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

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ABSTRACT

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

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

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

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

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

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

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

1. Literature review

1.1. Medicalization and inequality

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

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

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

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

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

1.2. Medicalization & infertility

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

Not all individuals are receiving treatment, however. According to the most recent NSFG, among women experiencing reproductive problems, those with a college degree are four times more likely to receive ARTs compared to those without a college education (Chandra et al., 2014). Such statistics reflect the stereotype of infertility—that it is a white, wealthy, heterosexual woman's issue—but, do not reflect the reality—that just as many women of low SES are infertile compared to their wealthier counterparts (Chandra et al., 2013; McCormack, 2005). Moreover, men are often left out of the equation despite being equally implicated (Almeling and Waggoner, 2013; Culley et al., 2013). One-third of infertility is characterized as female-factor, another one-third as male-factor, and the other one-third as unexplained, yet medical treatment focuses on treating women's bodies and often reduces men's roles to the provision of semen samples (Bell, 2015; Lorber, 1989; Lorber and Bandlamudi, 1993). Women in same-sex relationships are also increasingly seeking medical care for their fertility, but are often overlooked in this arena due to heteronormative assumptions of reproduction (Donovan, 2008). Despite these disparities, there has been a lack of research on how individuals of diverse social locations relate to and are affected by the medicalization of infertility (Bell, 2014; Litt, 2000).

2. Methods

I interviewed 95 individuals among those at the margins of mainstream understandings of reproduction, including 41 infertile women of low socioeconomic status, 30 men who were part of an infertile couple, and 24 women in same-sex relationships who were accessing medical treatment to assist in conception. I also interviewed those at the center of mainstream understandings of reproduction—17 white, heterosexual infertile women of high socioeconomic status. While I recruited each group separately, they were all part of a larger research agenda to understand disparities in infertility and assisted reproductive technologies. Comparing the experiences among the marginalized groups to each other as well as to those in the dominant group allows for a comprehensive understanding of stratified medicalization along various dimensions of inequality—gender, class, and sexuality.

I recruited all participant groups in the same way through posted flyers and snowball sampling. Moreover, I interviewed participants with the same interview guide, albeit tweaked for various circumstances unique to each group. I conducted the majority of semi-structured interviews in study rooms of public libraries. After obtaining informed consent, the interviews lasted, on average, approximately 90 min. During our conversation, I asked participants about a variety of topics including desires for medicine, attitudes about medical treatment, and their experiences of reproduction. Upon interview completion, participants received a $10 grocery store gift card. Participants also completed a demographic questionnaire prior to the interview.

While I recruited the participant groups in the same way and interviewed them with primarily the same questions, I recruited them at different time points and for different purposes, resulting in variations in their demographic characteristics. I recruited the women of low SES between 2008 and 2010 in an effort to understand classed experiences of infertility. As part of a larger study on infertility, I purposefully and strategically sought racial diversity among the women of low SES because it allowed for comparison of women marginalized (poor women and women of color) within infertility stereotypes to women enmeshed within such stereotypes (white and wealthy). Thus, the women of low SES in this study are half black (51%) and half white (49%) and five percent of them completed college. In contrast, as past studies have demonstrated, recruiting men to participate in research, particularly on reproductive issues such as infertility, is a difficult task (Lorber and Bandlamudi, 1993; Throsby and Gill, 2004). While I was able to recruit a substantial number of men in 2013, most were from a single demographic group—white, heterosexual, and of high SES. Three men self-identified as Black and 27 as white. The majority of male participants had at least a college degree (80%), and all but two were employed. Similarly, recruited in 2014, all of the women in same-sex relationships were white and two-thirds (67%) had a college degree, which is consistent with the demographics of those seeking medical treatment to assist in pregnancy (Centers for Disease Control and Prevention, 2013). Finally, all of the straight women of high SES, recruited in 2010, were white and most were college educated (76%).

To be eligible for the study, all participants had to be between the ages of 18 and 44. On average, participants were in their early to mid-thirties, with a mean age among women of low SES as 31 years, among men as 35 years, among women in same-sex relationships as 36 years, and among straight women of high SES as 35 years. Half of the women of low SES received some type of infertility service, 70 percent of which were diagnostic consultations with little to no follow-up. All of the men in the study sought medical treatment for their reproductive difficulties, and while all of the women in same-sex relationships sought medical assistance in achieving pregnancy, two women ultimately pursued self-inseminations over medical technologies. All of the straight women of high SES sought some form of medical treatment for their infertility. Nine (22%) of the women of low SES received private health insurance, while all of the women in same-sex couples and straight women of high SES had private health insurance. The majority of men (93%) were insured as well.

