

# Privacy, privatization, and the politics of patronage: ethnographic challenges to penetrating the secret world of Middle Eastern, hospital-based in vitro fertilization

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## Abstract

In recent years, in vitro fertilization (IVF) has spread around the globe, including to the Middle East. Privacy, privatization, and the politics of patronage are all key issues affecting anthropological research in Middle Eastern hospital-based IVF clinics. IVF-seeking patients generally desire privacy, even total secrecy, when pursuing these treatments, due to cultural issues of stigmatization, particularly regarding male infertility. Thus, ethical issues surrounding the informed consent process are of prime importance. Furthermore, privatization of medical services in the Middle East has left patients—and anthropologists—with few choices other than private IVF clinic settings in which to pursue treatment and research. Both the ethos of patient privacy and medical privatization affect the ability of anthropologists to “penetrate” the secret world of IVF. Permission to conduct ethnography in private hospital IVF clinics may be difficult to obtain without the help of highly motivated physician patrons, who are willing to recruit their private IVF patients for ethnographic interviewing. This article provides a personal account of some of these challenges as faced by a medical anthropologist during a 15-year career of hospital-based IVF research in the Middle East.

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## Introduction

Since the birth of Louise Brown, the world’s first “test-tube baby”, in England in 1978, new reproductive technologies have spread around the globe, reaching countries far from the technology-producing nations of the West. Perhaps nowhere is this globalization process more evident than in the Middle East, where in vitro fertilization (IVF) centers have opened in countries

ranging from the small, petro-rich nation-states of the Arab Gulf to the larger but less prosperous countries of North Africa.

Egypt and Lebanon provide excellent settings for investigating this global transfer of new reproductive technologies. Egypt is considered to be one of the poor, overpopulated Middle Eastern nations; yet, it has been on the forefront of IVF development in the region, now hosting approximately 50 IVF centers. Lebanon, which is dwarfed in size by Egypt, nonetheless is home to approximately 15 IVF centers, all developed in the relatively brief period since the Lebanese civil war officially ended in 1992. Thus, despite economic problems and civil strife in both of these regionally underprivileged countries, Egypt and Lebanon boast

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vibrant IVF industries, which have grown dramatically over the past decade.

Without a doubt, the main feature of the IVF industry in Egypt, Lebanon, and most other Middle Eastern countries is its location in the private sector—a form of privatization that forms part of a much larger global trend toward privatization of health care services in the non-Western world. Since the late 1980s, the World Bank and other international organizations have been placing high priority upon reducing the role of government and increasing the role of private providers in the social sectors, including health care (Bennett, McPake, & Mills, 1997). Their campaign for such reforms began with the World Bank's publication of *Financing Health Services in Developing Countries: An Agenda for Reform* (World Bank, 1987), achieving full support with the publication of a report entitled *Investing in Health: World Development Report 1993* (World Bank, 1993).

As will be argued in this essay, medical privatization of this nature may constrain the ability of medical anthropologists to do hospital ethnography in countries such as Egypt and Lebanon. To wit, in Egypt, Lebanon, and other parts of the Middle East, the very private, personal problem of infertility and its solution through IVF are handled behind the private walls of private hospitals, given that privatization of hospitals has swept through the Middle Eastern region, particularly over the past decade. Thus, in order to study IVF in the Middle East, the ethnographer must gain access to private hospital spaces, which requires finding a medical “patron” who will allow this.

This article represents a critical reflection on the methodological challenges of “ethnographic penetration” into hospitals when: (1) hospitals become privatized and in some cases closed to the ethnographic research enterprise; (2) the medical topic being studied is sensitive and stigmatized—hence, a private and poignant affair for potential informants; (3) the political culture of the local IVF industry is shaped by a patronage system in which the anthropologist must become involved; and (4) the location of the hospital is in the Muslim Middle East, a highly politicized region where ethnographic access may be difficult.

### Methodological challenges

This article represents a reflexive, ethnographic retrospective on research conducted in five IVF clinics—four of them hospital-based and all but one privately held—in Egypt and Lebanon over the past 15 years. The impetus to include this very personal ethnographic account in a special issue of *Social Science and Medicine* devoted to “Hospital Ethnography” is my firm belief that medical anthropologists—and anthropologists in general—have an ethical obligation to be more trans-

parent about their methodology and about the potential constraints of ethnography when dealing with difficult subjects, in difficult places, at difficult times. Problems and politics of ethnographic scholarship, as well as the rewards of successful ethnographic engagement, must be discussed in an international journal such as *Social Science and Medicine*, which is concerned with the problems of doing social science research on medicine in countries around the globe.

Clearly, this commitment to greater scholarly transparency is shared by Sjaak van der Geest, the guest editor of this special issue. Van der Geest has written several compelling essays about the methodological and ethical challenges facing medical anthropologists working in both Western and non-Western settings. In one essay, van der Geest (1989) describes the lawsuit and ethnographic book-burning that actually ensued in the 1970s when a Dutch hospital, after being studied by ethnographically oriented scholars, is perceived to be tarnished by published ethnographic reports, which hospital administrators, at least, perceive to be unfair and overly critical. Commenting on this notorious case, van der Geest laments a situation in which “increasingly we are becoming subject to a medical regime which dictates what we should do, think and, yes, read” (van der Geest, 1989, p. 1340). In a more recent article, van der Geest (2003) examines problems of confidentiality and the standard anthropological practice of adopting pseudonyms in order to disguise persons and places in ethnographic publications, particularly on sensitive subjects. Based on his long-term ethnographic engagement in rural Ghana, van der Geest examines the many implications of both disguising and revealing the real names of communities and community members, particularly when the topic of research revolves around medical issues such as abortion or birth control, which may have many social, religious, and legal (i.e., criminal) ramifications.

My article follows upon the work of van der Geest in two important ways. First, it attempts to examine an under-appreciated aspect of biopower (Foucault, 1973)—namely, the power of medical regimes to dictate what we, as ethnographers, “should do, think and, yes, read”. When those who are not physicians attempt to penetrate the hospital clinic in order to apply an “ethnographic gaze on the medical gaze” (in part to examine structures of power), their ethnographic penetration may be viewed as unwelcome. Although the assertion of medical power may not result in legal suits and book burnings as in the Dutch case, biopower may manifest itself in attempts by hospital ethical commissions to keep ethnographers out of hospital clinics or, in other ways, limit access to patients (under the pretext of protecting patients’ interests). Perhaps this is one of the reasons why relatively few medical anthropologists have managed to work successfully in clinical settings in the

Middle Eastern region (see Ali, 2002; Cousins, 2000; Kahn, 2000; Kangas, 2002; Obermeyer, 2000a, b for recent examples).

