Coll. Antropol. **47** (2023) 2: 155–162
Original scientific paper
doi:10.5671/ca.47.2.7

Mitti and *Beej*: The Metaphors and Meaning Making of Infertility and Assisted Reproductive Technologies

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ABSTRACT

In India, it is estimated that approximately 9% couples struggle with infertility of which 56% couples seek medical care. Out of these treatment seeking individuals, some require serious medical intervention involving the use of advanced Assisted Reproductive Technologies (ART) which include all of in vitro handling of human oocytes, spermatozoa and embryos for the purpose of reproduction. Through the present paper, the author explains how a complex, scientific technology is translated into local metaphors for its users to comprehend, convince and consume. Roughly understood as doctor-patient interaction, this process of meaning-making of how and why the technology works (or fails) wrest with the concepts of knowledge, power, authority and agency. The paper also shows how the translation of assisted reproductive technology into local meaning and metaphors is carried out in a socio-economic context with class connotations. It is based on the author's doctoral research on infertility, its experience and treatment in the infertility clinics of Lucknow, Uttar Pradesh. The paper finds that doctors often used the metaphors of mitti (barren womb) and beej (fertile seed) to explain the process of reproduction, its treatment and failure to the patients. It was found that meaning-making of the treatment process was done more carefully with patients from upper socio-economic background as compared to patients from the lower socio-economic background.

Key words: *infertility, in-vitro fertilization, assisted reproductive technologies, metaphors, doctor-patient interaction*

Introduction

Stuti and her husband are a couple in their early thirties. Stuti has been trying to get pregnant for two years now but she hasn't had any luck. Her husband accompanies her to most of her clinic visits and insists on sitting in with her during the consultation sessions. Today, when they entered the doctor's cabin their faces were hopeful. The doctor had told them that she would be performing a procedure on Stuti which will prepare her for the further treatment. In the previous consultation sessions, the doctor had mentioned about the procedure only in brief, talking about why it is performed. She hadn't spoken much about how the procedure is carried out. To explain how the procedure will be carried out, the doctor takes help of one of the anatomical models sitting on a counter behind her chair. She reaches for the model and then points towards the uterus.

> 'Stuti, this is your uterus where the baby grows. And this is your cervix…the opening of the uterus. We will take an instrument and go in through the cervix..and very gently, scratch the upper layer of your uterus. You know? To clean it and to remove a small piece…. which then we will send to the lab for analysis'. Stuti's face loses some color at the mention of the word 'scratch.' 'Will it hurt, doctor?' she asks nervously.

Now, I have known Stuti only for a few meetings but she has always come across as a strong, educated woman. In one of my earlier interactions with her, she had told me that she was a teacher and loved teaching children. She is very fond of her job and being surrounded by so many kids was one of the reasons why her own infertility always gnawed away at her. Through all her visits, she has always been smiles and positivity. But, sitting in the cabin, I can see her nervousness and restlessness growing. Suddenly, she does not seem very assured of herself.

> 'Yes, it will hurt, Stuti, but only a little. A lot of women go through this test, mostly without anesthesia' The doctor explained. Stuti's husband seems unsure too. 'What do you mean by scratching, doctor', He asks. 'No, not like that. Just a little prick, Mohit. You remember how I explained you the other day? That a woman's womb is like a field? Before sowing the fields, the field is tilled. This is same as that. In addition, we

Received for publication May 15, 2023

> are just removing a little soil from the field to check whether it lacks something. Stuti has already gone through one miscarriage because her soil is not fit. This time, we will prepare the soil well so that the seed can grow into a sapling. Mohit nods and asks what would be the price if they want to do this procedure under anesthesia. 'Today, we haven't scheduled the anesthesiologist. We will have to cancel today's procedure if you want one. Also that's going to cost you extra three to four thousand rupees. The anesthesiologist has to be arranged from outside' It is apparent that Mohit doesn't have the extra amount to spare and Stuti is also aware of that. Despite her sweaty forehead and shaky voice, she agrees to give it a try. 'Escort Stuti to the other room' The doctor says and asks Mohit to wait outside. Once the couple leaves, the doctor turns to the senior most nurse who was standing in the cabin, and says, 'we need to explain the smallest of things to these people. How it's done, why it's done, if anesthesia is required or not… and when it comes to the money, they always seek a discount/ Please go, Nurse. You handle this procedure; I'll deal with the other patients in the meantime. Let me know once it's done'.

