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Perfecting the Match: the Visual Economy of Egg Donation

Katherine M. Boulay
Technological University Dublin

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THE VISUAL ECONOMY OF EGG DONATION

KATHERINE M. BOULAY

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SUMMARY

This thesis is a response to the absence of discussion in feminist and cultural studies of Assisted Reproductive Technology's (ART) increasing utilisation of visuality and technology as complementary legitimating discourses. While critiques of the epistemologies and practices undergirding ART point to the fact that imaging technologies are used to reveal knowledge held in bodies, lacking in current theoretical work on ART, however, is an ethnographic engagement with how visual technologies actually produce the internal and externalscapes of these bodies, and knowledges about them. Mapping selective visual knowledges and technologies constitutive of the ART egg donation, the thesis engages with disparate visual artefacts and imaging technologies: snapshots of prospective egg donors, portraits of fertility clinic doctors and staff, commercialised websites, online databases, brochures, operating theatres, ultrasonography, laparoscopy and images of ova. Reading the marketing images, proliferating technologies and attendant media narratives deployed to sell, perform and legitimise egg donation across varied discursive 'sites', the thesis addresses the contemporary Anglo-American fertility industry's construction of, and reliance upon, multiple self-legitimating visual knowledges. Produced by new and established imaging technologies alike, it is argued that through these knowledges, which reproduce a visually dominant race and class-based discourse on 'legitimate' motherhood and reproduction, egg donation is both constituted and sustained.

The dissertation comprises five chapters together with an introduction and a conclusion. Chapter one constitutes discursively the field of egg donation, synthesising relevant critical literature alongside inscribing textually my own subject position. Culminating in a discussion of method, the chapter argues for the practical and theoretical necessity of moving beyond the medicalised and bio-technologised fertility clinic as the privileged fieldwork site for the ethnographic study of egg donation. Chapter two examines selectively the representational practices of the fertility industry's commercial culture. Simultaneously tagging an institutional rhetoric assuring intergenerational physical resemblance as testimony to its professional competence, while offering full disclosure of egg donation's biomedical procedures expressed through a range of image-based discourses, the chapter foregrounds the deployment of visuality surrounding the industry's claims to effect a perfect match between an egg donor and recipient. The critical point of departure in chapter three is directed at a set of mediated visual artefacts, beginning with websites. A close-reading of an egg donor recruitment poster found on a British clinic's website serves as catalyst for the chapter's exploration of the formation of racialised micro-economies in ART in which, as evidenced by industry and media discussion of processes of racialisation in the context of ART, in addition to interviews with informants, women's ova may be differentially valued according to racial taxonomies which are visually ascertained and upheld. The fourth chapter problematises the rhetoric of institutional competence identified in the discussion of chapter two. Drawing upon a fictitious account of egg donation and informants' narratives of professionalism, the chapter foregrounds how spoken and written assertions of institutional legitimacy are discursively underpinned by questions of visuality. The fifth and final chapter revisits visual artefacts produced by the industry, with a particular emphasis on egg donor and egg recipient application forms. Building on discussion in chapter three of the development of racialized micro-economies of human ova, the chapter tracks the industry's simultaneous and contradictory practice of race as both an occasionally visible biological 'fact' and an invisible social construction and concludes with a discussion of the primary role class plays in egg donation.

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Introduction

> In a conventional romantic fiction, a barrier to the shared happiness of the couple which must be overcome is the source of both character motivation and narrative progression. We see this convention being drawn upon in the representation of both 'happy' and 'desperate' stories of infertility. 'Happy' stories are often accompanied by a photograph of the 'successful' couple and/or their much sought-after infant(s). The photograph serves as proof or evidence of their happiness and thus provides a visual signifier to reinforce the narrative closure. The accompanying text includes descriptions of the couple's relationship, family ties, professional/work profile and other details in addition to the account of their infertility and its treatment. The baby is typically described as a 'miracle' baby, or a 'precious' baby (Sarah Franklin 1990: 212).

> To both use and read visual forms in social contexts . . . normally requires no skill beyond the range of social skills to which all members of society have access. But to use, read or redeploy visual forms within explicitly sociological contexts requires not just a familiarity with the specialized knowledge of the social and human sciences, but also a foregrounding and analytical disembedding of the tacit social knowledge that enmeshes visual forms (Marcus Banks 2001: 44).

In the decade separating Sarah Franklin's seminal cultural studies analysis of the British media's textual representations of *in vitro* fertilization (IVF) and the research undertaken for this study on the visual images and imaging technologies underwriting the contemporary Anglo-American fertility industry's performance and sale of egg donation, feminist interventions challenging reductive epistemologies, practices and representations of human reproduction have continued unabated and visual cultural studies has emerged as a transdisciplinary formation in its own right. Along with the increasing number of courses offered on visual culture, most notably in Britain and the United States, there is

now a significant annual output of scholarly material addressed to what the critic Claire Pajaczkowska broadly defines as 'the juxtaposition of questions from a range of academic disciplines [that] has multiplied the avenues of enquiry into the meaning of imagery in our culture and everyday life' (2000: 2). Concomitantly, in a continuation of an evolving, multifaceted project begun in the late 19th century, feminists on both sides of the Atlantic consistently meet the seemingly endless advent and rapid proliferation of new Assisted Reproductive Technologies (ART) with a range of responses that, above all else, strive to relocate human reproduction as a vibrant socio-cultural practice as opposed to a static biological function. In a parallel with visual cultural studies, this political engagement also has been carried into the British and American classroom; the teaching of debates around reproduction and ART is now a commonplace in women's studies and feminist theory courses at both the undergraduate and postgraduate levels.

While human reproduction and visual representation, two fields of inquiry common to both feminism and visual cultural studies, come together to form the primary conceptual domain addressed by this thesis, it is cultural studies that furnishes its methodological grounding and epistemological orientation. Cultural studies' commanding metaphor of the 'site', together with its commitment to the rigorous and sustained exploration of the 'everyday', are combined with academic feminism's above-noted re-conceptualization of reproduction and visual cultural studies' analogous reformulation of visuality as a socio-cultural practice and not a biological phenomenon, technological process or art historical domain. This blending of cultural studies methodologies with a conceptual field drawn in equal parts from feminism and visual cultural studies enables a reading of the

contemporary Anglo-American fertility industry's practice of egg donation that does not conceive of the simultaneous re-inscriptions and contestations of social hierarchies effected through it as auxiliary, incidental or irrelevant as compared to the 'real' work of this ART. Rather, because of its cultural studies orientation, and hence its acceptance of the theoretical challenge to foreground the interconnections among the selected discourses and practices comprising the site under investigation, this study comprehends this re-inscription and contestation of social hierarchies to be as much a 'product' (and thus equally deserving of investigation) of the quotidian practice of egg donation as are the pregnancies more regularly – and I would add, more optimistically than realistically – associated with it.

By focusing on the relatively under-theorized ART egg donation, this dissertation aims to contribute to a series of interwoven and densely layered debates on some of the myriad ways in which formulations of race and class, including specific racial and class taxonomies, intersect with a range of contemporary discourses on representation and representational practice as viewed through the lens of reproductive discourse and practice. Driving the study is a desire to bridge the gap created by the conjunction of feminist and cultural studies analyses of ART and feminist and visual cultural studies critiques of established and new imaging technologies, practices and artefacts. Therefore, through the medium of three heterogeneous yet at times mutually constitutive intellectual formations emergent in the latter half of the 20th century, I critically engage with the visual and public culture produced by and surrounding the contemporary Anglo-American fertility industry. Drawing its boundaries from the manifestly different foci of

other contemporary work in and across all three overlapping formations, my research 'site', its construction and the particularities of its engagement with the contemporary Anglo-American fertility industry require careful elaboration and it is to this that I now wish to turn.

In their effort to 'give a sense not only of the working methods of cultural studies but of their rationale,' the critics John Frow and Meaghan Morris write:

> Cultural studies often operates in what looks like an eccentric way, starting with the particular, the detail, the scrap of ordinary or banal existence, and then working to unpack the density of relations and of intersecting social domains that inform it. Rather than being interested in television or architecture or pinball machines in themselves – as industrial or aesthetic structures – it tends to be interested in the way such apparatuses work as points of concentration of social meaning, as 'media' (literally), the carriers of all the complex and conflictual practices of sociality (1993: xviii).

Combined with their subsequent assertion that cultural studies works to 'foreground the question of the relation *between* the description of textual/cultural networks and the position of enunciation from which that description is possible', Frow and Morris provide a model with which to conceptualize the nature of my visual ethnographic inquiry (ibid.: xxii; emphasis in original). Their work permits me to foreground the multiple, shifting identities of the institutions through which I moved and the material artefacts I collected, as well as my own constantly evolving and always difficult position in relation to the contemporary Anglo-American fertility industry – a discursive space that is always in the process of being renegotiated across numerous and often very disparate sites.

My study positions the contemporary Anglo-American fertility industry as an organizing centre against which different kinds of representational work are undertaken by individual firms. Two different kinds of establishment are foregrounded; on the one hand there is the fertility clinic, the biomedical institution which both arranges and performs the set of biomedical technologies known as egg donation, and on the other there is the third-party agency, which serves as an 'egg broker', arranging but not performing egg donation. My guiding premise, often quite crude, is that both types of institution want to attract new and serve existing clients and that they use their visual and public culture as well as a spoken and written discourse on visuality as a means of accomplishing these goals. What is more, I also argue that given the wider socio-cultural sensitivity surrounding human reproduction in general and fertility medicine in particular, firms simultaneously avail themselves of these media and practices in order to persuade and remind the wider public that their work is ethical and completely above-board. Also distinct from other contemporary work on egg donation in that my focus is not primarily on egg recipients, the consumers of this ART, but on egg donors, the producers (or the women who enable the consumers to re-produce), the terrain of my visual ethnographic study, further elaborated in subsequent discussions of methodology, is conceived as a set of specific locations of activity where notions of motherhood, kinship, race, and class are constantly negotiated, re-defined and defended.

The cultural studies critic Ann Gray concisely reiterates the key distinction between method and methodology. She writes that '. . . method refers to those different techniques of research which any researcher employs in order to construct data and interrogate its

sources, while methodology describes the overall epistemological approach adopted by the study' (2003: 4). Following Gray, and entering into an in-depth discussion of the research methods used throughout the thesis in chapter one, for the moment it suffices to state that in order to 'construct and interrogate' my research 'site' I selectively blend tape-recorded interviews with industry practitioners, industry and government documents, web pages, popular fiction, newspaper and magazine articles from the Irish, British and American press, and photographs and other visual artefacts from the latter as well as those produced by and for individual clinics and third-party agencies (ibid.). Throughout the dissertation, which is framed by images, 'close-reading' is used, as a metaphor and critical practice, to re-narrate the creative socio-cultural practices that constitute the performance of fertility medicine and which, I argue, result in the re-inscription of reductive and exclusionary formulations of race and class.

It is the issue of narrative coherence that I now wish to address. The imposition of narrative coherence on the textual material re-presented in this thesis is a function of my subjective experiences with the contemporary Anglo-American fertility industry and related discourses and practices and it is this that provides the text with a unifying, authorial voice. The textual format of my narrative derives from the evolving nature of the inquiry itself; the unfolding themes which arise out of the contemporary Anglo-American fertility industry's commercial practices necessitate an appropriately non-linear textual format. Among other things, this evinces the always 'becoming' nature of the study and the fact that it had no premeditated formula to which it was at all points epistemologically bound and determined to adhere. The correlative of this is that my

account of the Anglo-American fertility industry is partial and particular, characterized by blindnesses and prejudices. Of necessity it will always be incomplete and always unable fully to illuminate the conceptual space to which it is addressed.

The above notwithstanding, the conceptual space to which this thesis was conceived as a response is best exemplified by the first of the two epigraphs that open this introduction. Taken from Franklin's essay, 'Deconstructing "Desperateness": The Social Construction of Infertility in Popular Representations of New Reproductive Technologies,' the passage reproduced above devalues visual images. Although the reliance on images as a dominant mode for the representation of biomedicine to the general public had been well-established by the time of Franklin's writing, here her work evinces a closer alignment with a more longstanding, competing perception of visual images that figures them as secondary to written texts in so far as the production of meaning is concerned.[1] No sooner does Franklin signal the importance of the image-text dyad to the construction of a 'regime of medical and scientific "truth" about the infertile body' than she declares the semiotic capability of fully one half of this convention null and void (1990: 203). That images do not mean as well as or as much as texts mean is most clearly expressed in Franklin's summation of the relationship of the photograph of the happy couple and their child to the newspaper story about them. She writes that the image 'provides a visual signifier to reinforce the narrative closure' (Franklin 1990: 212). As it is the written text that supplies this closure, the image becomes no more than a mute accessory to it. Certainly capable of reflecting meaning, images do not make meaning themselves. This,

at least according to Franklin's formulation, is a job for the more authoritative written text.

Partly instantiated by but certainly not restricted to Franklin's essay, it is the overall refusal to acknowledge that, in addition to visual technologies and practices, visual images play a vital role in an increasingly global industry – one which with the advent of egg donation has raised anew fears that women of one class and/or racial taxonomy will be forced to produce so that women of another class and/or racial taxonomy might consume – that has been the catalyst for this study.[2] Despite the development of a body of scholarship that has consistently demonstrated that the Anglo-American fertility industry frequently falls far short of its oft-stated goal of enabling women to become pregnant with and to give birth to children, feminists on the whole have paid scant attention to visuality's role in this highly problematic industry. This is not to claim, however, the discovery of a theoretical *terra incognita*; although limited, a range of work on this and related areas does exist. For example, in the midst of a history of the concept 'life,' the critic Barbara Duden draws on the cultural theorist Rosalind Petchesky's influential work on foetal ultrasound imaging to explore visuality's relationship to Euro-American reproductive discourse and practice in the 1980s and early 1990s. Focused on roughly the same time span but working exclusively on the United States, the critics Carol Stabile and Valerie Hartouni also reference Petchesky in order to analyze the impact of various visual artefacts, processes and technologies on selected reproductive discourses and practices. Finally, in the context of a larger project on the cultural reception of new imaging technologies, the critic Sarah Kember interrogates visuality's relationship to

ART in Britain in the 1990s. Beginning with Petchesky, immediately below I briefly outline the work of each one of these critics that is fundamental to this dissertation.

In 'Foetal Images: the Power of Visual Culture in the Politics of Reproduction', Petchesky's foundational essay that links visuality to medical practices and disciplinary regimes, the feminist theorist 'explore[s] the overlapping boundaries between media spectacle and clinical experience when pregnancy becomes a moving picture' (1987: 58). Tracing the visual separation of the foetus from the woman's body that sustains it to anti-abortion propaganda ascendant in the United States in the 1980s, Petchesky demonstrates the prevalence of this visual convention of foetal 'autonomy' in ultrasound imaging and interrogates its consequences. According to her, just as is the case with the images produced by and for various anti-abortion groups, 'medical' images of foetuses *in utero* reinscribe politically nuanced narratives about pregnancy. Rendering the foetus as separate, even autonomous, from the woman's body in which it rests and to which it owes its existence and its potential, ultrasound images participate in the creation of what Petchesky calls 'a baby-man, an autonomous, atomized mini-space hero' (1987: 64). This, she states, has profound implications for women's lives, leading to increased surveillance of and control over women's pregnancies by medical personnel who are far more concerned with their newly created 'foetal patient' than with the woman in whose body the foetus rests (ibid.: 64). In an historically unprecedented move, as the foetus becomes visually separate from the mother's body, the mother, without whom the foetus cannot continue to develop, becomes its most likely adversary.

As if taking Petchesky's point, at the beginning of *Disembodying Women: Perspectives on Pregnancy and the Unborn*, Duden writes that the 'transmogrification of the unborn into part of an endangered ecosystem is a question of historical epistemology (1993: 2). Thus she proposes to

> examine the conditions under which, in the course of one generation, technology along with a new discourse has transformed pregnancy into a process to be managed, the expected child into a fetus, the mother into an ecosystem, the unborn into a life, and life into a supreme value (ibid.).

As in Petchesky's work, at the heart of Duden's enquiry is a concern with visual technologies. Reading two issues of *Life* magazine, one from 1965 featuring images of foetuses *in utero* and one from 1990 featuring images of eggs, sperm and early embryos, Duden traces a line between two different kinds of seeing. She writes, 'What makes the recent issue of *Life* so typical of a new kind of seeing is the disappearance of the frontier between visible things that are visibly re-presented and invisible things to which representation imputes visibility' (1993: 16). For Duden, the loss of the independently visible external referent which she claims is still in place in 1965 – and which is still in place in the ultrasound images read by Petchesky – is utterly problematic. It instantiates a new paradigm wherein we cannot visually verify for ourselves the existence of what we are told we see in medical images. Rather, we must rely on an outside authority to both make and make sense of images for us. Just as politically motivated as the visual separation of foetus from mother charted by Petchesky, the shift in regimes of visibility discussed by Duden contributes to both the increased surveillance of women and the

installation of the scientific as the absolute authority in our everyday lives. Rather than providing a window onto nature, as I discuss in chapter two following the work of the feminist critic of science Nelly Oudshoorn, this latter is a highly interested discourse that does not discover natural 'facts' but creates that which it seeks to investigate.

In the midst of a larger argument about gender and class which is carried through *Feminism and the Technological Fix* (1994), in the chapter 'Shooting the Mother: Fetal Photography and the Politics of Disappearance' Stabile extends Petchesky's argument. Reading the same set of *Life* magazines as Duden but to a different end, she tracks the importation of the same politically motivated visual separation of mother and foetus first identified by Petchesky into mainstream popular culture and she demonstrates that the disappearance of women from foetal imagery serves a conservative, anti-feminist New Right agenda. This leads Stabile to re-assert the socio-cultural character of human reproduction. She writes:

> Although feminists must insist that pregnancy is not necessarily synonymous with mothering, they must also insist that both are 'biosocial' experiences – that pregnancy, like mothering, is something that occurs within a specific social, economic, cultural, and historical environment and that the experience of pregnancy, as such, is structured by social relations (Stabile 1994: 94).

What is significant about Stabile's analysis is that she reaches this conclusion through an engagement with visual images aimed at a mass audience. In direct opposition to the kind of analysis proffered by Franklin, where the visual illustrates the political content that inheres in the written text, for Stabile, like Petchesky and Duden, as well as Hartouni who

is discussed below, political content inheres in the images and imaging technologies themselves.

If Stabile can be said to extend Petchesky's argument, then it is fair to claim that Hartouni extends Stabile's argument. Focused, like Stabile, on popular culture, across the seven chapters that comprise *Cultural Conceptions: On Reproductive Technologies and the Remaking of Life*, Hartouni accords theoretical primacy to vision as a socio-cultural practice and tracks the replication of class and racial privilege effected by visuality's imbrication in a wide variety of reproductive discourses and practices (Hartouni 1997: 3). Touching on IVF, egg donation, cloning, surrogacy, foetal surgery, etc., via the images that surround these, she charts visuality's central role in the production and maintenance of identities for these and related contemporary reproductive practices. For her, visual artefacts and technologies do not merely reflect or refract meanings made elsewhere: they are active participants in the construction and maintenance of the social hierarchies that reproductive practices reinscribe and through which they operate. Hartouni best conveys this in the midst of a larger discussion on infertility when she writes:

> . . . contrary to its popular presentation as a problem that overwhelmingly afflicts white, affluent, highly educated women, the incidence of infertility is actually higher among the nonwhite and poorly educated. Black women are one and a half times more likely to be infertile than are their white counterparts, but it is not black women whom specialists seek to save from their own nonfunctional bodies or to assist in fulfilling their biological destinies. When *Life* magazine chooses to feature the issue of infertility, along with the various new technologies that have been developed to 'treat' it, on its cover is situated not a black baby or a brown

> one, but a pink, blue-eyed toddler. What world is being held in place, however precariously, by the development and use of these new technologies is hardly a mystery. Both text and subtext are straightforward: white women want babies but cannot have them, and black and other 'minority' women, coded as 'breeders' (and welfare dependents) within American society, are having babies 'they' cannot take care of and whom 'we' do not want (1997: 45).

Unlike Franklin's reading of the photograph of the happy couple and their child, Hartouni's assessment of the cover of *Life* magazine's June 1987 issue accords an active role to visual artefacts and by extension to the visual technologies to which they at least partially owe their existence. This represents no less of a profound reorientation of the analysis of reproductive practice than does Petchesky's work, Duden's work, or that of Stabile. No longer merely an accessory whose capabilities are limited to documentation and illustration, visuality has become a major medium through which so-called legitimate reproduction is practised. Rather than existing independently alongside it, in Hartouni's work visuality has become inextricably linked with reproductive discourse and practice.

Providing a final example of contemporary critical work on the relationship between visuality and reproductive practice is Kember's essay 'NITS and NRTS: Medical Science and the Frankenstein Factor.' In it she argues that new imaging technologies (NITS) combine with new reproductive technologies (NRTS) to fuel the idea of a fully autonomous reproductive science and technology. This, Kember writes, is

> a patriarchal fantasy which is enacted or acted out to an inevitably limited degree in the face of women's persistent ability to have children and in response to an

> ongoing and ever-present fear of the female body read in the essentialist terms of its maternal function. The fantasy of fathering offspring without women is a defence against the anxiety provoked by the ultimate limitation placed on this desire' (1998: 88).

Extending a feminist critique of visual regimes of disembodiment first proposed in relation to the production and widespread dissemination of images of foetuses *in utero* to visual technologies of recent advent such as CT, MRI, and PET scans and ART, Kember uncovers an (impossible) anti-feminist fantasy.

One key difference distinguishes Kember's work from that of the other theorists discussed above. Unlike Duden, Stabile and Hartouni who are concerned with the complex interrelationships between gender and class and race, Kember is concerned uniquely with gender. In an echo of early feminist critiques of ART discussed in chapter one, this leads her to set up a rather crude opposition between female patients and male practitioners and technologies. While gender indisputably remains a vitally important category of analysis, Kember's reliance on it alone is problematic. Absent from her text is any sense of visuality's complicity in bringing an always already raced and classed female body to the operating theatre. Therefore, it is the work of the first four theorists on which I rely for a partial blueprint for developing an understanding of the ways in which visual images and imaging technologies actively participate in practices integral to the contemporary Anglo-American fertility industry and in the creation, construction, maintenance and contestation of narratives – be these beneficent, benign, malicious or ambivalent – about it.

That the visual does not merely bear witness to but is constitutive of egg donation is addressed in detail in chapters two through five. However, for the time being, it may be quickly illustrated here by means of a brief overview of three key phases of this ART.