Second, van der Geest is concerned with medical ethnographers' obligations to informants, particularly when studying culturally sensitive medical subjects. In such instances, patients themselves may regard the ethnographic gaze as unwelcome, or may agree to speak only under the strictest assurances of confidentiality. In the Middle East, both infertility *and* in vitro fertilization share this culturally sensitive status. Infertility is regarded as a great social onus, one that is most often placed squarely on the shoulders of women (Inhorn, 1996, 2003a). The proliferation of IVF clinics throughout the Middle Eastern region is one indicator of the extent to which infertile couples will go in order to have a child, even when they can ill afford the physical and economic costs of this expensive form of medical intervention. Yet, IVF, too, has acquired a stigmatized status, especially when it is used to address the "taboo" topic of male infertility (Inhorn, 2003a, b). Indeed, infertile Middle Eastern men may fear that their "weak sperm" are being replaced by that of fertile men in IVF laboratories, an act of reproductive substitution that is considered illegal within dominant versions of Sunni Islam. Thus, in the Middle East, infertility and IVF are shrouded in layers of secrecy and social suffering, making the ethnographic research enterprise potentially difficult, to say the least. That this may be true as well in other parts of the non-Western world is suggested by emerging ethnographic literature on infertility and IVF from India (Bharadwaj, 2002), China (Handwerker, 2002), and Israel (Carmeli & Birenbaum-Carmeli, 1994; Kahn, 2002).

Given these difficult ethnographic realities, my attempts in this article are two-fold. First, I reflect on how ethnographic access into the world of IVF is shaped—and potentially limited—by powerful feelings of privacy and protectiveness that pervade this clinical realm. If infertility is a stigma, and IVF is an even more stigmatized way of overcoming infertility, then both patients and clinic staff may be concerned about issues of confidentiality, and may be suspicious of ethnographic efforts to penetrate this secret world. Thus, concerns over medical privacy speak to ethical concerns within anthropology about "doing no harm to informants", and whether oral or written guarantees of anonymity and confidentiality can assuage informants' anxieties and fears (Fluehr-Lobban, 1991). Thus, in this article, I will discuss the anthropologically contentious subject of utilizing written consent forms—forms that are now considered an institutional review board (IRB) requirement in most American hospitals, but which have been decried by many anthropologists working overseas for adversely affecting the rapport-building process. In this article, I will attempt to show how written informed

consent forms and the difficult ethnographic practice of abandoning the tape recorder may help to assuage informants' anxieties about being "outed" as infertile IVF-seekers.

Second, I examine the general phenomenon of medical privatization in the Middle East, and the implications of that privatization for the practice of hospital ethnography. As I will argue, in an era of hospital and clinic privatization, powerful individuals—usually hospital or clinic administrators and directors—not only shape the internal culture and the political power structure of the clinic, but they also serve as powerful gate-keepers of ethnography, allowing or preventing ethnographic access as they see fit. In order for ethnographers to "open the gate to IVF", they may need to resort to powerful intermediaries and to adopt a client role in a patron–client relationship.

#### **Alexandria, Egypt 1988–1989: the lack of privacy in a public university teaching hospital**

The research upon which this article is based encompasses three distinct time frames. The first period is the late 1980s, or what may be called the "early IVF period" in the Middle East. The first two Middle Eastern IVF centers had just opened in 1986, and hence IVF was neither widely available nor widely understood throughout the region. In these early days, I conducted 15 months of anthropological fieldwork on infertility and IVF in Egypt, basing my research in Alexandria, Egypt's second largest city. There, with relatively little difficulty or delay, I received permission as a Fulbright scholar to work through a large, public, university obstetrics and gynecology (ob/gyn) teaching hospital.<sup>1</sup> Access was granted after hospital administrators, all of whom were senior ob/gyn professors, reviewed my ethnographic research proposal and questionnaire, and also submitted my file to Egyptian security forces, who concluded that I was a legitimate scholar. Thus, I was readily granted access to the hospital's outpatient infertility clinic, where hundreds of poor women from the northern Nile Delta region of Egypt sought care each year.

Over 15 months, I conducted in-depth, semi-structured ethnographic interviews with 190 women, 100 of whom were infertile and 90 of whom were fertile controls seeking gynecological and maternity care. With few exceptions, these women were poor, uneducated, illiterate, or only semi-literate housewives, who were forced to rely heavily on the only, public hospital-based infertility clinic, where medical services were provided on either a free or minimal cost-for-service basis

<sup>1</sup> The Fulbright program is designed to promote the international exchange of scholars to and from the US.

(Inhorn, 1994). The infertility services at the hospital were fairly impressive, at least during the late 1980s when I conducted my study. Although a handful of senior professors ran the hospital, none of them were directly involved in providing infertility services. Rather, a select group of highly motivated junior physicians, including a number of medical residents, constituted the clinical team. All of them hoped to become tenured professors, and many of them also had aspirations to open their own *private* infertility or more specialized IVF clinics—reflecting a common practice of “public-private” service among underpaid academic physicians in Egypt.

Given the general constraints of working in an underfunded public teaching hospital, these infertility clinicians nonetheless offered a wide range of diagnostic and treatment services for the hundreds of infertile women who passed through the doors of the hospital each month. Many of these poor urban women were seeking treatment at the hospital specifically because of the hospital’s widely publicized claims to a free, government-sponsored IVF program. By the time I finished my study at the end of 1989, the IVF unit in this public hospital had yet to open. Furthermore, it appeared likely that IVF was not going to be completely subsidized for poor infertile women lacking the resources to seek IVF in the private sector. Yet, shortly after I left Egypt, the hospital did, in fact, open its own public IVF center, and the first Alexandrian test-tube baby was born and heralded in the Egyptian media in early 1992. Thus, in the hospital ethnography that I was able to conduct there in 1988–1989, IVF was a prominent topic of discussion in my ethnographic interviews, and many infertile women hoped to be able to access this technology in the future (Inhorn, 1994).

As for the hospital itself, it was an imposing, tan cement structure located literally on the shore of the Mediterranean Sea. Yet, it was a relatively open facility, both in terms of its physical layout and its accessibility for the poor. As a physical structure, the hospital certainly did not generate feelings of privacy. The corridors were capacious, generally thronged with waiting patients, relatives of patients, and the many cats that roamed the hospital premises looking for mice (and perhaps placentas, according to hospital rumor). Corridor windows were often left open, bringing in a refreshing sea breeze, but also blowing sand from the piles left at the ends of hallways following uncompleted construction projects. Outpatients stood along corridor walls, as there was little seating of any kind. Inpatients generally shared large rooms with as many as 25 other women, who lay on beds with or without bed linen. Women who had been admitted for various inpatient procedures sometimes complained to me that they lacked privacy, feared their possessions would be stolen,

and were forced to share public bathrooms which were inadequate for the needs of the large patient population. In short, this hospital could not have been more public: It lacked all of the niceties of private care, patients themselves seemed “on display”, and privacy was clearly not privileged. Nonetheless, poor patients who entered this public teaching hospital often felt that this university hospital provided superior care, including for intractable infertility problems.

