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The margins of medicalization: Diversity and context through the case of infertility

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ABSTRACT

There is a prolific literature on medicalization. While that research highlights numerous effects of the process, it is just beginning to explore medicalization's complexity. In an effort to understand medicalization as a diverse, contextual process, I utilize the case of infertility in the U.S., a highly stratified, medicalized condition. I interviewed 95 individuals among those at the margins of mainstream understandings of reproduction—women of low socioeconomic status, men who were part of an infertile couple, and women in same-sex relationships who were accessing medical treatment to assist in conception—and compared their experiences to 17 straight women of high socioeconomic status who are at the center of reproductive care. Through such comparison, I examine the gender, class, and sexuality dimensions of inequality in medicalization. Ultimately, medicalization excludes, but it does so differentially and with different effects depending on an individual's social location. Such findings demonstrate that medicalization is not a fixed, universal process. It is fluid and relational and shifts depending on context.

Medicalization has been studied extensively in the social science and medical literatures (Conrad, 2007). Indeed, the term is now so ubiquitous that it has moved beyond academic walls into mainstream discourse (Bell and Figert, 2012). Most of the research on the process focuses on the shifting drivers of medicalization, its implications, and its rapid rise over the past fifty years (Conrad, 2005; Conrad et al., 2010). More recent studies are beginning to highlight variations within medicalization. It is no longer viewed in simplistic, top-down terms as it was in the 1970s; rather, the 'medicalization thesis' is now recognized as a more "complex, contested, and ambiguous process" (Ballard and Elston, 2005, 230). For instance, researchers have argued that medicalization is multidimensional and on a continuum. There are varying degrees of medicalization ranging from conditions that are minimally medicalized to nearly completely medicalized, with the categories shifting through time (Conrad et al., 2010).

Despite the extent of the literature and its shift to acknowledge a greater complexity, there is still little understanding about diversity within medicalization (Ballard and Elston, 2005). In other words, how might the implications and degrees of medicalization vary among individuals? While laudably and importantly highlighting the roles that the medical profession and consumers play in medicalization, there has been much less attention to the context in which medicalization takes place. For instance, the dozens of case studies on the process often generalize its effects (Litt, 1997). Indeed, as Clarke et al. (2003, 185) acknowledge, we need "case studies that attend to the heterogeneities of biomedicalization practices and effects in different lived situations."

I undertake such an examination through the case of infertility, a highly medicalized, stratified condition. Since the birth of Louise Brown, the first baby born from in vitro fertilization (IVF), assisted reproductive technologies (ARTs) and other fertility treatments have proliferated, making infertility synonymous with its medical treatment (Wilcox and Mosher, 1993). What used to be considered a natural, yet disappointing, process to be coped with is now considered a medical issue requiring treatment. This medicalizing of infertility has become so normalized that many deem its medicalization "hegemonic" (Greil et al., 2010). As Sandelowski (1993, 41) claims, "the treatment has become the illness."

Despite such medicalization, many individuals do not receive treatment for their reproductive difficulties. In the U.S., only fifteen states have laws that require private insurers to fully cover, partially cover, or offer to cover some form of infertility diagnosis and treatment (Centers for Disease Control and Prevention, 2013). Such limited insurance coverage, coupled with the high cost of

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treatment, results in unequal use of medical services. According to the most recent National Survey of Family Growth (NSFG), among women experiencing reproductive problems, only five percent with less than a college education received ARTs compared to nearly twenty percent with at least a bachelor's degree (Chandra et al., 2013). In other words, the medicalization of infertility reinforces the stratified system of reproduction by providing the option of reproduction to some groups and not to others (Bell, 2014).

Those individuals receiving treatment reflect the dominant stereotype of who is infertile—white, wealthy, heterosexual women. But, in reality, half of all infertility cases can be attributed at least in part to men, poor women of color have slightly higher rates of impaired fecundity, and over seven percent of women in same-sex relationships are receiving fertility treatment (Bell, 2014; Blanchfield and Patterson, 2015; Inhorn et al., 2009). In this paper, I compare the experiences of those outside of infertility discourses (i.e., women of low socioeconomic status (SES), men, and women in same-sex relationships) to those inundated within them (white, heterosexual women of high SES). In doing so, I not only find that certain class, gender, and sex groups are excluded within medicalized processes, but also that they are marginalized in different ways from each other. In other words, the findings demonstrate that medicalization is a diverse, contextual process shaping and maintaining inequalities.

1. Literature review

1.1. Medicalization and inequality

Put simply, medicalization is a process whereby natural life events or deviant behaviors become defined and treated as medical problems (Conrad, 2007). Despite its current prolific use, medicalization is a relatively modern process and concept. It was not until its introduction to the sociological literature in the 1970s that its use expanded, successfully moving into the discourse of popular culture (Bell and Figert, 2012).

