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Exploring Pronatalism and Assisted Reproduction in UK Medicine

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Abstract

Globally, procreation is highly valued, and motherhood has long been seen as the normative role for women. Production of a biologically-related family in keeping with social norms is a key driver of the growing demand for assisted reproductive technologies as a 'cure' for infertility, which includes the provision of *in vitro* fertilisation (IVF) within the UK's National Health Service (NHS).

In this paper I argue that pronatalism – a social bias in favour of biological motherhood – entrenches harmful social norms for women as a group. I will question whether assisted reproductive technologies in the form of IVF bring radical change to women, or whether radical change is in fact required before assisted reproductive technologies can be considered to be liberating. I will explore whether the NHS access criteria for IVF are enabling or restrictive of women's reproductive autonomy, paying particular attention to how the restrictions on sexuality and age contribute to this debate. I argue that despite the social harms of pronatalist bias, eliminating public funding of IVF would wrongfully target those women who are reproductively marginalised, for example, same-sex couples, trans groups, women of advanced maternal age and women who are unable to pay for treatment. Instead, I argue that access to IVF within the NHS should be maintained, but I propose amendments that ensure that the service is more equitably distributed to those in same-sex couplings. Further, I suggest ways that IVF can be included in a wider range of measures that tackle the social issues of infertility in women of advanced maternal age. Finally, I make recommendations for the medical profession to help reduce pronatalist bias, ensuring maximum autonomy for women when they are considering their reproductive futures.

Keywords: Pronatalism, in vitro fertilisation (IVF), National Health Service (NHS)

Introduction

The term *pronatalism* (rooted in the Latin 'pro-birth') describes the social bias that favours childbearing and biological motherhood (Petropanagos, 2017). Pronatalism urges procreation as a route to motherhood, as opposed to social motherhood, which includes adoption and fostering. In feminist literature, pronatalism is widely considered coercive and pervasive, defining women through their childbearing roles and essentialising them as reproducers (Petropanagos, 2017; Meyers, 2001; Ulrich and Weatherall, 2000; Corea, 1986; Firestone, 1970). Pronatalist social norms are deemed to perpetuate and reinforce a "motherhood mandate" (Russo, 1976): a set of social pressures on women to bear and rear children. This may influence women's reproductive decision making (McLeod, 2017; Corea, 1986; Russo, 1976). Recent literature by McLeod (2017)

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and older work by Corea (1986) has argued that in pronatalist societies, the desirability and normalcy of biological motherhood is strongly influenced by the belief that a woman's identity and value is linked to her ability to produce biological children. In contrast, other feminist work by Whitehead (2013) and Nelson (2009), considers the motherhood role outside of gendered expectations and identity achievements. Whitehead (2013) and Nelson (2009) reflect on the intimate connections made between biological mothers, and the desire to relate to one another as women. Further, Whitehead (2013) argues that biological motherhood is in fact liberating, giving freedom and choice to women. Whitehead (2013) and Nelson (2009) argue that it is precisely *because* motherhood is a normative role within society that it should be made maximally available for all women, and thus, why IVF services have become a widely advocated area of healthcare.

In the UK, the National Health Service (NHS) currently provides a publicly funded *in vitro fertilisation* (IVF) service, available to individuals who meet specific access criteria. The National Institute for Health and Care Excellence (NICE) (2013) guidance recommends that up to three cycles of IVF should be available on the NHS if the woman is between 23-39 at time of treatment, and if one of the prospective parents has been diagnosed with a fertility problem or infertility has been present for more than three years. For women aged 40-42 who have not conceived after two years of regular, unprotected vaginal intercourse or after twelve cycles of artificial insemination, NICE stipulates that one cycle of IVF should be offered. This is on the basis that the woman has never previously had IVF, there's no evidence of fertility problems due to a low egg count and there's been a discussion about the risks of IVF and pregnancy at this age. Despite the recommendation for IVF in women aged 40-42, many Clinical Commissioning Groups do not actually offer treatment for this group (NHS Choices, 2015). These state restrictions result in the majority of procedures for this group taking place in private clinics (HFEA, 2014). However, at £5000 (or more) per IVF cycle, treatments are expensive and therefore often inaccessible to many people (NHS Choices, 2015). Further, whilst there are no age limits for fertility treatment in UK law, clinicians in private clinics have a responsibility to decide whether a women's health will allow them to go through treatment and a pregnancy, which will discount many women over an age deemed "appropriate" (HFEA 2014). Yet, despite these various restrictions, the number of IVF cycles performed each year in the UK has increased steadily since 1991 (HFEA, 2014). The rising use of IVF where access is also shown to be restricted has coincided with ethical scrutiny regarding equity of access and what constitutes family norms, calling into question the dominant medical definition of infertility.

