

Preconceived Notions

Surely I was lost. When I arrived at a multistory building with a large sign that read, “Women’s Health Center,” I was certain I had come to the wrong place. I double-checked the address in my notebook, scratched my head, and wandered inside. “I’m looking for Dr. Bradley, the male infertility specialist,” I repeated to several passersby. Someone suggested the third floor, where I came upon a receptionist who directed me to the seventh floor. I stepped off the elevator there and into a hallway lined with locked doors. I explained my plight to a man rushing by in a white coat. He keyed in a pass code, opened a door, and sent me inside. A nurse said that she was expecting me, handed me a set of hospital-issue scrubs, led me to a dressing room, and directed me to change. I deferentially obeyed. This was my first day of fieldwork.

Dr. Bradley soon arrived, accompanied by a younger doctor, a fellow in training. The three of us introduced ourselves and chatted briefly. Decked out in scrubs, a hairnet, and a face mask, I followed the two men into an outpatient surgery room. On the operating table I saw the silhouette of a human form covered from head to toe in blue surgical tissue paper. In the center of the room, equidistant from all four walls, a circular hole cut in that tissue paper exposed the patient’s genitals. The scrotum, painted with yellow iodine, fluoresced under the lights. The penis lay flaccid. With no prior medical experience

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under my belt, I first learned here about scalpels and cauterization, varicoceles and hydroceles, and one of the best kept secrets in America: the prospect of restoring male fertility and repairing masculinity.

This book puts the world of male infertility under the microscope, magnifying the textures and contours, traffic and beats, colors and details of a dimension of our society that is often invisible and disregarded. To paint a full picture of this world, I provide two levels of analysis: institutional and individual. On the first level, I investigate the rugged history and development of male infertility science and medicine and explore the present-day institutions, institutional authorities, and practices that have been designed to address male infertility. On the second, I examine how infertile men see their lives, their futures, and themselves in a society that prizes male fertility and virility. Together, these institutional and individual perspectives tell a sociological story about all of the ways in which preconceived notions regarding men, women, masculinity, femininity, fatherhood, motherhood, and reproduction shape our understanding of male infertility today. Throughout this book I argue that the social process of constructing gender is tightly intertwined with the social process of constructing disease. The purpose of this book is to examine how culturally pervasive notions of gender shape our understanding of disease and how, in turn, disease impacts our personal ideas about gender. Male infertility provides a helpful case study for exploring the relationship between disease and gender.

A Sociological Approach

In modern American culture, *gender* is often considered a hard-wired, essential, and fixed part of our personal identities, and *medicine* is believed to be hard science, evidence-based, objective, and true. Sociologists, however, do not define gender or medicine in such rigid terms. Instead, we see gender as a *social category*: It is how we choose to express our sex assignment. Gender entails a set of social norms and culturally specific prescriptions about how men and women should look, act, perceive themselves, and engage with their social world. Gender is best described as an ideology, flexible and fluid, with the capacity to change over time and across space. Sociologists see medicine as another socially constructed category. The science of modern biomedicine is influenced by many social actors, including medical

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professionals and laboratory scientists; pharmaceutical corporations and health insurance providers; political groups, governments, and lawmakers; various environmental, humanitarian, and religious organizations; and the individuals whose everyday lives are affected by health issues. The job of medical sociologists is to untangle the social history of a disease, sorting out how authorities have been legitimized, how social institutions have been created, and how patients interpret their disease experience. In this space we discover society's deepest values, beliefs, and ideas. Our taken-for-granted assumptions and preconceived notions come to light, and we see how they have shaped our scientific understanding and treatment of disease. As the case of male infertility illustrates, sometimes medical science has to bend to accommodate society's gender ideals.