This relative lack of privacy at the public hospital allowed me, as a medical anthropologist, to recruit infertile patients into my study relatively easily, for I could often find them standing in the hallways outside what would eventually become the main IVF clinic consultation area. Infertile patients were often easy to spot, for they usually came to the hospital carrying with them large bags full of pelvic X-rays and other medical records. In many other cases, patients were recruited into my study by their physicians, several of whom took a keen academic interest in my study.

In the hospital, I was allowed to observe many aspects of patient care, including doctor–patient interactions in the infertility clinic and even some aspects of medical care, including ultrasounds and gynecological examinations. As also found by van der Geest and Sarkodie (1998) in their ethnographic study in a hospital in Ghana, physicians in this Egyptian infertility clinic generally had no qualms about allowing me, the medical anthropologist, to observe many aspects of clinical care, a reflection, I believe, of the relative openness (including to researchers) of this public teaching hospital.

On the other hand, in order to conduct confidential interviews with patients at the hospital, I had to find a private room, which was no easy task in this crowded and overtaxed public facility. Initially, some of the cooperative physicians on the infertility unit cleared a clinical exam room in order for me to conduct interviews. However, over the course of my study, I was asked by more senior and powerful hospital administrators to move the site of my ethnographic interviews several times, generally to less valuable rooms of the main hospital. Eventually, I ended up in an outpatient clinic attached to the main hospital, where both fertile and infertile patients came for their initial screenings.

Generally speaking, these poor women who agreed to participate in my study were grateful to have a medical anthropologist take an interest in them, their reproductive lives, and their “quest for conception” stories (Inhorn, 1994). Many had never before had an opportunity to share their difficult stories of profound social and physical suffering; thus, the interviews I conducted with them often seemed cathartic. Because the issues we discussed in interviews were often extremely personal and intimate (e.g., husbands’ impotency masked as female infertility (Inhorn, 2002)), all

interviews were conducted in private, usually in a clinical consultation room.

Arabic written informed consent forms were either read by or to each woman, most of whom were illiterate but could sign their own names after listening intently to the consent form. After greetings, each interview began this way, for the informed consent form served the dual purpose of explaining the general aims of the study, as well as explaining to each woman that participation in the study was voluntary and confidential. In my view, the informed consent process was crucial in reassuring women that what they told me would be held in the strictest confidence, and that their names would never be used in any published report. Indeed, once the study and its ethics of privacy were described in this way, I never had a patient refuse to participate in my study, and most patients subsequently spent many hours talking with me and my female research assistant, revealing many personal aspects of their lives.<sup>2</sup>

In both medical anthropology and anthropology in general, utilizing written informed consent forms, and particularly to one's advantage, is a practice that is rarely discussed. Rather, I have heard many of my anthropologist colleagues rail against IRB requirements that mandate the obtaining of either written or oral informed consent, for ethnographic canon indicates that informed consent impedes rapport building. Clearly, this anthropological critique has emerged as the result of the dramatic expansion of institutional review board (IRB) authority over social scientific research in general, with significant ramifications for the ways in which anthropologists are able to establish data-collecting relations with their informants. This critique does not mean that anthropologists reject ethical or even institutional accountability; rather, the IRB-imposed informed consent process represents an a-cultural form of standardization that does not respect local understandings of "risk", "benefits", or "consent". As a result, anthropologists have had to harmonize informed consent processes on the ground, through, for example, explaining and re-explaining why informed consent forms are necessary, leaving written copies, stressing the voluntary and confidential nature of collaboration, and describing informants as valued teachers.<sup>3</sup>

Yet, despite the awkwardness of the informed consent process for many anthropologists, obtaining written

informed consent at the outset of an interview can also be very useful when conducting ethnographic research in hospitals and other institutional settings where "paperwork" is seen as par for the course. More important, I would argue that the process of written informed consent may actually "break the ice" and lead to greater rapport when the topic being discussed is private, sensitive, or illegitimate/illegal. In such cases, informants may agree to speak only *after* they feel convinced that their "secret is safe" with the ethnographer. They also may take comfort in being given a copy of the written informed consent document, which they can take home and preserve among their personal medical records.

Thus, in both Egypt and Lebanon, where infertility casts a shadow over individuals' lives, using written informed consent forms to guarantee secrecy has worked to my advantage. In this initial study in an Egyptian public teaching hospital, women told me that they not only felt discredited by their stigmatizing childlessness, but also scrutinized by their in-laws and neighbors (Inhorn, 1996). Thus, many of them hoped to keep their hospital treatment-seeking secret, and considered me, in effect, the guardian of their infertility narratives. Indeed, several women in my study commented after our interviews were finished, "Now I've told you all my secrets".

Moreover, my initial ethnographic experience in an Egyptian public hospital taught me to break effectively with another anthropological convention—namely, the perceived need to tape-record all interviews. Even though informed consent forms guarantee confidentiality, tape-recorders, in my view, may introduce another level of fear and suspicion and thus may become a source of great discomfort for informants. When information is deemed private and secret, having such information recorded on tape introduces a kind of disconcerting permanency to an interview that may induce feelings of fear and anxiety.

Based upon women's reactions of discomfort and self-consciousness when I brought out my small tape-recorder (with a clip-on microphone), I quickly dispensed with this device, telling women "*mish daruuri*" (not necessary) and "*ma'alish*" (never mind). Judging by their visible relief, I decided that tape-recording ethnographic interviews in the hospital was not going to be my research strategy. It is a tape-record-less strategy that I have generally adopted ever since. In both Egypt and Lebanon, whenever infertile informants encounter the term tape-recorder in the informed consent form, they generally ask about it and whether this aspect of the interview is also voluntary. When I tell them "yes", then most ask *not* to be tape-recorded. Indeed, I have only rarely used the tape-recorder in hospital interviews, and only when informants have told me emphatically that they do not mind being recorded. When I have recorded life history interviews with infertile informants in the

<sup>2</sup>The use of research assistants, which I have employed in some of my hospital-based ethnographic interviews, is another topic worthy of methodological discussion, but will not be covered in this article due to space limitations.

<sup>3</sup>I am grateful to an anonymous reviewer, who shared these insights about the reasons for the anthropological critique of the informed consent process, as well as the many ways in which anthropologists are negotiating consent processes during fieldwork.



hospital, I have done so only with informants' expressed permission to tape-record. Instead, during most in-hospital interviews, I have taken short-hand written notes at almost verbatim speed, an admittedly carpal-tunnel-inducing technique that I learned in my previous career as a medical journalist.

