Looking Carol in the face

James Owen Drife

Carol is a stocky woman, who usually wears a grubby windcheater. She has lank brown hair and wears no make up, and her husband is a labourer with fingernails that betray his interest in car mechanics. They are pleasant, unimaginative people who have enough determination to cope cheerfully with living in a poor suburb, but neither of them aspires to upward mobility. They seem enviably content on their cluttered council estate, and their only problem is Carol's blocked fallopian tubes.

Like other gynaecologists, I see a fair amount of infertility caused by tubal problems. After surgery has been tried unsuccessfully the next step is in vitro fertilisation (IVF), a procedure that patients usually want desperately even when its failure rate has been explained. What I say to them is: "Unfortunately IVF isn't available on the NHS, but I can refer you to one of the private clinics near here. The waiting lists aren't long. The cost varies, but it's of the order of £1000 for each course of treatment. You may need several courses before you get pregnant." In Carol's case the meaning of these words is: "Push off."

The first time is the worst

Turning patients away is a new experience for me. The most upsetting thing about it is how easy it is becoming. Something that was formerly unthinkable is now part of my repertoire. With any shameful action the first time is the worst, the second time is easier, and eventually it hardly bothers you. This is how Agatha Christie's villains used to describe their homicidal careers, and the same applies to lesser misdemeanours like mugging, embezzlement, or refusing treatment to people who can't afford it. For the common criminal this loss of innocence is a solitary process, but things are easier for the doctor who embarks on a career of withholding treatment from the poor. He has the sympathy of his peer group, the approval of society, and the encouragement of the government. He can also expect resigned acceptance from the patients themselves.

You see, Carol comes from Anglo-Saxon stock. Her people have lived in England's feudal society since before the Norman Con-

quest and have never expected the same treatment as their betters. The English peasantry still regard socialised medicine with popeyed amazement. When I give patients an immediate date for operation their jaws drop and they gasp that they expected to wait at least a year. If I tell a woman with, say, a premature menopause that her condition is untreatable she will become thoughtful and stammer: "Well, I'll just have to go private, then." The yeomen and yeowomen of England expect the NHS to offer a second rate service, and infertile patients don't even look surprised, much less angry, when I tell them that their dynasty must come to a halt because expensive fertility treatment is not for the likes of them.

Disappointment compounded by debt

According to the Voluntary Licensing Authority for Human In Vitro Fertilisation and Embryology, only one of Britain's 30 centres is funded wholly by the NHS and access to treatment "continues to be determined largely by a couple's financial resources, a matter of continuing concern to the Authority." This restriction has been received by the profession with a mixture of resignation and enthusiasm. Some specialists have moved wholly into the private sector, while academic units have adopted compromise solutions, which mean that patients pay for only part of their care. Couples slightly better off than Carol may indeed raise a bank loan or sell their house to pay for private treatment. More often than not IVF is unsuccessful, and the luckless couple face disappointment compounded by debt.

Why has the country accepted that IVF cannot be free to all? It is not just because the service is new and expensive—we can afford new linear accelerators for cancer treatment. It may be because nobody dies of infertility, but—at least at the time of going to press—NHS treatment still isn't restricted to lethal diseases. Perhaps we feel that people like Carol don't deserve free care because blocked tubes are often the result of gonococcal salpingitis. Nevertheless, the NHS doesn't refuse to treat the drunk who drives into a lamp post or the heavy smoker with lung cancer, so I doubt whether primitive morality

is the real reason. Part of the problem may be our awareness that the last thing this planet needs is more babies—but we seem happy to treat women whose infertility is due to anovulation.

Pity, not sympathy

I think that there are two reasons why infertile couples do not excite public sympathy. The first is that unlike sick babies, crippled children, or pregnant women they don't look vulnerable. They look healthy, they keep busy, and usually they are reticent—even sullen—about their problem. The second, more powerful, reason is that each of us supports the NHS partly through fear that we may need it. Any day now we may develop a cancer, have an accident, or suffer a heart attack. We commiserate with such afflictions because we know we may be next. Those of us with children have lost the sympathy born of fear. Among the many emotions we feel in the puerperium is a trace of smugness. Though we may pity our infertile neighbours, once we have children we can never again fully sympathise with them.

Not the right Victorian values

The Victorians felt comfortable with pity and made charity a virtue, but, so far, Britain's return to Victorian values has not meant a rebirth of sentimentality. Our attitude to infertile peasants is one of yuppie indifference, and I doubt whether this will mature into compassion during Carol's reproductive lifetime.

As Carol's consultation ends the tableau has its comic aspect. The patient waddles off philosophically; the doctor, red faced, drums his fingers and glares at the dictaphone; the student frowns with respectful incomprehension; and the nurse looks at her watch. The implications crowd in on me and I wonder which non-essential service will be next to move into the private sector. Conscious of the team's morale, however, I bite back sardonic comments and call for the next patient, hoping that it will be someone I won't be ashamed to look in the face.