This book is not just a story about conceiving babies. It is a story about how we conceive of people—how we conceptualize men and women. Its aim is to uncover, unravel, and shake out all of society's preconceived notions about men and women that have influenced how we scientifically interpret and medically treat a couple's inability to get pregnant. Notions of gender inherited from earlier generations have influenced the development and organization of male infertility medicine over the past century and help explain how we conceptualize and understand male infertility today. According to the World Health Organization, male factor infertility affects no fewer than half of all infertile couples, and according to the American Society for Reproductive Medicine (ASRM), infertility is equally common in men and women.¹ Nonetheless, we often think of infertility as a women's issue, the wife's problem, a female disorder. Women are more likely to bear the social stigma of childlessness² and are more likely to undergo medical treatments, even in cases of male infertility.³

The National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) reports that 7.3 million American women have used infertility services.⁴ Fertility surveys have closely monitored fertility rates, fertility status, and use of infertility services among women in the United States since 1955.⁵ Yet the NCHS National Survey for Family Growth did not begin tracking male infertility until the twenty-first century, so less information is available on male infertility than on female infertility.⁶ Infertility is an estimated \$3 billion industry in the United States,⁷ and specialists who treat women dominate the market. Internet sites, books, and

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magazines devoted to helping couples combat infertility provide long checklists for women: fertility signs they should watch for throughout their menstrual cycles, diets and vitamins that will improve their fertility, questions they should ask their doctors. Articles and books by psychologists, social workers, and social scientists focus primarily on the grief, frustration, and depression suffered by infertile women. Despite the fact men are just as likely to be responsible for a couple's inability to conceive, the notion that women are primarily responsible for infertility still prevails in much of the world today.⁸ Where are all of the infertile men? How have they slipped so easily under the radar?

Masculinity and Virility in the Cultural Milieu

Some men “shoot blanks.” This popular idiomatic expression, used to describe male infertility, invokes the image of a pulled trigger, a firing gun, but no ammunition discharging to hit the intended target. The metaphorical gunman is powerless and ineffective; his equipment is inadequate. Compare the idea of “shooting blanks” to other colloquial jargon, such as “grow a pair” and “that takes balls.” These fragments of language illustrate the prevailing cultural belief that healthy testicles producing potent sperm are symbols of strength, courage, power, manliness, and masculinity. Throughout history and across cultures, the ideal macho man is depicted as virile and potent. A real man can get the sex he wants and impregnate a woman when he so desires. Certainly there are life stages and circumstances in which men do not want to achieve pregnancy. But as William, a businessman in his late thirties and one of the two dozen infertile men interviewed for this book, described the cultural expectations of masculinity, “Men should be able to gush sperm all over the place.”

Sociologist Lisa Jean Moore, author of *Sperm Counts: Overcome by Man's Most Precious Fluid*, has written extensively on representations of sperm and semen in a variety of “seminal enterprises,” including the donor sperm market, pornography, forensics, and fatherhood rights. On the basis of her wide-ranging research, Moore concludes that “men are clearly invested in the representations of semen as inherently linked to their sense of selfhood. . . . The more masculine the man, the more manly his semen and vice versa.”⁹ When I tell people that I study the social experiences of infertile men, I frequently hear responses such as “Oh, those poor guys” and “That must be so dif-

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ficult for men” or my favorite, “Being able to get your wife pregnant is like the whole point of being a man.” The general consensus is that real men gush sperm. Male infertility destabilizes the presumed fundamental basis of masculinity, disrupts traditional gender roles, and hits personal masculine identities right where it counts.

In 1992 researchers in Denmark announced an international fertility crisis: Over the previous fifty years, sperm counts had dropped more than 40 percent worldwide.¹⁰ The report was met with panic and denial in both the scientific community and the media.¹¹ Over the next decade smaller studies of male fertility among various nationalities proliferated. Sperm counts were believed to provide not only a window into a nation’s health but also a measure of national masculinity. As political scientist Cynthia Daniels humorously noted in her book *Exposing Men: The Science and Politics of Male Reproduction*, as the results of geographically specific studies were released, sperm counts of nations were being compared in Olympic competition terms. 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.”¹² Some news coverage depicted sperm as tiny soldiers or rockets at war with toxic threats. One report suggested a link between the increase of women in workplaces and colleges and decreasing sperm counts, implying that women’s rise in the public sphere was emasculating and feminizing men.¹³ The media coverage of sperm count research highlighted the threat of rising female power, the cultural value of virility, and the centrality of virility to masculine ideals.