While this is a story of medicalized infertility and its inequalities, not all participants were ‘infertile’ so to speak, as they could be part of an infertile couple in which involuntary childlessness was occurring. All women of low SES met the clinical definition of infertility in that they attempted to become pregnant for at least a year without success. Twenty (67%) of the men were directly implicated in the infertility diagnosis, with 13 participants diagnosed with ‘unexplained’ infertility, 10 ‘female-factor’ infertility, 6 ‘male-factor’ infertility, and 1 ‘male- and female-factor’ infertility diagnosis. Despite all being “socially infertile” due to their female partner-choice, 10 of the women in same-sex relationships met the medical definition of infertility or were diagnosed with a reproductive problem that hinders pregnancy (e.g., endometriosis). Additionally, as the findings demonstrate, defining infertility for women in same-sex relationships proves difficult, and many women, as one participant told me, still “felt infertile” after several unsuccessful attempts at becoming pregnant yet did not meet the twelve-month (heteronormative) medical definition of infertility. Two of the straight high SES women's husbands were infertile, while the remaining 88 percent of such women met the clinical definition of infertility. Regardless of the participant's infertility diagnosis, all of the individuals in this study experienced the standardized context of medicalized infertility (Mamo, 2007). And, as the findings reveal, the experience of infertility goes well beyond the doctor's office and its diagnosis. Indeed, similar to Peronaces et al. findings (2007), I found little difference between the experiences of those diagnosed (e.g., male-factor) compared to those whose partners were diagnosed or who have ‘unexplained’ infertility or ‘social’ infertility.

All interviews were transcribed verbatim. I generated the majority of the analysis from the data and created the codes inductively as I read the transcripts, similar to a grounded theory approach (Charmaz, 2006). I entered the codes into a qualitative research software program and was then able to refine those codes into hierarchical coding schemes (e.g., open, axial, and focused coding). I then formed a more formal, detailed and thematic analytical approach, ultimately identifying patterns and variations in responses. For instance, I asked the software program to pull all of the “medicalization” codes from each transcript into one report. I then analyzed the data from that report and began comparing across groups. After several iterations of this process, I applied theoretical ideas and inductively “discovered” more specific concepts, such as “conceiving medicalization.” All of the quotes used in this paper are the “most illustrative” examples among many of the participants with similar experiences. I only utilized and included data that were commonplace across participants in the various demographic groups. The research project in its entirety was reviewed and approved by Institutional Review Boards, and all names are pseudonyms.

3. Findings

In the findings that follow, I explore the contextuality and diversity of medicalization. To do so, I compare those at the margins of medicalized infertility (women of low SES, men, and women in same-sex relationships) to those at its center (straight women of high SES), in turn exposing varying experiences and processes of exclusion.

The construction of infertility as a medical issue rarely crossed the minds of participants. Its medicalization is so normalized that individuals across all groups—class, sexuality, and gender—referred to it in such a manner. While the participants all accept the medicalization of infertility, such an understanding has differential effects depending on one's social location.

3.1. "I didn't think I could really do it": on the margins of medicalized infertility

3.1.1. Women of low SES

For women of low SES, the middle-class structure of medicine coupled with financial and ideological barriers precluded them from accessing infertility services. Women such as Angie and Candace, recognize the medicalization of infertility, but have internalized their exclusion from it. As Angie relayed, "I think it's beyond more than what I can do. I think it's something medically that has to be done." And Candace laments:

> I didn't think—I maybe thought only a rich person could do it maybe. Or maybe—I don't know—maybe—I didn't think I could really do it like get a—get fertility pills or get my uterus scraped or—I had heard of things but maybe I didn't really think I could do it.

Due to its medicalized understanding (and the structural and financial constraints that accompany such medical solutions), Candace and Angie are discouraged from resolving their reproductive struggles, further driving the class divide.

Despite having internalized the notion that medicalized infertility is primarily for the wealthy, nearly half of the women of low SES sought some type of infertility service. Such attempts were in vain, however, as the majority of their medical visits were diagnostic consultations with little to no follow-up. One reason women of low SES discontinued care was due to miscommunication with physicians. Kayla's experience demonstrates such barriers. In asking Kayla if she had ever gone to the doctor to inquire about her struggles, she replied:

> No, I always tried to ask [doctors] do they have something to help me get pregnant but they say 'no' … My brother's baby mama told me that they had some type of pills that can help you get pregnant because she heard it from her auntie but she don't remember what the pills was called. And she told me to ask them but they said 'no.'

