVF.

LW: How would you define infertility?

Robert: Not having any chance of being able to have your own biological baby.

By defining infertility as the inability to have a biological baby with or without technology, Robert was able to resist the label of infertile, prove his fertility, and preserve his sense of masculinity. His definition of infertility depicts the very normal way that technologies were viewed by men in this study.

***“Tough It Out”: Enduring Treatments as a Display of Masculinity***

Six men in this study underwent varicocele repair surgeries, three of whom achieved spontaneous pregnancy through regular intercourse within months of surgery. Of the remaining three couples, two went on to pursue

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<sup>109</sup> Thanks to their comprehensive health insurance, both Robert's surgery and the IVF-ICSI procedure were performed at minimal costs to Robert and Jane, so there were no economic incentives to postponing IVF-ICSI, and no financial reasons to regret their treatment decisions.

IVF-ICSI prior to our final interview<sup>110</sup>, and one was making plans to try testicular sperm extraction with IVF-ICSI. None of the six varicocele repair patients regretted their decisions to have a varicolectomy, including those who eventually moved on to IVF.<sup>111</sup> The lack of regret by the three men who underwent what turned out to be fruitless surgeries, demonstrates the willingness of men to participate in the regimens of reproductive medicalization.

Two other men in the study, Shaun and Matthew, did not have varicoceles, but chose to undergo exploratory/reconstructive surgeries to correct anatomical abnormalities. Though their semen parameters improved slightly following surgery – from zero sperm to some sperm, the men and their wives were ultimately encouraged to pursue IVF due to low sperm counts and poor sperm motility. In both cases, the wives achieved pregnancy immediately with IVF. Neither Shaun nor Matthew had any regrets about their surgeries,

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<sup>110</sup> This includes Robert, mentioned earlier, who moved to IVF only a few short months after his surgery, and then eventually saw improved semen parameters.

<sup>111</sup> Marcia Inhorn writes that the vast majority of Middle Eastern male patients in her study suffered “buyer’s remorse” following treatments when they saw no improvements in their semen parameters (2009:266). Inhorn categorizes varicolectomy as a form of “male genital cutting,” along with circumcision and vasectomy. Inhorn’s use of the term “genital cutting” is intended to conjure up the unjust and inappropriate ways young girls around the world have been subjected to the cultural practices of female genital cutting, e.g. clitoridectomy. During her fieldwork, Inhorn witnessed the excessive use of “pointless and potentially damaging” varicolectomies (273). Many patients she interviewed had only subclinical varicoceles, and some patients even had normal semen parameters. Based on my observations in the United States, I would not use the term “male genital cutting” to describe varicolectomy, because it was generally justified as medically beneficial. In contrast to varicolectomy, clitoridectomy takes place in highly patriarchal cultures, and the purpose is to suppress women’s sexuality and enforce chastity. With that said, there was one patient in this study with a zero sperm count who, in my unprofessional opinion, should not have been advised to undergo varicolectomy. His own doctor, who I suspect in Chapter Two of “up-selling patients,” published a paper recommending that varicolectomy only be used on patients with poor semen parameters, and ‘zero count’ patients should go directly to MESA and IVF-ICSI. Not surprisingly, the patient still had a zero sperm count following his varicolectomy, and now plans to pursue MESA and IVF-ICSI.

even though they could have averted them altogether, by opting first for IVF-ICSI with basic testicular sperm extraction. Shaun and Matthew were surprised and thrilled when surgical exploration revealed the presence of some sperm in their ejaculate. Even though semen parameters were not sufficient to achieve pregnancy through regular intercourse, the mere presence of sperm was enough to restore some sense of masculinity, and speaks to the importance of sperm to men's definition of masculinity. Clearly, sperm makes the man.

Shaun, who had a zero sperm count due to a severed vas deferens (recounted in Chapter Four), had no qualms about taking advantage of all of the options available to him. When asked if he would ever decline a treatment due to possible pain or discomfort, Shaun replied,

No. I pretty much went in this headstrong. I said, "Hey, anything they're willing to try or do." I was just going to tough it out and go for it regardless. To answer your question, no, I didn't decline anything they asked me to try.

Clearly, Shaun was game for "anything" his specialist suggested. Choosing to "tough it out" was a way for Shaun to demonstrate his masculinity.

Like Shaun, men in this study unanimously said they would never decline a treatment due to pain or discomfort. The only slight exception was Bruce who admitted that, after being told he had to repeat a procedure that felt like his testicles were squeezed in a "vise grip," he requested general anesthesia the second time around. Nonetheless, he was ready and willing to try the procedure again. I was often surprised in interviews when patients

candidly recounted to me in graphic detail how a procedure turned their testicles black and blue, how “excruciating” a procedure had been, how the pain made them cry, and how they could not sit down or “ride [their] Harley” comfortably for days or weeks following surgeries. I confess that my surprise was due to my own preconceived ideas that men would not be willing to admit treatments were painful. In time, however, I realized that as men described the horrors of treatments they were actually constructing a narrative about themselves as courageous, heroic, self-sacrificing, and masculine.

Israeli infertility scholars Benjamin and Ha’elyon assert that pain is imbued with meaning by its sufferers. In their study, infertile women undergoing IVF described the pain associated with treatment as their “motherly duty” (2002:670,673).<sup>112</sup> Likewise, men in this study were willing to endure whatever was necessary for the sake of the family, to ‘take one for the team,’ as it were. How could I, as a woman, possibly understand how traumatic testicular surgeries might be? Men were describing pain so that I would understand the lengths they were willing to go to make conception possible and to spare their wives from painful and uncomfortable female-focused treatments.<sup>113</sup>

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<sup>112</sup> Many infertility scholars (particularly in the UK) discuss the intense pain women experience during IVF. In my observations in clinic settings, women were put under general anesthesia for laparoscopies, egg retrievals, and embryo transfers. This may be a relatively new practice or unique to some clinics, but it does make these procedures essentially painless. Any of these procedures without anesthesia would be quite painful. There is some superficial pain associated with hormone injections. IUI’s cause cramping, a sensation similar to the pain experienced during other cervical procedures, like a pap smear or the insertion of an intra-uterine birth control device (IUD). This pain may be managed with basic over-the-counter pain relievers.

<sup>113</sup> Benjamin and Ha’elyon argue that trust in one’s doctor is the prerequisite to getting women to willingly endure pain (675). In this study, doctors had to gain patients’ trust first, too. Doctors rarely

An elementary school teacher in his early forties, Matthew described his surgery as possibly “the most painful thing” he has ever had to do. Matthew was originally diagnosed as infertile over fifteen years ago during his first marriage. At the time he was told by his doctor that, due to his zero sperm count, there was no way he would ever be able to father a biological child. Years later, newlywed to his second wife, Matthew’s primary care practitioner mentioned that new medical options were now available to men with zero sperm, and gave him a referral to a male infertility specialist. A testicular biopsy recovered millions of sperm, and confirmed that Matthew had normal sperm production in the testicles. At the recommendation of his specialist, Matthew underwent surgery to clear an obstruction in his vas deferens. If the obstruction were successfully cleared, in theory, sperm would presumably join with seminal fluid, and Matthew and his wife would be able to achieve pregnancy through intercourse. A few months following surgery, semen obtained through masturbation showed the presence of sperm in his ejaculate, but the numbers were well below normal. Matthew’s specialist encouraged him and his wife to pursue IVF, which they did, and quickly became pregnant.

In our final interview, while looking forward to the birth of his first child, Matthew reflected on the aftermath of his surgery:

It was a long recovery. I was unable to do a lot of things for eight or ten weeks after the surgery. That was a little frustrating. It was in the middle of winter. I had to talk Liz through using the snow-blower. But it was a little frustrating and it was probably for those first three or four

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prepared men for the pain of treatments. Patients were told they would be back at work within 1-2 days of surgery. Patients never recovered this quickly. One doctor told me that most of the pain was in the patients’ heads, because men are especially – and unnecessarily -- sensitive about their genitals.

days when I didn't believe that Percocet was the thing to do, one of the most painful things — if not the most painful thing — that I've had to endure. I would do it again in a heartbeat, even if we didn't have the same results. There was just a need to know that we have ruled out everything in an attempt to have a biological child.