Infertility can cause men to question their ideas about masculinity, marriage, sex, and fatherhood and to think about their gendered bodies and body parts in ways they had not before. Throughout this book, I draw on a variety of sociological theories of gender to explain how male infertility doctors and infertile men construct notions of masculinity and conceptualize infertility. Fortunately, sociologists Cecilia Ridgeway and Shelley Correll have combined several prominent social theories of gender to develop a very concise gender system as a theoretical framework for examining and explaining how gender is constructed in our social world.¹⁴ According to the gender system theory, gender ideology operates at three discrete levels: in the broad culture, within institutions, and among individuals. Soci-

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ologists do not subscribe to biologically essentialist explanations of gender but also cannot deny that gender ideology is annoyingly pervasive, durable, and enduring. According to Ridgeway and Correll, the stubborn resilience of the gender system is due to the constant interaction and interplay between culture, institutions, and individuals.¹⁵ Cultural ideas about gender shape social institutions and get embedded in institutional practices. Sometimes society's ugliest ideas about gender, including assumptions that men are superior, more capable, and more competent than women, inculcate our social institutions. In other words, some social institutions are the nasty sausage factories of gender stereotypes, propagating outdated, inaccurate, and damaging ideas about men and women. As individuals we interact daily with social institutions, consciously or unconsciously accepting or rejecting these popular notions of gender.

Ridgeway and Correll employ the gender system theory to examine and explain gender discrimination in education, the workplace, and the home. The gender system also provides a nice framework for examining male infertility. My analysis uses the three basic levels of the gender system to look at how cultural ideas of male reproduction and masculinity have shaped the development of male reproductive medicine and are built into medical practices. I also consider how individuals conceptualize gender and how the interactions between medical institutions and patients reinforce or reconceptualize aspects of gender.

Contemporary gender theorists point out that over the life course, men and women are continuously exploring and deciding what gender means and how to enact it.¹⁶ Of course, people do not randomly dream up new ideas about masculinity and femininity to embody and portray; we are all active participants in a highly interconnected social world. We have inherited a long history of culturally defined gender norms, and we can see how our access to opportunities, resources, and relationships requires us to enact certain culturally prescribed masculine or feminine traits in various situations. When an individual does not, cannot, or chooses not to adhere strictly to prevailing cultural norms of gender, he or she may discover that being different requires a lot of gender work. Gender work entails mentally and emotionally processing how personal ideas about gender fit in or clash with ubiquitous cultural ideals of gender. Gender work requires digging deep, reconsidering personal values, and weighing the social

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and economic benefits and costs of conforming to society's expectations or going against the grain.

Gender studies frequently focus on the experiences of women, which, as sociologist Judith Wajcman observes, reinforces "the perception that gender is only an issue where the research subjects are female," ignoring the fact that men's experiences are also shaped by gender beliefs.¹⁷ While most feminist scholarship examines women's experiences with male dominance, over the past two decades a growing number of gender scholars have shifted their focus to men and masculinities, exploring the nuanced power relationships among men. Sociologist R. W. Connell argues that the hierarchy of gender is more complex than basic men-dominate-women models suggest, because men also strive to dominate other men.¹⁸ A hierarchy of men exists in which salient aspects of identity, such as race, class, sexual orientation, age, and ability, grant men access to different forms of power and resources, networks, and women. In its most culturally understood hegemonic form, masculinity is achieved and portrayed through whiteness, wealth, education, intelligence, attractiveness, strength, athleticism, fatherhood, and heterosexual prowess.¹⁹ Sociologist Michael Kimmel argues that manhood is equated with and defined by power.²⁰ In reality, the achievement of perfect manhood and masculinity is possible for only a small, privileged minority. As a result, most men suffer from feelings of powerlessness and inadequacy.²¹

There are multiple forms of masculinity, because masculine ideals change over time and across cultures, and the ways in which people enact masculinity vary by race, ethnicity, sexual orientation, socioeconomic class, and age. In other words, masculinity is a slippery topic of study. If we look across cultures, we can see empirical evidence that masculine preferences, hobbies, and interests are not connected to sex identity and that behaviors that one man may engage in to demonstrate his manliness another man may avoid for the same purpose. Forms of work, communication styles, and emotional expressions that are considered masculine in one culture or subculture may be deemed feminine in another. If masculinity is so dynamic, how can we isolate it under the sociological lens?