The above snippet has various ongoing threads but the one that I want to pull here is how a complex, scientific technology is translated into local metaphors for its users to comprehend, convince and consume. In the above case, Stuti is a literate woman who is a teacher by profession and yet inside the clinic, her identity is only that of a patient. It is her who gets schooled and educated inside the clinic along with her husband. This translation of technology to the couples is an interesting process to document. Roughly understood as doctor-patient interaction, this process of meaning-making of how and why the technology works (or fails) wrest with the concepts of knowledge, power, authority and agency. Through this paper, my attempt is to explain how infertility and its treatment is translated by the doctors and made explicable for the unwitting patients, who are often unaware of what the process may involve. The paper also shows how the translation of assisted reproductive technology into local meaning and metaphors is carried out in a socio-economic context with class connotations.

This mapping of metaphors is particularly of significance because how a clinician explains infertility to their patient and how they communicate the treatment process to the individual are an important aspect of the treatment process. During the course of my literature review, I encountered a variety of articles reporting the terms and expressions used by the couples to explain their plight[1–5]. However, not much could be found relating to metaphors used by clinicians to describe infertility and its treatment to their patients except for one article that highlighted the need for medical professionals to use metaphors in order to increase patients' understanding of complex medical procedures. The article provided an extensive list of metaphors used by lung doctors to describe various forms of pulmonary diseases[6]. The present research paper, thus, attempts to provide an insight into the use of metaphors by the clinicians in infertility clinics in order to make the global reproductive technologies more meaningful and comprehensible for the couples in local contexts.

Infertility, Technology and the Infertile

In India, it is estimated that approximately 9% couples struggle with infertility of which 56% couples seek medical care[7,8]. Out of these treatment seeking individuals, some require serious medical intervention involving the use of advanced Assisted Reproductive Technologies (ART) procedures. Assisted reproductive technologies, by definition, refer to all techniques and interventions which require the 'in vitro handling of human oocytes, spermatozoa and embryos for the purpose of reproduction'[2]. A wider term is 'medically assisted reproduction', which also includes the process of artificial insemination. Infertility causes a severe disruption in the lives of couples and after a certain point of time in married life, couples find themselves unable to move past this disruption, looking for ways to resolve 'normalcy' in their lives. ART, in the last four decades, has progressed beyond leaps and bounds and reached even the smaller cities in India. Because of the wide spread globalization and medical advancement, ART has become a very popular choice among couples struggling with fertility problems. Heavily promoted in the print and broadcast media, ART advertisements manage to pull the attention of couples struggling to conceive. These advertisements clearly state 'what' they can deliver to the couple but the 'how' is rarely discussed in the advertisement. This foregoing of how the technology works or fails is of importance because 'technologies are not isolated from the society in which they are embedded'[9]. They operate within a social context, and interact with the individuals on daily basis, affecting their physical, social and emotional fabric. Ricci writes that 'the ways in which technology is used cannot be understood without understanding how that technology is embedded in its social context. The most basic relevant groups are the users and the producers of the technology and one of the most important aspects of technological dynamics is the communication process via which new technologies reach the public'[10].

At this point, it would be notable to state that in medical anthropology, the process of healing is often as significant as the act of healing. How a patient perceives his process of healing and treatment often facilitates or impedes the process of healing itself. In case of infertility, a couple often undergoes months, if not years of emotional and social suffering before they decide to visit a clinic. Unable to conceive after repeated attempts takes a heavy toll on the psyche of the individual and the couple. They deal with a certain amount of self-doubt and incomprehension, as to why something that comes so natural to most couples is beyond their reach. Thus, upon walking into an infertility clinic they seek not only a solution but also some answers. They attempt to understand where and how their bodies have failed and if possible, how the natural course of reproduction can be corrected for them. This requires interpretation and mediation of a biological problem and its technological solution to the couples by the doctors. The technology of assisted reproduction is broken down and explained to the couple so they can decide to embark on the journey of parenthood. As human reproduction is a matter of not only biology but also ethics and morality, it is required that the doctor should keep the couple informed of the process at every stage and written consent is required for carrying out the procedures. Thus, the dialogue between the patient and the doctor is very crucial and an integral part of the treatment process.

Ethnographic Fieldwork: The Clinic and the Doctor

The data for this paper comes from my doctoral research on infertility, its experience and treatment in the infertility clinics of Lucknow, Uttar Pradesh. I conducted six months of fieldwork in a private infertility clinic in the year 2020 using the methods of participant observation and in-depth interviews of twenty-three treatment seeking women. Informal, unstructured interviews were conducted with more than fifty women. In the present paper, I mostly rely upon the data collected through participant observation, informal interactions and in-depth interviews with the couples undergoing treatment at the clinic. The data obtained through in-depth interviews was coded and thematic analysis was carried out manually. The data obtained through observation and informal interactions was initially written down in a fieldwork diary and later expanded into full-length fieldwork notes (mostly within the same week the observations and informal interactions were carried out). The women seeking treatment at the clinic came from a broad range of socio-economic backgrounds. Statistically, the majority of the women were from the middle income groups (49%) and the upper income groups (27%). The number of women from the lower income group was comparatively lower (about 24%), including women from both urban and rural backgrounds. It is notable that women from the middle and the upper income groups mostly came from an urban background. In terms of infertility status, 48% cases were of female factor infertility, 32% were of male factor infertility, 11% were of idiopathic nature and about 9% cases were of couple factor infertility.

