Childbirth, assisted reproduction, and embryo manipulation.
A sociological analysis of current reproductive medicine in the CR.

This research project deals with current reproductive medicine in the Czech Republic. It is based on the concept of **biopower** as an analytical idea of a method of governance and administration of a modern population (Foucault 1999). The project focuses on biomedicine as a concrete manifestation of this form of normalization of modern society, and subjects it to critical sociological analysis. **Biomedicine** is an approach to humans that corresponds to the Western concept of health/illness, to the idea of technological progress (Cahill 2001). Our project focuses on an analysis of **reproductive medicine**, as one of the key poles in the current form of biopower. Text by Rabinow and Rose (2003, 2006) define reproduction, "race", and genomic medicine as the three topics that emerge most clearly in the current form of biopower. The reason for focusing research on this area is the evident relation between reproductive medicine in the Czech Republic and the technological apparatus and with the commodification of health and illness. Also important in the context of biopower is analysis of the normative character of reproductive medicine, and its consequences in the broader social area of intimacy and sexuality, the institution of kinship, heteronormative reproduction, gender identity, etc. Moreover, reproductive medicine addresses the sensitive and fundamental theme of the life of each person; it is the subject of passionate public debate; it is one of the areas of medicine in which "miracles" take place. **The aim of this project** is through qualitative study to describe, analyze, and interpret the way in which power and hegemony are applied/negotiated in biomedicine in the social field of biological reproduction.

Current state of research

Medicine is one of the key institutions in which the modern concept of scientific-technical progress and professionalization is being realized, and as such it has great power in the administration, control, and normalization of society. The late modern system of medicine is conceptualized within the social sciences in the context of its role as one of the fundamental pillars of modern and late modern society. This method of thought/analysis is derived from Foucault's concept of biopower. Focault describes **biopower** as the "controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes" (1978:141). Michel Foucault describes the process of "taking over the power over life" by the political power of a society that has assigned itself the task of administering life (1978: 139) within several social environments, medicine being one of them. As Foucault describes it (1978: 139-140), bio-power is the power over life, concentrated around two (non-antithetical) poles: 1. the body as a machine (an idea with its beginnings in the 17th century) concentrated around "disciplining of the body, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls (ibid.) ensured by an *anatomo-politics of the human body*, as Foucault calls it. The second concept (2.) has formed around the inevitable biological processes and variations of these mechanisms of life, such as procreation, birth and death, health, life expectancy and longevity (ibid.). In this form, which developed later than the first one, power over life consisted of supervision and interventions that Foucault calls *regulatory controls: a bio-politics of the population* (Foucault 1999). The ultimate social field and context par excellence where this negotiation takes place is late modern **biomedicine.**

The term biomedicine refers explicitly to the existence of two fundamentally differing principles in the practice of medicine, which can be traced from the times of early Greece: a preservative approach, and a restorative approach called biomedicine. While the preservative approach concentrates on the health care of the whole population, the restorative one, dominant today, is associated with categorization and treatment of individual patients´ illnesses (Cahill 2001). The term biomedicine (or the "Western", or "allopathic") is used today in social science discourse to refer in general to "professional Western medicine", where the prefix *bio* emphasizes that this is a biological, therefore scientific and objective medicine (Gaines a Davis-Floyd 2004). The category *alternative*, or *non-conventional* or *complementary* medicine (CAM - *Complementary and Alternative Medicine*) encompasses basically all other healing practices – for example natural healing, traditional Chinese medicine, homeopathy, psychotronics, kinesiology, and others.[1] The biomedical approach to health and sickness specific for modern Western society can be analytically conceived as one of the basic manifestations of modern biopower – a method of governing and administrating a modern population.

[1] While the boundary between classic and alternative medicine is relatively clear, the dividing line between individual alternatives is fuzzy. The category of non-conventional medicine has been interpreted to include every form of healing different from that which the medical community regards as "correct"; that is, in accordance with scientific discourse. Individual alternative medicines are linked only by their definition outside bio-medicine – all are healing practices that do not fulfill the criteria of classical medicine (according to Křížová (Křížová 2004:17) these are in accord with the cognitive apparatus of Western society based on "sufficiently reliable clinical verification of effects").

