

Clinical Encounters

Dynamics of patient-centred practices
in a Dutch fertility clinic

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Summary

What makes many people with fertility problems so persistent in their use of fertility treatment (and IVF in particular) once they have visited a fertility clinic? What makes it so difficult to jump off the roller coaster of treatment? And in particular, in what way does visiting a fertility clinic – and the experience of clinical encounters – affect people in terms of the (further) medicalization of their fertility problems? These were the questions that formed the starting point for the study presented in this thesis, in which I portray the daily practices of a Dutch fertility clinic (constituting hospital ethnography) and provide insight into the situated accounts of couples visiting this clinic. Further, this thesis examined – inspired by Foucauldian notions on the workings of disciplinary power – how these clinical encounters affect the experiences and views of people with fertility problems and their (further) use of fertility services and technologies. By looking in such detail at the complex and dynamic relationship between clinical practice and people's experiences, this thesis intends to contribute to an understanding of the complexity of women's and men's responses to reproductive technology, and more broadly, seeks to advance the theoretical understanding of processes of medicalization in clinical practice.

In Chapter 1 (*Introduction*) the motivation to do this study, the study aims, and theoretical framework are provided. Previous studies in this area have found that people with fertility problems are often persistent in their use of IVF and find it hard to escape the so-called medical treadmill. This persistence exists despite the many critiques and concerns which have surrounded these technologies from their early introduction, related to, for example, the limited success rates, the physical and emotional burden of treatments, the potential risks, ethical issues, and the costs involved. The first generation of feminist social scientists seeking to understand the rapidly increasing medicalization of fertility problems, and couples' persistent use of advanced reproductive technologies (ARTs), mainly pointed to the dominant discourses (regarding patriarchal and medical-technical imperatives) forcing women to use these technologies. A second generation of social scientists, however, not only considered the impact of these dominant discourses, but also sought to comprehend – in a more nuanced way – the ongoing medicalization of fertility problems by listening to the views and experiences of the women (and sometimes men) involved, and by placing these experiences, views, and responses in the context of people's socio-cultural world and their daily life circumstances. However, these later scholars rarely looked at the actual daily practices in fertility clinics, such as the clinical encounters in consultation and treatment rooms.

This thesis takes as its point of departure the premise that clinical practices – and thus the way fertility services are offered – differ over time and in different localities. Biomedicine is not a monolithic enterprise: local factors reshape the way global technologies are used in particular sites and at different times. The way clinics organize their work and clinic staff offers their services and deal with their patients is assumed

to affect the way people view ARTs, and the way they can and do make use of these services. Since the first successful use of IVF in 1978 (in the United Kingdom) many changes in this field have taken place worldwide, including in the Netherlands, both at policy level and in fertility clinics, partly addressing the aforementioned concerns and critiques. The study upon whose results this thesis is based set out to portray how, in a particular Dutch clinic (the Clinic for Reproductive Medicine of the UMCN St. Radboud, hereafter referred to as the Radboud fertility clinic), three decades after the first IVF baby was born, fertility treatments – and IVF in particular – are provided. In the first place, this thesis thus constitutes hospital ethnography. Further, it starts from the basic anthropological notion of understanding a subject in its context. The clinic is seen as part of a larger societal system: other parts of the system – and I have given most attention to the prevailing ARTs and health insurance policies – interact with what is going on in the clinic. Next, the Foucauldian notion of disciplinary power (or biopower) is taken up as an appropriate concept with which to analyze the workings of power in the medical realm. In particular, I build on the work of social science scholars such as Lupton (1997) and Sawicki (1991) who have claimed that people (women), by going to the hospital and being ‘disciplined’ by the medical regime, become more and more inclined to look at themselves and their (fertility) problems with a ‘clinical gaze’, and to think of medical solutions only.

In this thesis the role of medical technologies in processes of medicalization is also emphasized. The mere existence of medical technologies – in this case ARTs – *and* the way they are presented and explained to (potential) users, shape the views and expectations of the people visiting a fertility clinic. In particular, I build on insights about the impact that visualization and fragmentation of the body interior and/or bodily processes in biomedicine has on the way people perceive their own (ill) bodies, and understand medical diagnoses and interventions, as forwarded by Sandelowski (1993) and other scholars. Finally, while ART policies, society at large, clinical practices, biopower, and medical technology are in this thesis assumed to affect people’s responses to their fertility problems, I do not assume that women and men docilely and submissively obey such biomedical or socio-cultural mandates. Rather, following Lock & Kaufert (1998), I see them as pragmatic actors making use of reproductive technologies in the way they consider most appropriate for enhancing the value of their daily lives, given their particular situation at that moment in time.