In asking for something to "*help*" her get pregnant, the physician may not have understood that Kayla was having *difficulty* in her own attempts at doing so. Kayla's experience is reflective of a patient's "narrative surrender" in which doctors are taught to be skeptical of patients' narratives about illness (Foucault, 1973; Frank, 1995). In this case, the provider's skepticism may have been enhanced by the underlying stereotypes about the (hyper)fertility of young, poor women of color (Sandelowski and de Lacey, 2002).

Women of low SES were also challenged by the structure of medicine itself. The current, fast-paced culture of medicine with shortened appointment times and increased allied health professionals proves especially trying to low-income women who do not have the time or financial resources to have follow-up appointments. Nicole reflects on such barriers:

> The only way I could ever talk to [the physician] is if I have an appointment and I don't understand that. And they—it's like they don't understand that, you know, we can't just always pay $20 all the time or $25 every time just to have an appointment just to talk to you for two seconds … And then they always want you to have an appointment in the middle of the day and, you know, well, you know, I go to work to be able to afford this appointment, you know? It's—and it's very frustrating … This year I just let it go for the most part because I just can't do that all the time. Just—I mean my job is my number one priority right now. I've got to keep my job.

The structure of the medical institution results in further barriers for women of low SES to receive treatment for their infertility. Indeed, Nicole discontinued care after encountering these difficulties, reinforcing the classed divide.

3.1.2. Men

Men (of high economic standing) in this study did not face the financial, structural, and ideological barriers faced by the women of low SES. They did, however, confront medicine's "feminization" of reproductive care, which similarly precluded them from the medicalized experience. Reproduction has long been considered a "woman's responsibility," which is reflected in its medical treatment. As Mikkelsen et al. (2013, 1978) suggest, the woman is the patient, while "the role of the man is often reduced to providing a semen sample on time." Larry's experience reflects such sentiments. He recalls, "[my wife] was doing all the work, and it was me that was just kind of like on the sidelines." Seth similarly reports that he does "anything that the doctor asks of me, which is very little … it's like—it's like, 'I'm doing nothing.'".

Being on the sidelines not only maintained reproduction as women's responsibility, but it also maintained men's masculinity in the process. For instance, Tim relayed:

> I don't recall going to any of the appointments. But I recall there being several … I was always a bit of a distance from it … I think that I had to be the strong one, is the role I was often put in there.

Geoff echoes Tim's experience: "You just have to let her kind of take out her frustrations on you and you just have to be the rock and that's what you have to do." Through its exclusion of men, the medicalization of infertility upholds the gendered stereotype that women are in need of care, while men are the "strong" ones to provide it.

Much of men's sidelining was due to the rigorous appointment structure of fertility care as previously described by Nicole. Brent describes how such structure prevented him from participating in care:

> It hasn't—I have to go give blood maybe a couple times, but it's not a huge inconvenience for me. It's a—the only—I mean again, the only thing that I have to do—it's a way bigger inconvenience for her that she has to go all the time. And I feel bad for her that she has to go that much. I mean she's got to go for ultrasounds. And when you're in the midst of it, she's going three times a week-four times a week. I mean I could go with her, but I've got to work, too, right, so now we've got two people taking off of work to go to sit there where she gets an ultrasound and they say, 'You've got six follicles. See you tomorrow.'

Brent uses the quantity of appointments to excuse his absence from attending them. As he alludes, medicine has constructed and reduced men's role in reproduction to mere “ejaculatory extensions” (Culley et al., 2013, 229). Its intense focus on women's bodies and lack of emphasis on the role men *can* play in the treatment regimen allows men to draw on the structural aspects of medicine as their barrier to involvement. In turn, men can enhance masculine activities, such as work, and further distance themselves from the feminine arena of reproduction.

3.1.3. Women in same-sex relationships

While women of low SES were excluded and men were pushed to the sidelines, women in same-sex relationships pursuing fertility treatments were included in care, yet such inclusion often had the effect of marginalizing their experiences of reproduction. In other words, there can be movement between the medicalized center of infertility treatment and its margins. For instance, in contrast to women of low SES, defining infertility medically is one of the only ways to access treatment for same-sex couples. The heteronormative underpinnings of medical and insurance institutions initially prevent lesbian women from accessing treatment to assist in pregnancy. Helen's story relays such a barrier:

> The [insurance company] asked me, ‘well, have you—do you have regular exposure to sperm?’ And I'm like ‘I just told you five minutes ago I'm a lesbian. Definitely not.’ So I actually—we were denied coverage, um, so it was going to have to be out of pocket. And then, um, Rose from the billing … she called me and she's like, ‘you have endometriosis. You should not have to pay for this.’