Parallel with Foucault's analysis of biopower, a critical approach has developed in sociology of the self-presentation of medicine as a progressive institution fundamentally improving health and the living conditions of the population, as well as doubts about purely altruistic motives in the behavior of doctors (Dubos 1959, Illich 1976, Cahill 2001). René Dubos (1959) expressed his disillusionment with the ability of medicine to improve health, and McKeown and McLachlan (1971) came up with the sociology of medical pseudo-progress. In the 1970's the concept developed – especially in a critical context – of medicalization, which describes the tendency of medicine to expand its domain and monopolize control over areas it previously did not control – birth, dying, menopause, treatment of addiction, mental disorders, and sexual dysfunction – and thus aggrandize its power and authority (Conrad 1992).[2]

The concept of the power of medicalization corresponds to Foucault's concept of pastoral power. Foucault (2001) in this context refers to the development of the techniques of power focusing on the individual and aimed at controlling him. Pastoral power is seemingly kind and protective; the shepherd leads his herd and protects it for the good of the individual sheep. A good and responsible shepherd must sometimes be prepared to take harsh decisions in order to reduce the burden that that weak or sickly sheep would otherwise place upon the flock as a whole (Foucault 2001). Pastoral power over individuals cannot be associated only with the power of the state over its citizens. According to Illich (Illich 1976) and other adherents of the political economy of medicine (Lupton 2003) it is the state that is controlled by the interests of the medical-industrial complex. As pointed out by Rose (Rose 2007), the new pastoral power has long been no longer one-way. "It takes place in a pluralistic and contested field, traversed by the codes pronounced by ethics committees and professional associations, by the empirical findings generated by researchers, the attitudes and criteria used by employers, insurers, and test developers, and promoted by psychologists and biotech companies, the advice offered by self-help organizations, and even, one might add, the critical perspectives contributed by religious organizations and sociological critics" (Rose 2007: 73).

The key to medicalization is the definitional -ism. "Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat it" (Conrad 1992: 211). In the process of medicalization, patients are not always just passive objects under the power of the professionals: some illnesses and disorders were medicalized precisely as part of an effort by patients to give their symptoms a medical definition. Thus it was in the case of post-traumatic stress disorder or chronic fatigue syndrome. On the other hand, there is perceptible resistance to the medicalization of some problems, accompanied by efforts to demedicalize them, as in the case of childbirth (the natural childbirth movement, for instance), homosexuality, or some mental disorders (Čada 2009). Active participation by patients in medicalization and demedicalization is evidence of the power that medical awareness has – to define a problem in medical terms means to acknowledge its existence.

Ivan Illich (1976) made use of the term medicalization to make a radical critique of current medicine: doctors and commercial medical institutions create unrealistic notions about health, on the basis of which they try to stimulate demand for treatment and the dependence of the population on medical approaches to social problems and to processes that are entirely natural. Ivan Illich also argued the iatrogenic (that is, life and health threatening) effects of medical procedures, which he described on the individual, social, and cultural levels. The undesirable by-products of medical progress, he said, do not take place as the result of systemic or human failure, but are the routine products of the everyday practice of well-trained medical professionals, and at the same time immune to any solution. With the growing technologization of medicine and the medicalization of society its impact only keeps on growing.

Illich with his critical view of the medical system became the founder of the field in sociological research on medicine: political economy of medicine (Lupton 2003). It criticizes current health care for being dependent on medical technology and yielding to the interests of the pharmaceutical companies, insurance companies, and professionals.[3] According to this criticism financial resources should be allocated towards research on the social

[2] Conrad points out two main theoretical sources of this current: Talcott Parsons (1951), and theory of labeling. In Parson's functionalist theory medicine is mainly an institution of social control: through it society controls its stability, which is threatened by disease. Parsons defines disease as a specific type of deviation. The sick person does not carry out his usual social role, but is not negatively sanctioned for this, for he is not held responsible for his disease. The condition for the absence of sanction is the correct behavior in the role of the patient, the responsibility to make clear that the illness is unwanted and temporary, seek specialized assistance and submit to the treatment process (Parsons 1951). The theory of labeling inspires the concept of medicalization especially in emphasizing the key role played by the process of definition.

[3] The loss of control by doctors over important aspects of carrying out their profession, caused by regulation by the state insurance companies and the economic management of the organizations they work for is conceptualized in the social sciences as the proletarianization or the routinization of the medical profession (Křížová 2006, Dent 2006). Economic considerations, the processes of

and environmental roots of disease and the maintenance of good health instead of the exclusive focus of medicine on pharmaceutical and technological solutions of acute symptoms (Lupton 2003). These characteristics of current bio-medicine are the subject of further empirical analysis in the social sciences and their conceptual grasp of the existing situation. According to several of them this situation is linked to the way late modern administration and government function through biopower. Anthropologist Paul Rabinow and sociologist Nicholas Rose in their text *Biopower Today* (Rabinow, Rose 2003, 2006) define three fields in which these current forms of biopower are displayed. These are race, reproduction, and genomic medicine.