Thus, to summarize, my first ethnographic encounter in the world of infertility and IVF in Egypt convinced me of the ethical importance of the informed consent process in my hospital-based interviews with poor women. Informants expected me to carefully guard their identities as infertile, IVF-seeking patients. Thus, an ethos of medical privacy prevailed, and as long as I could assure women of that privacy through the written informed consent process, they were more than willing to share their stories of suffering with me. Furthermore, because the hospital in which I worked was a public, university teaching facility, these women were generally prepared to participate as informants in my study, for they recognized the hospital as a university research center. Many were even pleased to be part of my *bahs* (research), telling me that it made them feel that they had important knowledge to share. The physicians, too, accepted the merits of my endeavor, for as academicians, they were all involved in their own research programs, and many of them assisted me in patient recruitment. Thus, achieving ethnographic access to infertile, IVF-seeking patients in this public, university teaching hospital was relatively easy in 1988–1989. But, when I returned to Egypt in 1996 to study IVF in much greater depth, I was to learn first-hand about the new phenomenon of medical privatization and the limits on ethnography in the private hospital setting.

#### Cairo, Egypt, 1996: the top secret world of private hospital-based IVF

When I returned to Egypt in May 1996, Egypt was in the midst of what may be characterized as an "IVF boom period". Since the early 1990s, Egypt has been in the midst of massive reproductive technology transfer, with new urban IVF centers cropping up on an almost monthly basis. Furthermore, the vast majority of these IVF centers are located in private hospitals in Cairo and Alexandria.

In the midst of this IVF explosion, I spent the summer of 1996 in Cairo conducting in-depth, semi-structured interviews with 66 mostly middle- to upper-class women. Unlike the patients in my first study, these women were ones who could pay for high-priced, private IVF services. They were generally well-educated professionals, who were often accompanied by their husbands. Indeed, in 40 % of the interviews I conducted in these IVF clinics, husbands were present and participated, often enthusiastically, in discussions. Almost all of these

affluent Egyptian couples were undergoing IVF at two clinics situated in private hospitals in elite suburbs on the outskirts of Cairo. These two clinics were among the three most established and respected clinics in the city at that time, and they received a daily influx of new patients, especially during the summer months, which were the busiest and were therefore ideal for my research.

In retrospect, I realize how very fortunate I was to gain access to these top clinics in Cairo, since penetrating this private hospital-based world of IVF proved to be significantly more challenging than entering the public teaching hospital in Alexandria. Indeed, my ethnographic research experience in Cairo in the summer of 1996 provides a powerful example of the significant interactive effects between medical privacy, medical privatization, and the politics of patronage in the medical world.

Namely, gaining access to private IVF clinics in Egypt involved resort to a classic Middle Eastern patronage pattern known as *wasta* (Eickelman, 1998; Gellner & Waterbury, 1977). *Wasta* is both person and process. *Wasta* is the process of using intermediaries to "make connections", connections that may be either micro- or macro-political in nature. A *wasta* is also an individual with the personal political power to "make things happen". In the Middle East, persons with the power to make connections between patrons and clients of different types are found at all levels of society and in many social situations and institutions. As I was to learn, *wasta* was to be extremely important to me, the ethnographer. Without it, I would never have gained the hospital access necessary to study IVF in contemporary Egypt. My *wasta* came in the person of a powerful and highly respected senior academic physician in Cairo, who, because of his inherent academic interest in my study and because of his personal connections in the world of IVF, intervened on my behalf to help me gain access to the two aforementioned IVF clinics. Indeed, this physician served as my Fulbright sponsor, and was committed to helping me succeed in my research, asking for little if anything in return.<sup>4</sup>

I came to Egypt thinking that I would conduct my study in this academic physician's private IVF clinic, which he co-directed with two other well-known physicians. Their center employed a relatively large staff

<sup>4</sup> I have chosen not to use the names of physicians, hospitals, or clinics in this article, in order to prevent legal entanglements in publication. However, like Sjaak van der Geest (2003), I believe that at least some informants desire and deserve public recognition, and thus do not wish to be cited under a pseudonym. In many other publications, including all three of my books (Inhorn, 1994, 1996, 2003b), I have used the real names of hospitals and some physicians. I have never, however, revealed the names of my infertile informants.

of assistant physicians and laboratory personnel, and at the time of my study, approximately 80 new patients were attending the center each week. However, there were two problems facing me. First, during an introductory meeting, in which the three physician co-directors of the clinic asked me to speak at length about my study and its methodology, it became clear to me that at least one of the individuals was uncomfortable with my ethnographic project, for reasons that were not completely clear. Second, this free-standing IVF clinic—the only one not part of a larger Egyptian hospital complex—was facing considerable space constraints. Indeed, the first day I visited the center, which was tucked away in a small building on a tree-lined street, I was truly surprised by the small size of the clinic and the large number of patients who were squeezed into seats lining the walls of the waiting room. Because of the lack of space, there were no extra rooms in which to conduct confidential interviews. Furthermore, the physicians running this center perceived (correctly, I believe) that few patients would be willing to meet me outside the clinic to talk about this sensitive and private subject. Although plans were well under way at that time to move the IVF clinic to a larger facility next door, the building of the new structure would not be completed for at least another year.

Furthermore, at the time of my study, there were no public, university-based IVF centers in Cairo; the IVF industry there was entirely privately based. Thus, unlike my early days of easy access to a *public* university teaching hospital, I needed to gain access to one or more *private* IVF clinics in the capital city. Luckily for me, my physician sponsor drew upon his many personal connections in the world of Egyptian IVF, as well as his distinguished academic reputation among his peers. Following my disappointing initial interview with the co-directors of his clinic, he began making well-placed phone calls on my behalf to the clinical directors of several private hospital-based IVF centers in Cairo. I traveled around Cairo meeting with these IVF directors in their private hospital offices. As before, issues of privacy were cited by some as a powerful reason to prevent me from conducting face-to-face interviews with patients in their clinics. After a tense period of waiting—which lasted only three weeks, but which made me reconsider whether I would be able to carry out my IVF study as planned—the administrators of two hospital-based IVF centers in Cairo agreed to let me interview their patients, perhaps because of their trust in and respect for the physician who had connected me to them.

Thus, I began my study of IVF in Egypt in two private hospital-based clinics, where the clinical directors effectively became the patrons of my study. The fact that powerful physicians may serve as patrons to medical anthropologists was nothing that I had ever read about in the anthropological literature or contem-

plated before going to Egypt. But it was a reality that I experienced in a personally powerful way, and it is a one that I expect operates behind the scenes in many other hospital- and clinic-based ethnographic studies.