It was not until Helen's reproduction got a medical name, a diagnosis, that the insurance company would cover the cost of her treatment, thus allowing her access to care. In other words, Helen's *social* infertility due to her female partner choice does not equate with and does not receive the same treatment as her *medical* infertility.

Because of its dependence on medicalizing infertility for its coverage of the condition, insurance companies must determine how it is defined. Many companies rely on the standard, medical definition of infertility—the inability to conceive after twelve months of unprotected intercourse. While on the surface the definition's heteronormativity is apparent, it also presents more implicit effects and barriers for women in same-sex relationships who are trying to have children. Leigh's experience demonstrates:

> One of the really interesting piece—parts for us was the fact that—that insurance didn't cover it at all and in order for it to be deemed infertility, you had to have like received show receipts … but you need proof that you've tried to inseminate a certain number of times. I think twelve times is, uh, was what my provider, uh, had at the time. Twelve times so over the course of a year, twelve times and then it would kick in. So, um, we geared up for the cost at that point. We tried to, you know, able—on top of savings save extra to put aside for this for—for quite some time … [We] put it in the hands of a professional who knows what they're doing, um, especially because if we did it ourselves, it wouldn't show—it wouldn't count towards the twelve times.

In conceptually trying to align same-sex couples' reproduction with heterosexual couples' infertility, insurance companies not only force medicalization (by requiring documentation), but they also prevent accessibility to such medicalized treatments due to the excessive cost of twelve, medically-assisted inseminations.

Such heteronormativity is also reflected in medicine's standardization of care (Conrad, 2007; Fisher, 1986; Timmermans and Berg, 2003). As Helen's experience demonstrates, standardization often results in ignorance around context:

> And [the doctor] was like, ‘Okay,’ he's like, ‘Well, um, you know, you should go home and have sex.’ And I was like, ‘Mm, okay.’ I was like—I really didn't get it and it was my first time like going through this process, and I had no idea what he was talking about. And I looked at the nurse and she looked at me and like she was like you could see the panic on her face. And he was—he was just staring at me and I was like, ‘Oh, I can.’ And I was like, ‘I'm sure [my partner] will be happy with that, but I'm not really sure what that's going to do.’ And he just kind of looked at me and then looked at my chart and he was like, ‘Oh,’ you know. And it was—I—I kind of felt away about that when I left the office. I called [my partner] and I really felt kind of awful … I was like, ‘It just didn't feel good’, you know, to be kind of not recognized for—for who you were.

When physicians did acknowledge the couples' unique situations, they sometimes did so at the expense of context. For instance, Deb describes her experience:

> [The doctor told me] ‘Well, we'll try three or—three times and then if not, you know, we're done and let's like—let's work on Jill,’ which is my partner. And I was like, ‘Well, you know, you don't say that to other people.’ You know? I mean I'm going to do as many times as I want to do, you know, it's like (laughs) it's my money, you know.

The effect of medicalization focusing on the outcome of the situation rather than the patient, as often evinced in cases of medicalized childbirth, is evident in Deb's reflection (Becker and Nachtigall, 1992). The physician was concerned with producing a pregnancy rather than the contextual, social, and emotional factors behind such pregnancy for Deb and her partner. The heteronormative standardization of medicalized infertility caused doctors to overlook and miscommunicate with same-sex couples receiving treatment, resulting in negative feelings or failed pursuit of a child (Timmermans and Berg, 1997).

3.2. “We did everything”: in the center of medicalized infertility

3.2.1. Straight women of high SES

In stark contrast to those on the margins of infertility, straight women of high SES had nearly the opposite experiences to its medicalized construction. Rather than being discouraged from seeking treatment for their reproductive difficulties as were women of low SES, straight women of high SES cannot imagine an alternative response. For instance, Colleen believed medicine was “*the* answer” to her childbearing woes. She described to me her hope and optimism around the procedures:

> Oh, my gosh. This is the answer. An IUI [intrauterine insemination]. It's perfect. We're going to take, you know, we're going to make sure I have what I need and then we're going to make sure he has what he needs and we're going to put ’em together and of course it's going to be a baby. How could it not? How could you miss? It's perfect. And—and of course, you always know somebody who knows somebody who had that work the first time. And filled with all of that hope.