Our research project has chosen one of these three fields of negotiation in biomedicine as the subject of analysis: **reproductive medicine**. It is clear, however, that in practice the analytical terms used in these fields naturally overlap. The reason for focusing on this area is the strong link between biomedicine, technology, and the commodification of health and illness. The most important context is the analysis of the normative character of reproductive medicine and its consequences for the broader social arena (including taboo – sexuality, newly defined forms of kinship for example in the case of surrogate motherhood, etc, or the latent and manifested dictates of hetero-normative reproduction). Moreover this area deals with sensitive and fundamental topics in the life of every person, and is the subject of passionate public debate. It is one of the areas of medicine in which "miracles" happen.

State of the Art and Objectives of the Project

Current practice in **reproductive medicine in the Czech Republic** is a prime example of a radically medicalized area of human life and the application of biopower within the context of medicine. It combines two aspects of biopower: the anatomic politics of the human body, and the biopolitics of population: it focuses on improving the effectiveness of the human body in the area of reproduction, and "remedies" individual reproductive dysfunctions (meanwhile it is indicative that we speak rather of remedy than of treatment). The body, mainly the female body, is seen within this process as a machine the function of which is to conceive, carry to term, and "deliver" a "healthy" baby into the world, under the bright lights of the maternity ward and under the supervision of the doctor, who by weighing, measuring, recording, and disinfecting the child incorporates it into the world controlled by bio-medicine. Any changes in hospital organization of maternity are primarily evaluated through the lens of whether it increases the child mortality rate (Czech obstetrical practice boasts international statistics approaching zero in these criteria). It de-emphasizes the actions of the actual actors (the mother, the newborn, and the spouse). At the same time Czech medicine in this field monitors in detail and in the aggregate the reproductive capability of the population, which is expressed in concrete numbers; it determines the age limits for healthy and potentially pathological reproduction and the options for making use of the techniques of assisted reproduction; it works with statistics and graphs expressing rates of successful reproduction according to age, it limits access to assisted reproduction to those whose reproduction is not regarded as desirable, and positively and negatively sanctions various types of reproductive behavior (Zamykalová 2003; Zamykalová, Hašková 2006, Hasmanová-Marhánková 2008).

Doctors in the field of reproductive medicine work with sensitive and socially significant, morally encumbered relationships and concepts, such as parenthood, kinship, fatherhood, and motherhood. Their actions call for a number of ethical and legal issues. At the same time they wield enormous power, given by the circumstances of their knowledge, their use of advanced technologies, as well as their influence on public discourse. In the media reproductive medicine is depicted as a prestige profession, both in regard to the latest technological progress, as well as their successes which are often seen as "miracles". Reproductive medicine also strongly influences public discourse, and the perceptions of the risks connected with reproduction – there are few today who are unaware that the fertility of men is historically declining, while the fertility of women is linked to their age, and many potential parents try to improve their reproductive capability even before the beginning of their efforts to conceive on the basis of medialized medical recommendations.

The range of power available to reproductive medicine is, compared to other areas of medicine, very broad – it affects everyone, there is no self-treatment, everything is medicalized, almost all give birth (and many even conceive) under the care of doctors, there is now even a pre-pregnancy medical supervision, and the system of care during pregnancy is organized in detail and governed by extensive norms (Hasmanová-Marhánková 2008). At the same time reproductive medicine is an extraordinary example of a field of medicine penetrated by the private money of patients – they are required to pay from their own resources for all procedures not paid by the insurance companies.

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globalization, social and health care policies, and pressure by interest groups now enter into the clinical decision-making. Besides heavy administrative burdens, economic and management abilities are also becoming an integral part of the doctor's role.

However, reproductive medicine is not just the domain of modern and financially expensive technology, constantly being improved through intensive research. At the same time it is a very important social field, where norms and values, concepts of kinship, heteronormativity, etc. are being negotiated. Within this concept the biomedical method of care for the health of individuals consists of three areas on which our research is focused.

These are:

- assisted reproduction
- pre-implantation diagnostics, manipulation with the embryo
- obstetrics.

