

ART eligibility for lesbians and single heterosexual women in Victoria: How medicalisation influenced a political, legal and policy debate

ABSTRACT

KEY WORDS

Sociology, medicalisation, assisted reproductive technology, lesbian parents, donor insemination, activism

This article analyses the seven year long Victorian political, policy and law reform debate over eligibility criteria for assisted reproductive technology (ART), emphasising the ways in which medicalised discourse and assumptions framed the arguments advanced by various stakeholders. It argues that despite the positive political, social justice and health gains for lesbian and gay prospective parents and their children that were ultimately achieved, the case made for the decriminalisation of self-insemination and increased access to clinical ART services also involved some disappointing political and intellectual compromises along the way. Although lesbian activism regarding ART eligibility criteria was often consistent with a position of what could be called ‘constructive medicalisation’ (Broom and Woodward 1996), the debate also demonstrated how easily constructive medicalisation arguments were side-lined in favour of arguments drawing on dominant medicalised discourses about infertility treatment and risk.

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Introduction

In December 2007, Victorian Attorney-General Rob Hulls announced State Labor Government plans to implement most of the Victorian Law Reform Commission’s (VLRC) Assisted Reproduction and Adoption Reference recommendations. These included extending eligibility for clinically assisted reproductive technology (ART) to all lesbians and single heterosexual women, and decriminalising self- or home insemination (i.e. the insertion of fresh sperm into the vagina by a woman and/or her partner via needle-free syringe). Hulls’ media release marked a considerable victory for Victorian lesbian parenting activists and their supporters. Sustained and dedicated work by activists over seven years, in conjunction with close consultation

with law and policy-makers, in no small measure contributed to the Government’s decision to substantially reform the Victorian ART laws.

The VLRC’s ART and Adoption reference was sparked initially by political fallout from the landmark Federal Court case known as *McBain v Victoria* (2000). This case won Melbourne gynaecologist Dr. John McBain the legal right to provide *in-vitro* fertilisation (IVF) to his single heterosexual client Leesa Meldrum. In the wake of the McBain judgement, the way was paved for Victorian doctors to provide ART procedures to women without male partners. Despite this, a policy requirement that such women qualify as ‘medically’ rather than ‘socially’ infertile was reinstated by the Infertility Treatment Authority (Victoria’s regulatory body) after legal advice on the policy implications of the McBain decision. A controversy erupted in late 2000 over the distinction between medical and social infertility, drawing attention to a range of anomalies and inconsistencies between Australian federal law and state-based ART legislation (see Walker 2000;

Szoke 2000; McBain 2000; Skene 2000). This culminated in the referral to the VLRC in late 2002 of a range of laws pertaining to adoption and assisted reproduction, including the *Infertility Treatment Act 1995* (Vic).

Lesbian activism pertaining to ART eligibility first gained momentum in Victoria in 1999 with the formation of the Fertility Access Rights Lobby (FAR). FAR's objectives included obtaining access to clinical donor insemination for Victorian resident lesbians, and clarification of the status of self-insemination, given that the wording of the *Infertility Treatment Act 1995* (Vic) indicated it could be illegal for anyone other than a 'Registered Fertility Specialist' to inseminate a woman (FAR 1999). Self-insemination using sperm provided by sympathetic male friends or acquaintances (also called 'alternative' insemination in the literature) has been documented in women's health movement and lesbian health publications since the mid-1970s as a relatively simple and woman-controlled conception practice (see Boston Women's Health Collective 1976; Feminist Self-Insemination Group 1980; Pies 1988). However, concerns about the status of this practice arose locally due to the wording of the Victorian ART legislation. At a time when lesbian-friendly GPs were noticing increasing numbers of lesbians seeking information about pregnancy, FAR's concern was that health practitioners seeing lesbian clients could be acting illegally in assisting them to perform inseminations or giving advice about how to inseminate themselves safely and effectively at home (see FAR 1999).¹

As a sociologist and researcher of lesbian and gay family formation, and a member of the lesbian community, I was at different times an active participant in and keen observer of the political debate. Rights activism pertaining to parenthood gained momentum in Victoria around the time I began work on my study of concepts of family and kinship among Australian lesbian and gay parents. I attended several early meetings of the FAR Lobby and contributed to their first position paper in 2000. However, as an overt political strategy regarding parenting rights gained momentum, it seemed to me that a sociological contribution to the debate could best be made by

maintaining a degree of critical distance. I made my own submission to the VLRC reference as an independent scholar, and this paper builds on some of the ideas first aired in that submission, and other published and unpublished contributions I have made to the debate along the way (see Dempsey 2006a, 2006b).