One of the IVF centers in which I worked was located in a large, private high-rise hospital tower. The IVF unit, which shared space with the maternity ward overlooking the Nile River, was established by the hospital in the early 1990s. The physician-director who agreed to let me work there was highly revered by his grateful patients, many of whom eventually participated in my study. Among the patients I interviewed, this doctor was known for his tender mercies, such as calling and returning the calls of distraught patients; making middle-of-the-night house calls on IVF patients who believed they were in trouble; or taking on occasional charity patients who he knew could never afford to pay for even a single trial of IVF.

On the opposite side of town, I was given access to a second private hospital-based IVF clinic, located in a relatively small, two-story private hospital tucked away on a sandy back street of an affluent Cairo suburb. The hospital, which was co-owned by a group of university professors, was unobtrusive, as was its IVF clinic, which was located on the second floor in the midst of a general gynecology and obstetrics ward. As at the aforementioned IVF clinic, patients seated in the large general waiting area could have been IVF patients, or they could have been there for some other reason, making waiting less obvious and stigmatizing for those seeking IVF services.

As in the case of the aforementioned physician-director, a considerable “cult of personality” had formed around the academic physician who ran this private IVF center in addition to his university teaching and research obligations. Considered a “genius doctor” by his satisfied patients, he was described as “honest but gentle”, a physician was admired for his ability to deliver bad news in a straightforward but sensitive manner. This seemed to be particularly important to infertile men, for whom infertility is both demoralizing and potentially intractable.

Although these two popular Egyptian IVF physicians carried busy patient loads, they both took the time to recruit patients into my study. I was only able to interview these IVF patients once the physicians themselves had sought patients’ permission. As a result of this kind of careful patient pre-selection, only one patient refused to speak with me when I approached her to be interviewed. When I came to her private hospital room, she declined by offering two words in English—“top secret”.

As for the rest of the 66 private IVF patient-couples who agreed to participate in my study, I am quite certain that many of these women and their husbands only talked to me out of feelings of gratitude and

indebtedness toward their IVF physicians. Many of them told me directly that they hoped I would express this sense of gratitude in the articles and book I would write about IVF in Egypt. Indeed, after listening to patients' praise in interview after interview, I developed a profound sense of appreciation and admiration for these two IVF physicians, who placed patient care on the top of their priority lists.

Although many of these couples had tried IVF repeatedly over the course of several years, few of them had shared this information with any others, including even their closest relatives. In Egypt, IVF, in and of itself, is a stigmatized technology. Although this technological stigma has multiple sources, it mainly derives from the general public's view of IVF as *haram*, or sinful. Egyptians who are not intimately acquainted with IVF often believe that it involves potential "mixing" of eggs and sperm of different couples. Such "mixing of relations" outside of the marital union is considered illegal in Sunni Islam (the dominant form of Islam, which is the only form found in Egypt), and leads to the questioning of IVF children's paternity. Even though the Egyptian IVF clinics I studied were extremely careful to prevent such mixing from occurring, the Egyptian public essentially distrusted the technology on religious/moral grounds.

Given the moral opprobrium attached to IVF, the physicians who sponsored my study were rightfully concerned about maintaining the privacy of their IVF patients during the interview process. Not surprisingly, most IVF patients considered their use of this technology to be "top secret", and they agreed to speak to me only after carefully reading and signing informed consent forms guaranteeing their anonymity. As in my earlier study, we began our in-hospital interviews this way, and in all but a few cases, I dispensed with the tape-recorder completely. In every case, I interviewed patients either in private clinical consultation rooms assigned to me by the treating physicians, or in well-appointed private hospital rooms, complete with private bathrooms, where patients were recuperating after an IVF cycle or delivery of a test-tube baby.

Unlike my first study at the public teaching hospital, where poor women's privacy was virtually impossible to achieve or maintain, these private hospital-based IVF units were able to provide very private care, to the extent that it was impossible to know for certain whether a patient was coming to the hospital for IVF services. As noted earlier, both IVF units were situated discretely in the midst of general ob/gyn wards, allowing infertile IVF-seekers to blend in with the general patient population. Once IVF was initiated, each stage of care was carried out in private circumstances, often with only the doctor in attendance. Unlike in my earlier study, I was never allowed to be present at any aspect of patients' clinical care, including ultrasounds or surgical

procedures, nor did I enter the IVF laboratories. In other words, privacy prevailed, ultimately affecting the type of hospital ethnography I was able to carry out.

In summary, then, given the powerful ethos of privacy pervading the world of Egyptian IVF, I would never have been able to study it without the willingness of two Egyptian IVF physician patrons, who took the bold step of letting me interview their private IVF patients ethnographically. Furthermore, it was only through the traditional Middle Eastern process of *wasta* that I became connected to these IVF physicians by a powerful physician intermediary. In other words, without the power of patronage, I would never have been able to carry out a research project that eventually led to the publication of a book on the subject (Inhorn, 2003b). Although each of my physician patrons probably had their own reasons for allowing me to enter their private hospital-based IVF clinics, they shared the common commitment to providing high-quality patient care. Each of them told me that they hoped to learn from my study about what their "patients were thinking" and about how they might improve their clinical services. Thus, I delivered a final summary report to each of them before I left Egypt in August 1996.

#### **Beirut, Lebanon, 2003: comparing private IVF clinics during wartime**

My study of IVF in Egypt taught me about the intersections of medical privacy, medical privatization, and the micro-politics of the medical patronage system, including its potential importance to hospital-based medical ethnographers. But my most recent ethnographic journey to the Middle East has taught me a great deal more about the challenges of conducting hospital-based IVF ethnography on a difficult topic (male infertility) in a difficult place (post-war Lebanon) at a difficult time (during the US invasion of Iraq). To demonstrate the effects of these additional challenges, I will describe my third Middle Eastern research project on the use of IVF-related technologies to overcome male infertility in Beirut, Lebanon in 2003.

My journey to Beirut was, quite frankly, never intended. Rather, I fully expected that, as a scholar of Egypt, I would return to Cairo for all future IVF-related research. Following my 1996 study in Egypt, I maintained ongoing email contact with one of my Egyptian physician sponsors, who invited me back to his IVF clinic to undertake a new study on male infertility in the age of intracytoplasmic sperm injection (ICSI)—the relatively new variant of IVF designed as a solution to male infertility. The importance and high prevalence of male infertility had become clear to me in my studies of infertility and IVF in Egypt. Yet, a thorough review of the existing literature had convinced me that male



infertility was poorly studied by social scientists, in any part of the world including the Middle East.