To begin with the surgical procedure in which a physician extracts eggs from an egg donor's ovaries, it is an imaging technology in the form of a microscope placed on the end of a vaginal catheter that permits the physician to guide the catheter that enables her/him to gather the eggs which themselves cannot be viewed without this visual technology. Prior to this step, it must be determined that the eggs are ready for collection. This assessment is made visually: the egg donor undergoes an abdominal or a vaginal ultrasound. Looking at a monitor, the ultrasonographer counts and measures the eggs and prepares a report for the physician indicating whether they are sufficiently numerous and large to make their retrieval viable. After the retrieval, other imaging technologies, such as microscopes, guide the fertilization of eggs and the implantation of them into the recipient's body.

Prior to the performance of egg extraction, the industry relies upon several different advertising strategies, most of which are visually driven, to sell egg donation. These include but are not limited to banners running across web-based email accounts, emailed newsletters, newspaper and magazine advertisements announcing open evenings where doctors tell prospective clients about egg donation and other ART, and ads for local fertility clinics and egg brokers that outline the services offered by individual institutions and precede the showing of the main feature in cinemas.[3]

Acting as a bridge between advertising and donor selection and leading up to the performance of the surgical extraction of a donor's eggs are websites. Often filled with visual images, these may contain digitized photographs of clinic staff and facilities as well as digitized professional and amateur shots of prospective egg donors. These latter, appearing in web-based databases listing women who are willing to donate their eggs, purport to show not only what a prospective donor looks like but, through associations with material objects – for instance clothing and sports equipment – her class status and her personality. It is often on the basis of these photographs that the prospective egg recipient will select her 'perfect match'. This is the woman from whom she will receive eggs. Generally, she is the woman who most closely physically resembles the prospective egg recipient so that, at least according to the logic of the industry, no one will be able to see by visually comparing a child to her/his mother that s/he is genetically different to that mother.

By closely reading the visual images, practices and discourses outlined above, my goal in what follows is to contribute to an established tradition of feminist, visual cultural studies and cultural studies work and to engage with the often – but not always – reductive and exclusionary logic of the contemporary Anglo-American fertility industry. Rather than being merely a more interesting or novel way of reading the industry, coming at it through the visual seems to me an especially productive way to engage with the socio-cultural practice of assisted conception. Given, as I will argue, a longstanding race and class-based discourse on 'legitimate' motherhood, the visual provides a means of

engagement with practices about which we may not be comfortable speaking but which we have definitely become accustomed to image.

Before outlining the chapters of my thesis, it remains to be said that, with the exception of Dr John Schnorr of the Jones Institute and Dr Joseph D. Schulman of Genetics & IVF Institute (G&IVF Institute), I have changed the names of all of my informants and the institutions with which they are affiliated. Mentioned briefly in chapter one, Shelley Smith of the Egg Donor Program, who is not an informant, is not a pseudonym.

Summarizing the dominant medical narrative of egg donation to introduce this ART to the unfamiliar reader, in chapter one I go on to outline the particularities of this assisted conceptive technology's performance in Ireland, Britain and the United States. This is followed by an extensive review of relevant literature which builds upon the discussion above and is designed to familiarize the reader with feminist and cultural studies debates specific to critiques of ART. Rather than providing an equally thorough analysis of relevant literature on, for instance, ethnography, race, visuality, and critiques of science and technology at this point, I have chosen instead to address these and other areas of concern in the chapters in which they appear, often using footnotes to direct readers to additional relevant theoretical sources. In the chapter's third and final section I discuss the methods employed in the gathering of material artefacts and the conducting of the in-depth interviews.

Crossing the national borders inscribed in the first chapter, chapter two critically examines two very different moments when practitioners rely upon visuality to testify to their professional competence. The first of these is a discussion of an American doctor's telling of an anecdote about visuality in order to attest to his particular institution's ability to effect a 'perfect match' for any prospective egg recipient. Switching gears, the second and longer section re-presents a bank of collected images and reviews relevant critical literature on visuality. Closely reading a series of the industry's representational strategies, I argue that this different mobilization of visuality effects a similar testament to institutional efficacy, this time in the form of a discourse of openness about the practices central to egg donation and fertility medicine in general.

Re-reading an image taken from a website and first presented in chapter two, chapter three focuses on the representation and circulation of race in the representational strategies discussed in the previous chapter. Using a newspaper article about a shortage of African-American egg donors as a point of entry, I track through my informants the formation of racialized micro-economies of egg donation in the contemporary United States. In these I show how women's ova may be differentially valued according to racial taxonomies which, visually ascertained and upheld, demonstrate the socially-constructed nature of race, which is then re-inscribed in the biologistic speech of industry practitioners.

Similar to chapter three in that it develops from the discussion of strategies of representation of institutional competence first identified and discussed in chapter two,

chapter four closely reads a science fiction novel about egg donation. Re-identified in Robin Cook's *Shock*, the discourse of openness and closedness, which were first identified in chapter two, are contrasted with informants' narratives of professionalism. The chapter concludes by demonstrating that, as in the anecdote that opened chapter two, spoken and written narratives of institutional competency are unwritten by a discourse of visuality.

The fifth and final chapter examines egg donor and egg recipient application forms. Building on the discussion in chapter three in which I argued for the development of racialized micro-economies of human ova, the chapter concludes by identifying and tracking the highly contradictory practices of race and class in egg donation. I demonstrate how race simultaneously functions as a supposed biological fact and as a social construction. The chapter concludes with a discussion of the ways in which race may avoid being biologized while class does not.

Notes

1 For further discussion of visuality as secondary see Mitchell (1987, 1994), Jay (1993), Stafford (1996), Mirzoeff (1998 and 1999).

2 At this juncture, it is important to underscore that my intention in referencing Franklin's essay is not to single out her work as deficient. To be sure, at a critical point 'Deconstructing "Desperateness"' does enact a culturally pervasive impulse to divest the visual of any semantic autonomy. Yet, here and in other of her work as I discuss in chapter one, Franklin's interventions into the mainly textual representations surrounding ART and the practices comprising it in Britain are powerful and persuasive exercises. These, in addition to work such as her essay 'Fetal Fascinations: New Dimensions to the Medical and Scientific Construction of Fetal Personhood' (1991) in which Franklin does read images of foetuses and comes to many of the same conclusions as Petchesky, it appears to me, have not only accomplished the not insignificant feat of inflecting industry practice and industry-produced representations of new reproductive technologies but they have profoundly shaped subsequent critiques of ART and facilitated its entry into third-level education as a integral area of study. What is more, because in this article Franklin's stated objective is not a sustained engagement with visual representations of ART but is instead a critical analysis of written representations of it in order to 'demonstrate how popular representations of infertility contribute to the formation and widespread acceptance of this now common myth of the benevolence of new reproductive technologies,' it would be entirely inappropriate to condemn her work for its failure to attribute semantic autonomy to the visual (1990: 202). For a discussion of the importance of the visual to ART, see Franklin (1993).

3 Although I have never seen them, the journalist Rebecca Mead has indicated that some fertility clinics put ads in cinemas for their services in New York which run prior to the feature. She writes, 'Marketing strategies are ingenious. A New York egg-donation program advertises in movie theatres, inviting would-be donors to dial 1-877-BABY-MAKERS' (Mead 1999: 58).

Chapter One

The Commercial Layering of Egg Production: Siting New Fields of Inquiry

Figure 1.01: *Egg Donation, Inc.*

Multi-sited ethnographies define their objects of study through several different modes or techniques. These techniques might be understood as practices of construction through (preplanned or opportunistic) movement and of tracing within different settings of a complex cultural phenomenon given an initial, baseline conceptual identity that turns out to be contingent and malleable as one traces it. (Marcus 1995: 106).

According to dominant biomedical discourse and the contemporary Anglo-American fertility industry, egg donation may enable a woman who cannot use her own eggs to conceive to become pregnant and to give birth to a child. At a rudimentary level, this ART refers to the set of biomedical processes and procedures whereby one woman (the egg donor) takes a combination of hormones in order to stimulate her ovaries to mature a large number of oocytes or eggs.[1] Once mature, these are surgically removed by a doctor, ranked according to quality, fertilized *in vitro* and introduced into the uterus of another woman (the egg recipient). There it is hoped that at least one of these fertilized eggs, or embryos, will, as a result of the recipient having herself undergone a course of hormone therapy,[2] implant, develop and lead to the birth of a healthy infant.[3] This child, it must be noted, although nurtured *in utero* by her/his mother's body, will not be genetically related to her. This is because s/he receives one half of her/his genetic material from the egg donor who has donated her eggs to her/his mother and the other half from the egg recipient's partner, friend or sperm donor.

A woman's ability to conceive and sustain a pregnancy depends upon a number of factors. Among other determinants, at least one of her ovaries must be capable of maturing an egg that can be fertilized by a sperm cell. Foregrounding the importance of ovarian function and chromosomal regularity to conception and gestation, the University of Washington Medical Center publishes an eight-item list of indicators for their donor oocyte – or donor egg – programme. These are as follows:

1. premature ovarian failure
2. premenopausal oophorectomy (ovary removal)

3. genetic indications
4. poor response to ovarian stimulation
5. natural menopause
6. multiple failed assisted reproductive technology attempts
7. persistently abnormal oocytes obtained at IVF
8. assisted reproductive technology candidates >40 years old wishing to optimize their pregnancy rate and decrease their rate of spontaneous abortion and chromosome abnormalities.

   (Klein, N. Sewall, G. and Soules, M. 1996: 4)

Because items 1, 2 and 3 above hamper or preclude the maturation of viable eggs or the subsequent development of a healthy foetus, a woman with one or more of these three conditions who wants to gestate and deliver an infant may be considered a good candidate for egg donation. Items 4, 6, 7 and 8 above, which result from the performance of other ART, such as egg donation's parent technology *in vitro* fertilization (IVF), also serve as indicators for egg donation. At the same time, however, their inclusion in this list testifies to the difficulty a woman may experience in attempting to call a halt to the pursuit of assisted conception. Their presence reflects the fact that the failure of one ART to result in a sustainable pregnancy (or the birth of a healthy child) may frequently lead not to the recommendation that a client discontinue her pursuit of this but that she pursue ever more sophisticated sets of biomedical interventions in order to achieve this goal. As such, the presence of these four items here confirms a central tenet of feminist critiques of ART, which argues that once begun, the pursuit of pregnancy via assisted conception may be very difficult to stop.[4] Finally, unlike the items in the other two groups and despite the fact that the menopause has been medicalized in Britain, Ireland and the United States, item 5 does not reflect a medical condition.[5] Rather, it points to the fact

that, when she reaches somewhere between forty and fifty years of age, a woman's ovaries generally cease to mature and release eggs. Because this does not impact on uterine function, a postmenopausal woman can, provided she undergoes a specific hormone regimen, gestate and give birth to a child conceived from another woman's egg.[6]

Leaving aside the question of why a woman might opt to pursue egg donation, there is no doubt that, since its first successful performance in Australia in 1984, this ART has enabled a number of women to become pregnant with and to give birth to children (Cohen 1996: xi). Yet, like many other ART, egg donation does not have high rates of success. In its annual report entitled *2000 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports*, the Centers for Disease Control and Prevention (CDC) announced that for egg donation 'the average live birth per transfer rate is 43%' (2002: 53).[7] In other words, less than half of all transfers of embryos to egg recipients result in the birth of a living child. When it is taken into account that egg donation, like IVF, is comprised of multiple, multi-phase stages, such as the hyperstimulation of the donor, the procurement of sperm, and the retrieval, assessment, and fertilization of eggs, the failure of any one of which precludes the progression to the subsequent stage and thus effectively calls off the donation, it should become clear that the initiation of this ART by a prospective egg recipient does not automatically mean that nine months later this woman will walk away from a maternity ward with a healthy baby.

Despite its relatively low success rate, however, and as reflected in item 8 above, egg donation is routinely presented by representatives of the contemporary Anglo-American fertility industry as the best chance a woman about, at, or over forty years of age has of becoming pregnant with and giving birth to a child.[8] Provided she can afford the price tag, generally running to at least several thousand dollars, a woman around forty years of age, a woman who has been unsuccessful in past attempts to conceive and sustain a pregnancy through the purchase of other ART, and/or a woman with any other of the above conditions can elect to pursue egg donation. But the manner in which a client of fertility 'treatment' experiences the mobilization of this ART and makes the subset of related decisions it requires of her depends upon more than her financial ability to pay for egg donation.[9] Also fundamentally structuring a woman's experience of this ART is her country of residence and the type of relationship she wishes to have with her egg donor. Focusing mainly on the performance of egg donation in the United States, but referring on occasion to its practice in Ireland and, especially, Britain, in order to foreground the specificity of the American context, in the next section I move away from the dominant biomedical narrative of this ART. In a prelude to discussions in subsequent chapters of the socio-cultural practice of egg donation in the United States and the ramifications of this, in section I I situate this ART within differing national contexts.

I. Situating Egg Donation: Location, Commercialization and Anonymity

While many countries severely restrict the practice of egg donation and others prohibit it entirely, this ART, like others, is by no means uniformly available within those countries that do permit it.[10] A prospective egg recipient, therefore, must often travel in order to try

to become pregnant via another woman's eggs. Depending upon the location and the *modus operandi* of the institution from which she desires to purchase egg donation, the egg recipient may also be called upon to make at least two other decisions. First, she may have to decide between the pursuit of commercialized or non-commercialized egg donation. Second, she may have to decide whether both she and her donor remain anonymous, or whether she will go ahead and meet the woman who will provide her with eggs. If she selects the latter, she may also be required to determine the nature and degree of contact she wishes to have with her donor. Ireland, Britain and the United States have developed very different regulatory frameworks for assisted conceptive technologies. Beginning immediately below I briefly outline some of the most salient factors governing the practice of egg donation in each one of these countries.

Of the three nations considered here, Ireland's practice of egg donation is the most limited and difficult to chart. This can be attributed to the relative invisibility of ART in general in Irish society. The feminist researcher Susan Ryan-Sheridan is instructive on this issue. She writes:

> *In Ireland, there is no legislation,* no independent statutory body monitoring and controlling the technology. The technology has been introduced with no public discussion, no public anxiety. Very little is known at the political level about what is happening in this country in the field of new reproductive technology – the procedures, the results, the costs, the complications, or about the nature of the debates that have taken place in other countries. Although individual Catholic philosophers and theologians have written opposing the technology and although the recently published *New Catechism of the Catholic Church* condemns *in vitro*

> fertilization, the Irish Catholic hierarchy has been uncharacteristically quiet in a matter of crucial concern to it – the question of human reproduction. The whole nature of human reproduction is being dramatically altered within a matter of a few short years with the development of new reproductive technology, but when the Irish Catholic hierarchy speaks out against the modern-day 'destructive evils' facing family life, we do not hear about reproductive technology. We hear instead, that the dangers which threaten family life are *abortion, contraception and divorce* (Ryan-Sheridan 1994: 4–5; emphasis in original).

In the period between Ryan-Sheridan's summation of the place of ART in Irish society and this study, little has changed. Apart from the very occasional mention in the media, mainly occurring around international and hence non-Irish events, ART remains largely undiscussed.[11] Additionally, there is still no national regulatory framework in place concerning ART. While the Commission on Assisted Human Reproduction (CAHR), formed by the Minister for Health and Children, Micheál Martin, held a public meeting in February 2003, in order to begin to prepare policy, to date no recommendations have been made available to the public.

One of the key aspects of the practice of ART in Ireland pointed to by Ryan-Sheridan is the overall secrecy that surrounds the mobilization of sets of conceptive technologies. She states:

> In Ireland, control of the technology is in the hands of the medical profession. All details and statistics regarding the programmes, the numbers going forward, the results, the successes, the failure, all must be obtained from the doctors who

> administer the technology, and from my interviews I would say that there is a reluctance on the part of the doctors to be precise (ibid.:35).

This unwillingness to discuss ART in any detail is still in place at the time of this writing and it extends to the kinds of ART offered in Ireland. Not only is it difficult – if not impossible – to acquire statistics on success rates of various ART, it is also incredibly challenging to determine whether clinics in Ireland are in fact practising egg donation at all. From this it follows that it is equally difficult to determine exactly which clinics sell this ART, how often they perform it, how they attract prospective donors, how much they charge, etc. Thus, the most that can be said about egg donation in Ireland at the present moment is that it is most likely performed on occasion – but not very often.

The situation of egg donation in Britain is markedly different from that in Ireland. Under the Human Fertilisation and Embryology Act (1990), the Human Fertilisation and Embryology Authority (HFEA), which came into being in 1991, was given regulatory powers over the British fertility industry and this body governs the practice of egg donation and all other ART in Britain. All operational fertility clinics must be licensed by the HFEA and must undergo a yearly inspection in order to have that licence renewed. It is illegal to offer an ART such as egg donation or IVF in Britain without a licence from the HFEA.

Discussing the history of the inception of the HFEA in *Embodied Progress: A Cultural Account of Assisted Conception*, Franklin provides an illuminating account of the parliamentary debates that led to its passage. The main impetus for the formation of the

HFEA can be attributed to the *Warnock Report*, the published findings of the Warnock Committee, convened in 1982 and, as Franklin writes, 'set up to advise the government, Parliament and the general public on the matter of human fertilization and embryology' (1997: 86). Headed by the philosopher, Mary Warnock, according to Franklin the committee

> made various recommendations including the establishment of a licensing body to oversee developments and provision in the area of reproductive medicine, the establishment of criteria governing the status of children born of new techniques, and the criteria for legal limits on research on human fertilization and embryology (ibid.).

Emerging as an internationally recognized and respected organization, the HFEA has served as model for other countries, such as Ireland, that are attempting to develop policy and legislation governing the practice of various and sundry ART.[12]

While it is possible for a woman to become an egg recipient within Britain's National Health Service (NHS), it may not be easy for her to do so.[13] Waiting lists for donors are long and the availability of this and other ART varies from region to region. As is the case with IVF, some parts of the country are relatively well served, while in others there are no fertility clinics that offer egg donation. Provided she has the substantial financial resources to do so, a woman can bypass the NHS and significantly reduce her time on waiting lists by pursuing this ART at any of a number of clinics that offer it privately.

In the United States, the practice of egg donation is another story entirely. There is comparably less regulation of new reproductive technologies than in Britain and in other European and non-European states. As there is, crucially, no American equivalent to the HFEA, no national body oversees and regulates the sale of ART in the United States. The closest approximation to the HFEA is the CDC. Under the terms of the Fertility Clinic Success Rate and Certification Act (1992), the CDC must publish 'pregnancy success rates for ART in fertility clinics in the United States'(CDC 2002: 7). While American fertility clinics are, as indicated, obliged to report their rates of pregnancy success to the CDC, it is of paramount importance to note that this institution does not have regulatory power over clinics. Hence, it cannot shut down fertility clinics that do not report their numbers, that misreport their numbers, or that fail to adhere to good business practice – no matter how the latter is defined. The only sanction available to the CDC is the printing of a non-compliant firm's name and address at the end of its annual report under the title 'Nonreporting ART Clinics for 2000, by State' (2002: 507).

In addition to the obligation to provide the CDC with specific kinds of data, American fertility clinics also have the option of adhering to guidelines issued by the Society for Assisted Reproductive Technology (SART). These voluntary guidelines govern good practice, but neither SART nor the local and state authorities governing medical practice can impose sanctions on a clinic that contravenes them. The same is true of the guidelines issued by the American Society for Reproductive Medicine (ASRM) and by RESOLVE. The former is similar to SART in that it is another professional organization to which

fertility clinics can belong; the latter is an organization offering support and advice for women and men experiencing infertility.[14]

One manifestation of the relative lack of regulation of the practice of egg donation in the United States as compared to Britain concerns the number of embryos practitioners are permitted to transfer to the egg recipient. Under the terms of the HFEA, practitioners at British clinics can transfer at present no more than two embryos at any one time.[15] In the United States, by contrast, there is no official limit on the number of embryos a physician can transfer to a donor egg recipient.

Dr Ian Jackson of The Fertility Clinic, Inc., which is located in the American south, feels that the relative absence of regulation of the number of embryos a physician can transfer to an egg recipient in the United States is quite positive. He stated that when embryo quality is questionable, he might need to transfer more than two embryos to the recipient mother in order to have a better chance that at least one would implant and develop into a foetus. Under the terms of the HFEA this would not be possible in Britain.[16] Dr Jackson explained his view of what he felt was a key difference between British and American practices of egg donation as follows:

> In England there's so much regulation regarding the number of embryos that can be transferred that I think that that's a problem. I just transferred four egg donor embryos on an egg recipient and that is much more than I normally do. But it was all based on the quality of the embryos and the way that fertilization took place and how well the patient stimulated and a whole host of other factors and we all

agreed that it was going to be best to be aggressive here because the embryos were not in the best of shape.

Another fundamental difference between the practice of egg donation in the United States and in Britain has to do with the kinds of institution involved in the sale of this ART. As noted in the Introduction, two very different types of establishment offer egg donation in the United States. In addition to the American fertility clinic, which of course parallels the British or Irish fertility clinic, there is also the agency that arranges third party reproduction. Hereafter referred to as 'third-party agencies' (or simply 'agencies'), it is important to note that, owing to the HFEA's prohibition on commercialized gamete donation, there is no British equivalent to this kind of institution and at present neither is there an Irish equivalent.

The main difference between the third-party agency and the fertility clinic is that the staff of the former does not perform the sets of biomedical procedures carried out on the bodies of two women that are known as egg donation. The agency is a strictly non-medical entity. Like clinic staff, agency staff do match prospective egg donors to prospective egg recipients and they may also liaise with a practitioner's office in order to arrange the clinical practice of egg donation. Unlike fertility clinics, however, active medical practitioners do not, as a rule, staff third-party agencies. Their directors, co-ordinators and other staff members are by and large business people (who may or may not have a medical background in and/or firsthand experience of infertility).

Figure 1.02: *The Egg Donor Program, Inc.*

Shelley Smith, pictured in figure 1.02 with her two children who were conceived with donor eggs, is the owner and director of a third-party agency. Like many other agencies and fertility clinics Smith's firm, called The Egg Donor Program, operates at least partially over the internet. On its webpage, from which this image was taken, prospective donors can find out what criteria a woman must meet if she wants to donate at the firm and prospective recipients can view password protected profiles of prospective donors. Largely overlooked in feminist and cultural studies analyses of the practice of egg donation in the United States, these agencies and their reliance upon the internet are as much a part of the story I tell in this dissertation about commercialized egg donation in the contemporary United States as are the more widely discussed fertility clinics.