In Chapter 2 (*Methodology*) the reader is informed about the study design and methodology. The two main pillars of the study are hospital ethnography and prospectively following couples visiting the clinic. The ethnographic observations in the clinic provide insight into daily clinical practices and encounters, in what people – both women and men visiting the clinic, and clinic staff – actually do, undergo, and say when encountering each other and the reproductive technologies. By prospectively and intensively following twenty-three couples with fertility problems visiting the clinic, insight was acquired into these couples’ situated and lived accounts, their

experiences and views, and the changes therein over time. The couples were followed over a period of one to two years by means of in-depth interviews at their homes, observations and conversations at the clinics, phone calls and emails; in addition, some of the participants kept a diary on behalf of the study. The fieldwork for this study was undertaken in a period stretching from September 2003 up to August 2006.

In this chapter I also reflect on methodological issues that are particularly relevant to the current study and which may be expected to impinge upon the study process and findings. These issues include the role of the anthropologist as research instrument, the implications of approaching and studying couples (instead of single persons), and the fact that two of the thesis supervisors were involved as study subjects themselves (medical doctors at the clinic). Finally, I address a number of ethical issues encountered when carrying out the study.

In Chapter 3 (*Contexts*) a number of contextual facts, features, and forces relevant for the understanding of this thesis are provided (based on secondary sources), including information on the occurrence and meaning of infertility and childlessness (voluntary and involuntary) in the Netherlands, and in the help seeking behaviour of people when they find themselves confronted with fertility problems. Despite the fact that in Dutch society in the last decades voluntary childlessness has become more accepted and more common (in particular among higher educated women), a large proportion of Dutch people (women) confronted with fertility problems experience involuntary childlessness as distressing, and enter the medical field in search of a solution. In this chapter I also provide a portrait of Freya, the major Dutch patient organization for people with fertility problems, and sketch out the role of the mass media and the Internet in the Netherlands, as they are (worldwide) considered influential players/forces in the infertility arena. By providing information on their role in the Netherlands, I draw attention to the (potential) impact of these forces, firstly on what people consider to be possible, proper, normal, and feasible solutions once they are confronted with fertility problems, and secondly on the formulation of health policies.

In Chapter 3, I also delineate Dutch legislation and professional guidelines regarding ARTs and their coverage by health insurances. Overall, Dutch policy and NVOG (the Dutch professional organization for obstetrics and gynaecology) guidelines are directed towards providing access to high quality treatment to citizens with fertility problems. At the same time, a considerable number of constraints on the use of medically assisted conception are set at the supply side, based on ethical, legal, medical-technical, and/or financial grounds. Thus not all technologically possible treatments are made readily available, and neither is coverage by health insurances unlimited. From January 2007 Dutch basic health insurance pays for three IVF treatments; after a pregnancy of minimally twelve weeks or the birth of a child, a further three IVF treatments are paid for. Particularly striking is that risk reduction

currently receives more attention than it did during the initial introduction of IVF in the early 1980s.

In the last section of Chapter 3 I introduce the clinic where the study was carried out, and I point to a number of features that are specific for this clinic and/or of particular relevance for further understanding this thesis. The Radboud fertility clinic is – in some aspects – more restrictive than national policy with regard to the type of treatments that are offered and to whom; for example, at the time the study was conducted the clinic did not work with donor gametes, and as such did not offer fertility treatments to lesbian couples and single women (this policy changed partly from January 2008 onwards). The clinic is also particular in its aim of providing high quality, patient-centred care, which has resulted in it receiving the Dutch Infertility Award three times from Freya. It is currently also the only clinic in the Netherlands offering couples undergoing IVF on-line access to their medical files, aiming to empower patients and get them more involved in, and responsible for, decisions about their treatment trajectory.

In Chapter 4 (*Couples and their quest for a child*) I introduce the main players in this study, the couples whom I followed intensively over the course of their treatment trajectory. I first provide socio-demographic background information about them, and picture the diversity of their situations at the moment they found themselves confronted with fertility problems. Throughout the chapter I present case descriptions of some of the participating couples, to further illustrate the diversity among them. In the second part of the chapter I describe the way the participating couples acted from the moment they saw themselves confronted with fertility problems, including their ‘quest for conception’ in the biomedical and alternative health system and the way they approached adoption as an option (or not). At the end of the chapter I summarize their medical diagnoses, treatments, and treatment outcomes.