In medical discourse, the dominant definition of the infertile body is described as "a woman of reproductive age who has not conceived after 1 year of unprotected vaginal sexual intercourse" (NICE, 2013). Notably, this definition does not encompass the social nature of childlessness (accounted for by non-biological factors such as sexuality), which affects groups such as same-sex couples, gender-queer people and trans people. Based on their relationship status, same-sex couples cannot be defined as medically infertile. Similarly, for trans people the above medical definition of infertility is inadequate since the term "woman" is intended to apply only to cis-women, and trans men are not mentioned (Butler, 2011). An additional group for whom the medical definition of infertility is not always inclusive is age-related infertility in older women. These women are often assumed to have 'chosen' to postpone childbearing in favour of other life choices, for example, pursuing a career (Gentile, 2013). Women in this category can be framed as 'abnormal' and 'selfish' (Shaw and Giles, 2009), and thus are stigmatised for being infertile, rather than supported. In this paper, I favour a sociological approach to infertility, taking the definition of "the active but frustrated desire of a biological child" (Throsby, 2002, p. 26), understood as "involuntary childlessness" (ibid., p. 18). This allows for the inclusion of all groups of people, including those outside of hetero-normative couplings, trans groups, and those with infertility as a result of advanced maternal age.

In this paper, I begin in Section 1 by discussing motherhood in the context of pronatalist bias. This first section acknowledges the feminist argument that biological motherhood can be liberating for women, but emphasises that as a result of pronatalist stereotypes, women who do not bear children may experience stigmatization and other harms as a result of violating social norms. I therefore refer to pronatalism as described by feminist literature – that is, a pervasive and coercive social bias that links a woman's identity and value with her ability to bear children. In sections 2 and 3, I will address the prominent issues surrounding IVF treatments in the UK. Section 2 describes the reinforcement of pronatalism through the use of IVF, using three main groups of women to illustrate these effects. Section 3 turns to the issue of whether a publicly funded IVF service is justified. Within this section, I argue that where IVF has the potential to provide reproductive equality for same-sex couples, trans people and women of advanced maternal age, current public provision of IVF does not support reproductive equality in these groups. Taking account of the issues discussed in sections 2 and 3, section 4 makes specific recommendations for the medical profession that can help to reduce pronatalist bias and ensure fair distribution to reproductively marginalised groups, whilst also allowing for the continuation of a publicly funded IVF service.

The Motherhood Mandate – Pronatalism and Women's Choices

Within feminist literature, there are two broad schools of thought regarding the role of biological motherhood for women. The first perspective considers motherhood as liberating, and a way of accessing 'normative womanhood' (Whitehead, 2013). The second perspective critiques the pervasiveness of social pressures encouraging motherhood, defining women through their childbearing roles and essentialising them as reproducers (Petropanagos, 2017) - a process also known as *coercive pronatalism*. In this section I argue that harmful pronatalist trends of what is considered 'normal' for a woman of reproductive age can negate the liberating aspects that motherhood offers to those desiring a biological child.

Motherhood as Liberating

Whitehead (2013) and Nelson (2009) argue that biological motherhood is liberating by positioning women as individual agents and celebrating the intimate connection between motherhood and a woman's sense of self. That is, they suggest biological motherhood permits women not only to become parental figures, but also to carry out a role that is considered 'normal' for all women (Whitehead, 2013). Robertson (1994) argues that childbearing is a natural biological imperative, establishing the desire to reproduce as central to the meaning of one's life, and an essential component of human flourishing. This biological imperative, which generally rests on women as primary caregivers (Notman, 1980), highlights a preference for procreative parenting (i.e. reproduction forming offspring that are gestational and/or genetic). Pregnancy is sought by women as a potential state for exercising autonomy, and is often perceived as an important symbolic act for legitimising motherhood (Butler, 2011; Neiterman, 2012). The centrality and normality of biological childbearing in society results in IVF being seen as a technological advance that enables women to realise their reproductive desires and 'normal' bodily functioning. As such, the rapid development of IVF since the 1970s has undeniably given many opportunities to women who would otherwise have remained childless.