Unfortunately, despite my best efforts to write a carefully worded research proposal that would pass muster with the Egyptian security forces who now preside over the Fulbright scholarly exchange program in Egypt, I was not given permission to conduct my study of male infertility in that country, following a year-long period of successive proposal revisions.<sup>5</sup> Clearly, the rejection of my proposed study, as well as those of many other American Fulbright scholars hoping to conduct human subjects-based research in Egypt, had multiple sources, but could largely be summed up in one word: politics. These politics certainly included the tense US-Egyptian political relations, particularly following September 11th; the trend in Egypt toward heightened scrutiny of all Western researchers and non-governmental organizations, particularly following the notorious case of an Egyptian-American sociologist who was imprisoned for conducting social science research critical of the Egyptian government; and the sensitivity of my own research project on male infertility, which I came to view as an “ego-security” issue for the male Egyptian security officers on the Fulbright panel, who repeatedly rejected my proposal.

For me personally, “the writing was on the wall”. With great sadness, I realized that I would need to relocate my study of male infertility to another Middle Eastern country, where such research restrictions were not in place. To that end, I was encouraged to go to Lebanon, which had developed a thriving IVF industry and which had reinstated its Fulbright exchange program after many years of war-time suspension. Yet, with a US-led war on Iraq looming, and the regional consequences of that war yet unclear, I was personally very concerned about safety in Lebanon for me, my husband, and our young children. Indeed, during Lebanon’s tumultuous 17-year civil war (Fisk, 2002; Khalaf, 2002; O’Ballance, 1998), many Westerners, including American soldiers and academics, were kidnapped and/or killed.

How did I become convinced to carry out this project during a potentially dangerous period of warfare? I basically relied on my Lebanese and Lebanese-American colleagues, who provided me with thoughtful analyses of Lebanese society and politics, including likely Lebanese reactions to an American-led war in a neighboring

country. Furthermore, to gain access to Lebanon as a field site, the politics of patronage again came into play. I was very fortunate to have two powerful patrons who acted quickly to sponsor my Lebanese study. One was a Lebanese-American IVF physician, who regularly commuted between his private IVF clinics in the United States and two Middle Eastern countries, including Lebanon. This kindly physician, who was both an American clinical professor and a successful transnational private practitioner, invited me to base my male infertility study out of his Beirut-based private IVF clinic. My other Lebanese patron was a former colleague from Egypt, who was now serving as a dean at a Lebanese university. She quickly arranged a university institutional affiliation for me, which was a requirement of the Fulbright scholar program.

When I arrived in Beirut in December 2002 to begin my eight-month project, I immediately visited the private IVF clinic where I was to carry out my study. My IVF physician-patron was on his way back to the United States; however, I was introduced immediately to the staff of his clinic, who had been alerted to my arrival and encouraged by my patron (their boss) to assist me in my study. Whereas most of the IVF clinics in Lebanon were located in private hospitals, this IVF clinic was located in a small office building in a busy shopping district on the west side of Beirut (i.e., the Muslim side of town in the post-war geographic division of the city into a “Muslim West” and “Christian East”). In terms of its physical layout, the IVF clinic fully occupied both the fifth and sixth floors of an eight-story building. The lower level consisted of a large waiting area, where patients were seated in black leather chairs in a square formation around a central coffee table. Patients could watch a television placed in an upper corner of the room, while others came to pay for their procedures in the IVF clinic’s business office, which was attached to the waiting room behind a marble and glass counter. Beyond this front space of the clinic lay the examination and ultrasound rooms, three large doctors’ offices, an andrology laboratory for semen analysis, and a small kitchen. The upper level of the clinic included two operating rooms, the IVF laboratory, and a long corridor with four individual patient recovery rooms. In addition, there was a conference room, which tripled as a meeting area, a doctors’ lounge, and waiting area for husbands whose wives were undergoing IVF procedures. When men were asked to provide semen samples, they were usually taken downstairs to the first floor, where the clinic maintained a separate and physically isolated semen collection room, complete with stimulating videos for men to watch during masturbation.

This relatively spacious IVF center relied on a large staff of three full-time IVF physicians, an anesthesiologist, two embryologists, one andrologist, three nurses,

<sup>5</sup> All Fulbright grants require approval at the “host country” level. As a result, when a topic is politically sensitive, it may be turned down by in-country review panels. In recent years, Egypt’s Fulbright review panel has consisted of both Egyptian academics and Egyptian security officers. Increasingly, social science research projects, especially those involving interviewing, are being turned down in that country.

several office staff, and at least two physicians who were not full-time employees of the clinic, but who regularly brought patients to the clinic for IVF procedures. In addition, my Lebanese-American IVF physician-patron was himself present in the clinic at regular intervals for several weeks each year. Of all of these physicians, he was the only one who was an academic physician (in the US), and perhaps for that reason, he was the most committed to the success of my research project. Yet, because of his commuting relationship, he could not recruit patients for me directly on a day-to-day basis, and thus I relied on the other physicians and staff members.

Unlike my experience in Cairo, where two individual physician-directors of IVF clinics had served as the sole recruiters of their private patients into my study, patient recruitment efforts in the Beirut clinic were dispersed among the various physicians (each with his/her own patient load), as well as among two laboratory staff members, who I employed as research assistants. I found that the results of this more dispersed recruitment effort were mixed. Physicians were often busy and not necessarily consistent or interested in asking patients to participate in the study. Furthermore, when I arrived at the clinic each morning, I was asked by the receptionist to go directly to the private back office, where I could conduct the interviews confidentially. Hidden away in a back room of the private clinic, I would wait there, until a successfully recruited male patient was brought to me by a clinic staff member. On many days, I waited for hours, but met with no one. Any more direct efforts on my part to recruit patients—or to be seated in full view in the patient waiting area, where I had placed bright green copies of a study advertisement—were not considered appropriate by clinic staff, and thus were never seriously entertained.

Furthermore, I was told bluntly by one of the nurses during the first week of my arrival that my study of male infertility in Lebanon would “never succeed”. She pointed to the ongoing stigma of infertility, especially among the working-class southern Lebanese Shi’ite Muslim men who were the primary clients of the clinic. She told me how they and their wives sometimes hid in the private recovery rooms on the upper floor of the clinic, and would not leave until the “coast was clear” and other patients that they might recognize were no longer present. She was also very discouraging about the willingness of the staff physicians to help me, for reasons that she did not make clear.

Fortunately, the nurse’s dire predictions about the failure of my study did not prove correct, and I was able to interview more than 70 men, and sometimes their wives, during the eight-month period of my study. When the IVF clinic director’s brother joined the clinic as its business manager, he also proved to be an excellent recruiter and research assistant, putting many of the

men at ease about their participation in the research project. Having said this, for each man who agreed to be interviewed at the IVF clinic, at least one man (and perhaps two or three) refused to participate in my study. The reasons for refusal—or what one sociologist has termed “the meaning of non-response” in studies of men and infertility (Lloyd, 1996)—are, in my view, multiple and varied. On the micro-sociological level, male infertility continues to be stigmatizing for men in the Middle East, including Lebanon, since the social view of male infertility is one of profound emasculation (Inhorn, 2002, 2003a). My sense is that those men who viewed their own infertility in this way were most reluctant to speak with me, thereby keeping their secret safe. Men who refused to participate in the study often told the staff person attempting to recruit them that they were “not in the mood” to talk about the problem, or had no time to be in such a study. In some cases, men nearly pleaded not to have to participate in the interview, indicating a high level of distress over the subject.