Sociologist Adele Clarke, author of *Disciplining Reproduction: Modernity, American Life Sciences, and "the Problems of Sex,"* observes, "It is difficult to conceive of a more sex- and gender-constructing and

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maintaining discipline and set of practices and discourses than those of the reproductive sciences.”²² We can debate which hobbies, interests, skills, sports, disciplines, careers, or art forms are gendered masculine or feminine. But male reproduction, entailing the ability to have an erection, penetrate a woman, produce sperm, ejaculate, and fertilize an egg, is quintessentially masculine. (Even if someday this function can be performed by women, I am willing to bet that we will still think of it as a masculine act.) In other words, a study of male infertility can’t *not* be a study of gender and masculinity. Male infertility provides a useful case study for exploring masculine themes because infertility prevents men from accomplishing the most hegemonic form of masculinity. When women face infertility, their self-perceptions begin to fray. They are forced to engage in gender work, reconsidering their personal ideas about femininity and how to live up to them.²³ The personal stories recounted in this book capture how *men* reassess their values, make sense of their world, and reaffirm their personal masculine identities as compassionate husbands and responsible fathers-to-be as they come to terms with their inability to perform one of the most basic masculine functions.

Too often, gender scholarship that strives to examine men’s gendered life experiences is reduced to trivial comparisons of men and women. Such studies often emphasize gender difference, inadvertently supporting biological determinist explanations of gender, reinforcing a strict gender binary, and perpetuating the gender stereotypes that are used to justify gender inequality. Though women experience infertility, this is not a comparative look at the sexes. And although wives play important supporting roles in the stories presented, this is a book about men. It examines how infertile men grapple with a very distinct, traditional, salient notion of masculinity that has emerged from a strict gender system. To be clear, I do not endorse a gender binary or stereotypes of masculinity; rather, I show how infertile men must negotiate the rigid walls of the modern American gender system. As the stories in this book demonstrate, people are resilient and creative when it comes to gender.

The Invention of Infertility

In 2010 British biologist Robert G. Edwards won the Nobel Prize in Medicine and Physiology for the development of in vitro fertiliza-

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tion, the procedure commonly known as IVF. This technological innovation, pregnant with possibilities, breathed new life into the term “infertility.”²⁴ Just over thirty years ago, in a cotton-milling town in England, under the direction of Dr. Edwards, the conception and birth of Louise Brown sparked hope in couples around the globe that their days of childlessness were over. Louise was the first “test tube baby.” Since her celebrated arrival an estimated 5 million children have been born worldwide thanks to IVF techniques. Though Dr. Edwards will go down in history as the scientist who helped put an end to infertility, it may be more accurate to say that he started it.

Throughout human history, couples have suffered from one condition known by different names: barrenness, sterility, involuntary childlessness, and—as it is known today—infertility. The term “infertility” captures the marriage between involuntary childlessness and the active pursuit of medical intervention. The prevalent use of the word hinges on an important social expectation: that people who want a baby and cannot conceive should take advantage of the medical opportunities that are available for expediting conception. Infertility has become a medical experience as well as a social one. When we speak of infertility, we are often talking about a specific social context in which a presumably monogamous heterosexual couple cannot achieve their desire to create biological offspring. Infertility presents itself on a social stage, where personal desires play out in the realm of social expectations. Infertile couples turn to the world of medicine to help them in their quest for parenthood.

There are numerous possible causes for a couple’s inability to conceive, some of which are easier to pinpoint and repair than others. The sterilizing effects of congenitally malformed genitals, hormone imbalances, chromosomal anomalies, cancers, other diseases, and treatments for certain diseases and conditions are often all lumped together into a condition known by one name: “infertility.” According to the ASRM and in medical parlance, infertility is “a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of regular unprotected intercourse. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years.”²⁵

This technical definition, qualified by variables such as age, heterosexual sex, and numbers of attempted cycles, is a construct of recent decades. One medical manual published by the World Health

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Organization explains, “The time limit of 12 months is arbitrary, but corresponds with the fact that the majority (approximately 85%) of couples who achieve pregnancy spontaneously will do so within 12 months.”²⁶ There is no research demonstrating declining chances of conception following a year of unprotected sex. In fact, many couples do conceive after years of unprotected sex without medical intervention. The main purpose of the time limit is to alert patients to seek medical help in the race against the woman’s biological clock. The arbitrariness of the time limit demonstrates that disease is defined not simply by biological evidence but also by social actors.