The "drivers," or reasons behind medicalization, have shifted through the years primarily due to the development of biotechnology, managed care, and enhanced consumerism in the field of health care (Conrad, 2005). Originally associated with medical dominance, prestige, and the need for medicine to enhance its social authority, researchers now view medicalization as a more complex and contested process with individual patients at its helm (Ballard and Elston, 2005; Freidson, 1970; Zola, 1972). As healthcare has become commodified and constructed more like a business, patients have become consumers, thus playing a larger role. Patients are not passively accepting medicalization, they are actively pursuing or rejecting it. As Ballard and Elston (2005, 229) conclude, it is "now more important than ever to consider the specific social contexts in which medicalization occurs if consumers are its drivers."

Despite moving away from the social control aspect of medicalization in the literature, inequalities still exist in the process. As researchers have shown, medical values reflect societal values, and those values, including its inequities, are reproduced through medical treatments, technologies, and practices (Becker and Nachtigall, 1992; Quiroga, 2007; Vespa, 2009). For example, medicine is considered a "middle-class constituency," thus medicalization is historically rooted in specific class interests (Jain et al., 2002; Riessman, 1983; Steinberg, 1997, 40). In the nineteenth century, physicians and women from the upper classes joined forces in transforming life events into medical needs. Physicians did so for commercial self-interest and prestige, while the women did so to adhere to gendered norms of feminine frailty, which distanced them from stereotypes of the robust, immodest working class women (Ehrenreich and English, 2006). The medicalization of childbirth, premenstrual syndrome (PMS), and weight, for instance, were all driven by affluent women's desires for technology, partnership with high status physicians, and adherence to social norms (as they were based upon middle-class standards) (Riessman, 1983).

These are examples of what Clarke et al. (2003, 184) deem "stratified biomedicalization," which highlights the medical divide along the lines of gender, race, class, and other dimensions. Researchers are beginning to employ this term throughout their work (e.g., Kahn, 2010; Mamo, 2007; Shim, 2010). For instance, Shim (2010) theoretically explores stratified medicalization in her work on epidemiological research. She demonstrates how such research has reinforced sex, race, and socioeconomic status (SES) as legitimate biomedical concerns in their own right, constructed the dimensions as risk factors for disease, and labeled them targets for intervention. Ironically, despite reinforcing a medical hierarchy, the medicalization process naturalizes such disparities, making them go unrecognized and unacknowledged (Clarke et al., 2003; Light, 1989).

Studies like those of Shim (2010) and Clarke et al. (2003) have insightfully begun to theorize and expose the presence of stratification in medicalization. However, empirical work is needed that specifically addresses re-contextualizing medicalization. Medicalization is not a universal process with a singular meaning (Blum, 2011); rather, it "describes a social process" rife with diversity (Conrad et al., 2010, 1943).

1.2. Medicalization & infertility

Like many medicalized processes, infertility is one rooted in class, sexuality, and gender norms (Steinberg, 1997). In fact, some argue that socioeconomic factors instigated the medicalization of infertility. Prior to the 1950s, infertility was considered an emotional or moral problem rather than a medical one. This quickly changed in the 1960s and 1970s, with the development of laparoscopic technology and drugs to control ovulatory cycles. It was not until responding to socioeconomic factors, however, that the medical treatment of infertility began to flourish (Whiteford and Gonzalez, 1995). A perfect storm of factors collided to set its stage, including a decline in U.S. fertility rates, an increase in the supply of physicians of obstetrics and gynecology (OB/GYNs), and an increase in the number of women entering the job market and delaying childbearing (Whiteford and Gonzalez, 1995). Between 1968 and 1984, medical visits for infertility tripled from 600,000 to 1.6 million (Greil, 1991). Today, more than 160,000 ART cycles occur each year (Centers for Disease Control and Prevention, 2013).

Not all individuals are receiving treatment, however. According to the most recent NSFG, among women experiencing reproductive problems, those with a college degree are four times more likely to receive ARTs compared to those without a college education (Chandra et al., 2014). Such statistics reflect the stereotype of infertility—that it is a white, wealthy, heterosexual woman's issue—but, do not reflect the reality—that just as many women of low SES are infertile compared to their wealthier counterparts (Chandra et al., 2013; McCormack, 2005). Moreover, men are often left out of the equation despite being equally implicated (Almeling and Waggoner, 2013; Culley et al., 2013). One-third of infertility is characterized as female-factor, another one-third as male-factor, and the other one-third as unexplained, yet medical treatment focuses on treating women's bodies and often reduces men's roles to the provision of semen samples (Bell, 2015; Lorber, 1989; Lorber and Bandlamudi, 1993). Women in same-sex relationships are also increasingly seeking medical care for their fertility, but are often overlooked in this arena due to heteronormative assumptions of