In the discussion that follows, I briefly map the trajectory of the seven-year-long Victorian political, policy and law reform debate through analysis of submissions to the VLRC, newspaper articles and position papers released by the VLRC and activists over the course of the debate. In doing so, I emphasise the ways in which medicalised discourse and assumptions framed the arguments advanced by members of the lesbian and gay communities and law and policy-makers. I argue that despite the very positive political, social justice and health gains for lesbian and gay prospective parents and their children that were ultimately achieved, the case made for the decriminalisation of self-insemination and increased access to clinical ART services also involved some disappointing political and intellectual compromises along the way. On several occasions over the life-course of the policy debate and law reform consultation process, activists, supportive law and policy-makers and the members of the lesbian parenting communities who chose to make submissions advanced arguments that implicitly sustained the age-old stigmatisation of gay and lesbian relationships and sexual practices. Furthermore, two opportunities were insufficiently developed. First, was the potential to more forcefully interrogate the faulty thinking that continues to inform the regulation of ART in Western countries: notably, the veiled naturalisation of heterosexual relationships and practices that permeates the concept of 'infertility treatment'. Second, there was an under-utilised potential to build on the strengths of the Women's Liberation Movement and its characterisations of self-insemination as a positive and legitimate rather than 'risky' family-making practice.

I begin by exploring some conceptual parameters of medicalisation, making a case for beneficial and problematic implications of the concept as it applies to the political debate over self-insemination and eligibility for clinical ART.

This prefaces a more detailed discussion of the specific discursive frameworks and arguments made use of in the Victorian political and policy debate: notably, the recourse to ‘psychological infertility’, ‘risk’ and ‘harm minimisation’. Then, I consider alternative ways in which the problem of lesbians’ exclusion from some ART services and the solutions to this could have been framed.

Medicalisation themes in sociology and radical feminism

The medicalisation critique has been central for some time to sociological engagements with health and illness (Broom and Woodward 1996; Lupton 1997; Willis 2006; Possamai-Inesedy 2006). Broadly speaking, supporters of the medicalisation critique in sociology argue that a range of social problems or phenomena—for instance, childlessness, death, childbirth, emotional distress, infertility—have come to be viewed increasingly through the lens of Western scientific medicine. The classic medicalisation critique holds that Western medicine and Western doctors have accrued a vast amount of power and influence in regulating the kinds of issues that would have once been the concern of other disciplines such as religion and philosophy (Illich 1975). In this view, and in a medicalised society, major areas of social life become treated as diseases requiring specialised intervention and knowledge. This has the capacity to foster people’s dependency on experts to tell them how best to behave.

Problematizing the medicalisation of women’s reproductive capacities has also been particularly central to radical feminist engagements with ART. In the radical feminist critiques of ART that proliferated in the 1980s in the wake of the first IVF babies, surrogacy and IVF were reformulated as oppressive and debilitating patriarchal practices. The technologies were perceived as a means for the male-dominated medical profession to colonise infertile women’s bodies, appropriate natural processes of pregnancy and childbirth, and propel women towards medical solutions to the perceived problem of childlessness (e.g. Hanmer 1987; Corea 1984; Rowland 1984). Radical feminists were among the earliest Australian public advocates of lesbian self-insemination, precisely because it

required neither clinical consultation nor any other form of medical intervention in women’s bodies. For instance, Klein (1984) published a short essay championing self-insemination for lesbians in a well-known collection of radical feminist writings on the dangers of IVF and surrogacy (Arditti *et al* 1984). In this essay, Klein promoted self-insemination as a new, empowering, and emphatically non-clinical alternative for single women wanting to conceive, because it requires nothing more than a syringe, some sperm, and a woman’s own knowledge of her peak period of fertility.

While radical feminist critiques such as those cited in the preceding paragraph were valuable in alerting women to the side-effects (such as low success rates and other deficits of ART interventions), they tended to rely on understanding women’s bodies/selves as rather passive in the face of male doctors’ all powerful endeavours and manipulations. A widespread criticism of the radical feminist perspective on ART was that it could not incorporate a sufficiently complex understanding of how power operates between the medical profession and the women who utilised ART, particularly given many infertile women were ardent advocates of the benefits of these technologies (see Albury 1999; Kirkman 2001).