The patients and clinics mentioned in the article have been sufficiently anonymised and an ethics committee approval has been obtained from the Department of Anthropology, University of Delhi, for conducting the research work. In order to obtain informed consent from the research participants, a participant information sheet was prepared (which was also submitted to the ethics committee for approval) and shared with the couples seeking treatment at the clinic. The participant information sheet consisted of details about the research work, research questions, what kind of data will be obtained from the couples during the interviews and how the data will be utilized. Along with sharing the participant information sheet with the couples, they were also verbally informed about the research work and consent was obtained on both written and oral basis (depending upon the comfort level of the participants).

During my fieldwork, I spent a considerable amount of time inside the doctor's cabin, documenting the doctor-patient interaction. Before I talk more about the doctor and the patients at the clinic, I would like to give you a broad idea of what this clinic looked like. This clinic was located in one of major residential areas of the city and was a home-turned-into-a-hospital kind of setup. This is important to clarify because the nature of services offered, patient-doctor interaction and the affordability of medical services can and do vary to a great extent in fully-functioning hospitals, or corporate-backed multi-city infertility clinics. So, this clinic where I worked at, was a medium-sized personal enterprise, run by one infertility doctor, who was assisted by a junior doctor and ten technical staff members. The clinic had both OPD and IPD sections, along with an inbuilt ART lab. The clinic mostly catered to couples from lower middle class to upper middle sections.

During my fieldwork, my days at the infertility clinic would begin around ten o' clock in the morning. The doctor would not sit in until it was eleven o' clock; sometimes later. The clinic was located in an upscale residential area and had three floors. The top floor was used exclusively by the doctor as her private residence which allowed her the liberty to come and go into the clinic as she pleased. On a typical day, the patients would start reaching the clinic much earlier than the stipulated timing of the OPD (out-patient department). My responsibility in the clinic, before the doctor would sit-in, was to log the entry of patients in the OPD register and assign them token numbers. I would use this opportunity to interact with the patients and engage them in informal interactions. Swati would often visit the clinic during this time. She is a working woman and her morning visits to the clinic would always be done on the way to her work. Thus, she would always be in a hurry. During these morning visits, she would demand that the staff attend to her immediately so she can be on her way. Her treatment was still in the initial phase where injections were required every couple of days, to boost egg production. Upon her arrival, the clinical staff would shake off some of the laziness that surrounds a workplace before the working day really begins. The clinical staff would call the doctor and tell her a patient needs injections. This was done because the doctor kept a tight vigil on the number of injections in her stock and in order to use one, the staff was supposed to log entry in two different registers. Injections could not be used until the doctor had signed a prescription or the junior doctor had given the green signal to remove one from the refrigerated stock. This two-level permission seeking would delay the procedure and Swati would get impatient while pacing in the waiting room.

“Roz to lagana hota hai..pehle se ready kyo nahi rehte aap log?” (Why aren’t you prepared when this has to be done every day?) she would ask in a reproachful tone and the staff would shift their gaze and assure her that it will be done in a couple of minutes. These morning interactions, for Swati, always involved assertiveness on her part and passivity on the part of the clinical staff.

Once the doctor would come downstairs, the OPD would really begin. I would be expected to vacate the desk where the medical histories of the patients were being recorded. Another staff member would replace me and I would move inside the doctor’s cabin. Inside the cabin, my responsibility was to maintain a register of patient visits where I would enter the details of the interaction taking place between the doctor and the patients. I kept two different notebooks for this purpose. The first notebook I had would be my field dairy, where I would note down everything the doctor and the patient were talking about. In the second notebook, I would only write down the medical jargon, details of the procedures and medications prescribed to the patients. This second notebook belonged to the clinic and allowed them to keep a track of what was happening with a patient. At the end of the day, my task would be to summarize all the upcoming procedures onto a white board for other clinical staff to see. My role in the clinic, over the months, graduated from being a silent observer to an active participant. Majority of my fieldwork was done inside the doctor’s cabin and it allowed me to look closely at the relationship between the clinician and the couples, allowing me to understand the hierarchical, power infused dynamic between the doctor and her patient. I could witness how infertility, a social disease, was given the form of a medical disease and technology was presented to the couple as the ultimate solution. During the conversations between the doctor and the couples, ART was offered to the couples followed by a layman explanation of what it meant and why it was required.