Motherhood in Context: Coercive Pronatalism

Whilst it could be argued that motherhood liberates women by realising their desire for a biological child, it is important to consider this in the context of pronatalist bias. When a pronatalist society advances biological motherhood as an important identity, motherhood becomes a strongly

gendered norm, and procreation is reinforced as imperative (Purdy, 1996). Women make their 'voluntary' reproductive choices in an institutional context that severely constrains them not to remain single, not to choose childlessness, but to instead assume biological motherhood as a basic and core component of being a woman (Meyers, 2001). The 'desired' mothering role is problematised by the fact that in pronatalist societies, women are already socialised to see biological motherhood as central to their identity (Thompson, 2002). Social bias in the form of pronatalism can "impose values on individuals that are, in some sense, not their own because they might not adopt these values in the absence of pronatalism" (Petropaganos, 2017, p. 134). This could be seen to interfere with a woman's agency, rendering her unable to fully reflect and act on what she perceives as desired choices (Meyers, 2001).

Pronatalism is reflected in various aspects of British culture via the media, government policy, education, and healthcare practice. Women and girls are persistently bombarded with "messages that normalise, praise, and mandate pregnancy, which is typically depicted as part of the normal and best life course for women" (Petropanagos, 2017, p. 133). For example, celebrity 'baby bumps' are pervasively documented in entertainment and news media, while pregnancy photos, ultrasound images, and sex-reveal videos are widely shared on social media (ibid.). A further example is the advice given regarding medical procedures for female sterilisation. NHS Choices (2018) explicitly highlights that whilst sterilisation is considered for women "who don't want any more children or don't want children at all", it also specifies that women "may be more likely to be accepted for the operation if (they are) over 30 and have had children". With no medical reason for why sterilisation may be more likely to be offered to women over thirty who have had children, this clearly indicates that the medical profession expects all women of reproductive age to have had, or plan to have, children. It also implies that thirty is the ideal age by which to have had children, and makes an assumption about when women are most likely to embark upon motherhood. This example highlights how pronatalist bias can intervene with a woman's agency, complicating her ability to fully reflect and act on her desires.

In stating UK society is pronatalist, and thereby restrictive of a woman's autonomy, this does not mean I believe women are led blindly towards a mistaken quest to become mothers. I do not view women as incompetent decision-makers, and I do not dispute the fact that biological motherhood remains important for many women. What I do contend is that biological motherhood should not be assumed to be important for every woman, and other life options should be equally promoted and valued. In both cases – those for whom biological motherhood is important, and those for whom it is not – UK society would do well to keep a close eye on the harmful norms that stem from current pronatalist trends, which I discuss in the following section.

The Harms of IVF

In section 1, I outlined how pronatalist bias sees biological motherhood as what is 'best' for women. I now consider the use of IVF within medicine as a means to 'cure' infertility, and the repercussions of this in relation to pronatalism. While IVF provides choices for infertile people, I argue that it also drives harmful social norms by complicating a woman's autonomy. These harms can affect three main groups – women who are involuntarily childless (section 2.1), women who are voluntarily childfree (section 2.2) and women who mother via non-biological routes (section 2.3). I consider each of these groups separately in the next three subsections.

Harms to Women who are Involuntarily Childless

Where a woman is unable to conceive using IVF, she may suffer stigma as a result of her failure to reach biological motherhood (Petropanagos, 2017). Furthermore, many women blame themselves for infertility, even when it is unexplained (Kirkman, 2008; Greil, 1991). They may do

so, in part, because news media, and indeed healthcare professionals themselves, tell them that if "they just relaxed, they would get pregnant" (McLeod, 2017, p. 85), which seems to suggest that women are somehow responsible for infertility as a result of their psychological stress. McLeod further highlights that during IVF, these stigmatising messages are only heightened, for when "everything is timed so perfectly, how could it not work? If IVF fails, it must be the patient's fault" (ibid.). Socially, the effect of these stigmatisations often makes women feel desperate, unfulfilled, and as though they have failed (Sandelowski and De Lacey, 2002). IVF can perpetuate these negative associations, creating a cycle of distress (Cousineau and Domar, 2007).

In feminist literature, Raymond (1993) and Corea (1986) argue convincingly that IVF, in controlling women's bodies, is simply an arm of patriarchy – a medical procedure that increases the degree of male dominance in society. Corea (1986) describes how IVF may be used to control women's procreative power, and rather than medical procedures having fertility as the central purpose, instead lead more to the exploitation of women and thus an increase in male dominance. Similarly, Raymond (1993) argues that women undergoing medical interventions are rendered weak, with less ability to initiate their autonomy and freedoms in an already male-dominated society. Thus, the contrasting reflection that pregnancy is a potential state for exercising autonomy (see section 1.1) is highly questionable when IVF is used as a means of attaining this state. The considerable focus that IVF places on women's bodies is associated with an increase in male power by creating distress in women via the direct physical and psychological consequences of invasive medical procedures, and in so doing, weaken their identity.