Orthodox and constructive medicalisation

Parallel to the critique of radical feminist perspectives on ART and medicalised power, over the years sociologists have problematised what Lupton (1997) calls the ‘orthodox’ medicalisation critique, which understands any form of medicalisation as inherently bad. As Broom and Woodward (1996) note, sometimes there has been a tendency for sociologists to stress the dangers of medicalisation, or to define it in terms of all doctors having and exercising power over all patients. This runs counter to the findings of some empirical health research which has demonstrated how medicalising some health conditions can bring great comfort and relief to people who have them, and also how doctors themselves resist as well as perpetuate medicalised understandings of some health-related conditions (see Conrad and

Schneider 1980; Gerhardt 1989). For instance, in their work with doctors treating Chronic Fatigue Syndrome patients, Broom and Woodward (1996) document the existence of what they call 'constructive medicalisation' which promotes information sharing and a co-operative approach to managing the symptoms of chronic health conditions based on medical and 'lay' knowledge, thus assuming a less asymmetrical power relationship between the medical profession and the people they assist.

To apply Broom's and Woodward's insight to a different health context, the lesbian activism exemplified by the initial formation of the FAR lobby in Victoria provides a good example of power and knowledge sharing between the medical profession and lesbian communities. FAR was initiated and led by an openly lesbian GP who was generally supportive of the fact that women were inseminating themselves at home. In seeking to clarify the status of insemination in law, and decriminalise the practice if necessary, the goal was to build dialogue and workable healthcare relationships between members of the lesbian community interested in having children through either clinical assisted ART or home insemination, and the healthcare professionals who could support them in this quest.

To defend a constructive rather than anti-medicalisation approach to self-insemination, there are clearly a number of ways in which prospective lesbian parents can benefit from medical support in their quest for children. Despite the insistence on the simplicity of self-insemination for the non-expert in Women's Liberation Movement publications (e.g. Feminist Self-Insemination Group 1980; Klein 1984), arguably the practice has become more complicated in intervening years. For instance, the average age of women bearing their first child in Australia has risen from under 26 in the early 1990s to nearly 30 in 2003. First births in women over 35 now comprise 12% of births, compared with 6% only ten years ago (see Laws and Sullivan 2003). Although population-based figures on lesbian mothers are not available, it is likely this general trend towards older motherhood among women also applies to them. Women may experience a

range of age-related fertility problems when they attempt first or subsequent pregnancies in their mid to late thirties or older (Chapman *et al* 2006).

More recent self-help resources for lesbian prospective parents document numerous ways in which the support of health care professionals can assist women who choose to inseminate at home (see Pepper 1999; Mohler and Frazer 2002). These include: fertility checks for women wanting to become pregnant; screening semen provided by the male friend or acquaintance to ensure it contains viable sperm and is free of sexually transmissible diseases including HIV; freezing and storage of semen to ensure it is conveniently available for use at the most fertile time in a woman's menstrual cycle; and ensuring all parties to the inseminations have adequate information about transmissible abnormalities or diseases that may be present in the sperm.

Thus far, I have established there is an orthodox and more nuanced position on medicalisation within sociological thought, and argued that the origins, composition and aims of the FAR lobby in Victoria can usefully be aligned with constructive medicalisation. An additional conceptual dimension to medicalisation more characteristic of (but not confined to) the work of Foucault and his followers is also relevant to understanding what I will later contend to be a more negative outcome of medicalisation in the Victorian debate over ART.

Medicalisation and the dominant discursive frameworks within which ART is understood

Writers influenced by Foucauldian understandings of medicalised power have emphasised medicalisation as located in discourse, or the bodies of language, conceptual frameworks, and ways of talking and writing about health we have at our disposal (see Foucault 1986; Rose 1994; Lupton 1999; Lane 2006). In this view, medicalised power is not something held or wielded or shared with others by doctors or a distinctive social group called the medical profession. Rather, it operates as a surveillant and disciplining power influencing the population, in the sense of producing guidelines, language and

dominant ways of understanding the body and health-related phenomena.

For instance, the notion that responsible health-seeking behaviour is primarily about the avoidance of 'risks' has become all pervasive in contemporary public health discourse and practice. As Lupton (1995:80) observes: 'a philosophy of risk presupposes an understanding of reality in which unfortunate events are deemed to be both predictable and avoidable'. Risk discourses and frameworks are now largely taken for granted in the rules, regulations and common parlance of disciplines such as medicine and epidemiology, and also among the general population. Risk discourses draw on a particular notion of responsibility, whereby the obligation is to engage in a process of pre-empting and circumventing possible negative outcomes (Lupton 1999). For example, in the arena of reproductive medicine, the emphasis on risk is evident in the extent to which gamete donors to reproductive medicine clinics are screened on the basis for 'high risk' behaviours regarding HIV and a range of other sexually transmissible diseases (Fertility Society of Australia 2002).