Metaphors and Meaning-Making of ART

The meaning-making of the technology and the metaphors used by the doctors to communicate with the patients involved recurrent use of the terms *mitti* and *beej* , as we have seen in the opening anecdote of this paper. The term *mitti* referred to the barren womb of the intending mother and *beej* was the fertile seed of the intending father. When a couple would first arrive in the clinic, the doctor’s job was to ascertain whether it was the *mitti* that required ‘*khaad paan*i’ (manure) to regain its fertility or whether it was the *beej* that was of poor and dormant quality. During the very first counselling sessions, the doctor would begin with her description:

> *‘Aapki bacchedani ek khet jaisi hai. Jisme mitti aacchi hogi aur beej bhi accha daala jaayega, tabhi paudha ugega (*Your womb is akin to a field that requires fertile soil and quality seeds to produce a sapling). As doctors, it is our job to find out where the problem lies and to find its solution’.

The first counselling session would end up with a series of diagnostic tests that would be prescribed to the couple in order to find out if it was the *mitti* or the *beej* that required treatment. Once the test reports would arrive and the infertility status of either the husband or wife would become clear, the doctor would present before the couple, her ‘airplane model of treatment’. This model was also suggested to the couples who had already been to other clinics but had not been successful in conceiving.

In this model of explanation, childbirth was portrayed as the destination and in order to reach there, a couple would have to undertake an arduous journey. This journey could be completed through multiple routes. In the clinic, the doctor would present the couple with two choices: first, to attempt normal childbirth at home but assisted by fertility enhancing drugs. This would require the couple to visit the clinic multiple times a month and take oral medicines for several months. Here the doctor would explain to the patient that she was ‘preparing the field’ or ‘increasing the virility’ of the *beej* with the help of the medicines.

This would be done for a couple of weeks or months and based on the couple’s new test reports, the doctor would suggest that it was time for them to get acquainted with ART. The doctor in the clinic where I worked, would explain:

> ‘Imagine you have a destination to reach and to get there you have been walking’. But time is running short and you’re getting late. You have to hurry up. So, what do you do? Do you keep walking or do you get a bicycle? A bicycle will take you faster to the destination. In case, you need to arrive at your destination early, or the cycle is not working for you, you will get into a car. The car would be faster than the bicycle but it will cost you more. And in case you are in a real hurry and have no time to waste, you will buy an airplane ticket. Which route you take to reach your destination is decided by a number of factors such as how far you are from the destination or how much money you can afford’.

In this explanatory model, the doctor would refer to medication as the walking. Getting a bicycle would be artificial insemination i.e., IUI. The airplane in this example would be IVF. There were very few cases in the clinic where the doctor would urge the couple to travel in the airplane. She would generally begin with walking or a bicycle, depending upon what the test results said. In her opinion, the airplane journey was risky and should be avoided unless there was no other option available. In her line of treatment, she would begin with prescribing medicines first, then injections, then IUI and if all of this failed, she would counsel the couple for IVF. Sometimes, there would be couples who had already done the walking and bicycling at other clinics, and they would demand the airplane journey as soon as they walked into the clinic:

> Patient: We are tired of the other techniques and only want IVF.
>
> Upon this, the doctor in the clinic would ask them.

> Doctor: Why do you want to get on the plane right away? If it doesn't work it's a plane crash.

In most of these counseling sessions, the couple would end up agreeing to the doctor's advice and choose a course of treatment that the doctor would deem fit for their case. Apart from these explanatory models of how the various assisted reproductive technologies worked, the doctor would also explain certain aspects of the treatment process in layman terms. In cases of male infertility due to poor quality of sperms or no sperms, the doctor would explain that:

> 'your husband's germs are not of standard quality and number. They do not have virility. Thus, we will require his sample which we shall clean and choose the best germs. These germs would be put inside your body using an injection. Once good quality seeds have been sowed in your field, the sapling would grow'.

This was how the process of intra uterine insemination, i.e., IUI would be explained to the couples. The couples would mostly nod, with one or two questions from the couple about how much the process would cost and what were their pregnancy chances after the procedure was carried out. Most women would be worried if the procedure would be painful for them. 'This procedure is much easier than delivering a baby *(bacha paida karne se to aasaan hi hai ye kaam)'* the doctor would say. Explanations about how IVF works used to be more difficult for the patients to follow as it would require more complex procedures such as increasing the egg production in the ovaries, surgically removing the egg, fertilizing it with the husband's or the donor's sperm and then transferring the embryo back into the female body.