Physical complications of IVF may include medication side effects, perinatal problems, and increased risk of ectopic pregnancy (NHS Choices, 2015). On a psychological level, when a woman enters the medical realm, a diagnosis of infertility may reduce her sense of control as she is rendered 'abnormal' and 'diseased' (Sandelowski, 1991). In their research paper presented at the National Council of Family Relations in Philadelphia, Greil and Porter (1988) discuss how journalists, social scientists and clinicians of IVF describe women as 'driven' in their pursuit of pregnancy, sometimes feeling that they have no choice but to undergo treatments. Greil and Porter (1988) and Frank (1989) describe the psychological process of how women can even become addicted to fertility treatments, unable to stop in their pursuit of a pregnancy. The notion that IVF gives women bodily control is therefore questionable on many levels. Gupta and Richters (2008) consider that in seeking bodily control, this presumes women's bodies are something to be owned, rather than something to be embodied. They argue that in owning ones body, there is the potential for the body to become fragmented into parts, and thus objects for reproductive technologies to drive their use. Rather than viewing medical interventions as something that facilitate bodily control, it is perhaps more accurate to consider the way in which these interventions actually exacerbate women's feelings of having *lost* control as a consequence of losing bodily ownership (Gupta and Richters, 2008).

The medicalisation of women's bodies is not just limited to fertility treatment, but includes a number of medical interventions experienced by women receiving healthcare. For example, women have long been held as the responsible party for contraception in heterosexual relationships (Davis, 2015), and whilst medically evidenced as effective, common treatments such as the oral contraceptive pill nevertheless have the risk of adverse effects such as mood changes and high blood pressure (NHS Choices, 2017). Another example is the medicalisation of childbirth. In recent decades, an increase in medical interventions (for example, caesarean section) has been reported, despite many of these births being identified as uncomplicated (Sadler et al., 2016). These interventions are coupled with a worrying spread of abusive and disrespectful practices towards women during childbirth, including physical violence and psychological manipulation (ibid.). A systematic review by Bohren et al. (2015) looking at the mistreatment of women during childbirth in health facilities globally, found that women were suffering physical abuse in the form of slapping

and pinching during delivery, and were frequently spoken to using blasphemous language. In short, women's bodies are often seen as apt for medical intervention, and in the example of female contraceptives, as sites for the resolution of problems that affect both men and women. While some of this is biologically unavoidable, it is worth considering the psychological effect of having a body that is so often subject to medical intervention, and the control that is relinquished by women in their interactions with medical care.

Harms to Women who are Voluntarily Childfree

In discussing the harms of IVF to women who are voluntarily childfree, I use the example of choice in reproductive decision-making. Rawls (1972) considers it a common assumption that, for the majority of individuals, more choices are always preferable to fewer. This assumption is reasoned by the notion that individuals "are not compelled to accept more if they do not wish to, nor does a person suffer from a greater liberty" (ibid., p. 143). This is certainly assumed by proponents of IVF, where it is felt that an increase in choice for those who wish to bear children should not have any effect on those who have already chosen not to. But this assumption is questionable. Women who are voluntarily childfree can be stigmatised as selfish and uncaring, and their childfree lifestyles are often associated with individualism and the breakdown of the biological family (Park, 2002). For example, these women may instead decide to focus on their career, removing them from family-making and traditional roles in the home (ibid.).

When women make the decision not to reproduce, they are measured against the 'normative' model for other women in their social group (i.e. those of reproductive age), and may be found to be 'deficient'. The increased availability of IVF has likely added to the pressure that some women feel, making the decision not to have children almost impossible when the expectation is so great. As recognised by Earle and Letherby (2007, p. 243) "ambivalence (to childlessness) was a more acceptable response to the experience of infertility prior to the development of technological 'cures'". Indeed, in a world providing a growing choice of 'cures', many women who actively choose not to have children face constant pressures to justify their childfree status (Wyatt, 2012), sending the message that failing to have children is socially unacceptable.