Emphasising risk reduction may come at the expense of a constructive medicalisation approach to the issue under consideration. For instance, in the case of home-insemination, risk frameworks set the scene for emphasising medical supervision of inseminations as necessary due to a range of potential threats or harms to the inseminating woman or the ensuing child's well-being, such as those that could eventuate through contracting a sexually transmissible disease. This is not to suggest that disease transmission is an irrelevant concern in ART clinical practice or attempts to conceive in general. The point is that an undue emphasis on risk may over-inflate the actual likelihood of harm. Risk-focused arguments also potentially stigmatise the individual person who incurs the purported risks, rather than emphasising the positive benefits of medicalisation in a more value-neutral manner.

An excessive preoccupation with risk is one way in which medicalisation may negatively preside over the conceptual and discursive arena

of ART. Anthropologist, Sarah Franklin (1993) alerts us to another, although Franklin does not explicitly situate her work within a conceptual framework of medicalisation. For Franklin, the terminology used in constructing ART law and policy is critical in a process of inventing a so-called natural basis for heterosexuality in family formation, instead of broadening public perceptions about what are or could be other valid relational foundations for parenthood. She draws attention to the manner in which the seemingly benign term 'infertility treatment' is actually a metaphor that constructs medical intervention in reproduction in a political rather than value neutral fashion. In constructing failure to conceive as a disease requiring treatment, the use of ART by heterosexual couples is naturalised, even when the so-called treatment circumvents rather than corrects a reproductive disorder. For instance, when the male partner in a married heterosexual couple has no sperm, the male partner is not actually the recipient of any medical treatment in the sense that the intervention can correct his condition. Rather, the treatment metaphor naturalises or fosters a certain taken-for-grantedness about the procedure of using another man's sperm to facilitate his wife's pregnancy.

In the above discussion, I have argued that medicalisation can operate constructively, in keeping with Broom and Woodward's ideas, yet may also serve to limit the dominant discourses and conceptual frameworks that structure commonplace understandings of reproductive procedures including ART. In the remainder of the paper, I explore how in the period prior to the law reform reference activists initially followed the lead of the medical profession in seeking to broaden the category of infertility treatment in a manner that would include lesbian couples and single women within its ambit. I then turn attention to the political and policy debate after the law reform process commenced. The various contributors to the law reform process sometimes drew on arguments consistent with constructive medicalisation, but also harm minimisation arguments emphasising the risks inherent to self-insemination.

From social and medical to psychological infertility in the Victorian political and policy debate

The controversy arising over 'psychological infertility' began towards the end of 2001, several months after a vigorous public debate in the wake of the *McBain v Victoria* decision about the distinction between so-called medical and social infertility (see Walker 2000; Dempsey 2006 for detailed analysis of this distinction and the debate). To briefly recapitulate, this distinction was made by former federal Minister for Health, Michael Wooldridge, who proposed that the McBain ruling did not change the fact that there were two categories of women seeking reproductive services who should be treated differently: heterosexual women with male partners, and single heterosexual women and lesbians with no male partners. The Minister deemed the latter group ineligible for assisted reproductive services unless they had a diagnosable reproductive disorder on the grounds 'there is a simple alternative, which is intercourse'. The Minister based his distinction on the federal *Medicare Act 1984*, in its requirement that services provided from the public purse be 'clinically relevant' (Whelan 2000:4). Subsequent to this, the Infertility Treatment Authority sought a legal opinion to determine how the McBain ruling should be translated into policy. The opinion obtained by the statutory body from Gavin Griffiths QC backed up the Minister's proposition that the heterosexual relationship requirement remained, although the McBain decision had clearly waived the marriage requirement. Although FAR obtained an alternative legal opinion from Peter Hanks QC which claimed the ITA's advice reinstated direct discrimination on the basis of relationship status, the alternative legal opinion failed to convince the ITA and Griffiths' advice has informed the ART eligibility policy in Victoria since this time.

The debate over psychological infertility began after Dr. John McBain brought to light ambiguities in how the concept of medical infertility was put into practice. The ITA announced in November 2001 that they were considering allowing donor insemination to lesbians and single heterosexual women assessed as 'unable' to have vaginal

intercourse with men (see Dargan 2001; Costa and Ketchell 2001). Then Victorian Health Minister, John Thwaites, defined this condition as 'coital dysfunction' (Dargan 2001). McBain, as chairman of Melbourne IVF, made a case for recognising lesbians as medically infertile due to psychological factors in the following quotation from the *Herald Sun* newspaper:

There are a number of single women and those in gay relationships who, for some psychological reason, are unable to have sex with men. That should be recognised as part of infertility. In a humane and enlightened society, psychological reasons are accepted to be genuine medical problems (Dargan 2001:2).