Despite the tremendous pain he endured for a treatment that proved to be insufficient to achieve pregnancy, Matthew declared he “would do it again in a heartbeat.” For Matthew, his willingness to endure pain (and forgo the painkiller Percocet) for the sake of his family was a way he could display his masculinity.

In my first interview with Matthew, he said that for fifteen years he had thought of himself as infertile. However, once his specialist conducted a physical exam, and concluded there was a high likelihood that his testicles were producing sperm, he never thought of himself as infertile again. In our final interview, I asked Matthew again if he thought of himself as infertile. He responded:

No. . . . And I don't know why. That sort of seems odd to me that I never really think of myself in that way.

LW: Did you ever think of [your wife] as infertile?

Matthew: Not once.

LW: How would you define infertility?

Matthew: Inability to reproduce.

Technically, Matthew had healthy sperm in his testicles all along -- a fact that he was unaware of for fifteen years. The chances of him ever achieving spontaneous pregnancy in the future are still very slim -- a fact Matthew is now aware of. Nonetheless, finding out that sperm are present in his testicles gave

Matthew permission to shed his infertile status. Finding out sperm were restored to his ejaculate, and then learning his wife was pregnant bolstered his identity as fertile and masculine. The fact that Matthew did not actually impregnate his wife through sexual intercourse demonstrates how medical technologies are easily naturalized by their users and rendered invisible in the conception process.

### ***The Role of Wives in Decision-Making***

So far this chapter has described how treatment decisions reflect a masculine narrative about men's affinity with technology and male toughness. The great surprise of this study, given the findings of previous research, was the influential role wives played in making treatment decisions. Anthropologist Matthew Gutmann argues that social studies of reproduction have neglected to investigate women's influence on men's actions, perpetuating the misconception that "men will do what they do sexually and reproductively regardless of women's intervention" (2009:35). This study suggests that many men are indeed amenable to women's needs, desires and feelings when it comes to reproductive choices.

In their 1993 study Lorber and Bandlamudi examined the power dynamics of marital bargaining among couples with male factor infertility, as they made plans for treatments. At the time of their study, female-focused treatments like IUI and IVF were the primary solutions to male infertility. The authors argued that because women bear the social onus of childlessness, as well as the burden of medical treatment, women have less bargaining power in

decision-making (Lorber and Bandlamudi 1993:33). Most women in the study took responsibility for their husbands' infertility by submitting themselves to painful and invasive treatments. Some women in their study felt coerced and pressured by their husbands to undergo IVF to produce a biological heir when they did not want to – a phenomenon the researchers attributed to “the constraints of a patriarchal relationship reinforced by the cultural mandates of biological motherhood and technological solutions” (40).<sup>114</sup> It is important to note that Lorber and Bandlamudi base their study on data collected in 1989, prior to the advents of IVF-ICSI and testicular sperm extraction, and the growing popularity of male-focused treatments. In other words, the couples saw their only medical option as IVF, for which men produce a semen sample, and women undergo weeks of hormone therapy and invasive procedures. The medical options available today require more active participation by men.

In the present study husbands and wives were asked to describe the decision-making process they went through as a couple to create a treatment plan. They were asked if they believed each person – husband and wife – had an “equal vote” in decision-making. Twenty-nine-year-old Dale, a Ph.D. candidate in social psychology, explained that he and his wife Alice discuss all of their options together, but generally agree on the treatment steps Dale’s doctor presents as the best choices for them. Dale stated,

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<sup>114</sup> In 1998 Iranian scholars Baluch et al (1995) published a study of “Male Infertility in a Male Dominated Society.” They argue that men have greater household control, but that once men are diagnosed with infertility, wives gain more household control. So, while Lorber and Bandlamudi see wives of infertile men as less powerful when it comes to treatment decisions, Baluch et al find that infertile men become less powerful in household decisions.

I feel like most of [the decisions] actually have been fairly even because we both want the same thing. ...So, I feel like most of the choices have been presented in a way where it seems more probable in terms of reaching our goal. So even though...we've obviously talked about all these different choices, I feel like for the most part...we come into those discussions already pretty much agreeing.

In a separate interview Alice corroborated that because their “ultimate goal is the same,” they find that they are “on the same page” when it comes to making treatment decisions.

Like Dale and Alice, many couples said they usually came to the table agreeing on the best options for them. When husbands and wives agreed with each other, it was generally because they both agreed with their doctor(s)'s recommendations. For example, Mark and Eva agreed that they should begin with reconstructive surgery for Mark, and then move on to IVF-ICSI if that did not help them achieve pregnancy. As Mark explained,

We just sort of talked about what we wanted to do, what we felt comfortable with and who we would speak to next...I don't think it was a very difficult conversation or decision that we made. We both...had similar goals and...so it was never any anxiety around our discussions. We just sort of went from one appointment to the next, and doctors helped me to where we needed to be.

LW: In the decision-making process, do you think there was one person whose vote counted a little more?...

Mark: I'm thinking it was fifty-fifty.

Mark's wife, Eva, echoed his thoughts. She

I think from the beginning we were pretty much on the same page, that we knew we wanted a child, and we...both knew that this was biologically -- that was our first choice. Obviously, we had talked about all the options that were out there, adoption and everything... As far as the surgery was concerned and things like that, he never had a doubt in his mind that he was gonna go through that, and I supported whatever

he wanted to do...When it came to the *in vitro*, and they said that's what we needed to do, we both kinda were just in agreement that that's where we were going. Anything that came up that was new, where we didn't know, we just had a discussion, and we seemed to just pretty much agree from the beginning on everything.

Interestingly, when male-focused treatments were the first option for treatment, men and women reported that they discussed options together and found that they were, as Alice and Eva said, "on the same page." In these cases, subjects described the process as "collaborative," and each spouse's vote in decision-making as "equal" or "fifty-fifty." However, in cases that involved more female-focused treatments, husbands and wives related that the wives had more power in decision-making because women are more invested in motherhood and because treatments would take place in her body.

One couple, Jason and Louisa, were diagnosed with both male and female infertility issues. When I asked thirty-eight year old Jason, a systems engineer, if he believed either he or his wife had "more vote" in treatment decisions, he responded, "No. I think it's fifty-fifty." In a separate interview I asked Louisa, a thirty-two-year-old radiographer, the same question. She replied, "I have pretty much more vote." When asked why, she responded, "I don't know, because I'm a woman and I know better for myself." While Jason reported an egalitarian or "fifty-fifty" approach to decision-making in their marriage, Louisa believed that she had more power in decision-making. Louisa also believed that their infertility was more likely due to her issues than Jason's issues.

Like Jason, other men in the study reported that decision-making power was equal. However, as they spoke, they realized that perhaps their wives had more control in decision-making. When I asked Shaun to describe how he and his wife, Kelsey, made treatment decisions, he explained,

We really sit down and weigh the pros and cons and our options, and whatever sounds best to us, we do. It's not like she makes the decision. I make the final decision. We really have to come to an agreement, which we pretty much did the whole way through...

LW: Would you say that either of you – maybe your vote counts a little bit more in the decision-making process?

Shaun: I mean, to be honest, probably hers...It's her body, and...she ultimately would have the final say, 'Well, I'm not doing that,' which I would have to go back and rethink a few things. But, honestly, that really wasn't the case any part of the way, but if you want a...more definite answer, I would say Kelsey probably had the ultimate decision.

At first Shaun reported that he makes “the final decision.” After some reflection he retracted his answer, admitting that his wife had “the ultimate decision.” For men in this study like Jason and Shaun, it was difficult to admit that their wives had more power in decision-making.

In a separate interview with Shaun's wife, Kelsey, a junior vice president at a manufacturing company, I asked how decisions regarding plans for treatment were made. She replied without hesitation,

I'd say that the ultimate decision relies on me... Shaun is one that...wants to make sure that I'm comfortable with...what we're doing, and if I agree, then he kinda like listens to my judgment call...It's just kind of been that way.