Commercialization

As stated, commercialized egg donation is prohibited in Britain under the terms of the HFEA and, to the best of my knowledge, it does not exist in Ireland. The same is not true of the United States, where the distinction between commercialized and non-commercialized egg donation is determined by whether or not the prospective egg recipient engages a known 'volunteer' to donate her eggs to her. Also signalled by the term 'non-commercialized', a known volunteer is a woman – a sister, daughter, friend,

mother, aunt, niece, etc. – who has offered her eggs to the prospective recipient.[17] She is someone with whom the latter has developed a relationship that pre-dates the prospective recipient's decision to procure another woman's eggs in an effort to become pregnant. This should not be taken to mean, however, that a known donor receives no compensation for the expenses and loss of time she incurs as a result of the actual donation and the significant amount of preparation that precedes this. Depending upon where she lives, with what clinic she works and the arrangements she makes with the prospective recipient, designating a donor by the use of the term 'volunteer' can be slightly misleading. A known volunteer receives compensation for, at the very minimum, the expenses she incurs in travelling to and from the clinic. Thus, in the American context the term 'non-commercialized' egg donor points either to a self-recruited donor who is known to the egg recipient or to a donor recruited by the prospective egg recipient. It is important to note that this term does not indicate a donor recruited by a fertility clinic or a third-party agency, and nor does it indicate that no money changes hands.

Many American fertility clinics are willing to accommodate a prospective recipient who arranges for a relative or a friend to donate eggs to her. Others are more hesitant when it comes to working with donors they have not recruited themselves. Dr Jackson's clinic is an example of the latter. At this institution it is a requirement that all prospective donors and prospective recipients undergo psychological screening. Donors not initially recruited by The Fertility Clinic, Inc. but treated by Dr Jackson are no exception. As he explains, this is because one of the aims of the screening process is to determine whether or not the

prospective donor – no matter how she is recruited – is being coerced into donating her eggs. According to Dr Jackson:

> Everyone undergoes psychological evaluation. Both the egg recipient and the egg donor. For the egg donor, it's mostly we're looking to make certain that they're not being coerced. This would usually be by a woman's husband. He'll act like a pimp, you know, and try to get them to make money on their eggs. By requiring psychological screening we try to make sure that if a woman is a designated donor – for example, the recipient's sister – that she's not being coerced by her family members.

In this dissertation I focus exclusively on commercialized egg donation, leaving aside those cases in which a sister donates to a sister or a daughter to a mother. With several notable exceptions, deriving mainly from my use of visual materials produced by British fertility clinics together with theorists' work on the British context, my concern in what follows is with prospective egg donors who have been recruited by American fertility clinics or third-party agencies. These are women who can expect to receive at minimum $1,500 for their donation and who, regardless of whether or not a subsequent relationship does develop, are initially unknown to the prospective recipients who purchase egg donation from the institutions located throughout the United States with which these donors are registered.

Anonymity

While, in the American context, the distinction between commercialized and non-commercialized egg donation does hinge on whether or not the prospective donor and the

prospective recipient know one another, it is not by any means the same as the distinction between known and anonymous egg donation. The term anonymous donation, initially the standard for the fertility industry in the United States, still the standard in Britain and assumedly in Ireland, and modelled on sperm donation, refers to a situation in which the prospective recipient receives no identifying information about the prospective donor and vice versa. Advocates of anonymous donation maintain that knowing very little about one's donor minimizes the allegedly negative impact that the purchase of third-party gamete donation may have on the nuclear family. According to the logic of this argument, the less one knows about one's donor, the easier it is to obscure the fact that reproduction of the nuclear family depends on recourse to a third party. While the prospective recipient may learn her prospective donor's race, eye colour, hair colour, height, weight, etc., she does not see photographs of this woman, and the donor and the recipient do not meet, speak on the telephone, or email one another. Furthermore, in anonymous egg donation the donor may not be made aware of the outcome of the donation.

The opposite of anonymous donation, known donation has any number of permutations according to the kind and extent of contact with the donor desired by the recipient. In known donation, a prospective recipient comes into some form of direct contact with her selected donor at least once. Sometimes the donor is told whether or not the recipient succeeded in becoming pregnant and sometimes she is not. Again, this varies according to the practice of the clinic or agency and/or the desires of the recipient.

The experience of Anne Ames, a Los Angeles-based woman who twice donated her eggs through a third-party agency for which she now works, exemplifies this. Although Ames learned that her second donation was unsuccessful and that the recipient did not become pregnant, she received no information as to the outcome of her first donation. Nonetheless, she did meet her first recipient and this woman's husband. As Ames says, she quickly developed a strong connection with this woman:

> The two times I've done it I have met the couples. The first time my husband and I went out to dinner with them and I really bonded with the recipient mother. We snuck off to the bathroom and let the boys drink their beer and we talked about her bout with cancer, her struggles, the heartache of realizing that she would be unable to have children of her own. We cried about this together and bonded and they were there also at the morning of my retrieval and took me out to breakfast afterwards. But they live in Connecticut so then that was it in terms of the contact I had with them. You know, at that point it was just kind of like if they wanted to get a hold of me, they could. Otherwise, I felt like I didn't need to know anything but just wished them luck. It was really an amazing experience.

Although meeting both this woman and her second recipient proved to be positive experiences for Ames, not all fertility clinic and agency staff are convinced of the beneficial effects of known donation. Laura Green, the director of Texas Third Party Agency, is more comfortable with anonymous donation. Of her firm's practice she states:

> Our intention is to have this all anonymous. Now if the two want to meet, which we have a case of right now, it makes me a little nervous. I'm really not sure what the ramifications of that might be. But both sides seem to be comfortable with it

and we'll just see where they go. But the way we're set up is for anonymous donation.

Green's hesitancy about known donation is in marked contrast to what Nancy Young, the director of Oocyte Donation, Inc., a third-party agency with branches on both the east coast and the west, the latter located in Beverly Hills, California, feels about it. Proud of her programme's policy of openly advocating known donation since its inception in 1989, Young challenges one of the cardinal principles of the *Warnock Report*: she does not insist on anonymity. On the contrary, in order to allay their anxieties about their pursuit of third-party gamete donation, she recommends that her clients meet their donors. Highlighting one of the key differences in the way egg donation is practised in the United States as compared to Britain and Ireland, Young explains:

> You know, years ago, the whole world wanted this field to be anonymous and we stood out as an agency that encouraged clients to meet their donors. As a result of this, I actually had a lot of doctors who would come to my booth when I was at seminars and they would yell and scream at me that this was the most terrible thing. How could I release a donor's picture to a couple? How could I arrange a meeting between a couple and their donor? Because these doctors were used to sperm donation, they felt that known egg donation was not right. So we got a lot of flak in the beginning but, slowly, people have got more used to the idea that, yeah, couples want to meet this lady. Now they don't have to meet her, you know, face to face like you and I are sitting. They could meet over the internet and email each other. They could talk on the telephone. But I think it's the best thing. The best gift that a couple can give themselves is to actually meet their donor. And I say that to every couple. Because if a client doesn't meet their donor, a lot of things start to happen. They start wondering if I did a good job when I wrote the donor profile. Did I tell them who the donor really, really is? They haven't met

her so they've got to trust me so they start wondering. And I say to couples, what if after your baby is born, your baby has a certain characteristic or a certain look on the face or, you know, a dimple or something and you're in a supermarket one day and you walk into this lady and she is the spitting image of your child. And you know this happens because I've had people say to me that I look just like someone else. And your heart's going to beat all of a sudden and you're going to think, 'Ah! She's my donor!' And you're going to be petrified. But, if you had met her, you wouldn't be petrified because you'd know exactly who she is. You're never going to have to wonder. You're not going to be wondering and saying, 'Oh, she's got a dimple like my child.' 'Oh, she was a donor before. I wonder if she was my donor.' Why play that game with yourself? Why not just meet her and ask her the questions you want to. Overcome your fear. Move on. If she's been psychologically screened and she's an appropriate donor, she's not going to hunt you down and she's not going to be in your life forever. So, I always say to couples, you might not believe it now but the best gift you can give yourself is to take time out and meet your donor. I've never had a couple regret it.

According to Young the preservation of the nuclear family depends upon a double transgression of its boundaries. The first transgression, approved also by CAHR, the *Warnock Report*, the HFEA, SART, ASRM and RESOLVE, is the recourse to third-party gametes. When a married, heterosexual woman cannot use her own eggs to conceive, both *Warnock* and Young declare it permissible that she attempt to do so via another woman's eggs.[18] But, unlike *Warnock* in particular, Young goes on to advocate a second transgression. This is the meeting of the donor and the recipient. Advising her clients to forego anonymity, Young insists that the only way that a prospective egg recipient can assure herself that the donation will be a single event is by meeting her donor, speaking to her on the telephone, or emailing her. It is solely through some form of contact with

her donor that the recipient can learn that this woman understands that she is giving up an egg and not a child. In other words, a meeting acts to assure the recipient that the donor will not initiate a third breach of the boundaries of the nuclear family and attempt to claim as her own any child resulting from her donation.

I am convinced that Young's preference for some form of known donation represents the future of egg donation in the United States. As one among many pieces of evidence that the practice of this ART is moving in this direction, I take Green's willingness, discussed above, to arrange a meeting between her prospective egg recipient and the woman the recipient has selected to be her donor. Hesitant though it is, Green's acquiescence to her client's demand suggests that there may exist an extra-institutional consensus among some egg donation clients that it is desirable to break anonymity and to meet one's egg donor.

Equally indicative that some form of 'known' donation represents the future of egg donation is the large number of firms offering their prospective recipients access to identifying information about prospective donors. Through the medium of the donor database, many clinics and agencies enable their clients to learn the names, educational, medical and social histories of women interested in donating their eggs. These databases and the diverse roles they play in the construction and normalization of identities for prospective egg donors are discussed in subsequent chapters.

In the Introduction I discussed how, with several notable exceptions, visuality's imbrication in ART has been overlooked by feminist and cultural studies critics. The same might be said of egg donation. As compared to IVF, for example, it has received substantially less critical attention than its parent technology. That this is the case may be seen from a review of the literature relevant to this study. In addition to providing evidence of the relative marginalization of egg donation in critiques of ART, this review also provides a vital critical context to my study. Through an extensive history of feminist and cultural studies engagements with ART and related areas, I further develop the critical base from which, as discussed in the Introduction, this work departs and with which it wishes to engage in an ongoing conversation.

II. Feminist and Cultural Studies Antecedents

Across the wide array of literature on ART in existence today, a range of texts which includes, but is not limited to, guides to the various 'treatments' available for women and men experiencing infertility, ethical treatises aimed at a general readership, discussions of procedures, practices and research specifically geared to the medical community, science fiction and feminist critiques, an often invoked point of reference is the birth of Louise Joy Brown, 'the world's first test-tube baby.' To reinscribe this here, by the time Brown, who was conceived as a result of IVF, was born in July 1978, a body of work on assisted conception, albeit small, was already in existence.[19] Divisible into two groups, this early work encompassed science fiction explorations of ART (including, of course, Huxley's *Brave New World*) and the activist-academic work of feminists.

Representative of the first group is David Rorvik's *In His Image: The Cloning of a Man* (1978). Initially passed off as non-fiction, this novel tells the story of Max, a rich man who wants a son. Deciding to have himself cloned, he hires a scientist, 'Darwin'. Like Max, this man is devoid of any ethical sense whatsoever and he begins experimenting on women so as to be able to acquire, manipulate and re-implant the egg that will carry only Max's genetic material and from which his son will be born. Similar to Rorvik's novel in that it both depicts the fertility industry as completely lacking in ethics and raises the prospect of autonomous (male) reproduction is Robin Cook's *Shock* (2002). Discussed in detail in chapter four, this novel recounts the horrific experiences of two Harvard doctoral students who sell their eggs to a fertility clinic outside of Boston in order to finance a year in Italy writing up their dissertations.

Leaving aside the science fictive for the time being, representative of the second group of early work on ART is Shulamith Firestone's *The Dialectic of Sex* (1971). Unlike Rorvik and Cook, Firestone evinces no anxiety about ART. What is more, unlike virtually every other feminist and cultural studies critic of assisted conception since, she wholeheartedly looks forward to its advent.[20] Firestone maintains that, in conjunction with a socio-cultural revolution, new reproductive technologies will free women. She writes:

> As long as natural reproduction is still necessary, we can devise less destructive cultural inducements. But it is likely that, once the ego investments in parenthood are removed, artificial reproduction will be developed and widely accepted (Firestone 1971: 214).

After the revolution destroys the oppressive socio-cultural imperative to reproduce within the confines of the nuclear family, reproductive technologies will be developed which will assume the work, currently done by women, of nurturing foetuses and delivering infants. A desirable alternative to pregnancy and childbirth, ART had, according to Firestone, the capacity to free women from the inherently unfair demands of biology. Hence, it would play an integral role in the new era of gender equality that was to be ushered in post-revolution. If for no other reason, Firestone's work is remarkable for this complete acceptance of ART. As demonstrated by three key anthologies on assisted conceptive technologies, two of which were produced in the middle of the 1980s and one of which was published at the end of the decade, this optimism largely disappears from feminist activist and academic work on ART after Firestone.

By the early 1980s, as the availability of IVF and other high-tech ART was increasing, many feminists in Britain, Australia and the United States who, like Firestone, were also activists, had become hostile to the notion of any liberatory potential existing within assisted conceptive technologies and the overall tendency in their work ran toward condemnation.[21] Mainly referring to gestational surrogacy and sets of technologies such as amniocentesis, IVF, ultrasound, pre-implantation genetic diagnosis (PGD) and cloning – not egg donation which, despite its increasing viability, was either characterized as a set of technologies to be employed in the far future or ignored altogether – ART was viewed as thoroughly dangerous and completely undesirable for two primary reasons. First, it was understood to diminish women's say in and control over their own corporeal processes. With ART, it was technology and its usually male owners and operators – and

not women – that was seen to control all aspects of reproduction. Second, in addition to being misogynistic, ART was understood to be emphatically racist and classist. Seen as forwarding the already eugenic predisposition of patriarchal society, ART was charged with having been developed in order to produce the kinds of offspring desired by the wealthy white men who allegedly were most invested in it: 'perfect' blond-haired, blue-eyed males. As a corollary, PGD and amniocentesis were charged with having been developed in order to prevent the conception and birth, respectively, of embryos and infants deemed substandard by racist and classist patriarchy. Foregrounding the issue of reproductive autonomy in my overview of this first generation of feminist critiques of ART, I now turn to the first of three feminist efforts from the 1980s to address assisted conceptive technologies.

Perhaps the most well-known of the early feminist texts addressing ART is the anthology entitled *Test-tube Women: What Future for Motherhood* (1984), edited by the activists and researchers Rita Arditti, Renate Duelli Klein and Shelley Minden. A foundational text in feminist critiques of ART, *Test-tube Women* framed the terms of many subsequent debates over assisted conceptive technologies. It includes a wide variety of women's voices, such as those of professors, lawyers, housewives, and high school students. These come together to argue persuasively that ART threatens women's freedom and self-determination because it necessarily takes the control of women's bodies away from the women who inhabit them and puts it instead into the hands of mainly male medical professionals.

These same sentiments, albeit strengthened, are echoed in *Man-Made Women: How New Reproductive Technologies Affect Women* (1985), which was published one year after *Test-tube Women* and contains essays by many of the contributors to it. This anthology collects the proceedings of the panel 'The Death of the Female' presented at the Second International Interdisciplinary Congress on Women in Groningen, Holland (Raymond 1985: 9). Covering different technologies and practices such as amniocentesis, prenatal sex choice and surrogacy, the anthology's seven papers express deep concern over the theft of '. . . not only the control of reproduction, but reproduction itself, from women' (ibid.: 12). As a direct result of this, they raise the question of the possible future obliteration of the female from the human species (ibid.). Hence, where *Test-tube Women* charted ART's negative impact on women's autonomy in reproduction, *Man-Made Women* goes one step further. In a more ominous rehearsal of Rorvik's fantasy of uniquely male reproduction, it raises, as a supposedly logical outgrowth of the application of patriarchal technologies in a patriarchal society, the spectre of the end of the female altogether. In presenting this possibility, the text as a whole strongly urges its readers to organize and act against this nightmare future.

Edited by the lawyer Jocelynne A. Scutt, the anthology *The Baby Machine: Reproductive Technology and the Commercialisation of Motherhood* (1990) concentrates in the main on ART in Australia but it is nonetheless relevant to this study.[22] It opens with Scutt's critique of Firestone in which she writes that the latter incorrectly assumed that '. . . technology is not patriarchal – or at least that women will control (or be in equal control of) biological technology' (1990: 2).[23] Focused on the processes of commercialization,

Scutt's anthology seeks to demonstrate how male control of not only reproductive technology but the commercial means of its dissemination throughout society robs women of autonomy. This is accomplished, among others places, in an essay outlining the development of the fertility clinic IVF-Australia, 'the first Australian commercial venture into marketing reproductive technology' (Koval 1990: 108). Tracking the efforts of researchers and practitioners at Monash University to open a chain of fertility of clinics in 'Japan, Singapore and the USA' the journalist Ramona Koval plots the greed and secrecy that accompanied efforts to cash in on ART and she charges that these processes reinscribe longstanding eugenic discourses and practices (ibid.: 111). Necessarily more narrowly focussed than *Test-tube Women* and somewhat less deterministic than *Man-Made Women*, *The Baby Machine* is no less condemnatory of ART than are its two forebears.

By the mid to late 1980s another strand of feminist critique of ART was coming into existence. Centred in Britain, and continuing into the present day, this set of work responded to issues raised in earlier texts and addressed the increasing number of different kinds of new reproductive technologies as well as the wider availability of them. Initially, it was not uncommon for contributors to this 'second wave' to belong to activist groups such as Feminist International Network on the New Reproductive Technologies (FINNRET) and Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINNRAGE).[24] However, when compared to the three anthologies discussed above, this work is much more closely aligned with the academy and written in the language of it. Looking, among other intellectual formations, to anthropology,

sociology and cultural studies and re-engaging with academic debates on human reproduction that were a consequence of feminism's move into the academy in the 1970s and 1980s, this later body of work complicates and re-frames discussion of ART.[25] Itself divisible into two parts, one of the first issues tackled, arguably in reaction to positions formulated in texts such as *Test-tube Women* and *Man-Made Women*, was that of women's autonomy in relation to ART. A second, and for all intents and purposes, more recently developed subset of this work, represented by, among others and as discussed in the Introduction, Hartouni, revisits questions of race and class in relation to assisted conceptive technologies.[26]

Two representative anthologies from this period are *Reproductive Technologies: Gender, Motherhood, and Medicine* (1987), edited by the critic Michelle Stanworth and *The New Reproductive Technologies* (1990), edited by the sociological researchers and critics Maureen McNeil, Ian Varcoe, and Steven Yearly. Although, as I discuss below, the two texts are quite different from one another, on one level they may be seen to share a commonality of purpose. Striving neither to introduce readers to ART nor to convince them of its dangers, each of the texts is committed instead to contextualizing assisted conceptive technologies and exploring the complexities surrounding their mobilization.

According to Stanworth, the aim of *Reproductive Technologies* 'is to offer a fresh appraisal of reproductive technologies – to evaluate their impact, to understand the often-ferocious debates that have arisen around them and to assist in formulating strategies for dealing with them' (1987: 3). Opening by stating that ART offers some women and men,

who might not otherwise have this opportunity, the chance to become parents, Stanworth provides an early and, as already noted, relatively rare feminist acknowledgement of one potential benefit of ART. Shortly after this, she raises the issue of the correct response to this set of technologies. Breaking rank both with guides to infertility 'treatment' aimed at the general public and to feminist critiques of the type discussed above, Stanworth argues that neither uncritical acceptance nor outright condemnation – whether based on anxieties about human interference into reproductive processes or on charges of misogyny – are correct responses to ART. Refusing at all points to be prescriptive, through the medium of the collected texts she offers a window on to ARTs' complexities in the expectation that women themselves will develop strategies when and as needed to deal with assisted conceptive technologies.

To my mind the best example of the kind of essay found in Stanworth's text is Petchesky's 'Foetal Images: the Power of Visual Culture in the Politics of Reproduction' which was discussed in the Introduction to this thesis. At that juncture my focus was on the formidable intervention made by Petchesky into the analysis of images of foetuses but it goes without saying that this does not preclude an alternative reading of the essay in which Petchesky's multi-layered response to ultrasound imaging may be foregrounded. Having noted this technology's military genealogy (and having refrained from exoticizing it),[27] as well as the controversies in the mid-1980s surrounding its possible overuse, and the often passive role it may force women to play in their own pregnancies, Petchesky writes:

> . . . we need to separate the power relations within which reproductive technologies, including ultrasound imaging, are applied from the technologies themselves. If women were truly empowered in the clinic setting, as practitioners and patients, would we discard the technologies? Or would we use them differently, integrating them into a more holistic clinical dialogue between women's felt knowledge and the technical information 'discovered' in the test-tube or on the screen? Before attacking reproductive technology, we need to demand that all women have access to the knowledge and resources to judge its uses and to use it wisely, in keeping with their own particular needs (1987: 79).

Whether it is a question of ultrasound, amniocentesis or any other ART, Petchesky advocates the development of a range of flexible, historically nuanced responses that acknowledge the variations among women. As a result, her conclusion is in keeping with the positions articulated in the other essays on, for instance, surrogacy, IVF and the politics of ART in general in Stanworth's text.

According to its three editors, the aim of *The New Reproductive Technologies* is to 'clarif[y] and analys[e] the social processes surrounding *in vitro* fertilization and other techniques' (McNeil et al. 1990: x–xi). Heavily reliant on the ethnographic and insistent on the importance of self-reflexive practice, the text derives from the 'British Sociological Association annual conference on science, technology, and society, held at Leeds in 1987' (ibid.: ix). For the three editors, 'The new reproductive technologies emerged as a rich case study – exemplar even – of what the sociology of science and technology is, properly conceived, and what it might achieve' (ibid.). Taken as a whole, the eight essays in the volume provide a critical history of ART. Early chapters chart its development, middle chapters track its institutionalization, and the final chapters, such as

Edward Yoxen's essay, 'Conflicting Concerns: The Political Context of Recent Embryo Research Policy in Britain', consider the extra-institutional implications of ART.