Metaphors of *beej* and *mitti* would be uttered multiple times and terms such as '*khet ki jutaai*' (tilling the field), *ghaas phoos nikaalna* (weeding the field) were often shared with the couples. This meaning making of the biological process of reproduction, its failure and treatment was heavily reliant upon the use of everyday examples to make them sound relatable and simple for the couples. If we look at the existing literature on metaphors used for infertility, most of the papers report the terms and expressions used by the couples to explain their plight. During my literature review for this paper, I could not find much information about how doctors and clinicians describe infertility and its treatment to their patients. How a clinician explains infertility to its patient and how they communicate the treatment process to the individual are an important aspect of the treatment process. Metaphors and explanations used during consultations at the various stages of the treatment are 'a powerful linguistic device which create images and allow patients to create their meaning'[11].These metaphors have both an expressive and an instrumental function. The expressive function is invested with feeling and attitudes that allow the patients to get into the depth of the meaning-making process. The instrumental function of these metaphors permits description of the treatment and its context. It allows them to make better and informed choices about their treatment. Rudge has written that 'metaphors are more than mere chance conveyors of words and their meanings, for they are considered to be rhetorical strategies that are used purposefully if not deliberately within networks of power relationships to reinforce and strengthen hegemonic meanings'[12]. Thus, when in a clinical setting, a doctor refers to a woman's body as a field, her uterus as the soil and a man's sperm as the seed, the doctor also reaffirms the societal and cultural norms of reproduction. As the reservoir of the seed, a man's role in the process of reproduction is of generative nature and as the soil, a woman's role is that of supportive nature.

Socio-Economic Context and Translation of Technology

Private healthcare is the reality around most parts of the world and it comes with its own set of benefits and problems. Infertility and its treatment is one such field where the private players are in the lead. Though there exists a statistical lacuna, it is an admittable fact that a major chunk of infertility treatment facilities in the country are privately owned. The government hospitals are far behind in terms of both reach and technology. Infertility treatment is mostly provided in gynaecology departments of public hospitals which operate on weekly basis, dedicating either two or three days for infertile couples. Most of these public hospitals are not provisioned enough to carry out diagnostic tests and procedures required for infertility treatment. This drives the struggling couples to seek private infertility clinics where they encounter exorbitant and unregulated prices for the treatment.

When a couple walks into a private infertility clinic they are seen as potential patients and are immediately taken up for consultation. In my fieldwork, I found that the preliminary consulting sessions would always be carried out by the doctor herself. She would not rely on the junior doctor or any other clinical staff to carry out the task of convincing the couple to get registered at the clinic. During the preliminary and the subsequent consulting sessions, the doctor would engage the couples directly and the treatment course would be explained to the patients diligently. However, whether these consulting sessions would be continued or carried out with the prior keenness was a different matter altogether. During the course of the treatment and interactions, the doctor and the clinical staff would become better aware of the financial standing of the couples. This knowledge would determine how the further consultation would go about and whether there was a need to attempt to translate the technology to some of the couples.

Within the clinic, the trend was that couples from the upper middle class, those equipped with money and English proficiency were made to understand everything with due diligence and reverence. They would always be received in the clinic with a bigger smile and a more polite greeting. The doctor would make sure to answer each of their questions with utmost patience. On the other hand, couples from weaker socio-economic background were seen unworthy of an explanation in the long run. They would be counselled when they first arrived in the clinic and at the beginning of the treatment. There was little to no attempt to keep them informed of the process at every stage.

Dhaniya, who was a patient at the clinic once told me that she had been seeking treatment at the clinic for over a year. I would often find her sitting in the most inconspicuous corner of the clinic, sometimes the corner chair in the waiting room and sometimes near the stairs leading up to the second floor of the clinic. 'How long have you been sitting here?' I asked her one day after noticing that she had arrived in the clinic sometime in the late morning and had been waiting for more than three hours. Couples who had arrived after her had already met the doctor. 'It's been three and a half hours, madam' she told me. 'Why don't you go and meet the doctor, then?' I asked further, taking the file she was holding in her hands and checking the details of her previous visit. *'Jab wo bulayenge tab milne jaayenge'*[a] she said with a faint smile on her face. She was waiting to be summoned into the cabin. 'Who is going to call you? Aren't you supposed to get your token number and then go inside according to the number allotted? You are a regular patient. You know the system, right?' I asked her. 'They don't give me a token. They say I am IVF patient so I don't need to pay for a token every time I visit. So, now, I don't know when to go inside. I normally wait for them to call me' Dhaniya explained. 'But then you have to wait a long time' I commented, seeing her tired expression. *'Haan! Time to lag jaata hai. Ek baar ham bina bulaaye andar chale gaye to doctor na bahut daata tha. Keh rahi thi ki paisa nahi di ho aur turant andar chali aati ho. Baahar baitha karo aur bulaane par aaya karo'*[b], Dhaniya said in a soft voice, looking around cautiously to see if anyone else could hear. She said that there was a time when she had entered the doctor's cabin without being called inside and the doctor had yelled at her saying the she doesn't pay on time and is eager to meet her at once. She had been told not to go inside the cabin until asked to.