The next five chapters are dedicated to the ‘clinical encounters’. In each chapter I focus on a different aspect or dimension of these encounters and fertility treatments, respectively: ethically sensitive requests for medically assisted conception; the practice and impact of patient-centred medicine; the way risks and rates are dealt with; the impact of visualizing technologies; and the burden of treatment. In each of these chapters (with the exception of Chapter 5) I seek to understand the dynamics between ‘clinical practices’ and ‘the way couples perceive and experience this’, and I analyse and reflect upon – inspired by Foucauldian notions of ‘disciplinary power’ and the ‘clinical gaze’ – how these dynamics (may) affect couples’ (further) use of fertility treatments, and thus also the further medicalization of their fertility problems. Chapter 5 (on ethical issues) is an exception because while I do present some specific clinical practices, I do *not* provide the experiences and views of the particular couples concerned, as I did not speak with the couples whose situations were discussed in the clinic’s multidisciplinary ethics meetings which are presented in the chapter.

In Chapter 5 (*Exploring ethical boundaries*) insight is provided into couples' requests for medically assisted conception that raise (ethical) concerns among Radboud fertility clinic staff – and are therefore discussed in the clinic's multidisciplinary ethics meetings – and into the contextual features that shape these concerns. Situations that raised concerns included couples where one or both partners were (potential) carriers of genetic diseases or suffered from serious psychical problems; where the man was terminally ill or of an advanced age; where the couple did not fulfil the clinic's criterion for a stable relationship; and some other situations. Contextual features include the fact that procreation takes place in a hospital (and that doctors are thus involved in decision making), the fact that this hospital is rooted in a Catholic community and takes a specific (ethical) stance, and the existence of Dutch legislation regulating the use of reproductive technology and addressing ethically sensitive issues.

In this chapter I argue that while these contexts definitely shape the contours of how ethically sensitive requests for medically assisted conception are addressed, they do not fully determine how decisions are made in particular situations. There remains an area of ambiguity and uncertainty. The Radboud fertility clinic holds bi-monthly meetings in which clinic staff discuss the requests which they consider ethically sensitive. They employ a number of practices in order to handle such situations, for example seeking scientific evidence and consulting colleagues, as they are aware that they are not always competent to judge the seriousness of their concerns. They also attempt to resolve ethically complex situations by looking for medical-technical solutions and referring couples to other clinics; and they mirror their concerns with couples as part of informed consent procedures, and (in some cases) in the hope of discouraging people from seeking further treatment.

Health professionals' personal values were also found to inform their concerns, as well as their appreciation of a couple's situation, which may make them more receptive to some couples' situations than others'. The space that clinic rules allow for ambiguity is sometimes used in favour of couples whose requests for medical assistance is shared or understood; while this space is not allowed in circumstances where the request is not appreciated by clinic staff. I further demonstrate in this chapter that some of the practices clinic staff employ lead to new ambiguities and uncertainties, and sometimes raise new ethical dilemmas. Moreover, I have argued that it is mainly because of these ambiguities and uncertainties that most couples, despite initial concerns from the side of the medical professionals, are allowed to re-take their reproductive autonomy and decide for themselves whether to start treatment. In practice, only in a few cases is access to treatment denied on ethical grounds; in most cases the principle of autonomy of the couples overrules the professional and/or personal concerns of the health care providers.

Chapter 6 (*Multiple dynamics of patient-centred medicine*) focuses on the daily patient-centred practices in the clinic. Overall, study participants appreciated the way services are offered at the clinic, though critiques were expressed as well. In particular, study

participants appreciated the friendly and committed way that clinic staff generally approached them, the fact that they were seen and treated as human beings rather than as numbers, the amount of time clinic staff (often) spent with them, the abundant information they received by different means of communication, and the empathic way in which they were (generally) dealt with. These patient friendly practices diminished the burden of treatment and facilitated informed decision making. Yet several study participants were less positive about how their privacy was dealt with (in particular with regard to the waiting room and the seed production room), and many also disliked being seen by several different doctors during their treatment trajectory. These critiques reflect the need study participants felt for privacy when dealing with an intimate subject such as medically assisted conception.