For my purposes here, by far the most significant text in McNeil et al. is Franklin's essay 'Deconstructing "Desperateness"'. Rejecting the notion of an impartial, disinterested, or neutral science, Franklin highlights the ways in which clinical and media narratives of and discourse on IVF come together. Using the example of 'media stories about the miraculous achievements of doctors', Franklin argues that this 'limit[s] the kinds of questions that can be asked about infertility and its treatment through a . . . fascination for details: why the embryo did not implant, what the woman wore at the insemination, how the doctor could not find the egg, and so forth' (1990: 224). She continues:

> It is as if, given the biological urge to propagate and the capability of modern science to improve the process, no more need be said. The marriage of natural urges and scientific progress has been pre-eminently portrayed by the media as a beneficent union (ibid.).

The careful elaboration of this construction of fertility 'treatment' as a 'gift' for women, achieved in part through Franklin's reliance on Foucauldian discourse theory, results in an analysis of IVF that avoids consigning the women who pursue it to either of two overly simplistic camps.[28] It neither renders IVF clients as the dupes of a system that they ought to have managed to avoid nor does it hold them up as reproductive pioneers embarking on a heroic journey that will contribute to women's freedom everywhere. Instead, as Franklin closely reads selected constructions of infertility circulating in the

popular domain she demonstrates how these and the women they concern are imbricated in and responsive to a complex and always evolving socio-cultural network.

The centrality of Franklin's work to this project cannot be overestimated. It is after all a quote from 'Deconstructing "Desperateness"' that opens the Introduction to this dissertation. But, as noted there, Franklin's scholarship, knowledge of which has become *de rigueur* for any feminist and/or cultural studies engagement with ART, is fundamental for more than its performance of a conceptual blindness to the constitutive role played by visuality in the contemporary Anglo-American fertility industry. Beyond this and beyond 'Deconstructing "Desperateness"' and at the most basic level, Franklin's work is vital to this endeavour because of its strong ethnographic component. Although at present – and no doubt a result of Franklin's intervention – the ethnographic represents a critical ingredient in the majority of other analyses of ART, at the time between the publication of 'Deconstructing "Desperateness"' in 1990 and her monograph *Embodied Progress* in 1997, ethnographically driven analyses of ART were the exception and most definitely not the rule. Therefore, moving away from McNeil et al.'s text, I now want to consider *Embodied Progress* in more detail. In addition to permitting me to elaborate an important critical antecedent, this part of the discussion will also serve as a frame for the presentation of related research and, in its turn, this latter will enable me to locate further the specificity of my own study.

In *Embodied Progress* Franklin interviews a group of IVF clients in England in the late 1980s. Drawing on her own ethnographic work and that of the anthropologist Marilyn

Strathern (1992a, 1992b) she demonstrates how this ART takes up and impacts on contemporary understandings of kinship. Franklin shows that, in the light of a dominant discourse on kinship which privileges genetic relatedness, many women enter IVF programmes as a result of the feeling that they must do everything in their power in order to try to become pregnant with and give birth to their 'own', genetically related child. As Franklin shows, this may mean that a woman mortgages her home to pay for (another) round of IVF or continues to undergo round after round of this set of expensive, painful and time-consuming biomedical interventions, even when all indications are that she will either not become pregnant or not be able to sustain a pregnancy. In a continuation of 'Deconstructing "Desperateness"', the effect of *Embodied Progress* is to show how the socio-cultural logic enveloping ART is woven into women's lives and how a set of biomedical technologies that is all too often characterized as a 'gift' for women quickly becomes a burden to many of them and raises as many if not more problems than it was originally supposed to solve.

As noted above, Franklin's influence on feminist and cultural studies critiques of assisted conceptive technologies has been phenomenal. In response to her work, there has emerged a range of scholarship which not only has sought to expand and complicate her findings but which, above all, has attempted to reinscribe and extend in various ways the complexity of position she accords her subjects. The critic Charis Cussins' work on the United States and the postgraduate researcher Monica Konrad's dissertation on egg donation in Britain provide two examples of ethnographically driven work that, indebted to Franklin's, expand feminist and cultural studies critiques of ART.

Cussins has produced two essays that, each for a different reason, is important to my own work. In the first of these, 'Producing Reproduction: Techniques of Normalization and Naturalization in Infertility Clinics', she argues that 'the diagnostic and treatment options and knowledge about human reproduction are mutually dependent' (1998a: 66). Focused primarily on IVF, this essay is of most value to my own study for Cussins' discussion of method. I therefore address it in further detail in the next section and I now wish to turn to the second of her essays to be considered here.

In 'Quit Sniveling, Cryo-Baby. We'll Work Out Which One's Your Mama!', Cussins addresses not one but two ART: gestational surrogacy and egg donation. Following Franklin and Strathern before her, this leads her to reject the notion of 'a fixed or unique natural base for the relevant categories of kinship' (Cussins 1998b: 40). Put differently, although biology may be one way of figuring relatedness, it is not the only way. Through the tropes of 'transparency' and 'opacity', Cussins tracks the ways in which biology is selectively activated (and inactivated) by clients of the two above-mentioned ART in their accounts of kinship.

What for my purposes here is significant about Cussins' work in 'Quit Sniveling' (as well as in 'Producing Reproduction') is less the conclusions she reaches about kinship and more her basic acceptance of ART as sets of practices and procedures that are fully integrated into our society and as such engender new practices at the same time as they draw on pre-existing practices (ibid.: 41). Traceable back to Stanworth, Franklin and McNeil et al., this acceptance has re-oriented feminist work on ART. No longer is it a

question of whether ART should be permitted to exist. Rather, the questions asked in Cussins' work are about the ways in which these are already imbricated in society and the implications of this on such practices as, for example, narratives of relatedness.

Konrad's doctoral dissertation, 'Anonymous Exchange Relations: Assisted Conception Between Ova Donors and Recipients in the United Kingdom' (1996) is one of the few studies primarily concerned with egg donation. Echoing Cussins' acceptance of ART and based upon fieldwork undertaken at several British fertility clinics and interviews with both egg donors and egg recipients, Konrad argues that the enforced anonymity of both donors and recipients that characterizes the egg donation programmes with which she worked actually constitutes social relations. That is to say, it cannot be assumed that, because the donors possessed no identifying information about recipients and vice versa, anonymous egg donation falls outside dominant anthropological formulations of the gift, in which the giving of a gift is understood to engender sociality and to compel a return.[29] Whether it is 'extra' embryos (embryos produced by the fertilization of a donor's eggs by a recipient's husband's sperm but not put into the body of the recipient) or whether, following Richard Titmuss' (1972) work on blood donation, it is blood donated at a local blood bank, Konrad shows that recipients donate. She also shows that donors receive. In other words, their donations derive from a sense of having received something – past good fortune, a genetic heritage – that they want to pass on in order to help other women to have what they want.

It is precisely the issue of this line between the transfer of human eggs as a gift and the transfer of them as commodity that is taken up in the work of the cultural studies theorist John Frow. He writes:

> Every society withdraws certain domains from market relations. The domain of religion, of personal life (including personal identity, bodily integrity, sexuality, and kinship ties), the political sphere, the sphere of public services, that of art and of some kinds of writing may conform, or may be presumed to conform, to a different logic from that of strict profit maximization. Exchanges in these spheres are not governed by the market: while things and services may be alienable in the sense of being transferable from one person or group to another, they are nevertheless . . . market-inalienable (1997: 131).

Using, among others, the work on commodities of the theorists Arjun Appadurai (1986) and Igor Kopytoff (1986), Frow interrogates the ways in which the determination of market alienability and market inalienability 'is drawn in contemporary capitalist societies in relation to the categories of the *person* and of *information* . . . '(ibid. 131–2; emphasis in original). As a result of both its precision and its concluding concern with the re-inscription of existing social inequalities, this analysis informs my own endeavour to plot the new paths travelled by increasingly alienable human ova as this invisible reproductive substance passes from one woman to another via progressively more complex networks of capital. In the next section I present some of the research practices that underpin these efforts.

III. Method

In the concluding section of this chapter, I wish to address some of the multiple research methods upon which I relied in order to gather the visual artefacts and data that drive this dissertation. Completing the task begun in the Introduction in which, following the distinction made by Gray, I considered this study's epistemological bases, below I outline the resultant, mundane activities undertaken over the course of the past five years. In addition to providing the reader with vital information about the structures, assumptions, and practices shaping this study, this discussion – which I continue throughout the remainder of the dissertation – enables me to clarify further my own evolving and subjective positioning in relation to both my informants and the larger discursive construct of the contemporary Anglo-American fertility industry. What is more, given the emphasis on analysis in subsequent chapters, this consideration, which addresses, among other topics, the issue of gaining access to informants in the highly sensitive world of ART, presents a unique opportunity for a more informal treatment of research ethics.

Within the subset of recent, ethnographically-driven feminist and cultural studies critiques of ART, it has become standard practice for researchers to participate in the daily life of the fertility clinic for extended periods of time. It is as a direct result of affiliations forged in the course of their residencies with personnel at these institutions that many researchers have been able to conduct in-depth interviews with women undergoing IVF and other fertility 'treatments'. Three notable examples of such practice include Franklin's and Konrad's associations with British fertility clinics and Cussins' work at clinics in the United States.[30] While these researchers' aims in conducting

fieldwork and their experiences in the field necessarily differ from my own, given that Franklin's, Konrad's, and Cussins' critiques of ART inflect this project to varying degrees, it is worth taking the time to outline briefly the nature of these critics' collaborations with the staff and patients at the fertility clinics at which they worked. In addition to providing important background for key cultural studies and feminist engagements with assisted conception, this discussion further elucidates the distinctiveness of my own contribution to the ongoing concern with human reproduction that characterizes feminism, visual cultural studies and cultural studies.

In *Embodied Progress* Franklin 'present[s] the results of research based in two British IVF clinics, one public and one private, during the years 1988 and 1989' (1997: 14). Forming the backbone of this ethnographic study, however, is a set of in-depth interviews with twenty-two self-selecting women whom Franklin was able to approach as a result of her residency in the private clinic. Recalling the long, exhausting night-time journeys in an unreliable car that she undertook in order to meet her informants at their homes and tape-record her conversations with them, Franklin enthuses about her informants' generosity in terms of both time and spirit. Exhausted as she may have been, she left each woman's home with more than simply another account of what it is like to undergo IVF. Through each of the almost two dozen, lengthy interviews she conducted, Franklin was able to develop a deep appreciation of the sacrifices that assisted conception demands of the women who elect to pursue it and the dilemmas they face in doing so.

For the fieldwork undertaken in support of her dissertation, Konrad was initially granted access to four British fertility clinics and writes that she was committed to working at them in the 'hope that a multi-clinic study would yield a breadth of informant contact in terms of diversity of patient views and experiences of clinical management' (1996: 82). However, as it became unfeasible for her both to travel throughout the country to conduct interviews with egg donors and recipients and to split her time amongst these four institutions, Konrad scaled back her original plan. Ultimately, she 'shadow[ed] medics at one very busy fertility clinic where [she] was permitted to sit in on consultations, operations and generally get a "feel" of the daily organization of the centre' (ibid.: 86–7). While the kind of enthusiasm that Franklin conveyed is absent from Konrad's summation of her fieldwork experience, the interviews she conducted as a result of her clinical affiliation are no less central to her work.

In direct contrast to Franklin and Konrad, Cussins' summarizes her fieldwork experience not by focusing on interviews conducted with patients and staff in the American clinics in which she worked but by foregrounding her 'socionaturalization' into the clinical environment (1998a: 69). This orientation away from the clients of ART and toward the seemingly unremarkable range of workaday habits and processes constituting the practice of fertility medicine represents an important shift in the ethnography of assisted conception. It enabled Cussins to focus on the mechanisms of exclusion in the daily life of the institution. Characterizing her project as 'politically deflationary', she writes:

> I looked for mechanisms of exclusion in such things as the making of appointments and the persistence of some treatment protocols rather than others. I

> didn't look at personal agendas or macro political factors except insofar as these were translated within the clinic into actions or representations that served to narrow the range of possible patients . . . [M]any of the mechanics of exclusion and objectification are wholly mundane, and are built into the fabric of the functioning clinic. The ethnographer can aim to show how external political effects get created out of, and sustained in, everyday local practices (ibid.: 68–9).

With her concern not to re-chart the complexities of individual experience but to track the creation and maintenance of 'political effects' (ibid.), Cussins' work anticipates my own. Like her, my interest rests less with individuals – be they patients or practitioners – and more with the ways in which specific, longstanding discourses, in this case those on so-called 'legitimate' motherhood, are played out at the level of the clinic. But, unlike Cussins, my interest does not end with this type of institution; it extends to encompass the third-party agency. As discussed above, although staff at these non-medical entities may not perform the set of pharmaceutical and surgical interventions known as egg donation, these firms are no less integral to the sale and practice of this ART in the United States, than are the medical centres where human gametes are actually handled and to which the majority of critical attention heretofore has been directed. As it turns out, it was the extension not of Cussins' methods but of Franklin's that enabled me to incorporate the third-party agency into the story I wanted to tell about the contemporary Anglo-American fertility industry.

Early in ***Embodied Progress***, Franklin writes that just as her '. . . account is not conventionally anthropological, so it is unconventionally ethnographic' (1997: 14).[31] Referring to the work of the anthropologist George E. Marcus, Franklin goes on to

characterize her study as a 'multi-sited ethnography' (ibid.).[32] According to Marcus, multi-sited ethnography 'arises in response to empirical changes in the world and therefore to transformed locations of cultural production' (1995: 97). He continues, 'Empirically following the thread of cultural process itself impels the move toward multi-sited ethnography' (ibid.). Having thus differentiated multi-sited ethnography from single-sited ethnography, Marcus goes on to define the former as follows:

> Multi-sited research is designed around chains, paths, threads, conjunctions, or juxtapositions of locations in which the ethnographer establishes some form of literal, physical presence, with an explicit, posited logic of association or connection among sites that in fact defines the argument of the ethnography (1995: 105).

Following Marcus, and as noted in the Introduction to this thesis, what follows is a multi-sited ethnography. Much like Franklin before me, I did not seek to immerse myself in a single community that was previously unknown to me.[33] Rather, initially fascinated by the fertility clinic, as a result of archival work I became equally intrigued by the connections I was making between this kind of institution and others such as internet pharmacies, drug companies, high-tech surgical and biomedical equipment manufacturers, banks, professional organizations, patient support groups, and, most of all, third-party agencies. Given my growing awareness of the multiple types of (often non-medical) institution central to the performance of fertility medicine, I was keen not to limit this project to the clinic. It therefore became very clear to me that a clinical residency of the type sought by, for example, Konrad was not appropriate to the aims of this study. Instead, I found that I would need to conduct in-depth interviews with

practitioners and staff at different types of institution. It was this mode of ethnographic work that would enable me not to provide an exhaustive archaeology of a single site but to foreground the often very tenuous distinctions between the non-medical and medical institutions that sell egg donation.

Before going on to give a more detailed account of my working methods, I wish to consider briefly the political implications of my work. On the political potential of multi-sited ethnography Marcus writes:

> The movement among sites (and levels of society) lends a character of activism to ... an investigation. This is not (necessarily) the traditional self-defined activist role claimed by the left-liberal scholar for his or her work. That is, it is not the activism claimed in relation to affiliation with a particular social movement outside academia or the domain of the research, nor is it the academic claim to an imagined vanguard role for a particular style of writing or scholarship with reference to a posited ongoing politics in a society or culture at a specific historic moment. Rather, it is a playing out in practice of the feminist slogan of the political as personal, but in this case it is the political as synonymous with the professional persona and, within the latter, what used to be discussed in a clinical way as the methodological (ibid.: 113).

I believe that it is in the above-mentioned wilful refusal fully to disentangle the fertility clinic and the third-party agency from one another that the political content of this project rests. By refusing to uphold the distinction between the medical institution (which in the United States is also a commercial venture) and the 'purely' commercial venture, it becomes possible to trace the ways in which reductive and exclusionary discourses about,

for instance, mothering and genetics, circulate widely, and permeate clinic discourse and practice to the same extent that they permeate agency discourse and practice. In other words, by connecting fertility clinics and third-party agencies this project follows a long line of feminist and cultural studies work on science and technology which aims to demonstrate, that far from inhabiting a world of their own, these highly interested discourses actively partake of the socio-cultural realm – the realm to which, after all, they owe their existence. As the anthropologist James Clifford writes, '. . . science is in, not above, historical and linguistic processes' (1986: 2).[34]

From this project's inception at George Mason University in Fairfax, Virginia in early 1998 I began collecting material from American fertility clinics and third-party agencies. This included gathering brochures, advertisements and stories about institutions from the popular media as well as tracking clinics' websites and attending open evenings. Further discussed in chapter two, these latter are seminars in which doctors explain the various ART sold by their clinics to interested members of the general public. Upon moving to Napier University in Edinburgh in late 1998 I continued this work and collected as much information as I could on clinics in Britain. Similarly, I repeated the process and set out to find out as much as possible about Irish clinics when I moved to the Dublin Institute of Technology in July 2001.

My contact with clinic and agency practitioners and staff came towards the middle of the study and was heavily influenced and backed up by the archival work I did early in project. Due to the fact that the world of fertility medicine tends to be closed-off and

especially suspicious of researchers coming from without medicine, I anticipated that gaining access to practitioners and staff would be much more difficult than in fact it was. Discussed mainly in subsequent chapters as I introduce material from my informants, interviews with practitioners and staff at clinics and agencies were easier both to arrange and to conduct than I had ever thought they might be.

As a result of the two international moves made during the course of this project, I was very fortunate in that I was able to make two funded fieldwork visits to the United States. In the first visit, which took place in Autumn 1999, I stayed on the east coast. There I conducted exhaustive literature searches, familiarized myself with the medical regulatory environment, sought financial information on clinics and agencies and, by exploiting a family connection, I interviewed Dr John Schnorr, then of the Jones Institute.

Dr Schnorr was a vital asset to the project. He provided information on all aspects of the egg donation process, discussed his preference for anonymous donation and outlined the Jones Institute's egg sharing programme. In addition to this he provided me with a copy of his firm's donor application packet and recipient application packet, both of which are discussed in detail in chapter five. Finally, Dr Schnorr was an early but very important resource because the Jones Institute, as I also discuss in chapter five, had made an arrangement with a local bank whereby patients could apply for loans in order to pay for fertility 'treatment'. Although it has become quite common for clinics to make such arrangements, at the time I spoke with Dr Schnorr this was a phenomenon that was

entirely new to me. It is, therefore, no exaggeration to say that it is as a result of this conversation that I became interested in this 'thread' belonging to the larger industry.

The second fieldwork trip to the United States took place nearly two years later in October 2001. Much more intense than the first trip, the purpose of this visit, which involved a significant amount of travel, was to conduct as many interviews as possible. From Dublin I had contacted more than fifty fertility clinics and third-party agencies asking for interviews. I received thirty-one positive responses before I left Dublin and in total I conducted 18 interviews. While this is a small sample, I do believe that, in conjunction with the material artefacts presented, it provides a fair representation of clinic and agency staffs' and practitioners' formulations of egg donation and its imbrication in discourses on race and class.

Arriving in Washington, DC I immediately began conducting as many telephone interviews as possible, catching up on archival work, finding out as much as I could about my informants, and attempting to schedule a trip to the west coast. Although nearly as fatiguing as the face-to-face interviews, I found the telephone interviews exhilarating and I was often completely bowled over by my informants' generosity. This ranged from agreeing to take time out of a busy schedule to speak to me over a lunch hour – which was extended to an hour and a half and then to a second hour – to an insistence on paying for the telephone call so that I, a student, would not be financially burdened. Rather than introduce a cast of characters here, I have chosen, as previously noted, to discuss

selectively aspects of my relationship with my informants as their (fictional) names arise in the course of the subsequent chapters.

In the following chapters, I also selectively narrate parts of my west coast journey. Absolutely exhausting, this began with a 4:30 a.m. arrival to a packed but oddly quiet Dulles airport where, shortly after 11 September, there were scores of armed army officers, check-in was inexorably slow, and bag searches were thorough to say the least. Arriving in California later that morning I checked into a motel, attempted to make sense of the city and headed off to interview Anne Ames, only to get horrendously and embarrassingly lost. Finally succeeding in meeting her a full hour after I was to have arrived at Starbucks, I spent the rest of the week, true to the cliché, driving on the freeway from one interview to the next. At night, terrified that my tape-recordings would be erased in airport security machines, I stayed up transcribing tape after tape.

Before leaving for Los Angeles, I had also intended to spend evenings preparing for the next day's interview. Although I succeeded in doing some of this, most of which involved going through newspaper archives in local libraries, the bulk of this preparation was unnecessary. My informants did not expect me to have a sense of their business but, rather, seemed thoroughly to enjoy explaining to me the ins and outs of what they did. Although I had written out many questions for the first interviews, I soon came to find that my informants, the majority of whom were quite experienced in dealing with the media and speaking publicly, did most of the talking. Although my initial sense was that I

was being steered away from what I wanted to know, I gradually came to appreciate these detours and I now look at them as among the richest materials that I gathered.

IV. Conclusion

Beginning by tracking one American fertility clinic's discourse about matching egg donors to egg recipients, in chapter two I discuss the way in which egg donation represents an instantiation of the construction and subsequent commodification of 'biological' motherhood. Posited as 'true' or 'real' or 'full', naturalized as differentially accessible according to technological advancement, and dehistoricized when cast as formerly the only type of motherhood on offer, 'biological' motherhood is, of course, none of these things. It is a specific construction of motherhood. Furthermore, it is this construction of motherhood, rather than the possession of a set of pre-existing and technologically sophisticated knowledge, equipment and skills, that enables the development and then the performance of the set of biomedical interventions known as egg donation. From a close reading of one clinic's discourse on matching, it quickly becomes apparent that egg donation does not represent a biomedical breakthrough which finally enables the application of appropriately corrective technology to malfunctioning female bodies. Rather, it appears that egg donation exists because of a renewed insistence on a specific definition of mother. It is this that drives the development of the knowledge, equipment and skills that enable a select set of women to claim this role.