Upon further interaction with Dhaniya, I learned that she has had two rounds of embryo transfer (ET) in the clinic and both the attempts had failed. She hadn't paid the amount of the second embryo transfer in full and was often reminded of the same by the clinical staff. After the failure of the second ET, the clinical staff would not receive her calls and when she had tried to ask the reason of her ET failure, one of the clinical staff had behaved rudely with her. No one wanted to entertain her. *'ab pata nahi kya hoga..kuch batate hi nahi hain ye log. Ham har hafte aate hain yaha aur dawai lekar chale jaate hain. Jo bhi test kehti hain doctor ham sab karwa lete hain.. report dekh ke bhi bas itna kehti hai ki hi haan theek hai..poori baat nahi batati hain..ham bahut pareshaan hai, madam'* [c] Dhaniya was troubled that she did not know where her medical treatment was going and what would be the further course of action. She had questions and doubts but no one seemed to bothered enough to answer. Dhaniya believed that if she paid the amount of her second ET the doctor might agree to do a third ET as well. 'But you don't have the money to give it to them?' I had asked. 'No, I don't. My husband works on contract-basis in a government office. He is a peon there. He does not earn enough money. Even for the first ET, we had to borrow money from our relatives' Dhaniya revealed in a soft voice. 'Does the doctor know that you don't have the money?' I had asked her. Dhaniya nodded. 'She asked me what does my husband do when we had first arrived in the clinic. She knows we are not rich' Dhaniya had said before asking me I could send her file inside the cabin so she would be called inside soon. The question of employment was not exclusive for Dhaniya. During the hours, I would sit inside the doctor's cabin, I had noticed that the doctor had her own way of building rapport with the patients. She would often ask during the initial consulting sessions where the couple was from and what kind of work they did. While the couples often saw this as an amiable quality of the doctor who was bothered to know about their personal lives as well, for the doctor, it equipped her with a preliminary knowledge base to approach the couple. The initial aim of the doctor would be to get the couple to like the clinic and once the financial situation of the couple would become clearer to her, she would decide how much efforts to spend in translating the treatment process to them. If the couples were from a lower socio-economic class, the explanation process of the medical condition, diagnosis, test results and the treatment procedures would be bare minimum.

The differential explanation of ART treatment to the couples based on their socio-economic status was not limited to the consulting sessions only. In case of treatment failure, it could be observed that the couples from weaker socio-economic background were given the rationalization of an ill-fate whereas couples from affluent families would be told that the reach of science was limited and one can only try again and again until the treatment works. So, while some couples would hear phrases such as *'ye waala aapki kismet nahi tha'*(it is not your destiny), *'jab naseeb me hoga tabhi milega'*(You will get it only if you are lucky), some couples would be told that *'kuch cheezein doctor ke haath me bhi nahi hai hain..ham to bas apni taraf se koshish karte hain'* (Some things are not even in the hands of doctors...we just try our best), *'abhi science ne itni tarakki nahi ki hai ki har koshish me ek baccha ho jaaye'* (Right now science has not progressed enough that a child can be born in every endeav-

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[a] eng. I will see the doctor when they call me.

[b] eng. Yes, it takes time. Once I went inside without them calling me to the doctor. The doctor scolded me a lot. She said that I have not paid the money and I dare enough to walk inside without any delay. Sit outside and come inside when called.

[c] eng. Now I do not know what is going to happen. They do not tell me anything clearly. I come every week, take the medicines, get the tests done that are asked. The doctor looks at the reports and tells me that everything is fine but she does not say anything more. I am very exhausted, Madam Ji.

our). Invocation of godly might was, however, a common phrase used for both lower and upper class couples, *'Bhagwaan ki marzi kea aage ham kuch nahi kar sakte', 'ishwar ke ghar me der hai, andher nahi'*(We cannot do anything beyond God's will).

However, it can be surmised that within the clinic, a couple's worth was calculated in terms of the number of IVF cycles they could afford. How they were to be treated inside the clinic, how knowledge and information was mediated to them throughout the treatment cycle was strictly decided on per-cycle negotiation basis. If the couple agreed to the amount demanded by the doctor without negotiating for a discount, they would remain in the good books of the doctor and the clinical staff. They would be explained in detail why a test was being written, why a certain medicine was being prescribed or why getting a hysteroscopy was necessary in their case. Couples from weaker socio-economic background would not be accorded that courtesy and would often be unaware of the nitty-gritties of their treatment.