While the women of low SES hesitated seeking care because “only a rich person could do it,” women of high SES, such as Colleen, did not think twice about such a "perfect" solution. Women of low SES are confronted with financial and structural barriers not faced by higher-income women, which causes them to be excluded from medicalized infertility despite their acknowledgement of its conceptual presence.

Unlike the women of low SES, the straight high SES women not only knew how to communicate with their physicians, they also often controlled the interaction. Becca's experience exemplifies such relations:

> I found out every single test I had to have, figured out where in my cycle it had to be done and got everything done in like two months … But I mean like that CDC website I went through every single clinic and then made a spreadsheet for my age range. And then when I would go into the doctor's office, I had all of the tests and they were all color coded with little tabs and like a little notebook. I do, you know, looking back like most people throw like a manila envelope at 'em, you know, with their tests in 'em and they're like, "Did you want this back?" And I'm like, "No, that's your copy."

Rather than the misunderstanding that occurred with Kayla, Becca actually went to physicians with her own diagnoses, questions, and treatment ideas. Her access to resources and knowledge allowed Becca to be in control of the medical interaction.

Such control is evident in the advantaged women's ability to work the system. Nadia reflects:

> I lied actually. I had only been trying for six months but I told [my doctor] I had been trying a year because I had a feeling that it was going to be problematic and I didn't want to waste any more time.

Because Nadia knew the medical definition of infertility and was not required to "prove" or document her attempts, she was able to exaggerate the length of time she had been trying to get pregnant, a tactic that allowed her to gain access to infertility treatments earlier. Unlike the women in same-sex relationships, the straight women were not only able to avoid the expense and emotional and physical effects of twelve medically assisted IUIs, they were also able to more quickly access care by evading such lengthy time bounds.

As Nadia's story demonstrates, straight women of high SES were clearly at the center of fertility care. In contrast to men who were sidelined from treatment and able to focus on other priorities such as work, the women oftentimes could not think of anything else in life beyond their reproduction. Carole describes the preoccupation as "just going through the days … I felt like I was just going through the motions of life for a while." Rather than being able to focus on work, as Brent did, many of the straight high SES women quit work to adhere to the rigorous treatment schedule. Stacy describes such sacrifice:

> I need to have a, you know, just a slower schedule right now so I can get into these appointments and not worry about like how I'm going to find that four or five hours … And so I went down to three days a week during that time so I could kind of do my—my—the doctor I needed to do and it wasn't always the same days of the week because when they needed to see you depended on, you know, the whole cycle of the month.

Stacy went from working as a full-time lawyer to working part-time in order to accommodate the frequent, rigid medical appointments required of infertility treatment. Women of high SES were in class positions in which they could make such life-altering changes.

While the sexual contexts of women in same-sex relationships were often disregarded and mistaken by physicians, the sex lives of straight women of high SES were overrun by prescriptions for sexual activity. Maureen, a straight woman of high SES, reflects that "when you're having sex because it's your job, it loses all the romance out of it." Carole echoes Maureen's experience:

> I mean we did everything [doctors] told you to do. And it was, you know, like I said, it was just like a job, you know, it was totally—it certainly takes the romance out of things and it certainly is grueling and time-consuming and (pauses), you know, just it's not spontaneous, it's not anything, you know? It's just—it's kind of sad. And it's—it's tense. That's—that's what it is. It's a lot of tension in your marriage.

It is well established that "the healthcare system reflects the same value system at work throughout society" (Becker and Nachtigall, 1992, 467). The standardization of care and its embedded heteronormativity go unnoticed among straight women of high SES since they fit the mainstream stereotype of infertility. Its prescription of sexual activity was a "grueling" experience for the straight women of high SES, yet an "awful," marginalizing experience for women in same-sex relationships, such as Helen, who were "not recognized" for who they are.

All participants lived through the medicalized experience of infertility, as they all interacted in some way with physicians and medical institutions regarding their reproduction. The effects of these encounters, however, varied along the lines of class, gender and sexuality. Women of low SES often received no treatment for their infertility, men were placed on the sidelines of care, and the needs of women in same-sex relationships frequently went unrecognized. All of these experiences contrast with those of straight women of high SES who, in the center of care, construct and control their own treatment and shift their lifestyles to accommodate care.