The convenor of the FAR lobby at the time appeared to encourage this characterisation of lesbian sexuality, in the interests of facilitating increased access to clinical ART for Victorian lesbians. In a response to John McBain's proposition published in *The Age* newspaper, she stated that allowing for psychological infertility would enable most lesbians to gain access to donor insemination, on the following grounds:

A lot of lesbians have had sex with men during their adolescence, during the coming out process. That doesn't mean that they are now able to have sex with a man (Costa and Ketchell 2001).

While it is no doubt true that a lot of lesbians consider themselves unable to have sex with men, arguably this comment also did a substantial injustice to the empirical evidence that some lesbians intermittently have and enjoy recreational sex with men throughout their adult lives. Alternatively, other women in lesbian relationships have a history of long-term relationships with men and do not regard this as part of an immature phase of adolescence (e.g. see Stein 1997; Jagose 1996). More pertinently, though, engaging with McBain's comment in this manner implicitly endorsed the legitimacy of psychological infertility as a concept, rather than attempting to undermine the dubious premises on which it rests. In stating that most lesbians would be unable to have sex with men and that this could qualify as psychological infertility, there is only a short leap of logic to the

conclusion that all lesbian sexual practices represent sexual dysfunction. As a gesture of lesbian activism, the willingness to support psychological infertility thus ran counter to historical activist campaigns within international lesbian and gay communities to have homosexuality removed from influential medical diagnostic tools such as the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Illness (DSM).

It is of course important to keep psychological infertility and the initial lesbian activist response to it in its appropriate historical perspective. Later, FAR officially withdrew support for a policy position based on a notion of psychological or social infertility on the basis of objections raised within the lesbian community about its stigmatising implications:

We do not endorse the use of terms such as social infertility or psychological infertility that are designed to apply to those women who do not have sex with a man in order to conceive ... The terms serve to inaccurately portray and inappropriately pathologise lesbian sexuality and single women (FAR 2004:10).

Constructive medicalisation and risk-focused arguments in responses to the VLRC ART and Adoption Reference

Subsequent to the psychological infertility controversy, the debate over ART eligibility was largely played out through contributions to the four-year-long policy and law reform process.² Analysis of submissions to the various law reform consultation documents reveals activist groups and individual members of lesbian and gay communities drew on a range of what I term constructive medicalisation and risk-focused arguments in making the case for extending clinical ART eligibility criteria to all lesbians seeking pregnancy and decriminalising self-insemination.

Some arguments consistent with a constructive medicalisation perspective accentuated the benefits of having a supportive clinical infrastructure that would enhance lesbians' ability to comfortably inseminate at home. Some women think of inseminations as more than an instrumental process; they are conceptualised as part of a process

whereby the couple enact their intentions to form a family, and the home setting is preferred for this reason (Dempsey 2002). In the following quotation, the invasive or privacy-violating dimensions of having donor inseminations performed in the clinical setting were contrasted with the more intimate, couple-focused experience of trying to become pregnant at home:

We would really love to be able to take the sperm home and self-inseminate. I'm really not all that keen on the whole group experience feel of the clinical scene. I mean, really, who wants to involve all these outsiders in such a personal thing. We don't want the doctors! Just give us the sperm!

(Submission 137, Consultation Paper).

As one of its arguments, the FAR Lobby highlighted how extending eligibility criteria could assist in curbing discrimination known to be faced by lesbians when seeking information about fertility and conception issues from health-care practitioners:

For those using self-insemination, some attempt to gain support and information from health care providers and are told they cannot be helped. GPs who regularly see lesbian women report that some women have been rejected by other health care providers (FAR 2004:12).

The FAR lobby submission also noted a range of benefits to men providing sperm should clinical services be freely available. These included convenience, healthcare advice and attentiveness to individual healthcare needs:

For the known sperm donor [benefits include]: access to counseling and medical advice; convenience (e.g. if the known sperm donor lives interstate, travels a lot, cannot be readily available). Prospective known sperm donors who want to donate to a particular couple/woman but have health problems (e.g. cancer requiring chemotherapy) could donate prior to treatment.