Translating the technology, in the particular clinic where I worked, was not limited only to the couples. A majority of the staff in the clinic was unskilled without any professional degree in nursing or infertility treatment. The doctor would often struggle to provide instructions to the staff who were too used to doing things in their way. In a certain case, the husband's semen sample was left out in open for an entire afternoon instead of being refrigerated which rendered it useless for the upcoming IVF procedure. The doctor, in that case, was forced to ask the husband to provide a second sample and the staff was given a lesson in the importance of storing semen sample at an optimum temperature as soon as possible. In the clinic, during the course of my fieldwork, my role was not only that of a researcher. I was also seen as a temporary, extra appendage in the clinic which could be used by the doctor to get maximum output. Thus, she attempted to not only educate her patients and staff in the process of infertility treatment but also me. In return of letting me continue my work in the clinic, I was expected to carry out paper work and assist in minor procedures. Thus, the doctor insisted that I learn some basic procedures such as prepping the ultrasound machine, assisting in minor surgical operations, giving injection to the patients, taking a detailed case history and writing it in medical syntax. Needless to say, I ended up learning some of these and failing at most of these.

Conclusion

A doctor's cabin is a place where identities and roles are rewritten. From a politician to a pauper, each gets reduced to the status of a patient. There takes place a reallocation and negotiation of knowledge and authority, where the doctor assumes the role of the expert and the patient becomes the subject upon whom that knowledge is tested. No matter what influence, power, and knowledge lies with the patient, once he walks into a doctor's cabin his social identity is peeled off to a bare minimum and a new identity is assigned to him. This shifting of knowledge, power, authority and agency within the medical setting is an important process because it guides the treatment experience of an individual. Within the clinic where I worked, the dialogue between the technology and the patient was unidirectional. Doctors, as bearers of medical knowledge and technology withheld crucial and important information from the patients in several cases. Explaining the technology to the patient was the bare minimum that they bothered to do and even that was a discriminatory practice with socio-economic background of the patient being a strong factor.

Medical practitioners are instrumental in the understanding and acceptance of any new treatment process in a society. Whenever a new technology becomes available in the medical field, the purpose of the technology is to reduce human suffering. Most of these technologies keep on evolving and are only best understood by those practicing them. The human aspect is missing in these technologies and their application. Those on the receiving end of these treatment methods, most often understand very little about them. These technologies require an assessment of profound human values and social preferences in order to become universally acknowledged. Commonly, such issues are dealt with in the public policy arena, and necessitate a high level of interaction between scientists and policy makers[13].

In August 2018, the Ministry of Health and Family Welfare announced its plans to implement a charter of patient rights which was also advocated by the National Human Rights Commission. The objective of the charter was 'to generate widespread public awareness and educate citizens regarding what they should expect from their governments and health care providers–about the kind of treatment they deserve as patients and human beings, in health care settings. The charter believed that informed and aware patients can play a vital role in elevating the standard of health care, especially when they have guidance provided by codified rights, as well as awareness of their responsibilities. Seventeen rights were listed in this charter which were right to information, right to records and reports, right to emergency medical care, right to informed consent, right to confidentiality, human dignity, and privacy, right to second opinion, right to transparency in rates and care as per prescribed rates, right to non-discrimination, right to safety and quality care according to standards, right to choose alternative treatment options if available, right to choose source for obtaining medicines or tests, right to proper referral and transfer, right to protection for patients involved in clinical trials, right to protection of participants involved in biomedical and health research, right to take discharge of patient, or receive body of deceased from hospital, right to patient education, and the right to be heard and seek redressal.

While all these rights are relevant in the field of infertility and ART treatment, the right to information, right to informed consent, right to confidentiality, human dignity and privacy, right to non-discrimination and right to patient education are much more crucial. ART technology has been able to travel past the initial criticism and reluctance with which it was met at its genesis and has become increasingly popular. The role of the doctors in simplifying the mystifying nature of the ART treatment for its patients is something that shall be practiced evenly, allowing couples to make better choices. The metaphors employed and the explanatory models used are doing their bit in educating the patients about their medical situation and through this paper I have provided the documentation of the process of translating the technology in the local terms. And I shall conclude by stating that irrespective of the fact whether the patients understand the technology or not, ART has carved its own niche in the Indian society where it will continue to plant a seed of hope into the barren wombs of infertile Indian women.