The regulation of **assisted reproduction** in the Czech Republic is relatively liberal: unlike in other European countries, all techniques of ART except for surrogate motherhood are allowed and commonly used in the Czech Republic (in vitro fertilization, intra cytoplasmic sperm injection, assisted hatching, selective reduction of embryos, cryopreservation of oocytes and embryos and donation of sperm, eggs or embryos). Also, infertility is perceived primarily as a medical problem requiring high-technology treatment, techniques of assisted reproduction are widely accepted and their use in cases of infertility is regarded as correct and expected behavior. A survey conducted in Czech households in 2005 showed that 80 per cent of respondents would choose in vitro fertilization as the solution in case of infertility (Slepičková 2007). However, we can identify three factors that limit the access of patients to treatment of infertility in the Czech Republic: official access to treatment only for heterosexual couples, the age limit for women undergoing infertility treatment (39 for treatment covered by health instance, 49 for other treatment), and the financial cost of the treatment as the health insurance covers only three IVF attempts with a limited number and quality of drugs.

The relatively liberal regime for assisted reproduction creates a great amount of room for autonomy by doctors. The decision whether treatment is appropriate for specific patients, and when treatment has no hope of success, as well as the range of techniques used in the Czech Republic, is to a great extent up to the doctors. In most cases doctors have at their disposal a much greater range of approaches and techniques than is technically, financially, and psychologically viable for the patient to undergo. The treatment can never be too good nor all the possibilities exhausted – which creates pressure on patients to try to get the maximum available to them (Sandelowski, Holditch-Davis, Harris 1999). Some limitations on treatment on the other hand require patients to be active, to carefully choose, calculate, and negotiate their treatment (Slepičková 2010). Doctors openly admit that their practices do not always correspond to the official limits, that their judgment of specific cases is individual, and that they provide care even at the cost of violating official regulations. This is most often the case with assisted reproduction for women with no partner or for women exceeding the age limit, shared assisted reproduction for lesbian couples, and "surrogate motherhood", which is made possible through a series of steps which are legally regulated (donor assisted reproduction and subsequent adoption). This negotiation is significantly socially structured, despite Parsons' characterization of the doctor's role as universalistic, affectively neutral, functionally specific, and focused on the collective (Parsons 1951). Besides the interests of patients, and the doctors and institutions that provide the service, or legal stipulations about the nature of treatment and its financing, such characteristics of the patient as gender, status, sexuality, or ethnicity also play a role (Thompson 2005, Zamykalová 2003, Slepičková 2010). At the same time negotiation takes place not just over the use of various procedures of assisted reproduction, but also negotiation over the boundaries of fertility and infertility, who and in what manner should, may, or may not become a biological parent.

In the process of assisted reproduction, Czech law requires every couple to undergo a **genetic examination**. Donation of reproductive cells is permitted and regulated under law no. 20/1966 on Care for Human Health, as amended. In accordance with that law and according to international norms (for example the Agreement on Human Rights and Biomedicine, Directive of the European Parliament and Council 2004/23/EG on the Setting of Quality and Safety standards for the Donation, Sampling, Analysis, Processing, Preservation, Storage, and Distribution of Human Tissues and Cells), a program was created in this country for the donation of reproduction cells.**(**http://www.gennet.cz/). The project studies the handling, discussion, and negotiation of the status of the **embryo**, the issue of stem cells, etc.

In the process of assisted biomedical reproduction, a major role is played by the phase of pre-implantation diagnostics, which represents a new method of dealing with human embryos, but presents new issues concerning the definitions of human life and of kinship, and of health and illness (Zamykalová 2003). Within the framework of bio-society (Rabinow 2006) the embryo becomes a borderline object, a part of two differing worlds at the same time: on one hand the object of argument over moral values and their setting into norms, on the other hand the subject of a scientific description of the world and humanity's place in it (Williams, Wainwright, Erich, Michael 2008, Mulkay 1997). All this within the context of research on stem cells, where the human embryo/batch of cells finds itself on the frontier of thought on the definition of humanity and the idea

of an embryo as "just" a bunch of cells; it is the object of scientific study and at the same time an object of morals and ethics (ibid.). The very example of the argument over the social, clinical, biological, and moral status of the embryo demonstrates the interrelationship between the terms of man, the human body, health, and illness in modern biomedicine. At the same time from this negotiation arise dilemmas that effect the definition of the human embryo and the way we treat it.