In late 2004, the Royal Women's Hospital in Melbourne agreed as an interim measure to make sperm-screening, quarantine and storage facilities available to lesbian and single heterosexual women with known sperm donors who wanted

to inseminate at home. Arguments in submissions consistent with a constructive medicalisation perspective emphasised the range of benefits in having these facilities continue. For instance, one woman who had tried unsuccessfully to conceive with known donor sperm through home-insemination gave a number of reasons why these facilities were welcomed: notably, for educative and fertility-enhancing purposes:

I was so pleased when I heard through a friend that the Royal Women's Hospital is now running an outpatient program where women can have known-donor sperm vetted and stored, and be taught how to use it at home. A program like that would have been perfect for someone like me—someone who can find their own donor, would like the process to be as natural and non-intrusive as possible, yet is keen to avoid the possibility of dud sperm (like we had)

(Submission 236, Position Paper: Access).

Conversely, various risks to public health and to women and children's health through use of unscreened sperm were emphasised in submissions. For instance, in Submission 149 to the VLRC Consultation Paper, a lesbian prospective parent argued that women who could not afford to travel interstate to access donor sperm and who were not able find a suitable donor may decide to go ahead with self-insemination anyway and risk contracting an STD:

[They] may end up putting their health at risk in entering into less than ideal arrangements with known donors, with whom they do not feel entirely comfortable.

On a similar theme relating to children's health and public health in general, the FAR lobby advised that for children 'conceived via self-insemination with fresh semen this can increase the risk of transmissible infection to the mother and foetus' (2004:2) and that 'the spread of infectious diseases via the use of unscreened sperm is a potential risk [to public health]' (2004:12).

Another very popular risk-focused argument in support of extending eligibility for ART was to assert that Victorian lesbians are currently 'forced' into a position of self-inseminating, in the absence

of clinical supervision of known donor arrangements or access to clinical supplies of sperm. In this view, lesbians were incurring potential harm to themselves and the children they might conceive because they were 'driven' to this method by the lack of other alternatives:

I worry that women are being forced to practice unsafe medically unsupported self-insemination
(Submission 98, Consultation Paper).

The drive to parent is for many women independent of their marital status and their sexuality. All that limiting access does is force women into much more dangerous situations in order to achieve the outcome of a much desired child (Submission 82, Consultation Paper).

Problematising risk-focused arguments

Although risk-focused arguments were advanced by the FAR lobby and prospective and current lesbian and gay parents themselves in support of extending eligibility criteria for ART, these arguments served to reinforce the historic stigmatisation of lesbians and gay men and their sexual practices in a number of ways.

In the first instance, the emphasis on the inherent riskiness of self-insemination for women and children construed the extension of clinical eligibility criteria as primarily a harm-minimisation rather than a constructive medicalisation measure. Harm-minimisation measures, by definition, are policy or programme decisions made in order to decrease the health problems that may accrue from behaviours that are very much socially and morally contested (see Zajdow 2005; Kleinig 2008). This means self-insemination was construed in risk-focused arguments as morally on a par with behaviours such as unprotected vaginal or anal intercourse with strangers and intravenous drug use. In Australia, these are the kinds of heavily stigmatised behaviours to which a harm minimisation policy discourse usually applies, and the people who participate in these behaviours are also socially stigmatised.

Furthermore, given the extent to which gay men are known to be lesbians' semen providers, risk-focused arguments implicitly capitalised on a

popular perception that gay men are sexually voracious and irresponsible disease vectors, who should never be trusted to abstain from unprotected sex throughout the period of inseminations, or to give accurate information to lesbian friends and acquaintances about their sexual histories. This is despite the fact that for many Australian lesbians and gay men entering known donor negotiations extensive discussions about sexual health and testing for HIV/AIDS and a range of other STDs forms a standard part of the pre home-insemination negotiations, and there is a great deal of accurate community-based knowledge in circulation as to how pre-insemination negotiations and STD testing should proceed (see Borthwick and Bloch 1993; Dempsey 2006b). There was also a certain irony in implying lesbians are more than willing to put foetal health at risk with their conception practices, at the same time as arguments about risks or harms to children through gay and lesbian parenting are refuted extensively in the child development literature, including within documents commissioned for the VLRC ART reference (see McNair 2004).

To portray lesbians desiring pregnancy as 'forced' to use self-insemination also obscured the active and unproblematic choices made by many lesbians who do not want or need clinical intervention in their conception practices. For instance, two Australian research studies to date have found that New South Wales-resident lesbians who have legal access to all ART services are no more likely to use clinical insemination services than self-insemination even though legal access to donor insemination for 'fertile' single women is available in that state (Report of the Sydney Lesbian Parenting Conference 2000 cited in Millbank 2003; McNair *et al* 2002). Arguably, too, the metaphor of force used in this context implies that lesbian prospective parents are so irrational and overwhelmed in the face of their desire to have children that they cannot be trusted to make responsible decisions about how to get pregnant that are in the best interests of the children they are yet to conceive. In other words, it positions lesbians as powerless and irresponsible in the face of their own implicitly desperate drives to have children. This is a deeply anti-feminist and paternalistic

argument that effectively re-capitulates the all too frequent popular portrayals of infertile heterosexual women as irrational in the face of being 'desperate' for children (e.g. Pfeffer 1987; Kirkman 2001).