Like Kelsey, other wives who were facing the option of IVF seemed well aware that they were in the control seat. When I asked twenty-eight-year-old Karen,

an administrative assistant, who had more say in decision-making, she replied candidly, "I'm more demanding. Probably I do." Thirty-one-year-old Rebecca, a chemist, explained that she and her husband had "equal say" until they reached the decision to pursue IVF. She related, "I think Kurt was willing to let me lead...For me, it was a bit hard, the whole process, physically."

The physical investment IVF requires of women gave women more power in decision-making. In one case, husband and wife, Carl and Rita, pursued three rounds of IVF. Carl explained that it was important for them to agree upon how many embryos to transfer for each round of IVF. However, it was up to Rita to decide how many IVF cycles to pursue. After three rounds, Rita decided to call it quits. Carl admitted that he "might go for a fourth attempt," but Rita's "vote weighed more heavily," because "it's her body." In a separate interview, Rita acknowledged that Carl "would respect my feelings if I felt like I was tired of the process."

Two men in this study deferred to their wives to lead the decision-making process from the beginning, because they believed their wives' careers better qualified them to make treatment decisions. In private interviews, these two wives corroborated that they indeed had more power in decision-making than their husbands. Abe and his wife, Katie, a pediatrician, mentioned earlier, opted for varicocele repair over IVF. Another subject, Donald, supported his wife's decision to pursue IUI first, because he believed that she, as a biochemist, could make a more informed decision than him, a radio announcer. In addition to Donald's unexplained low sperm count, his

wife Carol was diagnosed with polycystic ovarian syndrome (PCOS).<sup>115</sup> Dan acknowledged that Carol had more power in decision-making, but quipped with a laugh:

I think she probably made all of [the decisions], but she might have, like, made me feel like I was a part of the decisions. . . You know how women...make the husband's feel like they're a part of the decision-making process? They have that way of figuring it out.

This remark humorously captures the dance couples participate in to honor the hegemonic norms of masculinity and gendered power relations. Carol, the biochemist believes she is more knowledgeable and capable of making treatment decisions, but also understands that her husband should have at least an equal vote in the decision-making process. In order to protect his masculinity, she attempted to make him feel a part of the process.

Unlike Lorber and Bandlamudi's study, no women or men reported feeling pressured into treatments that they did not want to pursue. However, 'veto power' was exercised by some husbands and wives in decision-making. For example, two women expressed that they would have liked to have pursued IVF, but their husbands had moral objections to the procedure and so it was out of the question.<sup>116</sup> Leonard and Janet, mentioned earlier in this chapter, could not agree on what to do with leftover embryos if they were to pursue IVF. Thirty-eight-year-old Janet, a full-time homemaker, explained their predicament:

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<sup>115</sup> When the low sperm count is unexplained, there are few male-focused treatment options available. There are no surgical solutions. The only possible solution would be the less common hormone therapy, but since Carol also had infertility issues, IUI was the most promising option.

<sup>116</sup> Interestingly, there were no cases where men wanted to pursue IVF, and the wives had moral objections to it.

We kind of disagree, because I'm sure that there's a good possibility that there wouldn't be any embryos left, and [if there were] I would probably donate them to science, I'm guessing...I think that's an option, whereas he feels like it's alive, and he didn't feel comfortable...So that kinda marks IVF out of our decision-making.

Leonard and Janet chose to pursue hormone therapy for Leonard in lieu of IVF.

Another subject, Bruce, explained that he had more decision-making power than his wife, because he vetoed sperm donation. He described,

I, from the beginning, ruled out donor sperm and/or donor eggs. I'm not interested. Where Lacey, I thought, felt the same way. And then she let her mom talk to her one night, and have her decide that maybe she would be interested at some point in trying that. And that's not an option for me.

LW: Okay. What are some of your thoughts about sperm donation and egg donation?

Bruce: I think if you can handle it – I don't know what the right word would be. Not necessarily, 'emotionally,' but if you can get past and not be hung up on the fact that biologically one of you doesn't have a hand in it, then it's great...I have a friend who did this and they had used donor eggs...The children are almost two-years-old, and the wives still struggles very much every times someone says, "Oh, you know, she has your eyes, or--" It's a constant battle with them. She's constantly emotional over it...I don't know how I would react. I don't know how [Lacey] would react. And I just feel like we're a team. Either we're both in it or we adopt, and consider that 'both in it.'

Bruce, whose story is recounted in Chapter Three, knew that his wife had good fertility and he had a zero sperm count. Though he claimed to be against both donor sperm and eggs, only donor sperm would be necessary to help his wife conceive. He worried how he would "react" to a baby that was biologically his wife's and not his. Bruce's story also reveals how threatening Bruce perceived his mother-in-law's influence on the decision-making process.

Bruce had to assert his power (and masculinity) in his marriage to exclude his mother-in-law from treatment decisions and ensure that he was no less biologically related to his children than his wife. When I interviewed Bruce's wife, Lacey, separately, she did not express any interest in sperm donation, and believed that she and Bruce had a "pretty equal" say in decision-making.

In the case above of Leonard and Janet, Leonard's objections to IVF spared his wife the physical toll of treatments. In Brian and Lacey's case, however, Lacey underwent the more invasive IVF-ICSI procedure instead of the simpler donor sperm insemination to appease her husband. After two failed rounds of IVF, Brian conceded that "the decision to quit IVF would be [Lacey's]." As in several other cases previously, men and women agreed that wives could exercise veto power when it came to female-focused treatments.

### ***Sperm Donation***

In interviews patients were asked to describe their thoughts regarding sperm donation. The majority believed the question did not apply to them since they had some sperm in the ejaculate or found in the testicles. As demonstrated in the case of Bruce and Lacey, even though using donated sperm at home or in conjunction with IUI is a much simpler and less expensive solution to infertility, couples unanimously preferred the more invasive and expensive types of treatment that would make biological paternity possible.<sup>117</sup>

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<sup>117</sup> Prior to the innovation of IVF-ICSI in the mid-1990s couples with extremely low sperm counts or zero sperm regularly resorted to sperm donation to achieve pregnancy. The availability and preference for IVF-ICSI has driven down the demand for donor sperm. However, demand for donor sperm among single and lesbian women has increased significantly over the past two decades, and this demographic group now comprises more than half of the consumer base for sperm banks.

Most men and women in the study claimed they did not oppose the use of donor sperm in principle (as in, “It’s fine if other people do it”), but felt uncomfortable with its use for themselves. Men and women expressed discomfort with the thought of having a baby that was biologically the wife’s, but not the husband’s. Several patients and wives described adoption as a more equitable option, because the child would carry neither parent’s genes.

Sperm donation presents a major obstacle to masculinity. As sociologist Lisa Jean Moore (2002; 2007) posits, sperm represent the men who produce them: good sperm come from good men; bad sperm from bad men. To resort to donor sperm would be to acknowledge that the husband is not good enough to fulfill the role of biological fatherhood, or “uphold the patriarchal status quo through their biological contribution to the creation of a child” (Becker 2000:134). Laura, whose story is mentioned earlier in this chapter, explained that her husband, James, would have a tough time with sperm donation, or the thought of “raising another man’s child.” As a couple of doctors in this study explained, many of the processes for assisted reproductive technologies reduce the role of husbands to mere sperm donors. What role would be left for men if they could not even do that much?

Most couples in this study never discussed using donor sperm with their doctors or each other. Men with low sperm counts saw no reason for using donor sperm when IVF or IVF-ICSI was possible. Earlier I argued that many men strived to protect their wives from the dangers of IVF by undergoing male-focused treatments. However, men preferred that their wives undergo IVF or

IVF-ICSI using their own sperm before resorting to the less invasive treatments associated with donor sperm. In other words, men's desire for biological offspring trumps their desire to protect their wives. While sparing one's wife pain and discomfort is a chivalrous display of masculinity, fathering a child is, perhaps, a more greatly prized aspect of masculinity.