4. Discussion & conclusion

As Brubaker (2007, 549) proclaims, "The myriad ways medicalization constrains and expands reproductive choice, and is experienced by women at various social locations in different ways, is an area we need to continue to explore in research and in theory." Indeed, this study begins to explore such diversity in medicalization. Examining medicalized experiences among individuals from various backgrounds exposes its stratification as well as its contextualization.

This variation is often overlooked, however, as medicalization naturalizes and decontextualizes experience (Carrier, 1983, 952; Conrad, 2007). Rooted in medicine, an institution assumed to be an objective, neutral observer, the effects and context of medicalization often go unnoticed (Becker, 2000; Conrad, 2007). But, as Shim (2002, 190) notes, "biomedicine is an active participant in the construction of difference." Comparing the experiences of those on the margins of medicalization to those at its center strikingly exposes such differences.

Rather than a fixed, universal process, medicalization is fluid, relational, and shifts depending on context. Foucault (1973) demonstrated how the "clinical gaze" transforms an experience. Indeed, medicine's gaze did shape individuals' experiences of infertility, yet did so differentially depending on their social location. It is often assumed that women of low SES are on the margins of medical infertility treatment due to its high cost and sparse insurance coverage. While economics is certainly behind some of the variation and disparity, it cannot explain its entirety (Bell, 2010). As the findings demonstrate, the middle-class structure of medicine precludes women of low SES from attaining care with its high costs, limited hours, and doctor-patient (mis)communication. In contrast, women of high SES are inundated in the medical experience of infertility as active players in their medical plan and adjust their schedules to adhere to its rigorous treatment.

The men in the study did not have to shift their schedules, as they were on the "sidelines" of care. The medicalization of infertility reinforced the assumption that reproduction is a woman's issue with physicians asking "very little" of male patients allowing them to continue working and focus on being the "rock" for their wives. As the women of high SES revealed, they needed such support from their partners, as infertility treatment was a "grueling," time-consuming process that took over much of their lives.

Interestingly, one could argue that women in same-sex relationships seeking fertility treatment for childbearing are in the center of medicalized infertility, bringing physicians a whole new market for their services. However, medicine's standardized care pushed the women to the margins with its heteronormative assumptions resulting in costly treatments and demeaning comments. In other words, there is fluidity in medicalization not only between social locations, but also within them.

Ultimately, the heteronormative, classist, and gendered assumptions of reproduction and infertility informed medical practices, structures, and interactions, differentially shaping medicalized experiences. As Conrad et al. (2010, 1943) claim, medicalization is a "social process," constructed through human interaction, structures, and ideologies (Clarke et al., 2003). In turn, medicine reinforces those ideologies and its stereotypes in its applications.

The findings not only reveal medicalization as a social process, but also demonstrate the social factors around infertility. Infertility is not simply an embodied objective, medical condition. Rather, experiences of infertility are influenced by the context in which one lives, including the class, sex, and gendered practices and messages about infertility individuals receive. In researching those on the margins of our understanding of the process, the findings begin to overcome such stereotypes. In turn, we not only better understand infertility itself, but also the larger social factors at play, including reproduction, motherhood, and medicine.

It is important to remember that while research, including this study, often highlights the negative aspects of medicalization, the process also has its advantages. Medical treatment for infertility has allowed millions of individuals to attain parenthood. Moreover, although still unconsciously deterring and discouraging alternative family forms, medicalization has allowed same-sex couples and single individuals to become biological parents, a previously unattainable and unimaginable prospect. And while this paper highlights and discusses medicalization on its own accord, patients are also active players in the process. Individuals are not passive 'victims' of medicalization, but are themselves oftentimes driving the process, unconscious of its effects.

For the purposes of analysis and demonstration, the findings in this study were segmented by class, gender, and sexuality. But, in reality, these characteristics overlap, intersect, and inform, and are not separate entities. Many of the disparities discussed in the findings could be caused by several overlapping inequalities, such as race, age, and sexuality. For instance, the internalization of fertility norms experienced by Candace along class dimensions occurs along racial dimensions as well (Ceballo et al., 2015). Future research should conduct intersectional analyses to understand how medicalization is navigated by and applied to individuals differentially according to shifting dynamics of power and identity.

Medicine is not only shaped by ideologies surrounding class, gender, and sexuality, but it too, through the process of medicalization, reinforces and constructs such ideologies and its ensuing disparities. Examining infertility among those at its margins reveals their unique experiences as well as how medicalization contributes to their marginality.

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