Limitations of the study

The present research work was limited in two ways. First, I encountered severe gender limitations while conducting interviews and informal interactions with the men at the clinic. Hence, the study relies heavily on data obtained from the women at the clinic and a male perspective is missing. Secondly, the sample size of the study remains small due to time constraints and the onset of the COVID pandemic which affected the term of my fieldwork.

Acknowledgements

The above research was funded by University of Delhi Grants Commission through their NET-JRF fellowship scheme. I am indebted to my doctoral supervisor Dr. Chakraverti Mahajan for his academic insight and sustained support in making this manuscript possible. I am also thankful to the reviewers of Collegium Antropologicum for their valuable comments.

REFERENCES

1. BECKER G, Medical Anthropology Quarterly, 8 (1994) 383. doi: 10.1525/maq.1994.8.4.02a00040. — 2. DE LACEY S, Nursing Inquiry, 9 (2002) 43. doi: 10.1046/j.1440-1800.2002.00126.x. — 3. MEZINSKA S, MILEIKO I, The New Bioethics, 18 (2012) 36. doi: 10.1179/2050287713Z.0000000003. — 4. PALMER-WACKERLY AL, KRIEGER JL, Health Communication, 30 (2015) 612. doi: 10.1080/10410236.2014.888386. — 5. DELAUNAY C, SANTOS MJDS, GOUVEIA L, Reproductive Biomedicine & Society Online, 13 (2021) 62. doi: 10.1016/j.rbms.2021.05.003. — 6. ARROLIGA AC, NEWMAN S, LONGWORTH DL, STOLLER JK, Annals of Internal Medicine, 137 (2002) 376. doi: 10.7326/0003-4819-137-5_part_1-200209030-00037. — 7. BOIVIN J, BUNTING L, COLLINS JA, NYGREN KG, Human Reproduction, 22 (2007). doi: 10.1093/humrep/dem046. — 8. GREIL AL, SLAUSON-BLEVINS KS, SHREFFLER KM, JOHNSON KM, LOWRY MH, BURCH AR, MCQUILLAN J, Public Understanding of Science, 26 (2017) 789. doi: 10.1177/0963662515625402. — 9. GUPTA N, FISCHER AR, FREWER LJ, Public Understanding of Science, 21 (2012) 782. doi:10.1177/0963662510392485. — 10. RICCI O, Public Understanding of Science, 19 (2010) 578. doi: 10.1177/0963662509104724. — 11. CZECHMEISTER CA, Journal of Advanced Nursing, 19 (1994) 1226. doi: 10.1111/j.1365-2648.1994.tb01208.x. — 12. RUDGE T, Nursing Inquiry, 5 (1998) 228. doi: 10.1046/j.1440-1800.1998.00242.x. — 13. WATERSTONE M, Risk and Society: The Interaction of Science, Technology, and Public Policy (Springer, Netherfields, 1992).

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MITTI I *BEEJ*: METAFORE I OBLIKOVANJE ZNAČENJA NEPLODNOSTI I REPRODUKTIVNIH TEHNOLOGIJA POTPOMOGNUTE OPLODNJE

SAŽETAK

Procjenjuje se da se u Indiji oko 9% parova bori s neplodnošću, od čega 56% parova traži liječničku pomoć. Nekima od njih potrebna je ozbiljna medicinska intervencija koja podrazumijeva korištenje naprednih tehnologija potpomognute oplodnje (ART), koje uključuju sve in vitro postupke s ljudskim jajnim stanicama, spermatozoidima i embrijima u svrhu reprodukcije. Kroz ovaj rad autorica objašnjava kako se složena, znanstvena tehnologija prevodi u lokalne metafore koje korisnici mogu razumjeti, prihvatiti i konzumirati. Grubo shvaćen kao interakcija liječnika i pacijenta, ovaj proces stvaranja značenja o tome kako i zašto tehnologija radi (ili ne radi) bori se se s konceptima znanja, moći, autoriteta i djelovanja. Rad također pokazuje kako se prijevod pojmova potpomognute oplodnje u lokalno značenje i metafore provodi u socio-ekonomskom kontekstu s klasnim konotacijama. Temelji se na etnografskom istraživanju neplodnosti, njezinom iskustvu i liječenju u klinikama za neplodnost u Lucknowu, Uttar Pradesh, Indija. Rad otkriva da su liječnici često koristili metafore *mitti* (neplodna utroba)i *beej* (plodno sjeme) kako bi pacijentima objasnili proces reprodukcije, njezino liječenje i neuspjeh. Primjećeno je da je više pažnje posvećeno osmišljavanju procesa liječenja s pacijentima višeg socio-ekonomskog statusa u usporedbi s pacijentima i nižeg socio-ekonomskog statusa.