The ASRM definition of infertility was arduously debated and painstakingly crafted by medical and mental health practitioners, patients, and patient advocacy groups. Why is infertility called a disease rather than a syndrome, a condition, or a disorder? For some time, medical professionals avoided calling infertility a disease because the term “disease” was presumed to be a stigmatizing label. However, when health insurance providers refused to cover medical services coded for infertility, patient advocacy groups lobbied the ASRM to incorporate the word “disease” into the definition. Resolving an ambiguous condition that in many cases has no known etiology sounds like an expensive and doomed pursuit. A disease, by contrast, demands a call to arms. Diseases deserve research dollars, and patients with diseases are entitled to sophisticated medical interventions. In a footnote to its definition of infertility, the ASRM cites a medical dictionary, which defines “disease” as “any deviation from or interruption of the normal structure or function of any part, organ, or system of the body as manifested by characteristic symptoms and signs; the etiology, pathology, and prognosis may be known or unknown.” Infertility fits this description.

Some infertility treatments are designed to resolve the social issues that infertility presents rather than to fix biological problems. Several scholars have noted that IVF does not actually treat the cause of a couple’s inability to achieve pregnancy. Instead, it simply circumvents whatever is impeding conception to make pregnancy possible.²⁷ The first successful attempt at IVF illustrates this point. Louise Brown’s mother, Lesley, was diagnosed with blocked fallopian tubes. When her fallopian tubes could not be repaired, doctors manually removed the eggs from her ovaries and returned a fertilized embryo to her uterus, overriding the need for functioning fallopian tubes. The

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ultimate goal of many medical protocols for infertility is not necessarily to repair or replace broken parts; it is to make a baby and turn people into parents.²⁸ After the birth of a child conceived through IVF, often all that has changed are a couple's social roles, from non-parents to parents. The biological cause of a couple's infertility may remain unchanged, threatening to obstruct future attempts at conception. The disease has not been cured. It has merely been bypassed.

Historically, the inability to conceive is no respecter of persons. It affects the lives of people of all races, ethnicities, and socioeconomic classes. Infertility is notably a couple's disease. It often indicates that one particular man and one particular woman cannot reproduce *together*. Arguably, either or both partners might be able to achieve pregnancy if they were to attempt to conceive with someone else with better than average fertility. This caveat reminds us that our ideas about infertility are imbued with strong social norms regarding traditional values of heterosexual monogamy. Our culture is sympathetic to heterosexual couples who follow the "natural order" of mating yet cannot reproduce. We certainly do not expect couples to break the marital bonds of fidelity to achieve pregnancy. In fact, elaborate (and lucrative) sperm-banking systems have been created to give women access to healthy sperm without having to resort to extramarital sex.

Social scientists recognize infertility as a physical and social condition that affects women and men psychologically and emotionally. In many cases, infertility is a fixable "betwixt-and-between" condition,²⁹ the state of "not yet pregnant."³⁰ Infertility may be defined as a *process* whereby couples come to understand their inability to have children as problematic.³¹ Infertility causes grief, though not to the extent that the loss of a loved one might, because many couples find ways to repair their infertility or resolve their childlessness. However, the possibility that couples may overcome infertility at any time makes it a particularly unique and challenging ordeal. Not knowing what the future holds drags out the anticipation and prolongs and intermittently suspends the grieving process. Couples and doctors often believe that any physical impediments to conception can eventually be bypassed, removed, or cured by medical science.³² This faith in the power of medicine can make medical failures especially devastating. Even when pregnancy is achieved through infertility treatments, couples may grieve the loss of romantic and spontaneous

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conception. When pregnancy is not achieved, couples grieve the loss of an envisioned biological child.

Infertility is not life-threatening, but it is life-defining. The journey of infertility may incite feelings of personal failure, inadequacy, guilt, depression, powerlessness, and loss of control.³³ Because having biological children is seen as a natural and normal step along the life course, not having children can make couples feel stigmatized as not normal and unnatural or as not having achieved legitimate personhood.³⁴ Extensive social science research among women shows that infertility threatens women's own gender identity, particularly if the woman sees motherhood as imperative to womanhood and kinship as defined by genetic ties. Infertility destabilizes women's prescribed role and identity and motivates women to invest their bodies, time, emotion, and finances into medical care to avoid the stigma of childlessness.³⁵