Thus, issues of privacy again surfaced in my study of infertility and IVF in Lebanon, with male infertility representing yet another version of stigma. When men did agree to participate in my study, they were very concerned about issues of privacy and confidentiality. Because virtually all of them were literate, they read the consent form with great intensity and interest, signing their names in Arabic and/or English. On the consent form, I asked for a separate signature allowing tape-recording of the interview, an option to which few men agreed. Once men had signed and been given an anonymous study number, I gave each man a copy of the consent form, as well as my business card, to keep in their personal records. Once convinced of the confidential, anonymous nature of our conversations, many of the men in the study opened up with rich interviews that were often deeply personal and poignant.

Beyond micro-sociological issues of stigma and privacy, I am quite certain that larger religious-political issues also loomed over my study. This IVF clinic catered to a significant population of both Syrian men and conservative Shi’ite Muslim men from southern Lebanon, some of whom were active members of the Hizbullah political party. Some of these men were clearly deeply religious, sporting telltale beards and sitting in the waiting area with wives dressed in Iranian-style black chadors. Furthermore, it is important to note that many of these couples were seeking IVF services at the clinic from one of Lebanon’s only female IVF physicians, because conservative Muslim women prefer to avoid physical examination by a male doctor. Similarly, conservative Muslim men prefer to avoid physical contact with women outside of their families, and will generally not shake hands with female strangers. In terms of my study, such men were clearly uncomfortable speaking to me, a presumably

non-Muslim American female professor, in a private interview setting. When I did speak to such men, it was only in the presence of their wives and/or a male research assistant who remained with me during the interview. Furthermore, as the US-led war on Iraq drew nearer and nearer and the US government's rhetoric about Syria's need to disband Hizbullah grew stronger and stronger during the spring of 2003, patient recruitment into my study literally came to a halt at the clinic, as potential informants became distrustful of and ambivalent about working with an American anthropologist.

Given these various challenges of working out of a private IVF clinic in Beirut—which, because of its particular religious-political character, was powerfully affected by the war in Iraq—I decided that I should also look for a second clinic setting, much as I had in Egypt. Fortunately, by the third month of my study, I received IRB approval to recruit informants from the IVF unit of a large, teaching hospital affiliated with a prestigious private university. The hospital was an imposing structure of ten floors, located over two city blocks in west Beirut. Regarded as the premiere hospital in Lebanon, many patients, both private and indigent, came to the hospital for what they perceived to be its superior care. Thus, the hospital catered to a multi-sectarian patient population of Sunni and Shi'ite Muslims, Christians of various sects, Druze, and many foreign workers who had come to Lebanon in the post-war period.

On the seventh floor of the hospital was a small cluster of rooms constituting the hospital's IVF clinic. Unlike the other private clinic, which occupied two spacious suites of offices on adjoining floors, the hospital-based IVF clinic was small and intimate. A hallway off the main ob-gyn outpatient department led into the IVF unit, where patients sat in a tiny waiting area with two rows of 12 black leather chairs facing each other. Beyond the waiting area was a screen door, which opened and closed as the doctors and patients entered the operating and recovery room areas. Thus, the IVF unit had an almost theatrical quality, as the screen to the secret "backstage" world of the IVF clinic regularly opened and shut.

While women who were undergoing IVF procedures were allowed to enter behind the screen door, the nervous husbands usually waited outside, trying not to make eye contact as they sat facing each other, often rubbing prayer beads, in the small waiting room. Occasionally, men in the waiting room did chat, asking each other how many times they had gone through this agonizing ritual. Men could be heard giving each other encouraging words of "*insha Allah, khair*" (i.e., God willing, goodness will prevail).

For some men, the relative intimacy of this hospital-based IVF clinic was extremely uncomfortable. Not only was it obvious why they were there (i.e., to overcome an

infertility problem, most commonly male infertility), but they were asked to provide their semen in a small room located through a door located *within* the waiting room area. Men were handed a plastic cup and were asked, in full view of others, to enter the room for the purposes of masturbation. All those present in the waiting area, including in some cases elderly mothers and mothers-in-law, were fully aware of what was required, and they watched (and perhaps informally timed) the men as they went in and out of the semen collection room. For many men, the public nature of this act was deeply threatening, and performance anxiety problems, where men were unable to provide a semen sample, occurred from time to time. Although men sometimes complained about this to their physicians (and to the anthropologist), there was little that could be done. Indeed, even though this university hospital was a private facility, it shared the problem found in the Egyptian public university hospital: Namely, chronic shortages of available rooms meant that privacy could not be maintained in one of the most intimate acts—the collection of semen—that occurred within the hospital's walls.

Despite this significant shortcoming, the IVF clinic in every other way was a successful center, with a high success rate and many satisfied customers. The staff was relatively small, consisting of three physicians (each with his own private patients), two embryologists, a nurse who doubled as unit administrator, and a housekeeping staff member. The busy clinic operated during the morning hours, with between two and five IVF procedures carried out daily.

Ethnographically speaking, both the small, intimate nature of the clinic and its location in a major university teaching hospital were advantageous for my study. First, all three of the IVF doctors at the hospital (as well as a fourth one who joined the group toward the end of my study) were full-time academic physicians. They did not operate private clinics outside of the hospital, and thus put all of their energies into the hospital's own IVF services. Furthermore, they were all professors, who appreciated the benefits of academic research. Thus, they were interested from the outset in what could be learned through my study, and at least one of them mentioned the possibility of writing co-authored publications. Together, they gave me permission to interview their patients in the clinic, and they enjoined the IVF unit nurse to help me recruit men into the study. Furthermore, they allowed me to use the two consulting offices/ultrasound rooms within the small clinic in order to conduct my confidential interviews, even though it meant that they sometimes had to find alternate space in which to conduct their own patient consultations.