Risk-focused arguments designed to obtain harm minimisation policy and legal responses were evidently politically expedient, in that they were more likely to convince the authorities to extend clinical eligibility criteria. This was first apparent at a key moment in the debate in late 2004, after the first round of submissions to the VLRC process had been made. This occurred at the time of the Royal Women's Hospital decision to provide sperm-screening and storage facilities for lesbians inseminating at home. Then Victorian Health Minister, Bronwyn Pike, in a media release supporting this decision, stated: 'it's better for women who were going to do it [self-insemination] anyway that there were safeguards protecting the rights of the unborn child' (Dunn 2004:3). The clear implication in this comment was that prospective lesbian mothers cannot be trusted to do what is in the best interests of their children. The government and health authorities must step in to protect unborn children by making sure their mothers have access to medically supervised conception methods.

Arguably too, it was the taint of stigma and irresponsibility that risk-focused arguments could not escape in this debate that nearly served to undermine the activist goal of decriminalising home-insemination. The VLRC in their interim recommendations, as expressed in Position Paper One: Access, initially proposed that clinically stored sperm from known donors no longer be made available to Victorian lesbians for the purposes of self-insemination, on the grounds that women and children needed to be protected by the 'full range of safeguards offered through clinic treatment' (VLRC 2007:75). In this decision, it seemed as if the case for the potential harms incurred by self-insemination had been made so convincingly in submissions to the first consultation paper that the VLRC overlooked all the constructive medicalisation arguments in favour of clinically supported home-insemination, and moved instead to a position of prohibition or 'zero-tolerance' of the practice.

This recommendation was only reversed in the VLRC's final report after a great deal of concerted effort by activists and lesbian community members, who had to establish that lesbians could actually be trusted not to misuse the sperm they took home from clinics (e.g. by mixing it with other unscreened sperm before inseminating or not telling the child conceived with the sperm about the identity of the biological father). Indeed the final recommendations produced by the VLRC indicate that constructive medicalisation arguments were not the key focus in their deliberations and that the risk-focused arguments remained the most compelling. Their summative statement on why the sperm storage service would be retained did not mention any of the fertility enhancing, convenience or educative benefits of clinical services, giving preference instead to an emphasis on harm minimisation:

The commission believes that the harm minimisation benefits of the sperm storage service outweigh the unlikely potential for the program to be misused ... the purpose of the program is to protect those who self-inseminate from a range of risks associated with the practice ...
(VLRC 2007:69).

An alternative political strategy?

Rather than accepting attempts by the authorities to bring lesbians and single women within the embrace of medical infertility or harm-minimisation endeavours, an alternative strategy for activists could have been to resist risk-focused arguments in favour of promoting more constructive medicalisation arguments. This could have been done in conjunction with more forcefully questioning the continuing usefulness of 'infertility treatment' as the dominant metaphor guiding assisted reproduction law and policy. Despite the emphasis in the debate on problems with the concept of infertility, and a subsequent recommendation to remove the word 'infertility' from the name of the Victorian law, use of the 'treatment' metaphor was retained throughout the VLRC final recommendations, and the notion of treatment was hardly interrogated. To undermine the notion of infertility treatment would have set

the scene for constituting eligibility criteria on a different basis by accentuating another dimension of Justice Sundberg's ruling in the *McBain v Victoria* decision: the part that clearly framed IVF and donor insemination as 'services' rather than 'treatments'.

Arguing that the conceptual emphasis in ART legislation should be shifted from 'infertility treatment' to 'reproductive services' serves to highlight that *emotional* rather than *physical* or *medical* needs are paramount in the application of *all* assisted reproductive technologies, not only those that involve lesbians and single heterosexual women. Anthropologists Marilyn Strathern (1992) and Sarah Franklin (1993) in their pivotal work on the early years of ART in Europe discuss the notion of infertility treatment as a metaphor which effectively obscures the fact that men and women who seek ART services—regardless of their sexuality—do so because they want to have children, not because they are infertile *per se*. For instance, since the development of intra-cytoplasmic sperm injection (ICSI), the man who cannot produce viable sperm in sufficient quantities for conception to occur through intercourse does not become more fertile after the intervention of assisted reproduction. What the clinical procedure does, is to microinject his viable sperm into the nucleus of an ovum which may facilitate fertilisation and the production of a viable embryo. This process, when successful, enables the man and his female partner to have a baby, yet in clinical terms, the disease or underlying condition endures. Conversely, if a man has no sperm and does not wish to become a father, there is no medical reason to seek assistance.