Throughout history and across cultures, women have been relegated to the domestic sphere to raise children and attend to household needs. Motherhood, particularly in time periods and cultures in which women had no place in the public sphere, has been women's primary identity. For generations, women who have been unable to reproduce have suffered from feelings of personal failure, inadequacy, guilt, and depression. Childless women have historically been stigmatized for failing to live up to their most valuable—and, in some eras, only—social role. Of course, women today do not face the “motherhood mandate”—the social pressure to get married and raise children—to the same extent that previous generations did. At present, over 60 percent of women in the United States participate in the labor force, and women enjoy more promising and lucrative careers than was the case in the past. Women today are more educated than women of previous generations, and colleges now graduate more women than men. American men are more involved in childrearing and housework than at any other time in the past century. Still, women's bodies are physical symbols of fertility. Women alone enjoy the blessings and burdens of pregnancy, labor, delivery, and breastfeeding. When a couple cannot achieve pregnancy, the link between womanhood and reproduction lingers quietly in our subconscious.

When infertility appears in news headlines, we usually hear stories about women. We rarely hear about male infertility in the media and public discourse, and often when we do, the discussions lead

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us to believe that male factor infertility is uncommon among infertile couples. Though society is generally sympathetic to women's struggles with infertility, women are held primarily responsible for a couple's inability to achieve pregnancy. Why is society so reluctant to acknowledge male infertility? Even as we recognize its existence intellectually, we find it emotionally, socially, and psychologically difficult to make room for it in our social world. As Cynthia Daniels points out, male infertility reminds us that men are as physically vulnerable to disease as women, a fact that challenges our core beliefs about masculinity.³⁶ I would add that male infertility reminds us that men are also emotionally and mentally vulnerable, and that makes us uneasy. Masculinity is defined by physical prowess, size, and performance; the inability to impregnate a woman indicates ineffectiveness, incompetence, and even impotence and has been found to cause mental and emotional distress for men.³⁷ Our collective ability to look the other way when male infertility is glaring us in the face demonstrates that we—men and women—are unified in the cause of protecting masculinity. We are all coconspirators in protecting the big gender secret: Masculinity is fragile. Precisely because masculinity is equated with power³⁸ and the achievement of manhood is defined as having power and being powerful,³⁹ men and their masculine identities are particularly vulnerable.⁴⁰

Over the past several years I have heard countless anecdotes from doctors, scientists, patients, colleagues, and acquaintances about couples who thought the wife was infertile, only to learn that their inability to conceive was due to male infertility issues. Perhaps more compelling are the stories of women who have undergone grueling infertility treatments in an attempt to overcome their male partner's infertility. Why are these stories so common? The answers are both practical and sociological. When a couple cannot conceive, it is nearly always the woman who seeks medical help first. Sometimes primary care providers and gynecologists provide quick remedies for the woman, such as prescription drugs, without ever assessing the man's fertility status. Even in cases in which male infertility is detected early, some means for achieving pregnancy focus primarily on the female partner's body. There are simply more methods available, pharmaceutical and technological, for treating women than men.

From a sociological perspective, one very specific preconceived notion about gender has determined the direction and practices of

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infertility medicine: *Women are responsible for all aspects of reproduction* from contraception to conception, from fetal health to breast-feeding. When a heterosexual couple cannot achieve pregnancy, the problem is assumed to be *her*. This widespread assumption has resulted in a general lack of public awareness of the prevalence of male infertility. It has also channeled the direction of reproductive science and shaped the practices of infertility medicine. If reproduction is believed to be a women's issue, then more doctors are trained and licensed to treat female bodies, and doctors and scientists develop more technologies to treat those 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 to the treatment of infertile men.

The Heterosexual Paradigm

The director of a large international sperm-banking company, also a prominent male infertility specialist, was asked to speak at a meeting of a gay and lesbian infertility advocacy organization. Since lesbian couples represent the majority of clients at his sperm bank, he gladly accepted the invitation, assuming that the group wanted to hear about family-building options for lesbian couples using donor sperm. However, when he arrived at the meeting, he was surprised to find a room full of gay male couples. Confused, he stumbled through his presentation on donor sperm, all the while wondering, "Why am I here?" He had never worked with gay men before. The audience, equally flummoxed, sat speechless at the end of the presentation. Needless to say, there was no shortage of sperm in the room.