Harms to Women Who Mother via Non-Biological Routes

The third group of women to whom IVF may cause harm is those who mother via non-biological routes (i.e. adoptive mothers or second mothers in lesbian couples). Pronatalist trends may make these women feel like inferior mothers. For example, the wide acceptance of Robertson's "biological imperative" (1994, p. 61) to procreate assumes that non-biological mothers are removed from what is 'normal' (Brakman and Scholz, 2006). The norms underscoring our society that philosophers such as Robertson call *bionormative*, suggest that families ought to be biological because 'real' or 'natural' families are this way (Witt, 2014; Haslanger, 2009). As a result, non-bionormative mothers can be considered not to be their child's 'real' mother (McLeod, 2017), which is at the very least hurtful, but more likely, ostracising. Furthermore, not acknowledging a mother as 'real' may undermine legal processes, as non-bionormative mothers will have had to undergo procedures to attain legal status as a parent. With the increased focus on IVF as a way of treating medical infertility, social motherhood may become more entrenched than it already is as a 'second choice' route to parenting. Not only does this impact existing adoptive or fostering mothers, but it has detrimental repercussions for the many looked-after children in British society requiring family homes. Data shows that while the number of children in care in England is increasing, the number of adoptions has fallen (for example, from 5360 in 2015 to 4350 in 2017), which is thought in part to be due to higher success rates in IVF (The Guardian, 2018).

In this section, I have claimed that pronatalist stereotypes entrench harmful social norms in women who do not bear, or have difficulty bearing, children, and I argue that women's autonomy over their reproductive decision-making can be compromised. Furthermore, I have argued that a reliance on IVF as a 'cure' for infertility reinforces and perpetuates harmful social norms driven by pronatalist trends. Whilst these arguments invite reconsideration about whether current public funding of IVF in the UK is justified, the next section considers two examples for why IVF should remain available on the NHS.

Public Funding of IVF: A Corrective Tool for Reproductive Inequality

Concerns over the specificities of IVF provision are much debated, for example whether age or sexuality should affect eligibility for treatment (Carter et al., 2013; Smajdor, 2009). Yet, as McMillan (2003) observes, less attention has been given to the more general question of whether IVF should be state-funded at all. Considering widespread pronatalist trends, it is unsurprising that debates on IVF provision have largely defended public funding (Johnston and Gusmano, 2013; Warnock, 2002; McMillan, 2001). However, it is worth reflecting on whether state-funded treatment within the NHS legitimises biological parenting as what is 'best' for a woman, therein perpetuating pronatalist value systems.

Yet even if IVF provision is considered to reinforce pronatalist bias, thereby causing harm in the ways discussed in the last section, one common reason to keep public provision of IVF is that it promotes reproductive equality by offering fertility services to reproductively marginalised groups such as same-sex couples, trans groups, and women with age-related infertility (Brown et al., 2016; Nordqvist, 2014). Further, Nordqvist (2014) and Parks (2009) argue that by creating new forms of the family in these marginalised groups, pronatalism can be destabilised, as these families are less likely to adhere to traditional roles. For example, when a lesbian couple has children, "the act of procreation does not produce the culturally expected mother and father, but instead it reproduces two mothers and a donor, in other words, a "cultural unknown"" (Nordqvist, 2014, p. 481). These "cultural unknowns" are important because traditional norms in societies globally mean that the social role traditionally linked to biological motherhood often keeps women in domesticated roles as private homemakers, and consequently in social positions of inferiority (Nordqvist, 2014; Young, 2003). Providing IVF to same-sex couples, trans people, and older women, even by their very existence as non-traditional groups entering parenthood, can help to deconstruct the traditional mothering role that often leaves women in limited social positions (McTernan, 2015; Nordqvist, 2014; Parks, 2009).

This section considers three examples of reproductively marginalised groups where IVF has the potential to correct for reproductive inequality and help encourage motherhood in non-traditional groups. Section 3.1 considers IVF in the case of same-sex relationships (specifically lesbian couples) and trans groups, and section 3.2 the case of women with age-related infertility as a result of delaying childbearing in order to pursue careers.

Provision of IVF as a Corrective Tool: The Case of Same-Sex Couples and Trans Groups

Reproductive choices are made harder for same-sex couples – both gay male and lesbian - by the prevalent notion that "the normative family (i.e. biological and heterosexual) is the ideal place to raise children" (McTernan, 2015, p. 10). Provision of IVF for same-sex couples gives the same access to parenting as it does for heterosexual couples. It might also help challenge the 'normal' construction of the family through creating new family forms (ibid.).