However beneficial the advent of egg donation may be on an individual level to members of this select set, its very existence provokes no small amount of anxiety. This ART not only enables reproduction but, in order to do so and as a routine part of its practice, it draws upon the knowledge, equipment and skills used in cloning, abortion, embryo experimentation and other controversial practices. As it abuts on forceful public debates

about, among other things, women, reproduction, and the role and power of science and technology, the use of egg donation, like other ART before it, needs to be legitimated.[35] This effort to win legitimation occurs in the same scopic regime that constructs 'biological' motherhood. Therefore, an insistence on the historical embeddedness and specificity of the visual texts produced by and for the contemporary Anglo-American fertility industry reveals that the industry's construction of 'biological' motherhood and the legitimation of egg donation as a means of achieving it is accomplished though a visual economy of race and class. While appearing to circumvent 'biologically-based' barriers to 'motherhood', egg donation actually works on and reinforces social and cultural assumptions of who should and who should not mother. Opening with an analysis of the scopic regime that constructs 'biological' motherhood and a discussion of the strange biological logic of egg donation, chapter two continues my attempt to think through the socio-cultural implications of what are very expensive, inherently reductive and exclusionary formulations of motherhood and fertility.

Notes

1 Hormone therapy for donors lasts, at minimum, from between two to four weeks and involves some pain, inconvenience, regular blood tests and ultrasounds. Broadly sketched, the donor begins by self-injecting an ovulation suppressant each morning and then switches to an ovulation stimulant which should cause her ovaries to produce a large number of eggs. When these latter are determined via ultrasound to be of adequate size, the donor receives a third injection which prepares the eggs for retrieval. My informant Anne Ames, who donated twice and now works for the firm for which she donated, explains the preparation for the donation and the retrieval itself as follows:

> They begin with an ultrasound in order to take a look at where you are in your cycle and then they're able to gauge better when they're going to be able to do the retrieval. The next thing is to just to wait for your period to start and then usually they start you on birth control pills to get your cycle in sync with the recipient mother's. You'll take those for about the equivalent of a cycle and at the end of that time they do another blood test and check your hormone level and then they start you on a hormone called Lupron which lowers your oestrogen level. With it you get menopausal symptoms - hot flashes, mood swings. You give yourself one injection of Lupron a day and at about the eight day mark, there's another blood test to check your hormone level. If it's at where they want it to be, they will start you at that point on the maturing hormones. The one that we use most of the time is called Pergonal. At this time, you're going to continue taking the Lupron but you'll lower your dosage. Usually with Pergonal the only side effect is bloating. But, you're going to end up going to the doctor probably three, four, maybe five more times. Again, it does vary. If it's your first time, they're probably going to need to keep a closer eye on how your body reacts to the hormones. So you'll probably go in anywhere between every two to four days. My first cycle, I went in probably every two days. So you go in for a very quick blood test and ultrasound and it just takes 15 or 20 minutes. At this point they're going to start measuring your eggs and when they're big enough, you'll get the retrieval within the next three to four days. So at that time, you'll take one final injection and this basically brings you to that state almost of ovulation where your eggs are easier to retrieve. You give yourself that injection exactly 36 hours before the retrieval. Like if they say take it at 1:30 in the morning, then you take it at 1:30 in the morning. Then you can't eat – I believe it's 12 hours – prior because you're going

to have the anaesthesia and they usually do a twilight sleep or an amnesiac sleep. I've done both. With the first, you're literally just out for the time it takes to do the donation. With the amnesiac, you're actually awake but you remember nothing. Either way it's not painful. When you wake up, you will notice cramping – like menstrual cramps. We usually will prescribe Darvocet afterwards just in case and you can go home the same day. We suggest you rest 24 hours and then for about the next 24 to 72 hours you are going to feel cramping. It's pretty much inevitable.

There are two risks of egg donation. The number one risk would be infection. The retrieval's done by aspirating the eggs vaginally with a long thin needle attached to a vaginal ultrasound and it goes through the side of the vaginal wall into the ovaries where it pulls the mature eggs out into a test-tube. It only takes seven and a half minutes on each ovary so it's very, very fast. The only other thing that can happen, which is more common, is something called hyperstimulation. With it, your ovaries swell up to the size of an orange or a small grapefruit. It's very, very tender and this isn't going to affect your own fertility like an infection would but it's going to be incredibly uncomfortable and in some cases it can be painful.

2 The recipient also begins by taking Lupron so that her menstrual cycle can be synchronized with the donor's. This is followed by a course of pills designed to prepare the lining of her uterus so that fertilized eggs may implant. The day before the donor is scheduled for the retrieval, the recipient's uterus is prepared, via a hormonal injection, for the possibility of embryo implantation. After the extraction, the fertilization of the eggs from the donor, and a short period during which embryo development is gauged, a number of embryos are transferred to the recipient's uterus via vaginal catheter.

3 There is no consensus as to what constitutes a 'healthy' child. This depends entirely upon the recipient's definition of health. For example, for some a child with Down's syndrome will considered to be healthy while for others Down's syndrome may constitute a 'genetic' defect. See Katz-Rothman (1988) for an informative discussion of the impact of testing on pregnancy. For a critique of amniocentesis, see Rapp (1997). See Oakley (1984) for a critique of the impact of biomedical technologies on pregnancy.

4 See Franklin (1997) and Cussins (1998a) for further discussion of the difficulties a woman who has not succeeded in becoming pregnant or giving birth to live infant may encounter in attempting to halt the pursuit of pregnancy via ART.

5 See Lock (1993) for a discussion of the medicalization of the menopause. See Moscucci (1990) for an excellent history of the development and institutionalization of gynaecology in Britain.

6 See Van Dyck (1995: 175–204) for a discussion of the 'granny mum' as a discursive strategy designed to delegitimize egg donation.

7 Statistics reported by fertility clinics in both Britain and the United States are notoriously unreliable and difficult to evaluate. For instance, in literature provided to prospective patients clinics may report 'success' as the achievement of a pregnancy rather than a live birth. This means that even though the pregnancy may end in miscarriage, it can be reported as a success, thus giving an inaccurate picture of the efficacy of ART. The CDC report is designed to counterbalance this by providing data on live births. Increasingly, clinics also directly provide their prospective clients with statistics on live births achieved.

8 A decline in fertility in women over 36 years of age is well-established. See Klein et al. (1996) for a discussion of maternal age and maternal morbidity. See CDC (2002) for a discussion of egg production in older women and an explanation of the relationship between maternal age and embryo implantation.

9 The use of the term 'treatment' in conjunction with fertility medicine is somewhat misleading. ART such as egg donation and IVF do not treat infertility in the sense that they restore damaged organs and/or processes to a state of 'proper' functioning. Rather, these sets of procedures circumvent damaged and/or non-existent organs and/or biological processes.

10 For an informative discussion of regional disparities in access to ART in Britain, see Lesley White, 'The Baby Lottery', *Sunday Times* (29 October 2002). For statements of concern over the highly uneven availability of ART in Ireland, see transcripts from the Committee on Human Reproduction public meeting. Ryan-Sheridan (1994: 3–5; 35–37) offers a more critical view of the Irish context.

11 From July 2001 to August 2003, I have very informally tracked reports in the Irish media on ART in general and egg donation in particular. Stories on ART are few and far between and I encountered none on egg donation. A representative sample of articles on

various other ART includes a feature on Tony Barlow and Barrie Drewitt, two British gay men who engaged a surrogate mother in the United States to carry twins for them (Philpott 2001: 10), an exploration of ethics mainly in relation to IVF (O'Doherty 2001: 8), a feature asserting that Irish Catholic women contemplating or undergoing IVF were upset by a recent statement by the Catholic Church that IVF was wrong (Holmquist 2003: 4), and, on the occasion of the 25th anniversary of Louise Joy Brown, 'the world's first test-tube baby,' a woman's narrative of the devastating impact multiple, failed attempts at IVF had on her life (Devlin: 2003).

12 At the public meeting held by CAHR at Dublin Castle on 6 February 2003, continual reference was made to the HFEA by both speakers and audience members. What is more, Dame Mary Warnock gave the keynote address and Susie Leather, Chairperson of the HFEA, also addressed the audience.

13 See Doyal (1987) for a still highly relevant critique of the overall absence of NHS policy on infertility and its inability to adequately provide services for women (and men) with infertility.

14 For more information on the CDC, see www.cdc.gov. For more information on SART see www.sart.org. For more information on ASRM, see www.asrm.org. For more information on RESOLVE, see www.resolve.org and Aronson (1999).

15 Originally the limit was three embryos. This was changed by the HFEA in 2001 to two embryos in response to the increasing number of triplet pregnancies in Britain.

16 See Meek (2001a and 2001b) for reports of a British practitioner's ultimately unsuccessful bid to have the rule limiting the number of embryos to be (re)implanted to two overturned.

17 There is one exception to this in which a non-commercialized egg donor can be anonymous. This is called egg sharing. At the time (2000) that I spoke to Dr Schnorr, this was practised at the Jones Institute. In such an arrangement, also known as a shared cycle, a woman undergoing IVF receives a discount if she donates some of her eggs to a woman who is undergoing egg donation. Although it appears to be increasing, this is not accepted practice across the industry. Some practitioners, such as Dr Jackson, are not entirely comfortable with it. He explained to me:

> In this country I'm seeing a little bit more about shared cycles. That means an infertility patient comes in and needs IVF and they're going to split her eggs with somebody else. There are a couple of things to know about this. First of all,

> infertility patients usually are not the best donors. This is because they're older and they've got their own problems. Second, I think there may be a financial issue which is to say if the organization offering shared cycles is double billing, billing on both sides, they're profiting to a great degree. Third, and this really bothers me and I was actually asked to write an article on this but I never got a chance to finish it, if an infertility patient comes in and can't do IVF, a facility here in Florida tells them that if the woman agrees to donate for another couple, she will get a free cycle. I think that is over-enticement because that could be, you know, eight to eleven thousand dollars. ASRM has come out and said, 'Hey, listen, you shouldn't over-entice. It's not ethically appropriate.' So I have problems with that over-enticement. We've done shared cycles. But what we've done is say, 'Okay, an egg donation cycle costs $14,000. If a donor is going to be donating to two couples, since we're going to be sharing this, we're going to split the costs right down the middle.' It's not like I'm charging $14,000 to both couples and splitting a donor down the middle. But, I think there are places that are doing that, that are splitting the donor and billing both couples. So I think ethically, that's rather challenging.

18 See chapter five for a discussion, which relies in part on Franklin's work (1990), of the ways in which fertility clinic and third-party agency staff often reinscribe hetero-normativity in their prospective egg donor and prospective egg recipient application forms.

19 As an example of the centrality of this date, Franklin begins chapter one of her doctoral dissertation on women's experiences of IVF as follows:

> Since this thesis is concerned with the changing cultural construction of reproduction, it is appropriate to begin with the event popularly associated with the origin of debate about new reproductive technologies: the birth of Louise Brown in 1978 (1992: 1).

20 This is not to claim that post-Firestone all feminists and cultural studies critics have indulged in a Manichean view of ART as thoroughly evil. By and large, since the late 1980s and/or early 1990s theorists have been quick to point out the progressive potential, however unrealized it may be, that inheres in ART. See Hartouni (1997: 3) and Cartwright (1995a) for examples of this.

21 I exclude Ireland from this list because, as Ryan-Sheridan (1994) argues, ART arrived in Ireland with very little public debate.

22 See Albury (1984, 1999) for further discussion of reproductive politics and practices specific to the Australian context.

23 Although not fully addressed here, feminist and cultural studies critiques of technology represent an important and influential subset of work. For an analysis of technology and gender relations, see Wajcman (1991). For an outstanding critique of feminist responses to technology, see Stabile (1994). For discussions of science and technology in relation to the gendered body and the progressive potential of this, see Haraway (1990, 1991a, 1991b), Braidotti (1994, 1997) and Lykke and Braidotti (1996). For a critique of technology's production of the gendered body, see Balsamo (1996). For cultural studies critiques of technology, see Ross (1991), Penley and Ross (1991), Treichler, Cartwright, and Penley (1998), and Robins and Webster (1999). For a feminist critique of new technologies, see Warwick (1999).

24 According to Janice Raymond, FINNRET developed out of the panel 'The Death of the Female' at the Second International Interdisciplinary Congress on Women in Groningen, Holland in April 1984. Of the group, she writes:

> Its aims are: to monitor developments in the areas of reproductive engineering; to assess the implications of the new reproductive technologies, such as surrogate motherhood and artificial insemination, on the position and well-being of women internationally; to bring together members of the network periodically to pool information, strategize, and develop policies for women's groups to consider and discuss; and to educate women globally about the interaction of technology, population policy, and feminist goals' (Raymond 1985 9–10).

Patricia Spallone reports that FINNRAGE was born in July 1985 when 'women from sixteen countries met in Vällinge, Sweden, at an emergency conference on new developments in reproductive and genetic technology' (1989: 1). She describes its mandate as follows:

> ... to resist the development and application of [reproductive and genetic] technologies globally, in the interests of all women, in the knowledge that these technologies are harmful to women, a destruction of women's physical integrity, an exploitation of women's procreativity, and yet another attempt to undermine women's struggle for control of our own reproduction. (ibid.).

25 For a discussion of this move into the academy, see Kemp and Squires (1997).

26 Beginning in chapter three, I address ART and race. For discussions of ART and race, see Raymond (1993), Mies (1994), Williams (1995), Farquhar (1996), and Roberts (1997).

27 On ultrasound's military origins, Petchesky writes: 'The militarization of obstetrical images is not implicit in the origin of the technology (most technologies in a militarized society either begin or end in the military)...' (1987: 69).

28 For Foucault's derivation of discourse, see Foucault (1989) and Rabinow (1984).

29 Konrad's work is informed by Titmuss' comparative work on blood donation (1972). Although not specifically addressing human organs, Godbout and Caillé (1998) offer an update of the importance of the gift in contemporary society.

30 The feminist researcher Laura Shanner reports gaining extensive access to fertility clinics in Britain and the United States as well as in Canada and Australia. However, because she is less concerned with ART as a lived practice and more concerned to discern and take an appropriate 'moral' stance in relation to fertility 'treatment', I do not address her work here.

31 On the subject of ethnography, the anthropologist James Clifford writes:

> To call ethnographies fictions may raise empiricist hackles. But the word as commonly used in recent textual theory has lost its connotation of falsehood, of something merely opposed to truth. It suggests the partiality of cultural and historical truths, the ways they are systematic and exclusive. Ethnographic writings can properly be called fictions in the sense of 'something made or fashioned,' the principal burden of the word's Latin root, *fingere*. But it is important to preserve the meaning not merely of making but also of making up, of inventing things not actually real (1986: 6).

For further discussion of ethnography, see Clifford and Marcus (1986).

32 Franklin's introduction of Marcus into her text is very similar to my own and she relies on many of the same passages that I quote. See Franklin (1997: 14–16) for her discussion of multi-sited ethnography in relation to her own work.

33 Of her own project Franklin writes: '. . . this project did not involve the degree of habitation or dwelling within a community which is often, and rightly, considered the hallmark of a specifically anthropological ethnographic method' (1997: 15).

34 For additional critiques of science, see Latour and Woolgar (1986). For feminist critiques of science, see Easlea (1981), Fox-Keller (1985 and 1992), Fox-Keller and Lloyd (1992),

Fox-Keller and Longino (1996), Grosz (1994; 3–24) Jacobus et al. (1990), Oudshoorn (1990, 1994, 1996a, 1996b), Schiebinger (1993). For a visual anthropological critique of computer software, see Born (1999).

35 For an excellent discussion of how IVF and 'related technologies' were legitimated in Britain and the United States in the 1980s and 1990s, see Van Dyck (1995).

Chapter Two

Visual Discourses of Institutional Legitimacy

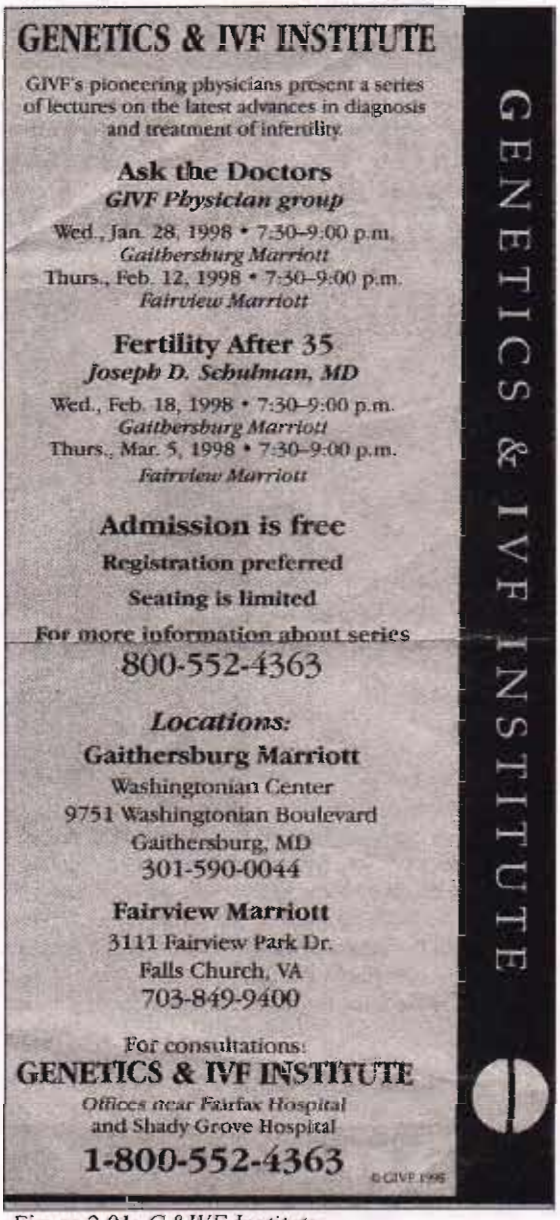


Figure 2.01: *G&IVF Institute*

Introduction: 'Fertility after 35'

On 5 March 1998 Genetics & IVF Institute (G&IVF Institute) held the seminar 'Fertility after 35' at a Virginia hotel (figure 2.01). As per the eighth item on the University of Washington Medical Center's list of indications for egg donation, Dr Joseph D. Schulman, the fertility clinic's founder and director, explained to his audience of approximately forty people that the quality of a woman's eggs declines as she ages. This, he stated, may lead to difficulty in conceiving a pregnancy and/or to foetal and infant impairment. Therefore, Dr Schulman noted, egg donation could be a 'very efficient reproductive option for a woman at, approaching, or over 40 years of age.'

In going on to call this ART a 'second choice for many couples', Dr Schulman acknowledged the potentially problematic fact that, in order for one woman to become a mother through egg donation, another woman's genetic material is required.[1] He argued, however, that this should not represent a major conceptual obstacle to a woman who desires a child but who cannot use her own eggs to conceive. Apart from the egg recipient herself and the staff at G&IVF Institute, the doctor told his audience that no one need know that a woman had used another woman's eggs in order to attempt to become pregnant. At the clinic's annual open day, when staff, current and former clients and their families gather on the firm's grounds for a party, Dr Schulman asserted that even the nurses, physicians, embryologists, office and other staff who co-ordinate and perform egg donations are unable, by comparing a child visually to her/his mother, to determine conclusively whether s/he was conceived as a result of an egg donation, as a result of another ART, or as a result of unassisted reproduction. Because of G&IVF Institute's

extensive database of prospective egg donors and its staff's expertise in matching the women in it to prospective egg recipients, the visual detection of what I hereafter refer to as 'genetic difference' was, the clinic's director declared, an impossibility.

Striking not for his conclusion but for the evidence marshalled to support it, Dr Schulman's declaration is consonant with the views of other geneticists. As the Irish genetics researcher Devin Scannell explains, 'genetic relatedness is determined by demonstrating a DNA peculiarity shared by parent and child that is so rare that it is unreasonable to maintain the two people are unrelated.'[2] In other words, the determination of genetic relatedness between a mother and her child rests upon the positing of a statistical likelihood: it is a mathematical calculation and not a visual determination.[3] Therefore, as Dr Schulman accurately told his audience, no one attending the open day would be able to tell by looking whether or not a mother and her child are genetically related. Operating in a register completely other to the visual, neither genetic difference nor genetic relatedness, as they are currently understood, can be visually determined.

Where Dr Schulman is not in line with contemporary formulations of human genetics is in the way he explains why it is impossible to ascertain a child's genetic heritage visually. In his anecdote, Dr Schulman attributes this impossibility not to the laws of genetics, but to the expertise of the staff of G&IVF Institute in matching prospective egg donors to prospective egg recipients. Because the clinic has a large number of prospective egg donors, Dr Schulman suggests that staff can match these women to prospective egg

recipients on a wide array of characteristics and, as a result, expertly conceal genetic difference. In so saying, Dr Schulman shifts the rationale for the impossibility of visual detection of genetic difference from the conceptual to the material: what once depended upon the internal logic of a bioscience now depends upon the actions of a number of trained medical personnel and office staff.

Dr Schulman's deviation from accepted genetic theory should not be thought to reveal a profound misunderstanding of his chosen profession or poor standards of practice, nor should he be regarded as a renegade operating on the outer fringes of biomedical science. What his statement does do is instantiate a broader imprecision regarding the function(s) of donated oocytes. By contrasting Dr Schulman's assurance about his staff's expertise in matching donors to recipients with the purportedly more authoritative scientific discourse on how genetic difference may be apprehended, it becomes possible to locate the emergence of two competing narratives about what exactly it is that a donor donates and a recipient receives when each party agrees to egg donation. According to Scannell, what is exchanged in this ART might best be defined as a 'reproductive substance'. That is to say, the donor donates a substance that the recipient lacks and that may enable her to conceive. According to Dr Schulman, on the other hand, what is exchanged might be defined as a sort of homunculus-like substance. In other words, the donor donates a substance that contains within it the conditions of existence of a particular individual who will possess specific pre-determined traits that are either identical with or very similar to those possessed by her/his mother.

The pairing of Dr Schulman's anecdote with Scannell's explanation of genetic relatedness suggests, like Konrad's work on egg donors and recipients in Britain does (1996), an absence of consensus among practitioners about precisely what it is that is donated in oocyte donation as practised in the United States. Formulations of the substance exchanged run along a conceptual gamut. Plotting the opposite extremes and selected points between them, discussion in this chapter examines distinctive ways in which the visual – or its limits – undergirds clinic and agency strategies for legitimizing the sale of this ART. In particular I wish to foreground two strategies of institutional self-legitimation. Section I sets out to examine clinics' and agencies' discursive claims surrounding their competence in effecting a 'perfect' match between an egg donor and a recipient. Building on this, section II foregrounds the ambiguity inherent in the commercialized visual imagery circulating within and across a fertility industry whose appeal is mediated publicly through its appropriation of different imaging technologies.