Another key area in reproductive medicine is **obstetrics**. In the Czech Republic in this social field the medical doctors' concept of dealing with childbirth clearly dominates. Social science analysis of Anglo-Saxon production describes a paradoxical development in which childbirth, historically and culturally the domain of women, taking place in the domestic environment, became an area until recently dominated in the institutional context exclusively by male doctors (Cahill 2001, Winnick 2004). At the same time authors on the subject point to the unequal power position assigned to various actors and types of skills in this field, especially the disproportion between formal university education (the doctors' guild) and practically-gained knowledge (midwives, nurses) and to the seriously unbalanced character of these relationships (ibid and Fischer 2009, Reiger 2008). A repeated target of sociological research on obstetrics has been the mechanisms which maintain the dominance of the medical approach over alternative midwife-assisted birth methods (Donnison 1977, Cahill 2001, Reiger 2008). The very duality of the approach is not the focus of the projected research. Instead, research focuses on the ways that trust is established in the first instance, and the manner in which alternative approaches are excluded; and, at the same time, how new knowledge and approaches in the area of obstetrics are adopted or rejected by the hegemony of bio-medicine.

The hegemony of bio-medicine is also reflected in the symbolism of the system that we have available for taking up the practice of obstetrics and knowledge about it. This has been vividly described in Winnick's study (2004) on the "language" of childbirth and the divergent usage of terminology related to it. On one hand there is the bio-medical term "delivery", on the other hand the alternative term "childbirth", with each connoting a different attitude towards the mother, the child, and the attending personnel. The mother either "delivers" the child to the world, or she is the key player in the entire process (Šmídová 2008). Analysis of the process of negotiation within the bio-medical conception of childbirth requires mapping out the power establishment of bio-medicine (with its potential challenges for change) and the mechanisms used to maintain it in the field of obstetrics, as well as to focus on the hegemony of status, ethnicity, and especially gender in this social field. Our initial concepts will be supplemented by recent analyses of hegemonic masculinity by authors in Critical studies on men and masculinities (Carrigan et al 1985, Connell 2002, 2005, Connell and Messerschmidt 2005, Hearn 2004, 2008, Howson 2006, 2008, Šmídová 2009).

On the general analytical level in regard to the three above-mentioned areas of reproductive medicine, we can observe that in **the field of Czech social science the concepts of biopower and bio-medicine have been applied to a very limited extent, and in secondary contexts.** Jaroslava Hasmanová-Marhánková has studied the structure of norms and risks in relation to pre-natal screening in the field of Czech health care (2008). Her research shows that rejecting the routine application of technology and its key role in categorizing pregnancy can bring women into fundamental conflict with institutions and professionals who are assigned to watch over them during the course of the pregnancy (Hasmanová-Marhánková, 2008). Ema Hrešanová likewise takes up reproductive medicine, specifically the culture of Czech maternity wards (2009), and Iva Šmídová analyzes changes in childbirth within the institutional environment of maternity wards and the production of gender rules after norms emerged for the attendance of fathers at childbirth (2008). Lenka Zamykalová (2003) described the frontiers of normality in the area of assisted reproduction and treatment of the embryo. Lenka Slepičková (2009) studied negotiation of partner and gender roles in the context of infertility and assisted reproduction. Karel Čada focused his attention on pharmaceutical policy in the context of two processes which he says characterize the two-way relationship between society and medicine – the medicalization of society and the socialization of medicine (2009). The broader context of the professional identity of doctors or the relation between alternative medicine and bio-medicine are the objects of research and study by Eva Křížová (2002, 2006). Eva Šlesingerová deals with analysis of the popular representation of genetics, the embryo, and DNA, while she points out the current patterns of negotiating the boundaries of group identity and the boundaries of humanity (Šlesingerová 2005, 2008).

Aims of the project

Reproductive medicine as it is practiced in the Czech Republic is strongly bio-medical, commodifies health and illness, and has a markedly normative and authoritarian character. Meanwhile it deals with key social themes in the life of every person; it is the subject of public discussion and adored as an area of medicine which triumphs

over the vicissitudes of "nature". The aim of the planned project is to describe, analyze, and interpret through qualitative study the manner in which the power and hegemony of bio-medicine is applied/negotiated in the social field of biological reproduction. On a further, analytical level we are interested in the mutual relationships, politics, and duality of biomedicine and alternative medicine (CAM), various concepts of the boundaries between health and illness, and the place/role of doctors in defining normality.

Our specific research questions are the following:

- How are the borders between normality/legitimacy in the definitions of health and illness negotiated within three selected/profiled specialized fields of reproductive medicine: 1) childbirth, 2) assisted reproduction, and 3) the issue of manipulation with embryos/DNA/stem cells?
- In what way is trust established within the system of modern reproductive medicine?
- How does the status of bio-medicine become norm, and how is normality established through biomedicine?
- By what paths are the categories of status, gender, and ethnicity introduced into this process?