When Donald learned he had a low sperm count, he asked his wife, Carol, if she wanted to use donor sperm. Here he recaps their conversation:

Yeah, I tossed that idea to her and she said she didn't want to do that because she works with DNA at work and she, her biggest hobby is genealogy, and so she's like, "Oh, no, I want to make my own." I'm like, "Even with me?" And she's like, "Of course, with you." "But, you know, think about if you could have like Rick Springfield's kid or something like that?" She's like, "I love you." Oh my gosh. It's weird. I just can't get over that she loves me, because I'm just kind of goofy.

Donald's story captures some of the insecurities men feel about their poor fertility. He wondered if, given the option, his wife would prefer the genetics of another man over his. Carol's response reflects the social value of having biologically-related children, and the ways that wives seek to protect their husbands' masculinity. Ultimately, the love his wife expressed for him (and his DNA) allayed Donald's fears, and confirmed his masculinity.

In this study, there were two couples who eventually resorted to sperm donation. Marshall and Jordan, whose personal stories are discussed at length in Chapter Four, both underwent extensive diagnostic procedures to locate sperm in the testicles. After spending thousands of dollars and having no luck, the only remaining options included sperm donation, adoption, or

child-free living. Both of the husbands explained that not having children was not an option, and though they had no objections to adoption, sperm donation was the most appropriate solution because their wives desired the experience of pregnancy.

The first time I interviewed Marshall he understood that he had a zero sperm count, and he planned to undergo exploratory surgery to search for sperm. When I asked him what his thoughts were regarding sperm donation, he responded:

I kind of feel in the back of my mind that she wants to have the experience of...giving birth, of having a child and having that happen in her body...I think ideally we both would want it to be biologically both of ours. But next to that I think she would really want that experience of carrying a child and delivering a child and having it be inside her and I think she really wants that, you know. I think physically she pines for it so I think that's definitely on the table.

Early on, Marshall expressed that a child that with biological ties to both he and his wife was their first choice, but he saw the potential for sperm donation to satisfy his wife's desire to experience pregnancy.

By the second time I interviewed Marshall, he and his wife Nancy had spent their entire savings on various procedures to locate sperm in Marshall's testicles. When the procedures failed to find sperm, Marshall knew sperm donation was the only way to resolve his wife's "really strong biological desire" to be pregnant, "a chemical thing, telling her, driving her." Marshall claimed that watching his wife suffer, watching her "get to that level of depression," was worse than dealing with his own emotional suffering. Describing his wife's emotions, he explained,

Her emotions are...more extreme and desperate and more of an absolute kind of a life and death struggle. Me, it's me and the suffering, feeling inadequate and feeling kind of helpless."

While Marshall struggled with feelings of inadequacy, he sees Nancy's suffering as a "life and death struggle."

Nancy believes that she could love an adopted baby just as much as a biological one, but adoption seems like an expensive option with the potential to go wrong. At the time of our interview one of Nancy's friends who had adopted a baby was going through a custody battle with the baby's birth father. Nancy explained,

I've known other people who go through the adoption process and then something goes wrong in the end and they either lose the rights they thought they had, or they lose the child, or the child was taken away, and I just don't think that I could deal with that.

Not only did adoption seem like a difficult route toward parenthood, Nancy really wanted to experience pregnancy. She described her desire this way:

Just the feeling of having a life growing inside of you, I think is amazing and I want to go through that. I mean, as a woman, I want to experience that...my nurturing of a child inside of my body from my own blood and from my own nourishment, and giving birth and having this...connection...Like I created this being, and, you know, just sort of that connection. I feel like I see pregnant women, and I don't even mind like the big belly thing and stuff like that, and it's something I've always wanted.

Nancy's first choice was to have a baby with Michael's sperm and her egg, but when that did not work out, she had no qualms about using a sperm donor.

She explained, "I don't have a problem with the sperm donation,

because...you have a baby. It becomes yours no matter what. [Sperm donation] never really bothered me.”

Though the zero sperm count was the root of their problem, Marshall had to find a solution to Nancy’s suffering and her desire to be pregnant. Marshall and Nancy consulted with a sperm bank, selected a sperm donor, and attempted artificial inseminations. The couple planned to take a few months off, save up more money, and continue to pursue pregnancy using donor sperm.

Using donor sperm challenges the “natural order,” and the patriarchal imperative that men biologically father their own children (Becker 2000:65). Yet Marshall focused on fulfilling his wife’s desire for pregnancy and easing her emotional crisis as the most important displays of his masculinity. Donor sperm became the means to that end. Marshall negotiated the obstacle his zero sperm count presented by reconstructing the problem as his wife’s suffering, and reinterpreting donor sperm as a gift to his wife. More importantly, Marshall and Nancy had chosen not to tell most of their family and friends about Marshall’s diagnosis. By selecting a sperm donor with similar interests and physical characteristics as Marshall, they hoped to have a child that would appear to be genetically Marshall’s. Marshall’s masculinity would be preserved so long as they kept the sperm donation a secret.

Another patient, Jordan, was devastated to learn he had a zero sperm count, but had no qualms asking his identical twin brother to provide donor sperm. Jordan recalls,

I called him and told him I had a zero count, and pretty much asked him if he'd do me a favor, and he was like, "What kind of favor?" And I was like, "Would you possibly be able to donate for me?" And he was like, no question about it.

The willingness of Jordan's brother, Justin, to help out was a great display of brotherhood and masculinity, and preserved Jordan's own sense of masculinity. Regrettably, what sounded like a great plan turned out to be a disaster. Justin had to fly cross-country to the city where Jordan's wife, Karen, was undergoing IVF. While away from home, Justin's pregnant wife went into pre-term labor and lost her baby. A few weeks later, Jordan and Karen learned that the IVF had failed. When Jordan and Karen approached Justin a second time to provide another sperm donation, Justin and his wife "beat around the bush," claiming Justin could not get the time off work to travel. Karen surmised that Justin's wife was opposed to the thought of Justin fathering Karen's baby when they were experiencing trouble having a child of their own.

Jordan and Karen pursued a second round of IVF using an anonymous donor, which also failed. By the time I spoke with them in final interviews they had taken in a young foster child, and had put infertility treatments on the back burner. Karen had not completely abandoned the idea of getting pregnant with ART, but they needed time to bond with their new son, save money, and come up with a treatment plan.

Both Jordan and Marshall grieved their own infertility, and were torn by their wives' suffering. While other patients in the study would not consider

donor sperm as an option, or considered it a last resort, these patients saw sperm donation as a viable solution to infertility. The cases of Jordan and Marshall illustrate the power of individuals to emphasize different aspects of masculinity, thereby reconstructing new notions of masculinity. For these two husbands, fulfilling their wives' desires for pregnancy and easing their wives' suffering was the best way they could perform their roles as husbands, and demonstrate their masculinity.

While previous scholars of infertility have emphasized sperm donation as an emasculating experience for men, it is important to recognize that the sperm banking industry was created and designed to preserve masculinity. As I toured a brand new sperm bank facility it struck me how the entire concept of sperm donation is constructed around strong social norms about female chastity. Sperm banks are complex enterprises that require a staff of biologists who are responsible for the procurement and proper freezing of human biological materials. Medical doctors serve on the board of directors. Sales agents and marketers recruit donors and recipients. Counselors help clients deal with the psychological aspects of infertility, and help match them to donors. The technologies are impressive: large refrigeration rooms filled with thousands of tiny vials of sperm, catalogued by race, ethnicity, and nationality; huge gas tanks on hand for the cryogenic process; elaborate computer databases for tracking donors and matching them with recipients; and a complex system for packaging and shipping sperm around the world. I realize that today single and lesbian women use sperm donation services. Yet,

originally, all of these technologies were created so that a heterosexual woman could get the sperm of a fertile man into her body without having to engage in sexual intercourse with a man other than her husband.

One male infertility specialist I interviewed divulged that in his profession it is not uncommon to “have to dance around the infidelity thing.” He recounted the story of a male patient who had a zero sperm count, yet his wife became spontaneously pregnant, which the doctor suspected was due to infidelity. The doctor explained, “[The patient] was a pilot so he was gone days a time. But he looked at it as a miracle, and I didn’t discourage that outlook.” In another case a male patient came in because he and his wife were having trouble conceiving a fourth child. The patient was diagnosed with congenital bilateral absence of the vas deferens (CBAVD). There was no way his first three children were biologically his. The doctor recounted, “I think he figured that one out. He didn’t come back for any follow-up...He didn’t want to have anything to do with [his wife] anymore.”