I. (Not) Seeing is Believing

Some of the best examples of the lack of consensus among American practitioners about what is being donated in egg donation can be traced not to Dr Schulman and other staff at G&IVF Institute but to three of my other informants.[4] I asked third party agency director Laura Green, practitioner Dr Ian Jackson, and Dr Daniel Cole, who works in a fertility clinic which has a small egg donation programme in the American mid-west, what a prospective egg recipient should look for in a donor and what prospective egg recipients actually want in a donor. When I posed the second of these two questions to Green, she replied:

> Number one, they want someone who looks like themselves. Number two, they want health: they want people who have pretty clean medical histories. Number three, they want intelligence. You can say those three things are the most important things that they're looking for in a donor.

Dr Cole also stated that, were he personally to pursue third-party reproduction, he would look for physical resemblance, health, and intelligence in a donor. Asked what he felt recipients should look for when selecting a prospective egg donor, he responded:

> DC: Well, that's a good question. I hadn't considered the question before. I have to look at that from my own perspective. What would I look for? I wouldn't do gamete donation, myself.
>
> KB: Why, could I ask?
>
> DC: I think it's inappropriate. I'd adopt. I think it makes socially and politically much more sense to adopt. I mean if I had to pick a gamete donor, I'd pick one who resembles me physically and I guess intellectually to the extent to which you can gauge that and I would look for somebody who has no major health liabilities – that's both actual health and family history or genetic background.

Dr Jackson also responded that physical resemblance, health and intelligence were traits his prospective recipients looked for in a prospective donor but, unlike Dr Cole and Green, he felt these were not the only criteria to look for, or even the most important ones. Describing intelligence, health, athletic ability, etc. as 'fluff', Dr Jackson maintained that there are only two criteria to look for in a prospective donor: youth and 'a history of reproductive capacity'. These, he claimed, are the 'two biggies' a prospective recipient should look for in a prospective donor in order to maximize her chances of

conceiving. However, Dr Jackson went on to say that, depending upon her priorities, a prospective egg recipient might go ahead and look for other qualities. He explained:

> Now for the highly professional women that, you know, have waited until their mid forties to find Mr Right, or Dr Right or whatever, they'll look at the educational issues as being of primary importance. Then you'll have somebody else who is an avid athlete and they'll look for athletics. A lot of people, I think, tend to go initially for basic features such as race, weight, hair colour, eye colour and then they'll look for the other stuff – the fluff.

Leaving aside Dr Jackson's reiteration of a punitive discourse on infertility that figures infertile women as having brought their condition upon themselves because they unwisely postponed marriage and childbearing,[5] his views come closest, of those of the three practitioners under discussion, to figuring egg donation as a set of biomedical interventions designed to enable the transfer of a reproductive substance from one woman to another. Through his declaration that youth and a history of reproductive capacity are the two major criteria to look for in a donor, Dr Jackson rejects a formulation of egg donation that figures it as a set of biomedical interventions enabling the potential transfer of, for example, intelligence or athletic ability from one woman to another. It was to exactly such a conception of donated ova that my other informants subscribed.

Green and Dr Cole go further than Dr Jackson in their formulations of what it is that an egg donor gives to an egg recipient. In their discussion of the qualities that either their clients or they themselves feel it is important that a prospective donor possess, they foreground the issue of genetic difference. In so doing they, like Dr Schulman,

necessarily figure egg donation as a set of biomedical interventions which have the potential to enable a woman to give birth to a particular kind of child. All three practitioners essentially claim that what a donor donates to a recipient is more than mere substance. Figured as 'genetics', physical and psychological traits are literally *seen* to pass from a donor through a recipient and into the child to whom the latter gives birth. In this formulation of egg donation, to which Dr Schulman, Green, and Dr Cole can all be understood to subscribe, what the recipient purchases is the potential to give birth to a child who possesses particular, visually apprehensible qualities.

Although their formulations of egg donation differ substantially from that of Dr Jackson, the views of Dr Schulman, Green and Dr Cole do not represent one of the poles on egg donation's conceptual spectrum. This position is reserved for third party agency director Nancy Young, who goes one step further in her claims for what gets transferred from donor to recipient in egg donation. Rejecting the notion that the achievement of physical resemblance between a mother and her child must be the ultimate goal of the matching process, Young presents not just physicality and intelligence, but personality, as heritable. That this is the case is clear from an anecdote she tells her clients and which she also told me. Young explained:

> I have a couple that has two children from two different egg donors: a daughter and a son. The daughter is now eleven and the son is six. The mother told me that although her daughter looks like her, they have no personality traits in common. They are very different people. The mother is very outgoing, outrageous, you know, the person of the party but her daughter is an introvert – she's quiet, her mother embarrasses her all the time, she doesn't like going shopping with her

> mom. Whereas this woman's son – who doesn't look very much like her – has just her personality. He can befriend anyone, he will walk up to anyone, he is the joker of the class. What my client said is what she regrets is not choosing a personality closer to her own when she chose her daughter's egg donor. Because if she had done so, she and her daughter would have had more in common as they grew up. Although she's working on it – trying not to embarrass her daughter when she goes out – it would have been much more fun for this woman to have had an outgoing daughter. And that's the lesson that she learned: it's not about your child looking like you because we don't all look exactly like our parents, it's what do you and your mom and dad have in common that's going to keep you together when you become adults. That's what I tell those couples. I tell them that story to say, it's not just what she looks like. Because I'm happy that she's going to have blonde hair or dark hair just like you. But if you have nothing else in common, you will drift apart.

Where Dr Jackson, through his claim that youth and the past achievement of pregnancy are the key traits to look for in a prospective donor, figures donated oocytes as a reproductive substance that may enable a woman who would otherwise not be able to do so to conceive, Young rejects the conceptual separation between person and substance that inheres in Dr Jackson's position. Installing an indivisible link between the two, Young figures donated oocytes as a hyper-miniaturized version of the donor. Should fertilization take place and implantation occur, donated eggs will enable the recipient to give birth to a child who possesses either the donor's personality or her physical appearance, depending upon which is presumed to match that of the recipient.[6] In marked contrast to Dr Jackson's end of the spectrum, genetics, for Young, determines both looks and behaviour. This means that, by judiciously selecting a donor, a prospective egg recipient can maximize the possibility that she will give birth to a child who either looks

or behaves like her, thus supporting Dr Schulman's claim that no one will be able to tell that her child was conceived as a result of egg donation.

The comments of Green, Dr Cole and Young demonstrate that Dr Schulman is not alone in eliding the difference between physical resemblance and genetic relatedness and they also make it possible to argue that the director of G&IVF Institute does not stand apart from all other industry practitioners as a result of his installation of the possibility of the visual detection of genetic difference. When Dr Schulman attributes this impossibility first to his staff's expertise in apprehending a prospective donor's physical and psychological characteristics and second, and based upon this, to their expertise in matching the donor to a prospective egg recipient, it becomes reasonable to conclude that, if a woman were to pursue this same ART at an institution whose staff did not possess these two different kinds of expertise to the same degree, she might literally see that she is not genetically related to her own child. This is a possibility that Green, Dr Cole, and Young reproduce in various ways in their own formulations of the matching process. By insisting, as Young does, first on the importance of personality to conceptions of relatedness and second on her firm's exemplary skill in matching prospective donors to recipients on the basis of personality, it becomes equally reasonable to conclude that, if one were to go to another third party agency, one might risk making a less perfect match than one would make at Young's firm. One would perhaps make the same mistake as the woman in Young's anecdote and give birth to a child who is seemingly markedly different from the one desired.

The installation of the possibility of visual detection of genetic difference between a mother and her child offered Dr Schulman, like Young and the others, a means of distinguishing his firm from its competitors. It allowed him to assure his audience that his institution was more expert than others in matching prospective egg donors to prospective egg recipients. But what is significant is not the claims made by the director of G&IVF Institute about what his staff can achieve, nor the fact that Dr Schulman makes such claims in the first place. What is of cardinal importance is the way in which this claim depends upon a specific mis-apprehension of the limits of human visuality. In order to make sense, it installs the impossible possibility of the visual detection of genetic difference. This leads me to conclude that an appeal to the visual is not just a key component of Dr Schulman's efforts to legitimize G&IVF Institute's sale of egg donation; it is fundamental to those efforts. Precisely because one cannot see genetic difference, one can look at a mother and her child and not know whether the child was conceived from her egg or from that of another woman. Crucially, it is at this point that this controversial ART becomes officially indistinguishable from unassisted reproduction. The limits of visuality, which Dr Schulman initially installs as having the possibility of showing egg donation to be a sort of 'false' motherhood, are ultimately what makes it if not 'real' (according to the biomedical discourses and practices from which it originates) then indistinguishable from 'reality'.

Turning away from a spoken discourse on the visual that is characteristic of American fertility clinics and third party agencies, I now look at how the visual materially undergirds other clinic and agency claims for efficacy. Having addressed the way in

which the unseen (and the unseeable) offers industry practitioners a non-pictorial narrative of institutional capability, I turn to the explicitly visual in order to track another set of industry-produced narratives about institutional effectiveness that aim to show what fertility 'treatment' can achieve, and by what means. Guided in the previous section by questions about visuality's role in spoken advertisements for the contemporary Anglo-American fertility industry, in what follows I am guided by a desire to critically engage with the images produced by and for the industry.

II. Is What You See, What You Get?

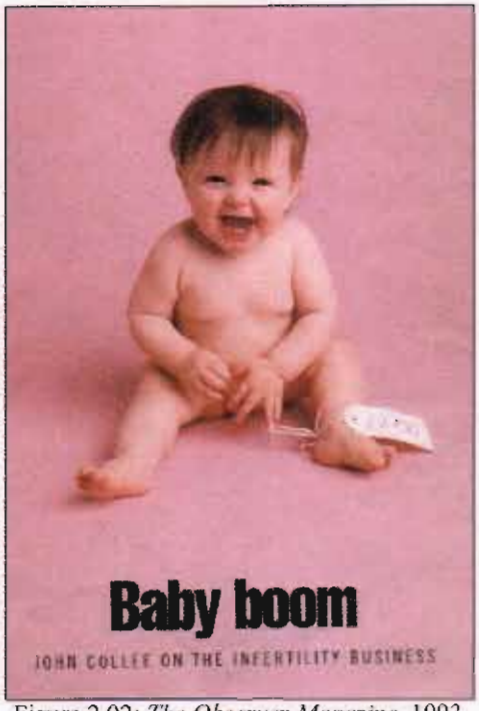


Figure 2.02: *The Observer Magazine*, 1993

Anchoring the remainder of this chapter's discussion of the images surrounding egg donation is my own 'image bank'. This is a collection of several hundred highly repetitive 'found' images – visual texts produced by the media, industry practitioners, and professionals hired by them – that I have gathered over the course of the several years that I have been working on this dissertation. The collection includes, *inter alia*, portraits, tables, charts, graphs and snapshots which, with a few key exceptions, exist embedded in clinic and agency brochures, newsletters, websites and advertisements, and accompany newspaper and magazine articles about the industry. My interest is in the ways in which these disparate texts, either found circulating in the public sphere or existing as pre-prepared promotional materials handed or mailed to me by my informants, construct egg

donation and the institutions that sell it. Attuned to the multiple identities that these images provide for specific clinics and agencies and for the industry as a whole, I argue that they perform significant cultural work and therefore deserve the sustained critique to which I subject them. In other words, I posit that the images that clinics and agencies use to sell their services do more than simply illustrate the written and verbal texts in which they usually appear and to which, as previously noted, most critical inquiry has been directed. In what follows, I attempt to determine what this 'more' might be.

Before considering what kinds of identities these images provide for clinics, agencies, staff members and ART, it is important to contextualize the proposed endeavour. As discussed in the Introduction to this thesis, despite Anglo-American feminism's history of engagement with visual culture, medicine and human reproduction, and their multiple points of intersection, there is an absence of sustained critique of the Anglo-American fertility industry's commercialized visual culture. In addition to Franklin's silence, as already discussed, on what the visual anthropologist Marcus Banks, writing in *Visual Methods in Social Research*, calls the 'conversations' that go on between 'persons who present images to a viewing/reading public' and the public to whom the images are presented, there is Konrad's silence on this same point (2001: 10).[7]

Konrad reproduces this silence in her brief discussion of the ways in which prospective egg recipients in Britain can decrease the time they spend on clinic waiting-lists. If a recipient can recruit a donor to the programme she can jump several places up in the queue, even if she does not end up being matched to this woman. To help recipients

attract donors, clinics give them recruitment posters to pin up in such places as supermarkets, doctors offices, and libraries. Although Konrad analyses this recruitment scheme and the reactions of recipients to it in some detail, she never addresses the image that actually comprises the bulk of the poster. This is a picture of a smiling young white woman playing with a white baby. All that Konrad does tell her reader about this image is that each recipient is given a set of six identical posters to distribute. As is the case with Franklin's work, there is no sense of the ways in which this image works with or against the appeal for eggs. Nor is there any sense of critical engagement on the part of Konrad with the type of ideal donor imagined in the image (1996: 47).

Egg Donation: A Growing Business

Fertility Successes Raise Demand, Price

By Barbara Vobejda
Washington Post Staff Writer

The first time Quincy Sultzbaugh donated her eggs, they went to a German couple who delivered triplets. The second set produced twins for a California couple. And the third time, a child was born in Boston.

Sultzbaugh, a San Diego PTA president, wife, college student and mother of two, is on the supply end of a rapidly expanding market in this country: the matchmaking of young women and their healthy eggs with infertile couples, desperate for babies and willing to pay.

Sultzbaugh endured a regimen of medical screening, counseling, daily injections, swollen ovaries and a painful procedure to retrieve her eggs. But, she said, "it's second nature for me to help someone have a baby."

Largely unavailable a decade ago, egg donation has revolutionized the field of reproductive technology, driving up success rates and creating a huge demand for the odd commodity of human eggs. In the past few years, thousands of young women have been organized in "donor pools," many of them catalogued on the Internet. And an expanding niche of businesses has developed to recruit the donors, match them with infertile couples and work in tandem with hundreds of fertility clinics across the country.

In the process, lots of money is

See FERTILITY, *A7, Col. 1*

Janet Lasley and husband Marc used OPTIONS, a business that finds egg donors, to have son, Charlie. At left is an OPTIONS ad seeking such a donor.

Figure 2.03: *The Washington Post*, 1999

These two questions – the ways in which the image might work and the kind of ideal donor it images and imagines – seem to me to be key. This is especially the case given

the whiteness in the image and Konrad's later assertion that 'minority populations in the UK do not, in the main, look favourably towards forms of female reproduction by means of 'third party' (extra-conjugal) assistance' (ibid.: 93). In what ways can the whiteness in the image be used to comment on and to problematize Konrad's point about minoritized populations not favouring ART procedures such as egg donation? Does the use of a white model in the image merely reflect a preference that is taken for granted at the level of the clinic? Or does it reproduce or contribute to the reproduction of a racialized conception of who buys egg donation? To what extent is it reflective of the reproductive preferences of members of communities and to what extent does it reproduce existing inequalities in access to healthcare? These are broad questions and the answers to them are necessarily highly nuanced, but given feminism's concern with ART, not to engage critically with images such as the clinic poster seems a critical oversight. To avoid reproducing this blindness, I now turn to my own image bank. My point of departure in what follows is the British context, with a move into the American context. Beginning with an image from a British clinic, my analysis leads me across the Atlantic. As a result of this journey, I conclude that, as discussed in subsequent chapters, just as wealthy consumers of ART can move easily across national borders, so too does the visual culture produced by and for the contemporary Anglo-American fertility industry move.

Three Visual Conventions

Figure 2.04: *Oxford IVF Unit*

Figure 2.04 appears on one of the Oxford Fertility Unit's webpages. The website offers a virtual tour of this clinic and of some of the fertility 'treatments' it offers. By clicking on hypertext links, site visitors can see pictures of human eggs, QuickTime videos of Intracytoplasmic Sperm Injection (ICSI) and snapshot-like photos of clinic staff.[8] Webpages, newspaper advertisements and brochures produced for American clinics contain similar images.

Rather than attribute to chance the high degree of similarity in the images used by unassociated clinics and agencies to represent their work, I conclude, following the visual anthropologist Richard Chalfen[9], that these very different institutions actively employ the same modes of 'visual/pictorial communication' (1998: 215). That is to say, it appears

that different clinics and agencies deliberately rely on the same kinds of images in order to represent their work. In what follows, I group these images into three major modes that I call 'visual conventions' and discuss in turn images of science, images of the child, and images of the donor.

Before turning to the actual images, it is first necessary to define the term 'visual convention'. By this term, I mean a combination of what Banks calls an image's 'internal narrative' and its 'external narrative'. According to Banks, the 'internal narrative' is the content of an image: what it is that the image is an image of. This is 'the story . . . that the image communicates' (Banks 2001: 11). Broadly speaking, it is possible to identify three different internal narratives in the three visual conventions I discuss below. In images of science, the images are about biomedicine, in images of the child they are about mothering (as in figure 2.04) and in images of the donor they are about the women who are willing to donate their eggs to prospective egg recipients.

Banks describes the external narrative as 'the social context that produced the image, and the social relations within which the image is embedded at any moment of viewing' (ibid.). Following Banks, I understand the external narrative of the three sets of images with which I am concerned to refer to, among other things, the Anglo-American fertility industry, the individual clinics and agencies that comprise it, and the advertising agencies and web designers employed by them. Crucially, it also refers to my own subjectivity as a feminist who is cognizant of debates on ART and who, as a result of this, tends to be

critical of the Anglo-American fertility industry. Finally, it also refers to the subjectivity of you, the reader.

My intention in using the term 'visual convention' is to signal the presence of and the tension between any given image's internal and external narratives. My use of the term is a way of keeping sight of the specificity of an image's content while at the same time considering how, given the social relations surrounding the image, this content can be understood to be over-determined (ibid.: 51). This permits me to ask a larger question about the Anglo-American fertility industry and the visual culture produced by it: to what extent is it possible to use the images produced by an industry to promote the sale of its products and services as a starting point for a critique of both that industry and of feminist and cultural studies critiques of it.

I do not respond to this question by offering, in the next three sections, a series of close readings of images. Although I look in detail at several images that I consider to be representative of one or another of the three visual conventions, my main concern is not exhaustively to catalogue any given image's internal narrative. My interest lies elsewhere. I am concerned with the ways in which the internal narrative and the external narrative can be understood to intersect, and I am also interested in the connections that can be established across the three visual conventions.

First discussed in the Introduction, it is the idea, derived from Frow and Morris, of 'the complex and conflictual practices of sociality' that I am trying to get at in my analysis of

the Anglo-American fertility industry's visual culture (1993: xviii). In grouping these images according to visual convention and in looking at the tensions among their internal narratives, their external narratives, and the three individual conventions themselves, it seems to me that I can use images of science, images of the child, and images of the donor to begin to get at the social relations that undergird these images and the work they do. To borrow a phrase from Banks, I can 'illuminate the distinctive texture of social relations in which [these sets of images are] performing [their] work' (2001: 51).

Images of Science

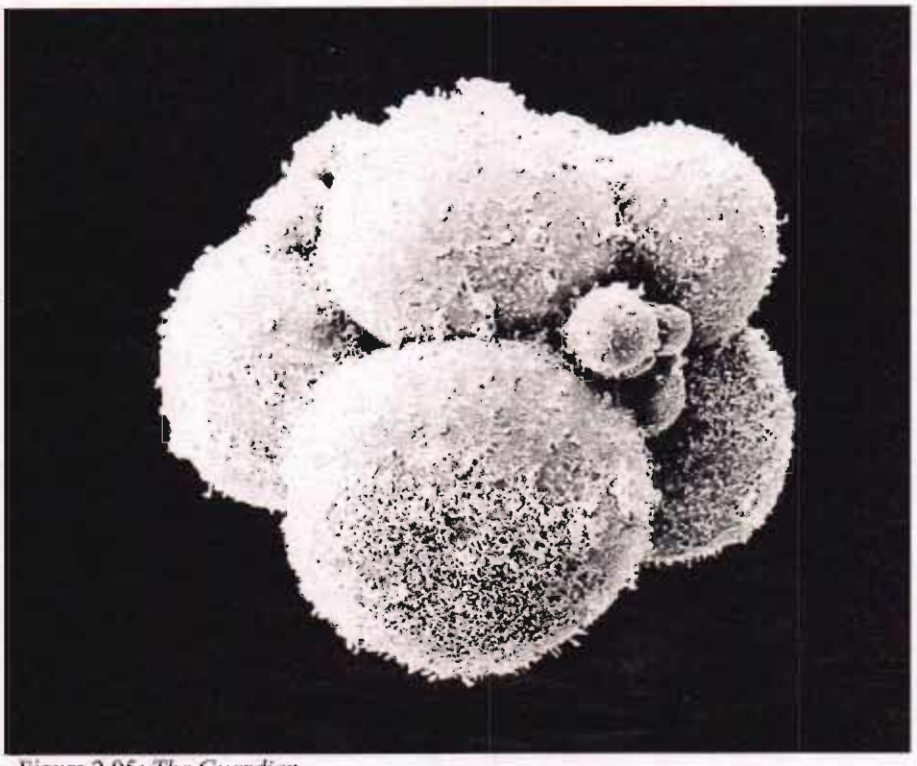


Figure 2.05: *The Guardian*

Produced by and for clinics, 'images of science' construct fertility 'treatment' as a biomedical enterprise. They show what it is that any one of a number of ART procedures consists of and they graphically demonstrate why the application of one or more of these procedures might be necessary. Among the most common representations in this visual convention are those of the doctors, nurses and technicians who perform procedures such as egg extraction and the receptionists and office workers who schedule patients for such procedures. Also within this convention are photographs and drawings of clinic exteriors and interiors, the places where the mobilization of ART occurs.

The images in this, the most varied of the three visual conventions, can be read as functioning to construct and reveal the 'truth' of what goes on inside the contemporary

Anglo-American fertility clinic. They do this through the convention's three main subgroups. I call the first of these 'reproductive images'; comprised largely of photomicrographs of human gametes, this set of images also includes cartoons of human gametes and drawings of female and male reproductive systems.[10] The second subgroup, 'non-representational images', includes charts, graphs and print-based advertisements. The third subgroup, 'images of staff', is comprised of two smaller groupings of pictures of clinic staff that I call 'posed shots' and 'candid shots'.

Reproductive Images

Images of human eggs are some of the most frequently recurring 'reproductive images'. Sometimes these gametes that are invisible to the naked eye appear alone; sometimes they are pictured at the time of fertilization. Often, but by no means always, they are stained pastel colours.[11] But no matter at what stage the eggs are captured or what colour they are stained, these images demonstrate, through a visual discourse of disembodiment that is mediated through a discourse of invisibility, that the fertility clinic is in the business of biomedical science.