In this chapter I also address the question of how the multiple dynamics resulting from these patient-centred practices affect the way couples decide and go about (further) use of reproductive technologies. First, I have shown that patient-centred practices do indeed enhance couples' ability – as they are intended to do – to consciously consider pros and cons regarding (further) treatment and thus make informed choices. Secondly, I have pointed to the inclination to start and continue treatment (up to three treatments), both on the part of clinic staff and the couples with fertility problems visiting the clinic. This inclination results from a combination of factors or processes, namely doctors' professional 'tendency to act'; the unspoken assumption that people come to the clinic to 'have their problem fixed'; the fact that fertility treatments are generally presented and considered as a trajectory (consisting of a package of three IVF or six IUI) treatments) instead of as a single treatment that is supposed to be immediately successful; and the health insurance regulations leading to the 'imperative of three IVF treatments'. This coverage of a maximum number of three reimbursed IVF treatments has two implications: on the one hand, couples come to see it as normal to think of doing three treatments; and on the other hand it also indicates a kind of final limit, which makes people less inclined to go beyond these three treatments. Due to the inclination to start and continue treatment, couples are not always explicitly asked – in particular not in between these treatments – if they indeed want to start treatment and/or switch to another treatment type or cycle, which I have referred to as a 'missed opportunity' in patient-centred medicine. Yet, I have also questioned whether – given the 'package deal' – not repeatedly asking couples whether they want to go on, but rather routinizing the treatment, might be preferable from the point of view of the couples, as they do not have to re-think each time their basic decision.

Finally, I have pointed to – looking at the patient-centred practices from a Foucauldian perspective – the possible unintended effects of patient-centred practices, which I call 'paradoxes of patient-centeredness', as they (may) interact with the basic principles of patient-centred medicine. From this perspective, the amount of information and support provided, the bonds created between doctors and couples, the trust couples have in clinic staff, and the ongoing visualization of the process of conception

mediated by medical technology, can be regarded as practices which strengthen lay people's 'clinical gaze' in terms of how they come to look at their body, bodily processes, and solutions for their fertility problem. Strengthening the 'clinical gaze' may make couples more inclined to think only in medical terms and solutions. Patient-centred practices, I therefore argue, while aiming at *and* succeeding in enabling informed decision making, may at the same time have the paradoxical effect of making people more inclined to pursue (further) treatments. This argument is further illustrated and elaborated in the chapters that follow.

Chapter 7 (*Weighing risks and rates?*) considers the way risks and rates are dealt with by clinic staff and couples. Couples indicated for IVF at the Radboud clinic are – as part of the clinic's patient-centred policy to empower patients and involve them in decision making – extensively informed about IVF success rates and the possible risks involved in the treatment. With regard to success rates, couples in this clinic are certainly not provided with false hope, as has been suggested in the past by some authors; on the contrary, the limited success rate (20-25% per IVF treatment cycle) is emphasized again and again. Regarding the way risks are presented to the couples indicated for IVF, two features stand out. Firstly, concern is expressed by staff about a number of risks involved (most emphasis is put on the risk of Ovarian Hyper Stimulation Syndrome (OHSS) and of multiple pregnancies), and knowledge gaps are made explicit (mainly regarding long term effects on mother and child). Secondly, while potential risks are underlined, at the same time couples are reassured that the risks are not 'irresponsibly high', and that they are to a large extent kept 'under control' (for example by transferring maximally two embryos, and by intensively monitoring follicle growth).

Despite the abundant information provided, the women and men participating in this study found it difficult to assess exactly what these risks and rates entailed for their own situation. Multiple pregnancies in particular were an issue that people found difficult to think of in terms of risk, especially when they would be pleased to have twins. They found it difficult to weigh the increased risks resulting from the transfer of two embryos against the decreased chance of success by transferring only one. Further, risk perceptions were not only informed by the information provided by the clinic, but they were constructed over time and in interaction with various experiences and influences (regarding self and others, from within and outside the clinic). Overall, the decision to pursue IVF treatment should not be seen as a decision purely based on a rational weighing up of the information on risks and rates. People's individual risk perceptions, the lottery like features of the IVF treatment, feelings of 'anticipatory regret', couple's strong wish for a child, the trust in the medical staff (which is of paramount importance), and the potential of medical technology, all contribute to the fact that couples are inclined to start and continue IVF treatment, even when they feel that the success rates are not really promising and they are scared by some of the potential risks or side-effects.