Though there is no data to prove it, it is highly possible that women in various societies throughout history have resorted to extramarital affairs as a solution to the problem of male infertility. Sperm donation, I would argue, is about preventing infidelity among women. Extramarital sex is physically and logistically a much simpler process than using donor sperm and arguably more effective. However, extramarital sex is a major violation of social norms and the marital contract, to the extent that it is never discussed as an option for

overcoming male infertility. Infidelity is particularly stigmatizing for “cheating” wives, and emasculating for the men who have been “cheated on.”

Recall from Chapter Three the men in this study who worried their wives regretted having married them or wondered if their wives wished they had married a more fertile man instead. (Wives in this study did not have any such regrets, and certainly never expressed interest in extramarital sex to achieve conception. Fidelity in marriage is a strong social norm.) The creation of sperm banking and the myriad technologies it entails circumvents the moral question of extramarital sex, and legitimizes the use of another man’s genetic material for conception. I would argue that all cultural practices intended to preserve female chastity, from chastity belts to clitoridectomy, are invented by men and are, at their root, about restraining threats to masculinity. Sperm donation is yet another technology invented by men for men, for the sake of preserving female fidelity and the masculinity of husbands. For couples dealing with male factor infertility, like Jordan and Karen and Marshall and Nancy, a biological child using the husband’s sperm is the first choice. When that fails, donor sperm is the lesser of two evils.

### ***Conclusion***

Men’s preference for and willingness to take part in male treatments simultaneously reflects men’s privileged relationship with technology, as well as a new commitment to share reproductive responsibility with women. Many men see pursuing male-focused treatments as part of their patriarchal duty to protect their wives from the risks of female-focused treatments. At the same

time, however, the stories shared in this chapter reveal the influential role wives play in decision-making. By participating in treatments, men acknowledge their important, and heretofore invisible, role in reproduction.

This study of male infertility tells a very particular cultural story about masculinity and the value of a biological child, the value of spontaneous conception, and men's relationship with technology. More often than not, infertile men perceive themselves as fertile so long as medical technologies are available to help them achieve pregnancy with their wives. In other words, the promises of technologies are enveloped into their own self definitions as 'fertile.' While epidemiological studies point out that men are statistically less likely than women to use medical services and make healthy lifestyle choices, this study shows that when men fall short of physiological ideals of masculinity, they willingly take part in medical therapies.

Narratives of masculinity play out as men engage with medical technologies. When couples are given a choice between pursuing a male or female treatment, men and women prefer to try the male treatment first. Male treatments are perceived as allowing conception to occur naturally, because men can impregnate their wives through sexual intercourse. Men and women in this study presumed men were less vulnerable to the risks of medical intervention. Nonetheless, when male treatments unexpectedly caused extreme suffering, men wore their pain like a badge of honor. Female-focused treatments, like IUI and IVF, were routinely pursued when male treatments

were not an option or when they failed and were considered a normal step toward parenthood.

As I have suggested elsewhere in this dissertation, renegotiating masculinity is not optional. Men are constantly forced to navigate the challenges to their masculinity. Constructing narratives about the value of taking on male treatments, about enduring pain, and about fulfilling a wife's dream to experience pregnancy, are the ways that men in this study renegotiate their masculinity. Constructing technology as a means for harnessing power is a key strategy for navigating the treatment process. As the infertile men in this study come to understand their relationship with medical technologies, they construct new masculine norms, demonstrating that the processes for constructing gender and disease are inextricably intertwined.

Chapter Six:  
CONCLUSION

Chapter Outline:

***Introduction***

***The Inescapable Power of Gender Norms***

***Medical Technologies: Interrupting a Crisis of Masculinity***

***Contributions in Research Design***

***Future Research Questions***

This research study was grounded in three well established sociological axioms: first, gender is a system and an organizing principle for societies (Ridgeway and Correll 2004; West and Zimmerman 2002); secondly, men have historically enjoyed a privileged social and economic status above women (de Beauvoir 1951; Friedan 1963; Ridgeway and Correll 2004; West and Zimmerman 2002); and thirdly, masculinity is defined in terms of having, maintaining, exercising and displaying power (Connell 1995; Kaufman 1994; Kimmel 1994; Kimmel 2006). This research study was designed to examine what happens when there is an assault on masculinity. What happens when a basis of male power is destabilized, when men cannot live up to socially defined roles?

In this study male infertility served as the empirical case for examining what happens when male performance falls short of social expectations. When couples are not able to achieve pregnancy, medical institutions and authorities are quick to respond. Due to prevailing gender beliefs, women have historically been held responsible for all aspects of reproduction, including infertility. Anecdotal evidence suggests that male infertility often goes undiscovered or is discounted as the real cause of a couple's inability to get pregnant. As a result, women have borne the brunt of social stigma and medical interventions for their husband's poor fertility. The oversight of men in medical contexts illustrates that, first of all, social ideas regarding women and reproduction have shaped the development of medical disciplines; and,

secondly, medical institutions are engaged in efforts to preserve men's sense of masculinity.

In more recent decades medical practices have developed to treat infertile men, but they, too, have been designed to protect and preserve men's sense of masculinity. The major contribution of this male infertility study is that it has revealed the tight relationship between gender and medicine, showing that medical practices must accommodate preconceived notions about gender. Gender informs – and sometimes trumps -- scientific reason. The rhetoric and practices of male infertility specialists, as well as the ways that patients conceptualize their infertility, reaffirm that hegemonic masculine norms are universally understood and accepted (Ridgeway and Correll 2004). They are surprisingly durable and enduring.

This study injected the existing new reproductive technologies (NRT) literature with a fresh perspective: an understanding of how men experience infertility. Integrated within this story are two major contributions to the study of masculinity. First, this study demonstrates the ubiquity of hegemonic gender beliefs, the double bind of masculinity, and the fact that 'doing gender' is not an optional endeavor. It also demonstrates the power of technologies to alleviate the emotional anguish associated with a crisis of masculinity, and also to provide individuals with a means to fix their broken masculinity.

### ***The Inescapable Power of Hegemonic Gender Norms***

According to Ridgeway and Correll's gender system, hegemonic gender beliefs are so ubiquitous that everyone in a given society knows what they are

(Ridgeway and Correll 2004). Regardless of whether or not we agree with stereotypes of masculinity or femininity, gender beliefs serve as the “rules of the gender game” (2004:513). As men and women engage in the work of ‘doing gender,’ they must make choices in light of the rules of gender. Men and women do not have to subscribe to widespread gender beliefs, but they do not have the luxury of ignoring them altogether. Men and women must acknowledge how their choices and actions measure up, compare with and relate to the already well established gender norms.

In regard to male fertility status, the prevailing gender belief is that fertility is symbolic of virility and masculinity. A heterosexual man should be able to impregnate his wife. In Chapter Three I described the many cultural contexts, from children’s literature to world politics, which illustrate and perpetuate this gender belief. The doctors in this study reiterated this gender belief in interviews and designed medical practices in light of this gender belief.

In October 2007 I attended the annual meetings of the Mental Health Professionals Group of the American Society for Reproductive Medicine. The theme for the meetings that year was male infertility.<sup>118</sup> During a mid-day luncheon I met several mental health experts, including social workers and psychologists: all women, and all specialists in infertility. I introduced myself to my table as a sociology graduate student, and explained my research study on male infertility. The group was immediately abuzz with comments about how

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<sup>118</sup> Of the approximately 150 mental health experts present, there were fewer than ten men. The two therapists invited to speak at the conference were both men.

traumatizing infertility must be for men. They admitted that they rarely saw male patients, but this fact only fueled their ideas about infertile men's suffering. In their view, men are so humiliated by their infertility, they are not even willing to talk to a therapist about it.

“What are you finding?” the whole table wanted to know.

I acknowledged that infertility was certainly very devastating for some of the subjects. However, I explained, most men in the study did not actually identify as infertile, nor did many describe their experiences as humiliating, devastating or emasculating.