Whilst IVF has the potential to enable reproductive equality for same-sex couples and diversify the normative family model, consultation of the current UK NICE guidelines (2013) shows that this claim is not currently supported. For example, for lesbian couples IVF on the NHS

is much more difficult to access than it is for heterosexual couples, as many are refused state-funded treatment unless they have tried to conceive using privately funded donor insemination six times prior to access (NICE, 2013) or they undergo tests to prove they are medically infertile (Stonewall, 2009). That these women are socially infertile (i.e. due to the gender of their partner) and have no possibility of conceiving a child together without intervention is not considered a sufficient basis to fund treatment.

Smajdor (2009) uses the following example to argue that this is a form of discrimination. Consider Woman A, whose husband is medically infertile, and Woman B, who has a female partner. Both Woman A and Woman B are physiologically identical and unable to become pregnant without medical assistance. It is only their social circumstance in terms of gender of partner that is different. Woman A can access publicly funded IVF, whereas Woman B is ineligible and cannot. This example illustrates how guidelines for state-funded IVF entrench heteronormativity through preferential treatment of heterosexual couples. This is problematic, and discriminatory against lesbian couples looking to conceive. In framing IVF as a purely medical treatment, thus making access decisions based on medical rather than social reasoning, the NHS restrictions to IVF access for lesbian couples are not just limiting, but unethical (ibid).

A second example where IVF needs development in order to achieve reproductive equality is in trans groups. For trans people undergoing gender re-affirming treatments, provision of fertility preservation (i.e. having sperm, eggs or embryos frozen and stored for later IVF use) would enable access to biological parenting. This option for trans people takes a similar rationale to those patients undergoing other forms of medical treatment that may impact on fertility – such as chemotherapy in cancer patients – where access to fertility services are routinely offered (NICE, 2013). However, according to the Equality and Human Rights Commission (EHRC), many NHS clinical commissioning services choose not to offer NHS fertility services to those wishing to preserve fertility prior to necessary gender-affirming treatment, despite it being a well-documented, funded option offered to patients about to undertake other life-enhancing treatments that may affect their fertility (Doward, 2018; BBC News, 2018). Charities supporting transgender children and their families also note the lack of signposting and information about fertility preservation to those wishing to commence fertility-affecting treatments (Doward, 2018).

Provision of IVF as a Corrective Tool: The Case of Older Women

A further example of how publicly funded IVF might correct reproductive inequality is enablement of motherhood in women with age-related infertility due to their delaying pregnancy in order to focus on their careers. There are of course instances where older women will have age-related infertility for reasons other than to pursue a career, for instance inability to find a suitable partner or the choice to remain single. However, empirical evidence from Mills et al. (2011) shows that the choice to further a career is one of the more common reasons for why women experience age-related infertility. Increasing numbers of women in Western societies delay childbearing in order to pursue careers (ibid.), which in turn has enabled greater employment choices for women and lessened the emphasis on the patriarchal breadwinner role (Lemoine and Ravitsky, 2015; Faircloth, 2014). However, in many professions, the crucial period for a woman becoming established in her career also coincides with her most fertile period (McTernan, 2015). Medical evidence shows a decline in fertility as a woman ages (Meczekalski et al., 2016), therefore women face a choice between either pursuing a career, or maximising their chance of bearing children. Additionally, women choosing to pursue a career before childbearing can be framed as 'abnormal' and 'selfish' (Shaw and Giles, 2009), which stigmatises rather than supports their resultant diagnosis of infertility (Gentile, 2013). A loss of reproductive equality for women with age-related infertility could be mitigated through increased provision of IVF, allowing these women the choice to further a career, and also have the opportunity of childbearing.

However, there are two ways of framing this debate. Either we focus on the individual woman, or the structure that placed her in this constrained position. If this issue is addressed by providing IVF on the NHS for women with age-related infertility, this risks making the structural problem of employment restrictions (such as less employment progression and lower paid job-roles for women having children) into an individual problem for the woman. For women deciding to delay child-bearing to avoid employment restrictions, from a fertility perspective, they become poorly functioning. Providing a limited chance at conceiving via IVF treats a medical problem, but does nothing to change the social structures surrounding the problem (McTernan, 2015). Furthermore, using IVF as a correction method for employment inequality between men and women has its own medical concerns. Evidenced risks to women of advanced maternal age include an increased likelihood of conditions such as pre-eclampsia and gestational diabetes. Further, offspring may be more likely to require intensive care and be at higher risk of prematurity (NHS Choices, 2015). In encouraging women to take these risks, or at the very least making the choice viable, women experiencing medical concerns arising from IVF could find themselves socially weakened (for example if they are unable to return to work), which further perpetuates the arguments outlined in Section 2.1 regarding loss of physical and psychological control resulting from IVF interventions.