As the sperm bank director explained to me, he believed that he had been invited to speak about his company's products and services. However, the attendees that evening believed that they were going to hear one of the world's leading male infertility experts discuss male infertility. Male infertility specialists treat infertile men, right? The gay men in attendance identified as infertile men. So what went wrong? Assumptions about universal heterosexuality inform and shape our language and social institutions, a phenomenon known in social science shorthand as heteronormativity. Infertility is a disease imbued with heteronormative ideas about family building. The con-

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fusion at the meeting stemmed from the fact that in the dominant culture, men are assumed to be heterosexual, so male infertility patients are assumed to be heterosexual men.

In medical parlance, male infertility is synonymous with insufficient healthy sperm, reflecting the heteronormative assumption that when there is only a male infertility issue, eggs are available, healthy, and reliable. Male infertility clinics are designed to address issues such as no sperm, low sperm count, and poor sperm quality. Gay men may perceive their inability to achieve pregnancy through sex as infertility, but chances are that between the two partners they have ample healthy sperm. Before attending the support group meeting, the sperm bank director had congratulated himself on his efforts to promote alternative family-building options. Unfortunately, he had never before considered the ways in which heterosexual norms are built into the language of infertility. He had taken for granted that male infertility medicine is a specialty designed to treat only heterosexual men; he had never considered that the term “male infertility” may be read differently by nonheterosexual men.

In my study of male infertility, all of the research participants were married heterosexuals. Heterosexuality was not a requirement for participation, but I never met an openly gay man or woman during my fieldwork. The bottom line is that male infertility clinics specialize in the treatment of heterosexual couples. Gay men rely on the same resources as infertile women to find an egg donor, a surrogate mother, and the services offered in an IVF clinic to achieve biological parenthood.⁴¹ Because it is statistically improbable that both partners of a gay male couple would be completely sterile and IVF now requires only one sperm, it is improbable that a gay male couple would have any practical reasons for consulting with a male infertility specialist. Similarly, lesbian couples may seek out donor sperm from sperm banks and use the services available in an IVF center, such as intrauterine insemination (IUI) or IVF, but lesbian couples do not seek treatment in male infertility clinics.

The infertility industry was conceived within the heterosexual paradigm and will most likely continue its gestation there. Nonetheless, sperm banks, egg banks, surrogacy programs, and IVF centers welcome gay and lesbian couples. In recent years, patient advocacy groups and mental health professionals have used the term “social infertility” to describe the experiences of gay and lesbian couples who

need donor gametes, surrogates, and assisted reproductive technologies (ART) to achieve pregnancy. The term acknowledges that “natural” conception is not an option for same-sex partners and recognizes that same-sex couples often endure the same physical and emotional burdens that heterosexual couples do as they travel the infertility path.

Research Methods

When I first set out to study male infertility, I designed my research study as an ethnography. Ethnographic fieldwork, a popular research method used in the social sciences, entails collecting written data through observation and interviews. As a trained ethnographer, my desire from the beginning was to go where infertile men go, understand infertility in the terms in which they understand it, and observe and learn how infertile men choose to deal with their infertility. My first foray into the world of infertility was to an infertility support group for couples. I introduced myself as a researcher and was invited to attend monthly support group meetings. Over the course of several months, I met dozens of infertile women and their husbands and one infertile man and his wife. On several occasions the token infertile man asked, “Am I the only infertile man here?” The other men present all claimed that they were fertile and were there just to support their wives.

I continued my foolhardy search for infertile men at a full-day conference for infertile couples hosted at a prominent university. The busy seminar schedule offered only one class on male infertility. Though the conference had drawn nearly two hundred people, I was surprised to find just four people in attendance at the male infertility class: two men, another woman, and me. If 10 to 15 percent of couples in the United States struggle with infertility and male infertility is the cause in half of all cases, where were all the infertile men?

Infertility support groups and IVF clinics abound in the United States and serve as great resources for recruiting research participants. However, infertility scholars have had little success in finding and recruiting men in these locales.⁴² Rather than studying the infertile (and usually invisible) male partners of women receiving treatment in IVF clinics, I chose to conduct research in male infertility clinics. At the generous invitations of several male infertility specialists, I spent over one hundred hours in five male infertility clinics in the United