In Chapter 8 (*Visual milestones in conception*) the focus is on technology – on the way reproductive technologies and their presentation and interpretation affect couples' views and experiences regarding medically assisted conception. First, I describe couples' initiation into the medical world of infertility throughout the examination phase. I show how from the very first moment they enter the fertility clinic, they are made aware of all kind of factors – bodily processes and substances – that play a role in conception. Over the course of examinations and treatments couples learn to distinguish a number of criteria that have to be fulfilled in order to make conception occur. These insights can only be known because of the use of laboratory and medical technologies that visualize and measure bodily processes and substances, and through the mediation of professionals who watch, judge, interpret, and communicate what is being observed. From a Foucauldian perspective, women and men with fertility problems thus learn to look at their bodies and the process of conception with a 'clinical gaze' and, I argue, become more inclined to assess their own situation according to medical criteria. This is in sharp contrast with people who try to conceive 'on their own' who are hardly aware of how they perform according to these criteria. The insights gained in the examination phase influence and colour – co-construct – people's views of the process of medically assisted conception.

In the second part of this chapter I demonstrate and argue that specific features of the IVF treatment (namely fragmenting and visualizing the process of conception in different stages) and the presentation, explanation, and interpretation of treatments and their results make these treatments (more) compelling to users, and as such also affect couples' decisions about treatment. I show how they learn to assess and judge the outcomes at each and every step in the process of an IVF treatment cycle. They become knowledgeable about the outcomes at the 'visualized milestones of conception' (as I have dubbed them), outcomes which they eagerly follow and retain and which become extremely meaningful. The outcomes tell them if a certain step in conception has been successfully passed or not. I further show that this fragmentation or phasing of conception, and awareness of the outcomes at each milestone, affect the mood of the couples in treatment: successfully fulfilled steps in a treatment cycle give hope to the couple involved; but on the contrary, disappointing results form a source of concern and tension. The outcomes also constitute a major source of ambiguity: on the one hand people are and want to be hopeful, but on the other hand they feel they should not have too much hope, but rather be realistic to prevent too major a disappointment in case of treatment failure. Still, couples' hope increases with each positive outcome. When they then reach the end of a treatment cycle, and in particular when an embryo is placed into the woman's uterus, the feeling of coming close to the desired end result becomes stronger, and hope increases even more. If the IVF treatment then does not bring the desired result, people are left with disappointment, but also with the feeling that they have been *very close*. When couples look back on a failed treatment, they do not only take into account the end result (that is, not being preg-

nant), but all of the small in-between steps are reflected upon: what went well, and what went wrong. The results at each 'milestone' are taken into account when assessing future prospects and may form an incentive to try again, but may also make people ambivalent about pursuing further treatment.

Chapter 9 (*Prepared to bear the burden*) provides in-depth insight into how couples experience the burden of IVF treatments (physically, mentally, and logistically) in the different treatment stages, and seeks to understand what makes them – and in particular the women – prepared to bear this burden (including the support provided by the clinic and their partners) and what makes them decide to no longer bear this burden. Most couples participating in this study did experience the IVF treatments as burdensome, though this burden was far from equally divided. First, there is gender inequality regarding the burden of treatment for women and men. While both women and men experience IVF treatments as burdensome, findings in the current study clearly confirm the idea (as generally presented in the literature), that women are more bodily affected than men, as almost all of the medical procedures of IVF treatment take place in the female body. Secondly, IVF treatment also affects different couples – and in particular different women – in extremely variable ways. I have asserted that women's different bodily experiences may be partly explained by the fact that the medical interventions actually do physically affect them differently, while the total number of IVF and other fertility treatments people undergo also affects the amount of pain and burden they experience. Further, I have argued that the way couples view, experience, and respond to the burden of treatment – and to the hormonal medicines in particular – is socially constructed, and as such is related to the meaning of having a 'child of their own', the information they have received (from inside and outside the clinic), and their experiences with and views about hormonal medicines.