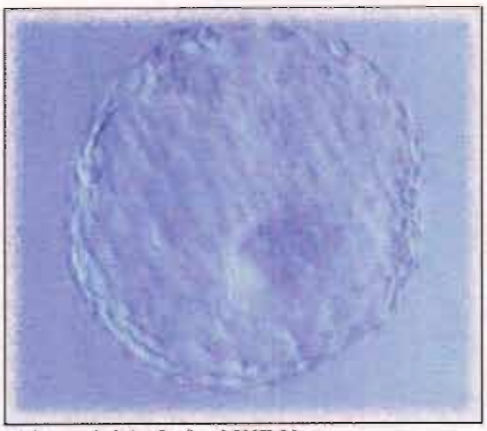


Figure 2.06: *Oxford IVF Unit*

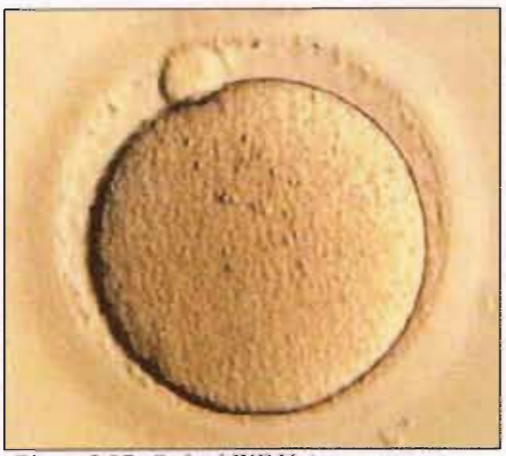


Figure 2.07: *Oxford IVF Unit*

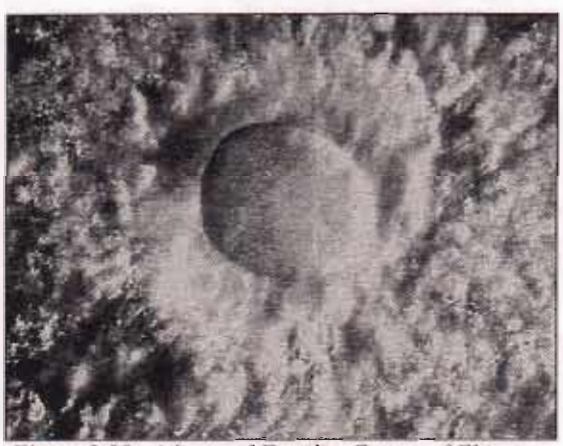


Figure 2.08: *Advanced Fertility Center of Chicago*

The eggs in the visual culture produced by and for clinics are disembodied. They appear as self-contained entities, as in figures 2.06, 2.07 and 2.08. Echoing Dr Ian Jackson's conception of oocytes as a 'reproductive substance', there is nothing in the images of eggs used by clinics to suggest that they 'belong' to or come from either a specific woman or indeed any woman. Like the foetuses discussed by Petchesky, Duden, and Stabile, these eggs appear to be free-floating, autonomous bodies which have an existence apart from the woman's body in which they mature. While this visual claim for oocyte autonomy is as inaccurate as those claims alleging foetal autonomy which were explored by the above-mentioned critics, the presence of these disembodied eggs in the contemporary Anglo-American fertility industry's visual culture must be considered to be as productive as the images of foetuses *in utero* discussed by Petchesky, Duden and Stabile. Instead, however, of legitimizing new-Right anti-feminism or a medical specialty such as obstetrics, these types of images serve to legitimate the contemporary Anglo-American fertility industry and they do so through their implicit associations with science.

Once detached from a specific body, an egg becomes something that is produced universally by female bodies. In short, it becomes 'natural'. As such, following the feminist critic Nelly Oudshoorn, it is a fitting object of inquiry for and can be apprehended and manipulated by science. As Oudshoorn writes, the 'traditional image' of science figures it as a discipline that through the work of 'clever scientists' can discover the 'unmediated truth of nature' (1996b: 122). Following, as discussed in the Introduction, Duden's work, I argue that, in as much as the contemporary Anglo-

American fertility industry's visual culture is concerned, the existence of this science is made manifest when the invisible egg is made visible with the application of the appropriate imaging technology to it. To reiterate Duden's point, reading images of, among others, newly fertilized eggs published in *Life* magazine in 1990, she argues that these images represent an 'evolution of vision' (1993: 16). They instantiate 'a new kind of seeing' because, in order for them to make sense, such images 'must be explained by some authority' (ibid.). While Duden discusses the set of images from *Life* magazine in terms of the American abortion debates in the 1980s, her conclusion about vision is no less relevant here. In order to be understood, these images of eggs must be explained by an authority. Without some kind of prior authoritative intervention, there is simply no way to tell what images such as those in figures 2.06 – 2.08 are supposed to represent. It is any given institution's ability to say what these images represent, an ability indissolubly tied to an institution's capacity to produce and wield these images, that serves to construct as a scientific institution the fertility clinic in whose visual culture these images of eggs can be found. Thus, the images of human eggs used by clinics work first to announce the presence of science and second to install the clinic as a scientific organization. In brief, they serve a purpose that goes far beyond the merely illustrative.

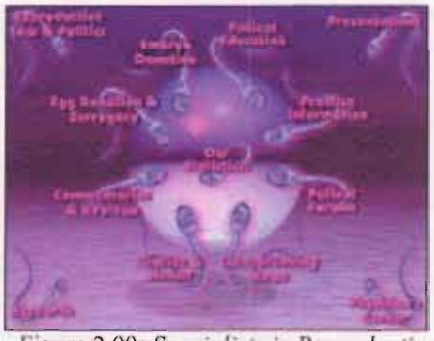


Figure 2.09: *Specialists in Reproductive Medicine & Surgery, P.A.*

Non-representational Images

The chart, table and graph in figures 2.10, 2.11 and 2.12 come from the Oxford IVF Unit's website. The pie chart gives information about the outcome of pregnancies achieved at the clinic as a result of the application over a thirteen-year period (1987–2000) of one or more unidentified ART procedures. The table presents the details of live births that resulted from IVF cycles at the clinic in the same thirteen-year period. The graph plots the effect of age on the achievement of live births and clinical pregnancies for an eleven-year period (1987–98). Banks writes that tables and diagrams 'are techniques used to present information . . . where spatial arrangement and non-linear order are necessitated and where the inevitable linear sequencing of words is insufficient (2001: 23). Calling tables a 'basic form of hypertext', he goes on to posit that along 'with other lists they are an intermediate form, midway between the linear flow of language and the open-endedness of a photograph or picture, demanding a combination of linguistic and visual reading skills' (ibid.: 24).

Although Banks does not address charts and graphs, the same can be said of them. Like tables, they are often used instead of words to convey complex sets of information and they also require two different kinds of reading skills (ibid.). But the charts, tables and graphs in the visual culture produced by and for the Anglo-American fertility industry are important for more than just the information they impart. Like the eggs discussed above, they do not work merely because they present disembodied data. Crucially, in the very act of presenting this data, they represent a second instance in which an image's form – *regardless of its actual content* – works to install the clinic as a scientific institution. That

Figure 2.10: *Oxford IVF Unit*

Figure 2.11: *Oxford IVF Unit*

Figure 2.12: *Oxford IVF Unit*

is to say, charts, tables and graphs present information in a particular way which, because it is understood to mean science and mathematics, can be as valuable as the information presented through it. Because of their form, charts, tables and graphs serve as implicit evidence that research data has been tabulated and therefore act as a guarantee of the clinic's access to a set of data and to a set of skills. By their very presence, they signal a scientific discourse. This, in turn, is a discourse that is productive in its own right. That this is the case is best illustrated by a brief return to G&IVF Institute's seminar, 'Fertility over 35'.

Instead of using pictures of babies or happy families to illustrate his address, Dr Schulman relied on charts, tables and graphs. When it is taken into consideration that fertility 'treatment' is both expensive and generally unsuccessful, in that more often than not it does not lead to a live birth, it is possible to see how the figuring of the clinic as a scientific institution is productive in and of itself. Because Dr Schulman relies on scientific images and does not dangle pictures of babies or families before his audience, he can redefine the meaning of the seminar. By using an approach found also in plastic surgery practices (figure 2.13)[12] and laser vision correction practices, the seminar becomes less of a performed advertisement designed to help the clinic gain clients. Showing himself and, by extension, the institution he founded to be sensitive to and respectful of the difficult situations facing his potential clients, focusing not on what they do not have but on the scientific facts, Dr Schulman makes the seminar seem less like a sales pitch and more like an educational effort. It becomes a way of explaining to people why they might be having difficulty conceiving and how the various and perhaps

unfamiliar ART procedures used at the clinic could enable them to circumvent these difficulties.

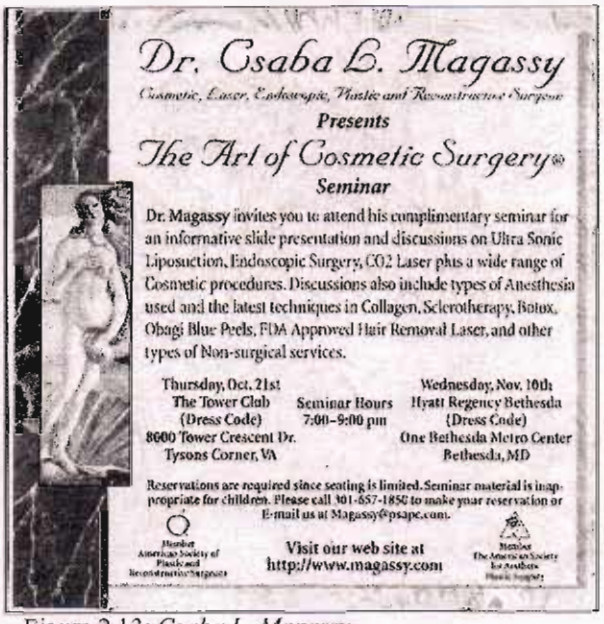


Figure 2.13: *Csaba L. Magassy*

Apart from charts, tables and graphs, the subgroup non-representational images may contain no image whatsoever. That is to say, many advertisements and parts of brochures, newsletters and webpages are text-based. G&IVF Institute, for example, advertised two of its seminars in the *Washington Post* (figures 2.01 and 2.15). Figure 2.14, which appeared in the same newspaper, contains an image and can be read as operating in a different manner from the advertisement for the seminars. Presenting an image of the desired outcome of fertility 'treatment' in order to recruit both donors and recipients to the clinic, figure 2.14 has an affective pull. In other words, it operates at least partially through a discourse of desire. By picturing what the reader supposedly wants, it attempts to draw the reader to the clinic.

Figure 2.14: *G&IVF Institute*

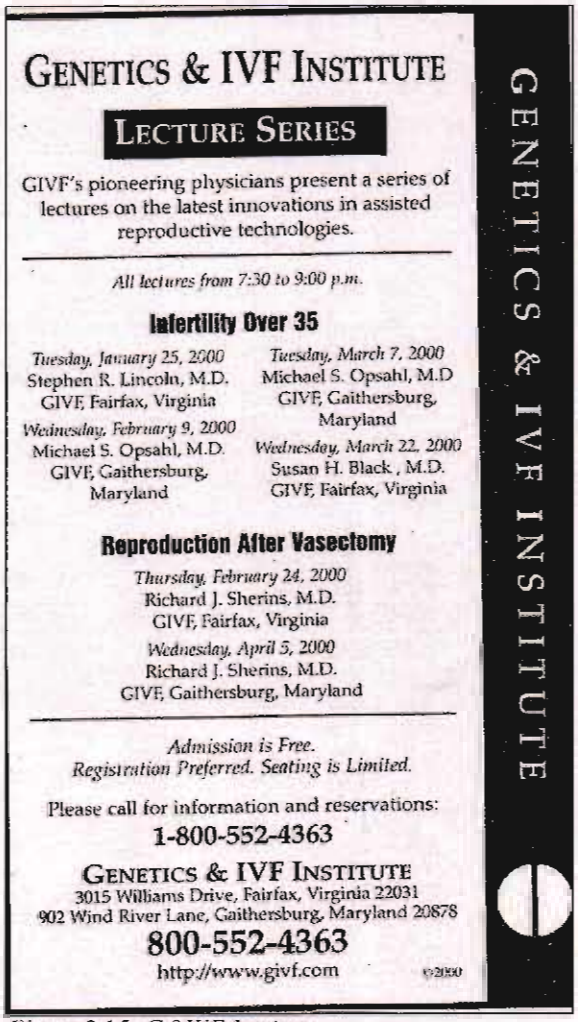


Figure 2.15: *G&IVF Institute*

The same cannot be said of the advertisements for the seminars (figures 2.01 and 2.15), which I suggest may be read as being emotionally neutral. This is partially because, except for the Institute's logo on the margin, it does not contain any image. However, owing to the complexity of the Anglo-American fertility industry's visual culture, the coding of the advertisement as emotionally neutral cannot be solely attributed to the absence of an image. The inclusion of an image of an egg, a graph, or even, as is the case here, the company's logo can preserve neutrality of tone while, as figure 2.14 demonstrates, the inclusion of a picture of a baby can change it. Therefore, the tone of the advertisement has also to do with the way the text functions as both text and meaning.[13] In terms of text as meaning, the advertisement presents basic information; it gives the name of two seminars, tells when and where they will be held, and gives contact information for the clinic. In terms of the text as text, this information is imparted across three sections, presented in the same font throughout, with the size of the font and the presence of bold or italicized text being the only variations.

Because of the combination of form and content in the advertisements for seminars, I read figures 2.01 and 2.15 as a continuation of the effort to cast the seminar not as a marketing event but as an educational evening, a reading consistent with the use of terms such as 'lecture'. As discussed above, I argue that the seminar works best when understood as an attempt to impart the 'truth' of infertility and to present the options available to those who suffer from it. Refraining from enticing prospective clients to the evening's discussion by showing pictures of babies they may not be able to have, a gambit that could possibly be construed as manipulative, the dominance of text in figures

2.01 and 2.15 works in a manner similar to the charts, tables and graphs. It serves to announce purely and simply that a seminar will take place and in so doing it underscores the informational nature of the event.

Images of Staff

Central to the construction of the fertility clinic as a biomedical institution is the firm's staff. Whether they are creating suitable matches, performing egg extractions, or explaining a procedure to a new client, these are the experts who bring science to women's bodies in order to effect the birth of healthy infants. Not unexpectedly, pictures of clinic staff comprise an integral part of the visual culture produced by clinics and, although I do not explicitly focus on it in this subsection, third-party agencies. As noted above, 'images of staff' can be divided into two subgroups: posed shots and candid shots.

Posed Shots

Found, among other places, in brochures, newsletters, and webpages, posed shots introduce staff members – mainly men – in a manner that can best be described as 'corporate'. Sometimes, as in figure 2.16, these images are formal; sometimes, as in figure 2.17, they are more relaxed. In the case of the latter they can be compared to the candid shots that I discuss below. However, whether these portraits are more or less formal does not really matter. Taken as a whole, this subgroup exemplifies another instance in which the content of an image can be understood to be secondary in importance to its form. That is to say, in as much as they are recognizable as portraits, posed shots unite clinic staff

Figure 2.16: *G&IVF Institute*

Figure 2.17: *Specialists in Reproductive Medicine & Surgery, P.A.*

Figure 2.18: *Dominion Fertility & Endocrinology*

with notions of sound management. They are able to do this because of portraiture's history as a visual convention that pre-dated photography and that served to align the subject depicted in it with connotations of power and respectability.

Writing about medicine in the eighteenth century, the feminist historian Ludmilla Jordanova points to portraiture as one strategy that provided doctors with a means of legitimizing their work and gaining cultural power (1995: 207). By the late eighteenth and early nineteenth centuries when '[t]he sense of chaos in medicine was high', portraits of practitioners served as 'a sign of professional competence' (ibid.: 212). This, argues Jordanova, was because they depicted the faces and bodies of medical men. This act of depicting medical men, she goes on to say, was important at a time when '[i]t was difficult to display the fruits of medical knowledge directly' (ibid.). Thus, in lieu of a depiction of the benefits of a then emergent modern medicine, Jordanova argues that portraits of medical men 'were the vehicles through which medicine was embodied and displayed . . . hence the significance of portraiture, of the face as a sign of professional competence' (ibid.). It appears that the face still plays this same role.

Figure 2.19: *Fertility Associates of the Bay Area*

Figure 2.20: *IVF New Jersey*

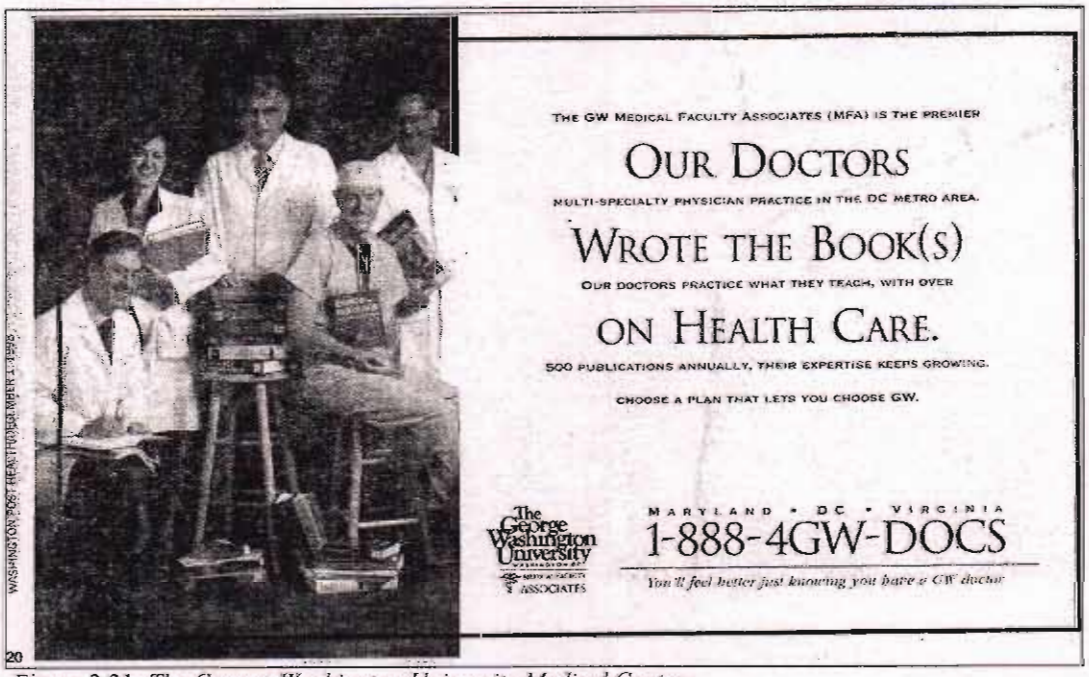


Figure 2.21: *The George Washington University Medical Center*

I argue here that, in the visual culture produced by the contemporary Anglo-American fertility industry, posed portraits of physicians, nurses, geneticists and staff members, no longer painted but photographed, act in the same way as their eighteenth- and nineteenth-century forerunners.[14] By displaying their faces and bodies, posed photographs of staff members conform to the generic conventions of portraiture and contribute to the construction of assisted conception as a rational procedure. By presenting fertility doctors in a manner that is understood to indicate respectability and 'middle-classness', portraits assure potential and existing clients that practitioners are neither 'mad scientists' nor money-hungry charlatans. Given that fertility 'treatment' involves the manipulation of human gametes and embryos and also costs large sums of money, clinics cannot afford to appear to be careless with either the gametes or the money of their clients. Thus, images that portray medical and office staff as cautious and conservative can be seen to accomplish much. Like non-representational images, they do not just help clinics (and agencies) gain clients. They represent one of several means by which individual clinics can attempt to legitimize their deployment of various ART. Although fertility medicine may be widely accepted on a national level, it may be barely tolerated on the local level. This means that, even if clinics do not directly or primarily serve the population of the place in which they are located, they must nonetheless negotiate that population on a daily basis.[15] Posed portraits provide clinics (and agencies) with one means of beginning to do this.

Candid Shots

Figure 2.22: *Advanced Fertility Center of Chicago*

Candid shots operate in a similar manner. They serve to reveal the 'truth' of what goes on at the clinic, both generally and during procedures such as egg extraction or *in vitro* fertilization.[16] They can be understood as offering the clinic a means of answering potential and existing clients' questions about what goes on during fertility 'treatment' and of allaying their fears about it.

Figure 2.23 is an example of the kind of image found in this subgroup. Taken from the Oxford IVF Unit's website, this image shows staff members performing a procedure on a woman. It represents one of the relatively rare instances in which we see the fertility

Figure 2.23: *Oxford IVF Unit*

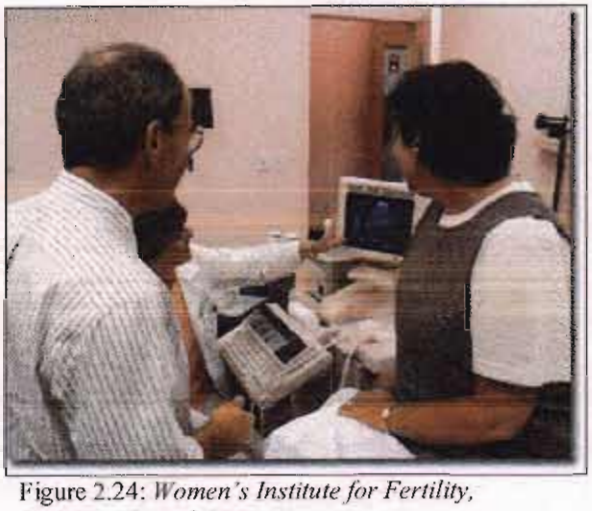


Figure 2.24: *Women's Institute for Fertility, Endocrinology & Menopause*

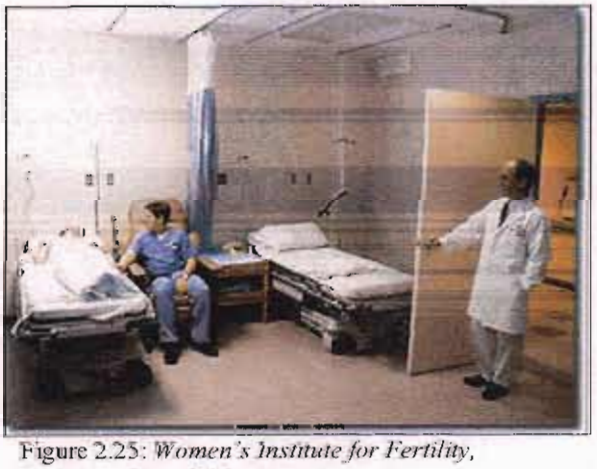


Figure 2.25: *Women's Institute for Fertility, Endocrinology & Menopause*

patient.[17] However, this woman's face is hidden. We cannot identify her, and the photograph can therefore be read as ultimately disembodying the patient.