Interestingly enough, the committee headed by Professor Louis Waller which drafted the first ART laws in Australia (the *Infertility (Medical Procedures) Act Vic 1984*) explicitly declined to define donor insemination (then known as AID or artificial insemination by donor) as a treatment for infertility in a report preceding that legislation:

... the Committee has concluded that the practice of AID as part of the management of infertility has become established in the Victorian community. Some claim that it is an important part of the treatment of infertility. This claim,

however, is misleading: it is a practice whereby infertility is circumvented.

(Victorian Government 1983:9 my emphases).

The 1984 Infertility (Medical Procedures) Act is far more circumspect in its use of the word 'treatment' than the 1995 Act that superceded it in Victoria. Indeed, in the preamble to Part 1 of the 1984 Act, a clear distinction is made between 'alleviating infertility' and 'assisting conception, and the notion of treatment does not even appear.

Concluding thoughts

At the conclusion of a period of difficult, long-term and dedicated political debate about laws and policies affecting marginalised groups, it is important to reflect on the process and outcomes along the way so that past experiences can inform future endeavour. In this paper, I have proposed that lesbian activism seeking change to, and clarification of, ART eligibility criteria emerged from a constructive medicalisation perspective, yet the political debate and process also demonstrated how easily arguments consistent with constructive medicalisation were side-lined in favour of more problematic medicalised discourses about infertility treatment and risk. One outcome of this—no doubt, often unintended—was subtle reinforcement of the historic stigmatisation of gay and lesbian people and their sexual practices.

Some may argue that despite the fact that risk-focused arguments are unduly stigmatising in this particular health context, it is naïve to suggest that they could have been avoided in this debate given the extent to which existing public health and ART regulations and laws are framed by notions of risk management. However, equally, it can be argued those engaged in activism have an obligation to be mindful of the broader social messages various political strategies convey about the people whose lives the laws and policies will affect. The political ends do not always justify the means.

When the new Assisted Reproductive Technology Act is proclaimed in Victoria, the scene will be set for providing a supportive clinical infrastructure for all lesbians and single heterosexual women wanting to conceive. This could include: access for all women to screened donor sperm from the general supply if needed

and available; provisions for semen storage when known men provide 'directed donations'; disease and fertility screening for semen from directed donations; and the provision of frozen semen transport receptacles to women wanting to inseminate in private at home. Adequate provisions will be more easily put in place for the semen provider's informed consent to home-based as well as clinical procedures and any ensuing extinguishment of legal paternity in related legislation.

All the above forms of clinical assistance should compliment and extend the family formation arrangements that men and women in the Victorian lesbian and gay communities have been organising among themselves for a number of years. They should optimise reproductive health for women inseminating at home and any children conceived of the procedures, as well as provide convenience, adequate support and information provision for men giving sperm. In these measures, which I propose should rightly be predicated on principles of constructive medicalisation, one can only hope that the scene is set for emphasising the pivotal role of healthcare provider/patient relationships predicated on mutual respect and trust as much as harm minimisation and risk management in the service of the goal of creating unconventional families with children.

Endnotes

- 1 FAR became a working group of the Victorian Gay and Lesbian Rights Lobby in 2002. The *Love Makes a Family Campaign* was established within FAR when the VLRC ART and Adoption reference was announced in 2003. FAR and VGLRL lobbied until the December 2007 Victorian Government decision for changes to the full spectrum of state laws influencing gay and lesbian family formation and the status of children.
- 2 The VLRC produced an initial Consultation Paper in December 2003, through which it asked for feedback on whether the eligibility criteria for ART should be changed, and in which it posed various questions about the access and eligibility regulatory framework for members of the public to base their feedback on. The Commission received 255 submissions in response to the Consultation Paper. On the basis of feedback received on the Consultation Paper, the Commission developed

a set of interim recommendations on access and eligibility, and self-insemination which were published in *Position Paper One: Access* (VLRC 2005). A further 351 submissions were received in response to the interim recommendations. After further consultations through meetings and forums throughout 2006, the Commission produced a final report in March 2007 (VLRC 2007).

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