The potential of IVF provision to enable reproductive equality in lesbian couples, trans groups and older women, and in doing so deconstruct the normative role of motherhood, is evident. However, as discussed in this section, current provision of IVF on the NHS does not support fair access for lesbian couples or trans groups, nor does it justifiably solve infertility in older women who choose to pursue careers before they become mothers.

Reducing Pronatalist Bias - Proposals for the Medical Profession

In this final section, I make a series of recommendations to help promote women's reproductive autonomy, whilst simultaneously limiting the social harms incurred by pronatalist bias. In section 4.1, I consider the benefits of continuing with a publicly funded IVF service, whilst also offering specific amendments to the access criteria. In section 4.2, I suggest wider proposals for the medical profession that support women who are infertile by focusing on reducing pronatalist bias via alternative methods of communication and evidenced information-sharing.

IVF Provision: Optimising Choice and Minimising Harm

Given my conclusions in section 2 of the social harms resulting from pronatalist bias, and that IVF provision acts to reinforce these harms by legitimising motherhood as what is 'best' for women, it would seem reasonable to argue against a publicly funded service. Furthermore, whilst section 3 highlights the potential of IVF to offer reproductive equality to reproductively marginalised groups, in reality, IVF provision as it stands does not currently support this. Again, it would seem reasonable here to withdraw a publicly funded service.

However, despite these conclusions, I in fact contend that the medical profession should continue to support state funding of IVF. This paper highlights the harmful aspects of IVF provision, but it also makes the case for providing opportunity for reproductive autonomy, and enabling the potential for reproductive equality in lesbian couples, trans groups and older women. For example, IVF may deconstruct normative modes of family-making and help challenge patriarchal norms that leave women in positions of social inferiority. An additional consideration is that IVF provides an opportunity for single women who seek to become biological mothers. In a cross-national European study (Testa, 2007), it was shown that having a supportive partner was the second-most important factor (health of the mother being the first) among childless men and women in the decision to have a child. Difficulties in finding a partner, or the breakdown of a

relationship, could mean that single women struggle to have a biological child, but IVF gives them this opportunity. Additionally, there will be some women who make a choice to remain single, and for these women, IVF gives further choice to those who may desire a biological child, but who do not necessarily desire a partner. On a more general level, for those who are involuntarily childless and cannot afford to pay for IVF, restricting funding would place heavy burdens on women to process their own frustrated desires, and to resist the pressures of pronatalism. Many women will continue to desire biological motherhood, and elimination of public funding would wrongfully target those women who are financially restricted. Therefore, rather than limiting public funding of IVF and leaving some women worse off, I propose that the role of the medical profession should encourage the most liberating and least harmful aspects that IVF can offer.

For lesbian couples, it is crucial to reduce discrimination against those that are involuntarily childless in order to support these groups to feel more liberated in society and to encourage new forms of family-making. I therefore propose that lesbian couples who have no chance of conceiving via 'expectant management' (conception through unprotected vaginal intercourse) should not have to privately fund six cycles of intrauterine insemination, costing upwards of £4800 (NHS Choices, 2017). Instead, this should be offered as a publicly funded service prior to consideration of IVF. I also support the Equality and Human Rights Commission's (EHRC) call for the NHS to offer trans patients equal access to fertility services, by routinely offering fertility preservation prior to any gender-affirming treatment. For those people choosing to undergo surgical transition to change sex, one consequence of surgery is a loss of fertility. Gamete extraction prior to surgery would offer fertility preservation in these groups.

For older women with age-related infertility as a result of structural problems within patriarchal societies (i.e. employment restrictions), I do not propose additional changes to current NHS access criteria, but concur that IVF should still be provided as it would to younger women, and that the age limit should remain at forty-two as advised by NICE (2013). Whilst being more lenient on IVF access restrictions for older women might be seen as a compensatory method for those who have not had the chance to bear children earlier in life, I do not offer any additional amendments based on the increased risk of medical problems and the decreased likelihood of conception (see section 3.2). Rather than maximising the use of IVF in older women, I propose that IVF should be offered as part of a broader range of measures that tackle age-related infertility as a social issue, not just a medical one (Lemoine and Ravitsky, 2015). Employers should give more attention to creating appropriate work conditions so that women can parent earlier without compromising their careers, for example providing on-site childcare and more flexible work arrangements for both parents (ibid.).