“Obviously, they are in deep denial,” clucked the woman seated next to me, a private practitioner from Manhattan trained in psychoanalysis. The others nodded in agreement.

Conversations like this one – with psychoanalysts, physicians, colleagues, family, friends and acquaintances – have come up countless times during the course of this research project. In fact, before most people ask about the findings of my study, they tell me that infertility is humiliating for men.<sup>119</sup> These conversations demonstrate the ubiquity of hegemonic gender norms within contemporary American society, and confirm the perceived cultural value of male fertility. They have also raised a very important issue for me to consider: Are men who claim not to be infertile, or not to be devastated

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<sup>119</sup> My husband, an R&D engineer, was once asked by a male colleague about my dissertation. He explained that it was a sociological study of male infertility. The colleague responded, “That must be awful for those guys. Being able to have children is like the whole basis of being a man.”

by their infertility, lying to themselves and me? Or, is it possible for infertility not to impact masculinity?

These questions illustrate the double bind of masculinity. If men admit that they are anguished by their poor fertility status, their masculinity suffers. If they deny that poor fertility is affecting them, then we presume their masculinity *really* suffers. I recognize the tension here, which makes it challenging to interpret men's words. However, the double bind of masculinity illustrates one very important point regarding how masculinity is different and unique compared to other aspects of identity. Masculinity is not defined by a list of interests, habits, activities or hobbies. Masculinity is defined as having, maintaining, wanting, embodying, exercising, and displaying power. To relinquish culturally valued symbols of power, like potent fertility, is to give up masculinity, and that is not optional.

As a caveat to the gender system model, Ridgeway and Correll recognize an important point made by many gender scholars: some social groups, e.g. racial or ethnic groups, create alternate "nonhegemonic gender beliefs," which they collectively understand counter the more predominant hegemonic gender beliefs (Connell 1995; Fenstermaker and West 2002; Ridgeway and Correll 2004:520). Because nonhegemonic gender beliefs are shared within a social group, the members of that group have alternate ways to demonstrate their masculinity and femininity, and are liberated from the social pressure to meet hegemonic gender norms.

The men in this study found themselves caught in a tight and lonely spot. They understood well that their poor fertility status symbolized a deficiency in masculinity. Yet, infertile men do not constitute or recognize themselves as a social group. None of the men in this study attempted to organize themselves or create nonhegemonic gender beliefs that would provide new pathways for demonstrating masculinity. Instead, some men emphasized their other recognizable masculine qualities, e.g. privileged class status, leadership skills or ability to be a good husband and father, and many of them used whatever resources they had, i.e. economic means and medical technologies, to shore up their masculinity. In other words, hegemonic gender beliefs served as the guiding principles for men as they constructed their own ideas about fertility and made decisions regarding infertility.

This study echoes the findings of previous research studies of erectile dysfunction. Infertile men, like men with less than ideal erections, are not fighting to reconstruct a new kind of masculinity that does not require perfect fertility and perfect erections. Rather, we are seeing a growing acceptance among men to utilize medical interventions to fix broken masculinity (Loe 2004). Are we witnessing a men's health movement? Attempts by medical experts to launch a men's health movement to raise health awareness among men<sup>120</sup> have quietly fizzled.<sup>121</sup> In the cases of erectile dysfunction and

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<sup>120</sup> See Courtenay, Will H. 2000b. "Teaming Up for the New Men's Health Movement." *The Journal of Men's Health* 8:387-392. This article was adapted from Courtenay's opening address at the Men's Health and Fitness Conference and Exposition, sponsored by the Philadelphia Department of Public Health in June of 1999. Courtenay called for a men's

infertility, men are not turning to medicine in a collective or organized way. Nor is the move toward medicine attempting to articulate an important social or political statement. Men are taking advantage of medical solutions because they understand the health imperatives laden in hegemonic gender norms. They are simply attempting to repair their fractured masculinity (Inhorn 2009; Loe 2004).

The stories recounted throughout this dissertation have shown that 'doing gender' is not an optional endeavor. It is mandatory. The men in this study were aware of the prevailing gender belief that weak fertility reflects weak masculinity. Their diagnoses pushed them to explain and rationalize how their particular, personal masculine identity would remain intact despite their poor fertility. The men in this study reported feelings of sadness, inadequacy or feeling like "less of a man." But no men in this study concluded, "I am not a man." Instead, they engaged in the work of renegotiating masculinity. Some of the men redefined their masculinity in terms of their age, social class, or athletic abilities. Many emphasized their identities as good husbands and potentially good fathers. Most willingly took on medical

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health movement comparable to the Boston Women's Health Collective of the 1970s, which still has yet to be seen.

<sup>121</sup> Over the past few decades the AIDS movement has raised awareness of AIDS and promoted research for a cure. The AIDS movement has involved a variety of social groups, including perhaps most prominently, gay men, but was not exclusive to men. I would argue that the AIDS movement, which was originally helpfully linked to the gay movement, did not launch a broader men's health movement.

treatments, despite pain, discomfort or potential risks. While doctors saw the cup half empty, patients optimistically emphasized the cup as half full.

Other scholars have perceptively noted that masculinity is characterized by feelings of powerlessness and inadequacy, because it is defined as a constant quest for what is unattainable – all power, control and perfection (Kaufman 1994; Kimmel 1994; Kimmel and Messner 2007). Proving one's masculinity is a constant, relentless and mandatory endeavor. I return now to my earlier question, is it possible for infertility not to impact masculinity? It is possible for infertile men to avoid extreme emotional suffering. It is possible for infertility not to negatively impact men's marriages, their work, and their sense of value as a person. But this is only possible because infertile men are constantly engaged in gender work, acknowledging the rules of the gender game, and relying on what resources they have available to them.

### ***Medical Technologies: Interrupting a Crisis of Masculinity***

In their 2004 study of IVF patients, Throsby and Gill assert that most attempts at assisted reproductive technologies are pursued in an emotional climate of grief, anger, guilt, envy, profound loss, and depression amid a major life crisis (2004:336). This depiction does not accurately capture the experiences of the infertile men in this study. While some of the men in this study had been searching out a male infertility specialist or a second opinion for some time, once they reached a male infertility specialist they were quickly ushered into medical treatments. Some men were undergoing surgeries within a few short weeks of diagnosis; other couples were beginning IVF work-

ups, including hormone injections for wives, just as quickly. Arguably, the level of emotional distress couples experienced was correlated with how long they had to wait to receive treatments and see results, like improved sperm counts or pregnancy. Because couples generally did not wait to see if they might still get pregnant without medical treatments, and began treatment protocols within a few short weeks of their initial diagnostic appointment, there was not time for most couples to sink to extreme levels of depression.

As other scholars have noted, the journey of infertility often entails profound feelings of grief and loss (Becker 2000:32,41-43; Greil 1991; Inhorn 1996; Mazor 1985:32; Webb and Daniluk 1999:8,12). Patients feel a loss of normalcy, loss of a gendered identity, and grieve the absence of the baby intended to be part of their lives and family. Forty years ago Elizabeth Kübler-Ross introduced a model for understanding the grieving process, which included five stages of grief: denial, anger, bargaining, depression and acceptance (Kübler-Ross 1969). Kübler-Ross's work has been tweaked and critiqued by various scholars, but by and large, her model has transformed practices for clinical psychologists, and is widely accepted by scholars and clinicians as the definitive model for understanding how individuals experience loss.

If the refusal of men in this study to define themselves as "infertile" qualifies as a classic case of "deep denial," I would argue that it is the hope offered by doctors and the promises of medical technologies that allows men to redefine their medical condition and suspends them in this first stage of the

grieving process. In 1999 the infertile men in Webb and Daniluk's study admitted that they had experienced a period of denial immediately following their diagnosis (1999:21). The subjects in the study were interviewed several years after their initial diagnosis, and had few treatment options available to them at the time they were diagnosed. In this millennium, however, many infertile male patients experience a quick and seamless move from diagnostic consultations to therapeutic treatments, which delays the subsequent stages of grief. If treatments work, and couples become pregnant, the grieving process ceases altogether. For others whose treatments did not help them conceive, sunk to extreme levels of depression over time.