The relative ease with which I was ultimately able to recruit infertile men at this university hospital-based IVF clinic, particularly compared to the other private clinic, was due to a number of factors. First, as in my

previous research in Egypt, I had an enthusiastic patient recruiter. In this case, it was not a physician, but rather the kindly and extremely helpful IVF unit nurse, who asked virtually every man who entered the clinic to participate in my study. Although some men refused her, the majority of them agreed. Second, their willingness to participate in my study reflected the fact that most of them had already read the bright green study advertisement (in Arabic) placed prominently in the waiting room. Thus, when asked by the nurse to participate, many of them had already acquired some interest in the study, telling me later that they would have volunteered on their own if the nurse had not first invited them. In addition to my study ads, I, myself, became something of a fixture in the clinic's waiting room, where I would sit between interviews with my briefcase and notepad. Clearly, I stood out as different, allowing the men in the waiting area to "size me up" as the Western female professor connected to the green study advertisement.<sup>6</sup> I sensed that most men evaluated me as a non-threatening, bespectacled, middle-aged, Western *duktura*, who was probably legitimately interested in male infertility. Indeed, my presence in the waiting room and my green study advertisement led to many animated waiting-room conversations about the potential causes of male infertility in Lebanon, including men's past traumatic experiences of the civil war. Furthermore, being in the waiting room allowed me to introduce myself to men directly, particularly after they had read the study advertisement. Thus, as in my early days at the public university teaching hospital in Alexandria, Egypt, I served as my own patient recruiter in many cases.

Finally, I am convinced that the location of this IVF clinic in a large, university teaching hospital had something to do with my recruitment success. Because of its reputation as a university research facility, the hospital catered to patients who were probably more psychologically predisposed to be part of a university research study. For the infertile and fertile men in my study, their very choice of the hospital's IVF clinic—amidst nearly 15 other private IVF centers in Lebanon—may have made them anticipate that they would be asked to participate in a research project. Evidence of this is reflected in the fact that successful patient recruitment continued throughout the weeks of the US-led war on Iraq. Thus, by the end of my study, I had

interviewed more than 150 Lebanese, Syrian, and Palestinian men at this clinic, with interviews sometimes lasting between two and three hours. By the time I left Lebanon in August 2003, I had conducted interviews with 220 men, most of whom related their subsequent infertility and disrupted life stories to "*el harb*", the Lebanese civil war, in which "nothing good was accomplished". Indeed, conducting this study of male infertility in a post-war society served to convince me, as a medical anthropologist, that war is neither good for health, nor for the human condition.

## Conclusion

This article has constituted a personal reflection on some of the methodological, ethical, and political challenges of doing hospital ethnography, especially on sensitive health topics, which are cared for in private hospitals, where powerful physicians serve as gatekeepers. Throughout my own 15-year career as a medical anthropologist working on infertility and IVF in the Middle Eastern region, I have faced some of these challenges. My desire to write about them in a special issue of *Social Science and Medicine* on "Hospital Ethnography" reflects my belief that discussion of such challenges may be instructive for future ethnographers, who will study IVF in other hospitals around the world.

My personal research experiences have taught me three important lessons. First, the medical privatization process being promoted by the World Bank and other development agencies has had profound effects on medical anthropology in general and hospital ethnography in particular. When hospitals are public and under direct governmental or academic supervision, they may be more accessible to researchers, who can work through local Ministries of Health or affiliated universities. Furthermore, in public or university hospitals, teams of academic physicians—who as professors, value research for the sake of research, as well as potential co-authorship—may be present to assist with ethnographic recruitment of their patients. However, when hospitals are private and under the authority of individuals rather than university or government agencies, permission to penetrate this private domain may become much more difficult and may ultimately depend upon the good will of powerful individual patrons (e.g., private hospital owners or clinic directors). Thus, medical privatization may serve as an impediment to anthropological access, and may require the medical anthropologist to invoke traditional patron-client ties, which operate in many parts of the world, including the Middle East.

Of the five Middle Eastern IVF clinics where I was able to gain access, four were private, but three of these were run by academic physicians, who appreciated the

<sup>6</sup> Although I do not reflect here upon issues of gender and positionality as an impediment to hospital ethnography, suffice it to say that male Middle Eastern colleagues convinced me, an American woman, to do this research. They argued that I would be more successful than a male ethnographer for the following reason: Because virility and fertility are homosocially competitive in the Middle East, men may have a harder time admitting to another man that their penises or their sperm are "weak".

research questions I was attempting to answer. Furthermore, recruitment of patients into my studies always worked best when these physician patrons assisted me directly in the recruitment process. Their patients, I believe, decided to speak to me partly out of feelings of gratitude to these physicians, which they conveyed through the interview process.

Second, IVF patients at private hospitals and clinics may be less willing to participate in ethnographic research projects than patients in public or university-based hospital settings. Private IVF patients may invoke issues of medical privacy—even secrecy—as a reason to refuse ethnographic interviewing. Because IVF in the Middle East continues to be stigmatizing, especially for cases of male infertility (Inhorn, 2002, 2003a, b), patients' desires for privacy and anonymity may be factors in their decisions about attending public/university versus private hospital-based IVF clinics, as well as their decisions about participating as ethnographic informants in research projects on the IVF experience. On the other hand, patients attending public or university hospital-based IVF centers are often more willing to participate as research subjects, given that these hospitals are known as research centers. In my initial study of infertility in a public teaching hospital in Egypt, I was able to recruit and interview nearly 200 women over a 15-month period, without a single refusal. Similarly, within a 6-month period in Beirut, Lebanon, I was able to recruit more than 150 male IVF patients into my study at a large private university's teaching hospital. In terms of patient numbers, these were my most successful study sites. I would argue that patients attending clinics in university teaching hospitals, whether public or privately based, are more willing to participate as research subjects by virtue of their presence at a research university. Such patients may be less concerned with privacy, since, as noted in the ethnographic descriptions of clinic space, patient anonymity—even in intimate acts of semen collection—could not be achieved at either of the university hospitals in which I conducted my studies.

Third, concerns over privacy, on the part of both physicians and patients, may affect patient recruitment, particularly when a health problem or its treatment is highly stigmatized. In the Middle East, both infertility and IVF are sensitive matters, accompanied by significant moral opprobrium. To that end, infertile IVF-seeking patients who agreed to participate in all three of my studies needed guarantees of confidentiality and anonymity, which came to them in the form of written informed consent forms. Despite widespread beliefs in anthropology that written informed consent forms are a major barrier to the building of rapport, especially on difficult topics, I have found over the years that informed consent forms are gaining currency in hospitals around the world, including in the Middle East. For

hospital ethnographers, they may serve as an important way to “break the ice” with potentially distrustful hospital patients. Once written documents of secrecy are signed and copies of those documents are given back to patients, many patients begin to relax, feeling reassured about their “narrative safety”. Thus, in my own hospital-based ethnography, informed consent forms are not just a painful formality; they are a tool toward greater intimacy and candor, especially when frightened hospital patients have no other basis upon which to trust the ethnographer with their medical secrets. Particularly when informants are infertile men—who must decide whether or not to speak about a deeply personal and potentially emasculating reproductive health problem—informing consent forms are, in my experience, imperative, helping to bring this hidden subject from behind its veil of secrecy.

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