De-Emphasising Pronatalist Bias

IVF may be deemed suitable for certain groups of infertile women, however, as I have stressed in this paper, the harms incurred by pronatalist value systems make it important that the medical profession does not rely on IVF as the only method of approaching infertility. Here, I look at why we need to normalise women who do not have biological children, and follow this with proposals for how pronatalist bias can be reduced, ensuring maximum autonomy for women considering their reproductive futures.

Normalising women who do not have biological children is important for all groups of women – those who are involuntarily childless, and those who have made the choice to be childfree. As I have discussed, placing a high value on biological motherhood is harmful for those who do not subscribe to, or cannot instantiate, this value. Further to this, the social value assigned to biological motherhood as a woman's normative role is not actually matched by what is statistically 'normal'. According to the Office for National Statistics (2012), one in five women in the UK aged forty-five had never given birth. That 20 per cent of women living in Britain are unable to live well

without having a biological child is unlikely, especially considering many of these women will be childless out of choice.

For some, the inability to procreate is indeed a fundamental barrier to their overall happiness (McMillan, 2001). However, for others, it will be disappointing but not at all tragic (Uniacke, 1987) and for others it won't be of any significance at all, as they will have purposefully chosen a life without children (Letherby, 2002). Pronatalist trends, driven by those valuing procreation, commonly assume that everyone experiences the inability to procreate as similar to McMillan (2001) – that is, a serious barrier to life happiness. However, Greil (1997) notes that by focusing on "clinical examples" (as most of the literature does), one lets "a select group of the infertile, who are almost certainly not representative of the infertile population as a whole, speak for the whole group" (p. 1699). According to Greil (1997), it is therefore not possible to conclude that because some of the patients attending fertility clinics experience psychological distress about their infertility, that infertility more generally is a cause for abnormality and suffering.

Interventions to minimise pronatalist bias can be applied across multiple domains, for example, making changes in the media, policy, and education. The set of proposals here offered focus specifically on how the medical profession can help to reduce pronatalist bias. Education for medical professionals on what is statistically 'normal' is important because it can alter the focus of current social norms and ideologies surrounding motherhood. Healthcare professionals should be especially mindful of pronatalism to ensure they do not reinforce social biases in their interaction with patients. Social biases can be morally complex, and development of critical thinking skills could be included to a greater degree in medical education and continued professional training.

Accurate information about social influences on individuals and their behaviours can help destabilise pronatalism, whilst general information about IVF success rates and risks is important for enabling informed reproductive choices for all women. Promoting women's autonomy in the reproductive healthcare context can be achieved by offering counselling that encourages critical reflection of personal values and biases. NICE (2013) requires that all patients undergoing invasive reproductive treatments are offered counselling to reduce the degree of physical and psychological stress. However, research suggests that efforts to improve these stressors using existing systems of consultation have limitations in terms of the quality of communication and provision of post-treatment support (Peddie, van Teijlingen and Bhattacharya, 2005). Shared decision-making is the consultation style most likely to increase patient autonomy and decrease the power asymmetry between doctors and patients (Deber, 1994; O'Connor, 1995), therefore, further efforts to develop strategies that facilitate a shared decision-making process between the doctor and patient should be considered. For example, critical reflection of personal values and biases should be included in consultations, not just in patients undergoing IVF, but also for those at the level of primary care. This could include offering specific fertility training that is more socially sensitive and mindful of pronatalist bias.

Finally, prospective parents should be given a range of family-making options that do not just include medical treatments, but also include promotion and explanation of social parenting, and this should happen early in a patient's presentation to the GP. For example, it should be highlighted that financial support for adoptive parenting matches the cost of IVF treatment (approximately £5000 per placed child), which is not currently a widely known fact (First4Adoption, 2018). In supplying more information, people can be made aware of what is available for both social and biological methods of parenting.

Conclusion

Pronatalist bias undermines a woman's reproductive autonomy, perpetuating harmful social norms about what it is to be a woman, and a mother. Placing so high a value on procreation that

women should be prepared to sacrifice their time, their employment prospects, their physical health and even their emotional well-being to be able to bear children, imposes undue restrictions on women as a group. Within this context, the liberating possibilities of IVF as a 'cure' for infertility are questionable. However, the possibility of promoting equality in reproductively marginalised groups, and allowing access to those who are financially constrained, is enough to warrant a continuation of publicly funded IVF in the UK. This conclusion is made on the basis that the medical profession should engage in broader methods of social support that help reduce pronatalist bias, and in doing so, allow greater autonomy for women who are considering their reproductive futures. With alternative methods of parenting, and social structures that support women in their reproductive years, perhaps at some point in the future IVF will no longer be needed as a 'cure' for infertility.

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