Recall from Chapter Four, Max, a subject who said he "almost" reached a point where he thought he might be an inadequate husband and father. Once his wife became pregnant he was able to put infertility and all of the anxiety it generated behind him. When the void in their family was filled with the anticipation of a new baby, the grieving process ended for Max and he looked forward to fatherhood. Contrast Max's experience with the journeys of Josh and Marshall, discussed in Chapters Four and Five. By our final interviews Josh and Marshall had endured the most medical treatments, still had no sperm, and were the most distraught men in this study. They were certainly not in denial, and openly shared their feelings of inadequacy, anger and sadness. In most cases patients were inundated with medical information and decisions before they had time to consider all of the social implications of their infertility. It was only when treatments failed to work for couples that

infertile men moved on to other stages of grief, and became angry and depressed.

Kübler-Ross's model of grief is used to explain how people deal with death. The loss of a loved one is a permanent, unchangeable life condition. However, the promises of new medical treatments, like *in vitro* fertilization combined with intracytoplasmic sperm injection using surgically extracted testicular sperm, remind patients that the inability to achieve pregnancy is most likely a temporary condition. Very few patients in this study ever had to consider how sperm donation, adoption or unrealized parenthood would impact their lives. Utilizing medical technologies alleviated despair, and was perceived as a natural and normal step toward parenthood. Infertility treatments serve as physical solutions to patients' emotional and social problems.

As recounted in Chapter One, the term "infertility" did not exist before the highly technologized medicalization of sterility became common practice in the early 1980s (Sandelowski and de Lacey 2002). Prior to the advent of *in vitro* fertilization, couples who could not have children experienced "childlessness" and "sterility." The term 'infertility' came into use to define the medical journey couples traversed to achieve pregnancy. This study shows, however, that in the case of male infertility, many patients describe 'infertility' as a permanent condition one does not settle into until all medical treatments fail. The irony here is that rather than defining their medical journeys as 'infertility' experiences, most patients in this study believed the medical journey

moved them away from and allowed them to stave off the label (and associating stigma) of infertility.

### ***Contributions in Research Design***

Compared with many studies of infertility the research design of this study was significantly unique in two ways. First, this study included ethnographic observations in clinical settings, which allowed me to examine how notions of gender and disease are constructed in the interactions between individuals and institutions. Secondly, this study did not recruit “infertile men” through support groups and counselors, but expanded the research sample to include men dealing with infertility who do not self identify as infertile.

According to Ridgeway and Correll, the three pillars of the gender system, culture, institutions and individuals, all perpetuate notions of gender. This study has captured the power of institutions in perpetuating popular gender beliefs. The authors argue that pervasive cultural ideas about gender shape and color all institutional practices. Because gender ideas are built into institutional structures, they are very resilient. As institutions and individuals interact, ideas about gender are perpetuated.

Male infertility clinics perpetuated beliefs about male sexuality and male reproduction. As the case of semen collection shows, clinical practices expect men to be effective sexual performers, and are unsympathetic and unforgiving to men who cannot live up to the masculine “hot man” ideal. On the other hand, when it comes to reproduction, doctors presume infertility is devastating

for men and are very sensitive to the fragility of masculine identities. They “empower” men by telling them they are not at fault for their poor fertility and cautiously avoid using words like “infertile” with patients. One doctor described men like “wild animals,” another believed men enjoy hearing they have “big balls,” and others posited that men like having medical conditions explained to them through mechanical metaphors and sports analogies. Wives, as viewed by some doctors, are a necessary evil. They are impatient, overbearing, controlling, and scientifically unknowledgeable, but they hold the information necessary for planning treatments.

The clinical encounters observed for this study provide very specific examples of how the gender system works, the ways that institutions teach men and women how to be men and women. For example, men are instructed to produce a semen sample on cue. Women are instructed not to ask too many questions during appointments. Clinical observations highlight the power of institutions to legitimize gender stereotypes and the durability of those stereotypes. However, the data collected in interviews illustrate another important aspect of the gender system, namely, the power of individuals to revise gender norms and the fluidity and flexibility of gender definitions. Patients described infertility as only one aspect of their life experience that could not define them as a person. They reaffirmed their masculine identities by emphasizing how masculinity changes over the life course or by class status.

In Chapter Four I described how this study's recruiting methods not only created a unique research sample, but led to compelling discoveries regarding men and masculinity. While other infertility studies have struggled to recruit "infertile men," this study quickly collected a research sample of men who were simply seeing an infertility specialist. In other words, they did not have to self identify as infertile. What emerged from this pool of research subjects were stories of men who downplayed, reconstructed or outright denied their poor fertility status. This study provides evidence that disease is indeed socially constructed, and researchers cannot assume that their categories of study are set and fixed. The research methods employed for this study should serve as an example to future studies of disease and gender. As researchers, we must broaden the scope of our inquiry, acknowledging that individual actors create their own identities and categories for explaining their social world.

### ***Future Research Questions***

This study broadens the scope of new reproductive technologies (NRT) studies to include men. This large and groundbreaking project has shown that there is room for medical technologies in men's reproductive lives. Medical technologies play an important role in repairing fractured masculine identities, and allow husbands to bear some of the responsibility of reproduction among heterosexual couples.

This study has demonstrated that reproductive technologies studies provide an invaluable space for studying constructions of masculinity. The

research sample for this study was primarily white, raising questions about how men of other races in America experience infertility. There were also challenges in this study to creating comparisons across socio-economic classes, which would have shed light on the differential ways that men across classes negotiate masculinity. In this sample, one Catholic couple and one Jewish couple had particularly unique journeys, which were guided by religious leaders, the guidelines of their faiths, and, as they described, the ways that God was directing their lives. I would recommend future research projects that examine more closely infertile men's experiences by race, class, and religion.

Missing from this study are men who learn from their PCP or an OBGYN that they are infertile, but never see a male infertility specialist. Some infertile men never see a specialist because they are not referred to one or they do not know where to find one. Other infertile men cannot afford (or assume they cannot afford) specialized medical treatment or feel uncomfortable seeing a doctor. More than likely, infertile men who never see a specialist experience the greatest emotional distress and suffering. It would likely be very difficult to recruit men in these situations for research, but I think their voices would be particularly beneficial in understanding the threat infertility presents to masculinity. Over the next few years it will be interesting to see how healthcare reform addresses the medical needs of infertile couples. Will male infertility treatments be covered? More or less so than female infertility treatments? Will men who have previously been diagnosed

as infertile begin to seek treatment? These questions can all help to guide future studies of men and infertility.

Contrary to previous studies of infertility, the willingness of the men in this study to engage with medical technologies indicates increased cognizance among men regarding their health issues. This study opens new doors for examining all aspects of men's health, including obesity, diabetes, heart disease, cancer, etc. Sociological studies that investigate how men deal with a range of health problems can provide more insight into men's relationship with technologies, the interaction between men and medical institutions, and personal constructions of masculinity. Such studies may also provide helpful information for the prevention of disease among the U.S. male population.

Throughout this dissertation I have argued that popular gender beliefs have shaped the development of medical science and practices in the treatment of infertile couples. I have shown that male infertility medicine is a relatively young discipline and less organized than female infertility medicine due to preconceived notions about women's responsibility for reproduction. I have argued that infertility medical practices are designed to honor men's powerful and privileged status, while still cautiously accommodating the fragility of masculine identities. I have demonstrated that infertility is emasculating for men, and infertile men strive to reconceptualize their fertility status in terms that are less threatening to their masculinity. I have shown that medical technologies are embraced by men as they restore fractured masculine identities, but more importantly, that their usage is built into

patients' new conceptions of what it means to be a man. As each of these points illustrates, notions of gender and disease are constructed by both medical practitioners and their patients, and reinforced through their interaction. Finally, the ways that gender and disease are constructed are tightly and intricately interwoven into individuals' identities.