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States observing clinical encounters between doctors and infertile male patients. I interviewed more than a dozen doctors, nurses, genetic counselors, laboratory technicians, sperm bank staff, and psychologists over the course of my fieldwork. Following my fieldwork I conducted telephone interviews⁴³ with twenty-four infertile men and their wives (separately) twice over an eighteen-month period.⁴⁴ (See Appendix B, “Interview Guide.”) The men, representing many walks of life, included a pilot, a carpenter, a schoolteacher, an electrician, and a state trooper. Most men in this study had no children at the time they agreed to participate; a few were raising biological children and stepchildren. All of the men in this study were heterosexual and married or engaged to be married. Marriage was not a requirement for participation, but married couples seem to make up the vast majority of couples seeking infertility treatments. The majority of the research subjects were upper-middle-class and white. Socioeconomic status is a curious variable among infertile households. Some of the men in the study had working-class backgrounds and working-class jobs, but because they had no small children to care for, their wives remained in the workforce. Most infertility studies, therefore, attract many “double-income, no kids,” or DINK, couples.

Participation in the study was open to people of all races and ethnicities. The overrepresentation of whites in the research subject pool reflects the patient populations at the medical clinics I visited, even in geographic areas that have large racial and ethnic minority populations. What prevents minority men from seeking out infertility treatment? Are treatments cost prohibitive, are minorities less trusting of infertility medical practices, or is the private experience of not being able to achieve pregnancy interpreted differently by minority men? Are minorities more likely to deny their infertility or need for medical care? Is seeking out medical assistance more emasculating or embarrassing for minorities than for whites? Unfortunately, this study cannot answer any of these questions. The whiteness of the subject pool for this study creates quite a tidy picture of how the most privileged members of society—white, married, heterosexual, middle and upper-middle-class men—who presumably have the most access to financial and medical resources, deal with a blow to their masculinity. If masculinity is defined by power, then this book effectively looks at what happens to the most powerful members of a society when they learn that they are not as powerful as they envisioned themselves to

be. This study provides the backdrop for future investigation into the social meaning of male infertility among single and homosexual men and men of various ethnic and racial groups in the United States and elsewhere.

Book Overview

The purpose of this book is to examine how gender and disease are socially constructed within social institutions and by individuals. At the institutional level of analysis, Chapters 2 and 3 show how gender ideology has shaped the development of male infertility medicine and practice. At the individual level of analysis, Chapters 4 and 5 look at how infertility affects patients' understandings of their own personal gender identities. While the first half of the book emphasizes the static and enduring qualities of gender stereotypes, the second half illustrates the fluidity of personal gender identities and the power of individuals to redefine for themselves what it means to be a man and to be masculine.

Chapter 2, "Seminal Work," provides a historical overview of the emergence of male infertility medicine. I argue that the development of male reproductive medicine lagged behind female reproductive medicine, owing to preconceived notions about gender and reproduction, resulting in a system that today is more focused on, and better prepared to treat, women than men. I present unresolved disputes among specialists, clinical errors, and potential health risks as the symptoms of the slow organization of the field and as factors that complicate the decision-making process for patients. Chapter 3, "Doctors Doing Gender," takes a peek behind clinic doors, where semen testing tests patients' masculinity and where doctors employ gendered strategies to connect with male patients. I consider the many ways in which male infertility specialists subscribe to the same traditional gender ideology that they blame for perpetuating the lack of social awareness regarding male infertility, and I discuss the complex role that doctors play in the gender system. Chapter 4, "Just a Medical Condition," delves into the gender work in which infertile men engage to preserve their masculinity. When disease presents a threat to masculinity, individuals create new understandings of disease in order to stabilize their personal gender identities and disconnect fertility status from masculinity. Chapter 5, "Taking Control,"

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describes how and why men embrace medical technologies. Men construct masculine narratives about the lengths to which they would go to make “natural” conception possible and spare their wives from painful and uncomfortable treatments. Chapter 6, “The Politics of Reproduction,” reviews the points made throughout the book that demonstrate how masculine domination has influenced and continues to underscore the development, organization, and treatment of male infertility.

This book clarifies one important point: Infertility is not just a women’s issue. Some men’s bodies refuse to cooperate with society’s expectations. Some men do not produce healthy, speedy, potent sperm. This physical inability can be emotionally, mentally, and socially problematic for men. In one of our many candid conversations, Dr. Bradley expressed his chagrin that among infertile couples, men are rarely properly assessed and treated. “It probably doesn’t help that your office is hidden in the Women’s Health Center,” I teased. He looked at me, genuinely confused. “The sign,” I said, trying to coax his memory, “on the front of the building.” The irony, it seemed, eluded him.