In the second part of Chapter 9 I reflect on what it is that makes most couples prepared to bear this burden of treatment. First, I outline how the couples in this study undergoing IVF treatment (generally) were and felt well prepared and supported by the clinic staff to expect and to bear the burden of IVF, which – as intended – alleviated the burden of treatment. Second, looking at the same practices from a Foucauldian perspective, I argue that it is precisely because the couples are well prepared and supported to expect and bear a substantial level of burden, that experiencing this burden becomes normalized in the context of IVF and therefore more acceptable. In addition, couples are and feel well monitored, which enhances the trust (most) couples have in clinic staff. Doctors, they believe, would not let them undergo these treatments if this were irresponsible; a belief that may make couples more inclined to continue treatment, despite the experienced burden. Third, I point to the significance of couples sharing the burden of treatment, and in particular to the importance of the men supporting their wives who bear the majority of the physical burden. This helps them (and in particular the women) to bear the burden of IVF: a burden shared is a burden halved. Fourth, while couples suffer substantially from the burden of treat-

ment, the hoped-for end result, a child of their own, is considered worth bearing this pain for; it makes bearing the pain meaningful.

But where does one draw the line? When is burden or pain meaningful and when does it turn into meaningless burden or pain? At this point in the analysis I once more return to notions of the ‘imperative of three treatments’ (referring to the maximum number of IVF treatments that Dutch health insurance pays for) and ‘anticipatory regret’, as the combination of these two notions helps couples delineate the limits of treatment and thus to a large extent indicate when women (and men) are no longer prepared to bear the burden of treatment. ‘Having done enough without becoming obsessed’ for most couples becomes equal to ‘doing three IVF treatments’ (or a maximum of four, to convince yourself that you have *really* done everything). At the same time, this limit of three (maximally four) treatments also renders (most) people more inclined to go up to the last possible treatment, as after all you will know for sure that the burden will *then* stop. The ‘imperative of three treatments’, I conclude in Chapter 9, is thus imperative indeed.

In the concluding Chapter 10, I bring together and wrap up the main study findings, addressing the research questions that were posed in the introductory chapter. I state that two factors – the strict boundaries set by Dutch policy regarding the use of ARTs, and the patient-centeredness of the Radboud clinic’s policy and practices – are key in terms of shaping the views, experiences, and actual usage patterns of men and women confronted with fertility problems. These key features influence the way couples pursue treatments in multiple – and sometimes paradoxical – ways: they may restrict the (further) medicalization of fertility problems, and may actually withhold (further) treatments from some people; they are empowering and enable informed decision making; and they may render – through the dynamics of ‘missed opportunities’ and the ‘paradoxes of patient-centeredness’ – couples more inclined to start and continue using ARTs. Subsequently I state that recognizing the compelling dynamics resulting from patient-centred practices and reproductive technologies without recognizing people’s capacity to assess the possible options would not do justice to the complexity of processes of decision making and medicalization. Throughout their treatment trajectory, couples *do* consider pros and cons, using the information that has been collected and provided, and in the light of their lived experiences (regarding the burden of treatment, side effects, results of previous treatments, and (non) appreciation of the clinic services); their views (ethical considerations, risk perceptions, the meaning of ‘a child of your own’, and the meaning of a life without children); and their life circumstances (partner support, already having a child, their age). Based on such considerations some couples in this study did not accept the limits set by Dutch policy and went abroad for treatment; some others did not pursue further treatment while they still had the right to do so (thus did not follow the ‘biomedical mandate’); while most couples in this study (and beyond) did show persistence, and decided to pursue treatments until they had reached pregnancy, or until they had used up their

three paid options (and some did four treatments). The latter couples did so despite the unpredictability of the outcome of reproductive technologies, and despite the ambivalent feelings they had about it. In the end, they pragmatically chose to continue bearing the burden of treatment, as for them the perceived benefits still outweighed the perceived costs (cf. Lock & Kaufert 1998). Trust in medical staff and in the potential of IVF – the technology of hope – is a way of confronting the uncertainty and encourages persistence in treatment. Finally, then, it is a structural measure, the limit set by Dutch health insurance to pay for three IVF treatments (per child), that puts a halt to the couples' persistence in help seeking for their fertility problems. Hence, I conclude, in the Netherlands, persistence in help seeking for fertility problems turns into 'bounded persistence'.

Processes of medicalization are generally understood as complex. The theoretical framework and subsequent methodological approach applied in this thesis (drawing attention to the dynamics between social contexts, health policy, clinical practices, *and* couples' lived and situated experiences) have proved to be most valuable. They have enhanced insight into the complexity of women's and men's responses to reproductive medicine (Lock & Kaufert 1998), both in terms of understanding couples' persistence with medical help seeking for fertility problems in particular, and in furthering our understanding of processes of medicalization in general. At the end of the conclusion I mention a number of implications of this thesis for 'the field' and for further research.