## APPENDIX I: Interview Guide for Patient Interviews

### General Information

1. Name:
2. Age:
3. Highest level of Education:
4. Occupation:
5. Marital status:
6. Are you currently living with your spouse/partner?
7. Do you have any children together?
8. Do either you or your spouse/partner have any other children, not from this relationship?
9. How long have you been married/living together?

### The Medical Encounter: Diagnostic Process and Treatments

10. How long had you been trying to get pregnant—not practicing birth control—before you sought medical intervention?
11. Did you or your spouse/partner initiate contact with the doctor regarding your inability to get pregnant?
12. Why did you choose to seek medical intervention?
13. What is the diagnosis/cause of your infertility?
14. What steps (tests, procedures, examinations, technologies) were taken to determine your diagnosis?
15. What medical professionals did you meet with before you had a diagnosis?
16. Has your diagnosis ever changed?
17. Do you trust this diagnosis?
18. Do you trust the medical doctors and staff you have met with?
19. What type of doctor is best qualified to treat infertility? Male infertility?
20. Who is the most competent doctor you've seen so far, and why?
21. Who was the least competent doctor you've seen, and why?
22. What treatments have you pursued so far?
23. How much have you spent on infertility treatments? What percent of the total has been covered by health insurance?
24. How much do you anticipate infertility treatments will cost you?
25. Have any of the treatments been physically painful or uncomfortable?
26. Have you ever set limits regarding the amount of time or finances you will invest in infertility treatment before seriously considering other alternatives?
27. Have you ever considered other alternatives because of physical exhaustion or pain due to treatments?
28. How influential is your doctor in helping you decide what will be the next step in the treatment process?
29. Have you ever questioned your doctor's advice?
30. Looking back on the treatments you've been through so far, would you do anything differently if you had it to do over again?

### The Collective Experience: Decision Making and the Emotional Aspect

31. What role did your spouse/partner have in your decision to seek help from a physician?
32. Did you or your spouse/partner locate infertility specialists?
33. Who schedules appointments?
34. Who makes decisions regarding plans for treatment? Is each partner's "vote" equal in decision making?
35. In your view, whose problem is this (man, woman, couples)?
36. Who is responsible for getting this treated?
37. Explain why you would like to have a biological child.
38. Have you considered sperm donation or adoption as possibilities for parenthood? Which would you consider first—a sperm donor or adoption? Why?
39. What are your thoughts or concerns about sperm donation?
40. What are your thoughts or concerns about adoption?
41. Some patients report feeling depressed and devastated by infertility. Others go through the grieving process, which includes feelings of shock, denial, anger, guilt, and fear. Could you please describe the emotions that have accompanied infertility?
42. Could you please describe the emotions experiences by your spouse/partner?
43. Has your spouse/partner experienced grief?
44. Do you think infertility presents a greater emotional struggle for men or women?
45. Have you had to take care of your spouse/partner's emotional well-being? How?
46. Has your spouse/partner taken care of you? In what ways?
47. What impact has infertility had on your marriage/relationship?
48. Have you seen counselors or therapists to talk about the emotional, financial, physical issues that have accompanied infertility? Has that been helpful?
49. Have you attended a support group? Is the support group for men, women or couples? Does it provide emotional support? Is it a place for gaining scientific knowledge about infertility?
50. Do you spend time researching the scientific aspects of infertility? Less or more than your spouse/partner?
51. How open have you been about your diagnosis with friends, family and acquaintances? Do you share your experiences regarding the diagnosis and treatments with others? With whom?
52. Do you ever try to hide what your infertility experiences from others? From whom?
53. Has infertility affected your relationships with others? How? With whom, i.e. men, women, co-workers, friends, relatives?
54. How do you think others perceive your experience/diagnosis?
55. (For infertility not due to ED...) Which do you think would be a greater psychological or emotional struggle—dealing with infertility or erectile dysfunction? Why?

### Lifestyle, Health, Sex, Fatherhood: A Look at Masculinity and Femininity

56. How has seeking medical treatment changed your lifestyle or routine? For example, do you have to take time off work for appointments or treatment? Have you had to sacrifice vacation or leisure time for treatment?

57. Have you had to change your personal habits, i.e. eating, exercise, working, sleeping, drinking, smoking?
58. Has the knowledge that you are infertile affected your sense of sexuality or sex life? Do you see yourself as a sexy and sexual person? Has your sexual self-perception changed since your diagnosis?
59. How have infertility treatments, i.e. medication, surgery, examinations, affected your sex life? How have treatments affected your sense of sexuality?
60. How do you think your spouse/partner would answer questions 45-48?
61. Have you ever had a medical condition or diagnosis in the past that has required as much or more attention than infertility? If so, how does your past experience compare or contrast with this one?
62. Have the financial demands of infertility treatment put a strain on your household finances?
63. Have you or your partner assumed most of the financial responsibility for treatment?
64. Have you always envisioned that you would someday become a father/mother? If not, when did you first realize that you wanted to become a father/mother someday?
65. How long has your spouse/partner wanted to be a father/mother?
66. How would you feel about your life if you didn't become a father/mother?
67. Has infertility ever caused you to question your ability to be a good father/mother?
68. Has infertility ever caused you to question yourself as a good husband/wife?
69. Have you ever felt that infertility reflects something about you? Does infertility ever seem to represent a personal failure?
70. How might your spouse/partner answer questions 53-58?

#### Masculinity

71. Do you think society has a standard view or consensus about how men should think and act?
72. Do you think society has a standard view or definition of masculinity?
73. Can you define or describe masculinity? What attributes would you ascribe to a masculine person?
74. Do you believe infertility has affected your (or your spouse/partner's) masculinity or sense of "manliness"? If so, how?
75. (For women...) Do you ever take steps to protect your husband/partner's masculinity? How?

#### Closing Questions

76. Are there any questions you wish I would have asked you?
77. Are there any other thoughts you would like to share regarding your experiences?
78. Were there questions that you chose not to answer or restrained from sharing some information, but would be willing to answer completely on an anonymous written survey?
79. May I contact you in the future to get an update on your fertility treatment?

## Appendix II

**Table 1.** List of the twenty-four male subjects in this study, including their ages, professions, diagnoses, and race. All names have been changed.

NAME	AGE	PROFESSION	DIAGNOSIS	RACE	WIFE	AGE	RACE
<b>Clinic 1</b>							
Sam	38	"House-husband"	Spinal cord injury	White	Miriam	28	White
Kurt	31	Scientist	Oligospermic	White	Rebecca	31	White
Mark	42	Teacher	Azo/blockage	White	Eden	30	White
Andrew	39	Sales	Diabetes	White	Sue	36	White
Robert	31	Tech Developer	Varicocele	White	Jane	32	White
Luke	23	Airforce	Oligospermic	White	Regina	26	White
Abe	31	Real Estate Planner	Varicocele	White	Katie	31	White
<b>Clinic 2</b>							
Bruce	28	Pilot	Azo/CAVD	White	Lacey	27	White
Lenard	38	Police force	Pituitary tumor	White	Janet	38	White
Tim	37	Tech Support	Varicocele	White	Allison	35	White
James	29	Sales	Varicocele	White	Laura	34	White
<b>Clinic 3</b>							
Craig	33	Police force	Varicocele	White	Jill	30	White
Donald	37	Radio Director	Oligospermic	White	Carol	39	White
Jason	38	Engineer	Oligospermic	White	Louise	32	Asian
Shawn	35	Sales	Severed vas deferens	White	Kelsey	33	White
Carl	40	Finance	Cystic fibrosis	White	Rita	39	White
Dennis	39	Teacher	Oligospermic	White	Kathleen	32	White
<b>Clinic 4</b>							
Dale	29	Student	Azoospermic	White	Alice	29	White
Jacob	26	Student	Anejaculatory	White	Clara	21	White
Max	38	Carpenter	Varicocele	White	Heather	37	White
<b>Clinic 5</b>							
Jordan	29	Electrician	Traumatic injury	White	Karen	28	White
Martin	38	Musician	Azoospermic	White	Nancy	28	White
Marshall	36	City Clerk	Azo/Chemotherapy	Hispanic	Jasmine	25	White
Spencer	42	Engineer	Varicocele	White	Margaret	39	Asian

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