By presenting the body of an unidentified and unidentifiable woman, the image renders this body anonymous. Like the eggs discussed above, it becomes 'natural' through its anonymity and can therefore be worked on by science.[18] Thus, this image can be read as more than a means of showing the 'truth' of what goes on during fertility 'treatment'. It can also be read as contributing to the construction of a notion of an inherently stable science which does not vary and which can be applied to any body, with the aim of teasing out of that body the end product we see in the second visual convention: its own baby. Ironically, however, a closer look at some 'images of the child' will reveal that this 'any body' is actually a raced and classed body, an argument further developed in chapters three, four, and five.

Appearing alone or combined with written or spoken assertions of professional competence, 'images of science' do not merely show the 'truth' of fertility 'treatment'. Their power does not rest simply on their ability to open the clinic up to the gaze of curious potential clients. Rather, the power of this set of images derives from the fact that it serves to align fertility 'treatment' with science, working to legitimize an industry that remains controversial more than twenty-five years after the birth of Louise Brown. By insisting on the scientific foundation of fertility 'treatment', the images in this visual convention work to normalize the deployment of ART. Showing the eggs and sperm that doctors work with, the doctors themselves, and even the procedures carried out by

doctors, nurses and technicians on 'every woman's body', they distance ART from the grotesque and the commercial.

Not only does fertility treatment disrupt dominant formulations of the family and motherhood, it also provokes questions about who has the 'right' to reproduce and when and under what circumstances a woman may exercise this 'right'. It also challenges dominant perceptions of how many children a woman has the 'right' to have and of what kind of children a woman has the 'right' to have.[19] For example, preimplantation genetic diagnosis (PGD), like ultrasound scanning and amniocentesis before it, opens up debates about whether or not it is 'right' for a woman to give birth to a child understood to be disabled in some way and at the same time raises questions about who has the moral authority to make such determinations.[20] Furthermore, the clinic's capacity to create, store, implant, destroy and/or experiment on embryos feeds into and reconfigures the abortion debates, especially in Ireland and the United States.[21] So too does its need to resort to 'trimming', a process by which, in higher order multiple pregnancies, one or more foetuses are aborted so as to increase the chance that a woman will give birth to at least one live infant.[22] By 'revealing' the workings of the clinic and by aligning both those workings and the act of revelation itself with science and 'scientificness', the photographs in 'images of science' render ART nothing more than a set of biomedical procedures designed to help those suffering from infertility to have a child of their own. It is to pictures of these children that I now turn.

Images of the Child

Figure 2.26: *Dominion Fertility & Endocrinology*

As noted in chapter one, the statistics required of both British and American fertility clinics reveal that the most likely outcome of ART is not the birth of a baby. Rather, it is a patient who needs to decide whether or not to undergo another round of ART in order to try again to become pregnant.[23] Despite this, images of young children abound in the visual culture produced by and for American fertility clinics and third-party agencies. Taken from Dominion Fertility & Endocrinology's webpages, figure 2.26 is an example of the type of image found in 'images of the child', the most widely used of the three visual conventions discussed here.

Unlike 'images of science', there is comparatively little variation across 'images of the child'. What variation there is generally concerns the way in which the child, who is usually but not always an infant, is presented. Sometimes – in figure 2.26 for example – the child appears with her/his mother.[24] She/he can also appear on her/his own (figure

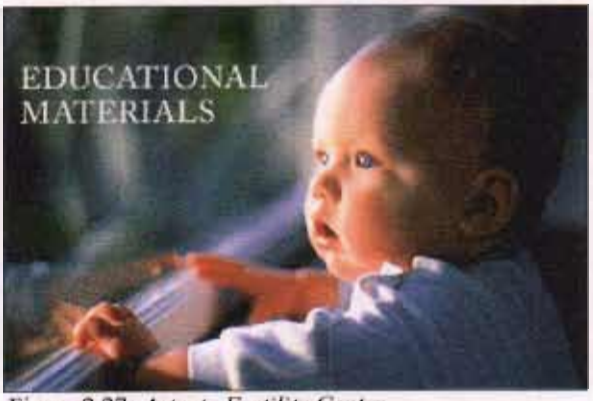


Figure 2.27: *Astarte Fertility Center*


Figure 2.28: *Creative Conceptions, Inc.*


Figure 2.29: *G&IVF Institute*

2.27) or within a nuclear family (figure 2.28). I have never come across an image of a child pictured only with her/his father. What is more, even taking into account websites belonging to organisations that facilitate lesbian and gay parenting, there are very few images of children being raised by lesbians or gay men. These, I imagine, would show pictures of children in the presence of two adult women or men.

Gender marking also produces a variation across the images in this convention. This is usually effected through clothing, accessories or the presence of a supposedly gender-specific toy. Sometimes, as in figures 2.27, 2.28 and 2.29, gender is indeterminate. This indeterminacy extends to the final variable in 'images of the child': age. Figure 2.28 and figure 2.29 show very young infants, while figure 2.27 shows an older child. In this visual convention, it is less common to find images of children who are more than two years of age. Figure 2.30, from a British clinic, is somewhat remarkable because it features not one but two children, both of whom appear to be slightly older than the infants and toddlers usually depicted. The same is true of the child on the left in figure 2.31 which is from an American third-party agency's website.

The visual convention 'images of the child' enables the Anglo-American fertility industry to link fertility 'treatment' to babies. The images show that egg donation and other ART procedures lead not to children but specifically to infants. Even figure 2.30, which does show older children, suggests, in the angle of the head of the child at the bottom of the frame and the cradling posture of the mother and father, a much younger child; one of the

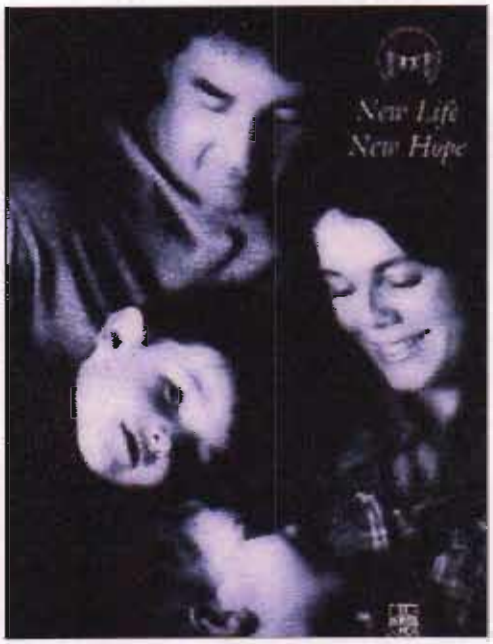


Figure 2.30: *Centre for Reproductive Medicine, Bristol*

Figure 2.31: *Creating Families, Inc.*

two children in figure 2.31 is, of course, an infant. There is a definite pictorial insistence that a potential outcome of fertility 'treatment' is, quite specifically, an infant. It is therefore possible to read depictions of infants across different advertising campaigns produced by and for different clinics and agencies. This enables me to not only to ask why fertility clinics routinely employ images of infants, but also to question the kinds of images of infants that clinics and agencies use.

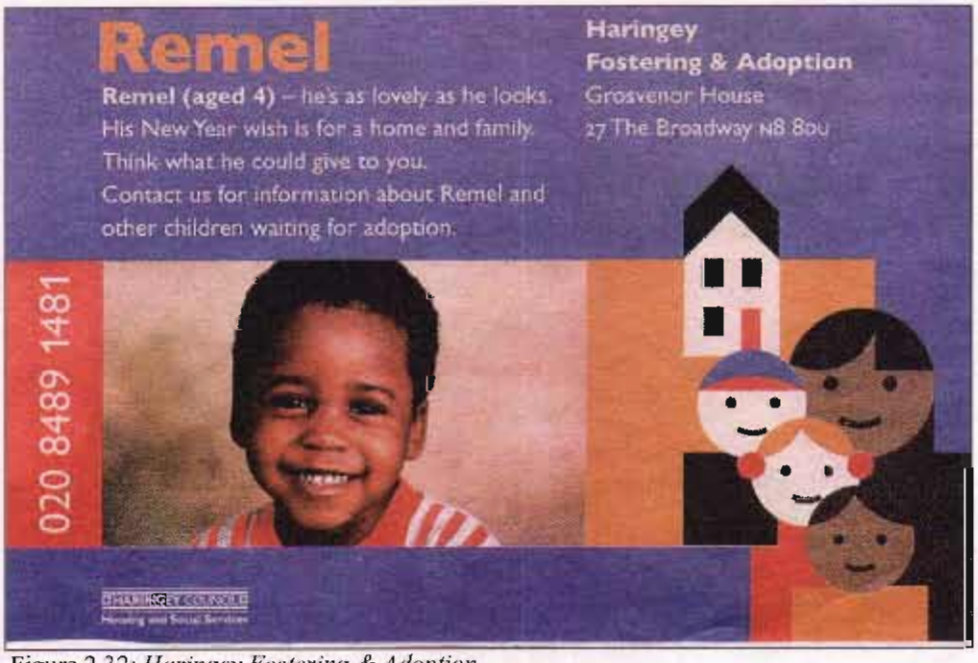


Figure 2.32: *Haringey Fostering & Adoption*

The major variations across 'images of the child' are limited to who is pictured with the child, the child's gender, and the child's age. The lack of variation in this group of images is startling, particularly when read alongside advertisements seeking to recruit adoptive and foster families (figures 2.32 and 2.33). What becomes immediately apparent is the dominance of whiteness in the group of images produced by and for fertility clinics and third-party agencies. To echo Hartouni's reading of *Life* magazine, where are the black,

Asian, and bi-racial infants? As I discuss in further detail in chapter three, they are largely absent from the visual culture produced by the Anglo-American fertility industry. When these images of infants are combined with 'images of science' and 'images of the donor', it becomes clear that they play a major role in the construction and maintenance of regressive notions of motherhood, parenthood and the family.

Figure 2.33: *International Children's Alliance*

Images of the Donor

Figure 2.34: *Tiny Treasures, Inc.*

The third and final visual convention to be discussed here is 'images of the donor'. As was the case in 'images of the child', there is very little variation across this set of images. Nevertheless, these pictures can still be subdivided into posed shots and candid shots. Regardless of the category to which an image belongs, the function of any photograph in this visual convention is to show an egg donor to potential egg recipients and curious members of the public.

For many recipients, seeing a photograph of a woman may be the first step in selecting her as a donor, and the ways in which these images are bound up in the flow of capital must therefore be foregrounded. 'Images of the donor' serve as more than simple likenesses. They work because they display much more than a potential donor's

appearance. Like the two other visual conventions, this one is also central to the practice of egg donation. All the images discussed below were taken from the websites of fertility clinics, third-party agencies or individual, 'independent' donors (women who will work either with clinics and agencies or directly with potential recipients).

Posed Shots

Figure 2.35: *The Egg Donor Program*

Figures 2.34 and 2.35 are examples of posed shots. The first image comes from *Tiny Treasures*, a third-party agency's website. The second is from Shelley Smith's third-party agency's website. Like the posed shots of clinic staff, the images in this subgroup operate within the visual discourse of professional portraiture. Because of this, their form is at least as important as their content. That is to say, by conforming to a convention which might best be described as professional studio portraiture, each image communicates an important message about the woman in it. It does this more or less regardless of how the woman actually looks. Whatever her physical appearance, the portrait asserts that the donor is middle class and serious in her intention to donate her eggs. This genre of image can work in this manner because it is widely known that professional portraiture costs money and requires time, and because the clothing, make-up and pose of the subject

underline her legitimacy as a donor. Because she can literally be *seen* to have invested time and money in a portrait that may lead to her becoming an egg donor, the woman in the portrait can be read as having decided to donate her eggs for reasons other than financial gain. She becomes a woman who is not in desperate need of money and who made a rational decision to donate; identified as neither poor nor reckless with her health, the potential donor can appear to be middle class.

The importance of 'middle-classness' and seriousness of intent cannot be underestimated. The question of a donor's class consumes the contemporary Anglo-American fertility industry. It is frequently mediated through a discourse on physical characteristics and, as I discuss in chapter five, an examination of, among other documents, donor application forms, provides strong evidence that clinics and agencies attempt to read class through a donor's physical features. Thus posed shots of donors may help women who are interested in donating their eggs to conform to one of the major criteria required of them by clinics and agencies.

Candid Shots

Figure 2.36 is taken from the website of the fertility clinic Specialists in Reproductive Medicine & Surgery, P.A. It is an example of a 'candid' shot. If posed shots work to assure recipients first of the respectability of donors and second of their physical appearance, candid shots can be understood to function in a different manner. Their primary importance is to provide a record of what the donor looks like. Of secondary importance is their ability to provide clues to the past, personality and habits of the donor

insofar as these can be supposed to be 'read' from the image. Unlike candid shots in 'images of science', those in this visual convention tend to be augmented by the inclusion of at least one posed shot. Of all the subgroups, this one appears to be the least used, and any work it does in revealing something about a donor's past, personality and habits can generally be considered to be duplicated in the donor application form.

Figure 2.36: *Specialists in Reproductive Medicine & Surgery, P.A.*

It is through reading donor application forms that it becomes readily apparent that donor legitimacy is primarily thought of in terms of class. When this is read alongside the visual insistence on whiteness that is most apparent in both 'images of the child' and 'images of the donor,' it begins to appear that the representatives of the contemporary Anglo-American fertility industry rely on racialized and classed discourses of legitimate motherhood in order to sell their services. By bringing images and written and spoken texts together, it becomes clear that discourses of race and class undergird the industry's formulations of 'legitimate' motherhood and react one on the other. In other words,

where race cannot be freely spoken of, lest a practitioner be charged with racism, class is subject to no such restriction. Conversely, while it is relatively difficult – but not impossible – to picture class, the same may not be true of race. As I will argue across the next three chapters, it appears from the industry's visual and public culture that the one may at times stand in for the other. But be this as it may, it should not be thought that race and class can, for all intents and purposes, be merged into one another. In terms of the American practice of egg donation, there is some indication of a liberalizing impulse with regard to race – provided it is underwritten with the appropriate class status – that has no parallel as far as class is concerned. By taking a second look at figure 2.04 and, through this, delving further into the contemporary Anglo-American fertility industry's visual economy, it is to this discussion that I now turn.

Notes

1 Following Franklin (1990) by referring to the 'couple' Schulman reinscribes hetero-normativity into the sale of ART.

2 See Fausto-Sterling (1992) for an admirably clear explanation of genetic inheritance, especially as regards gender.

3 See Mirzoeff for a discussion of visuality in medicine and 'the growing tendency to visualize things that are not in themselves visual' (1999: 5).

4 It is important at the very outset of this discussion to distinguish my remarks in what follows from a discussion of kinship in relation to egg donation. Although I skirt formulations of relatedness, my main concern is with a specific use of visuality in and around egg donation – and not with kinship. For discussion of kinship in relation to egg donation specifically, see Cussins (1998b) and Konrad (1996). For more a general discussion of kinship see Yanagisako and Collier (1987). For a discussion of kinship in relation to ART, see Strathern (1992b). For an in-depth discussion of kinship and critiques of the Euro-American model of biological kinship, see Franklin (1997).

5 For a discussion of the way in which this discourse is generally aimed at white, middle class women see Williams (1995), Hartouni (1997), Roberts (1997) and Shoat (1998). See chapters three, four and five for a more detailed discussion of the way the industry takes up formulations of race and class.

6 See chapter five for a discussion of the father's role in genetic inheritance. For an excellent discussion of the discourse of value in sperm donation based upon close readings of promotional material produced by American semen banks, see Schmidt and Moore (1998).

7 In addition to the visual culture produced by and surrounding the contemporary Anglo-American fertility industry, the centrality of the internet to the American practice of ART has been ignored by feminist critiques of the industry. The internet has become a key site for both the practice of ART and the dissemination of information about it. Many if not most clinics and third-party agencies have websites and conduct a significant amount of business through them. As in other industries, these range from relatively simple sites that have only a few graphics and offer basic information about the institution to complex sites designed by or in conjunction with professional web designers. Although generally regarded as recruitment tools, many of these sites may serve an educational function.

From interviews I conducted in October and November 2001, it appears that agency websites tend to operate as recruitment tools and clinic websites to operate as educational resources for existing clients. For a critique of the internet and its advocates' claims for its equalising potential, see Robins and Webster (1999). For critical analyses of various facets of internet use which do take account of gender, see Jones (1997) and Green and Adam (2001).

8 Intracytoplasmic Sperm Injection (ICSI) refers to an ART developed to assist conception when the male has a low sperm count or low sperm motility. In ICSI, eggs are retrieved from either an egg donor or an IVF patient and injected with a single sperm.

9 Pink criticises Chalfen and Prosser, in whose edited collection the former's work appears, for 'propos[ing] problematically prescriptive frameworks that aim to distance, objectify and generalise, and therefore detract from the very qualities and potentials that the ambiguity and expressivity of visual images offers' (2001: 3). I feel nonetheless that, in developing this framework, Chalfen does by his very prescriptiveness offer a language with which to speak about the set of highly repetitive images with which I am concerned here. For more extensive analyses of the ambiguity inherent in images, see also Mitchell (1986) and (1994). For further discussion of image-based research, see also Rose. For key interventions in the critical reading of images, see Berger (1972) and Tagg (1988).

10 A photomicrograph is 'an image shot through the lens of [a] microscope' (Cartwright 1995b: 81). See Cartwright (1995b) for a historical critique of photomicrography and other medical imaging technologies. See McGrath (2002) for an analysis of imaging technologies, including photomicrography, and the production of the female body as spectacle.

11 Writing that 'Twentieth-century microscopic imaging provides examples of medical visual culture at its slickest and most aesthetically polished,' Cartwright 'attempt[s] to rough up the smooth modernist surface of the microscopic image in order to uncover a history encoded in the interstices of this complexly layered field' (1995b: 83). Related to Cartwright's comments and the use of pastels, it would be interesting to consider in what ways the colours that eggs are stained can be considered to tie into what Martin (1991) identifies as the dominant narrative of heterosexual romantic love that characterizes the discussion of fertilization in American medical textbooks.

12 See Balsamo (1996) pp. 56-79 for a critique of cosmetic surgery and images such as Magassy's used to sell this.

13 See Banks (2001: 24) on the non-meaning of text in academic textbooks: 'The distinction between text and image, as found in illustrated academic textbooks, is not absolute. The syntax of languages such as English is sufficiently strong that the visual or design elements of the printed word in academic contexts is normally limited to mere style, contributing little or nothing to meaning' (2001: 24).

14 It is interesting to note that while no longer painted, some posed portraits such as figure 2.16 are made to appear as if they had been painted.

15 See chapter four for further discussion of firm's efforts to negotiate the public. Dr Jackson told me about the difficulties he encountered in getting one local college paper to run one of his recruitment advertisements for egg donors. The advertisement indicated that donors would be paid $2,000 'for their kindness and generosity'. According to Dr Jackson, the editors felt this figure was too high and as a result they made a global editorial decision 'that they would not publish any ads from *any* organization that had *anything* to do with human reproduction'. Dr Jackson's experience supports the view that, although ART may very well receive broad acceptance on the national level, this does not guarantee that it will be similarly accepted on the local level.

16 See Banks (2001) for a discussion of the photographic as evidence and documentary.

17 Fertility patients are seen less often than egg donors, but this appears to be changing slowly. Given that clinics and agencies often refer to a discourse on their clients' perception of infertility as shameful as a means of legitimising ART, the visual and discursive anonymity of clients is not surprising.

18 For more extensive analyses of the relationship between representations of the female body and science, see Jordanova (1989 and 1999).

19 See Arditti et al. (1984), Hartouni (1997) and Stabile (1994) for further discussion of ART's capacity for eugenics.

20 For a discussion of the ways in which the possibility of testing for foetal abnormality has impacted the experience of pregnancy, see Katz-Rothman (1986).

21 For an outstanding history of abortion in the United States, see Petchesky (1986).

22 In the United States, debate on 'trimming' (or foetal reduction) has surrounded reports of high-order multiple births such as the McCaughey septuplets and the Chukwu octuplets. As an example of mainstream press coverage, see Schindehette (1997) and Finkel (1999).

23 Green made a similar point when I spoke to her. The issue of success rates came up when I asked if her firm had many overseas clients. She replied:

We have some. But we have some because the rates are reported to be much higher in the States. But you know what? Now, I have not looked at the statistics myself. I know someone from England told me that their success rate was 30 per cent over there. Over here it's reported to be 80 per cent. But I have to tell you, it depends on what you're counting. This is really one of those issues where it depends on how you crunch the numbers. The numbers can be jiggled. Funny math. And it depends on what you're looking at. Are you counting how many take home babies versus how many cycles it takes you? If you're looking at *that*, it's not 80 per cent. But now if you're talking about embryos put back per pregnancy, it might be 80 per cent. Do you see, the factors that go in there? Are you putting back an embryo or are you putting back a blastocyst? Are you counting the pregnancy or are you talking about a live birth? And, so, you know, there really should be more standardized comparisons. Because actually, you know, I can at least say that at least in Dallas most everybody's pretty much the same as far as rates go. It really depends on what you look at.

24 Given the debates on older women as mothers, especially when egg donation is in question, it is interesting to note that the mothers and fathers in these images are young. They generally appear to be no more than about thirty-five to forty years of age – the age, as noted, at which doctors recommend egg donation to women.

Chapter Three

Summoning White Clients: The Racial Embodiment of Motherhood

> A friend of mine recently questioned my interest in a custody battle covered on the evening news. A surrogate mother who had agreed to gestate a fetus for a fee decided she wanted to keep the baby. 'Why are you always so fascinated by those stories?' he asked. 'They have nothing to do with Black people.'. . . In one sense my friend is right: the images that mark these controversies appear to have little to do with Black people and issues of race. Think about the snapshots that promote the new reproduction. They always show white people. (Dorothy Roberts 1997: 246)

> When I made that website up, I didn't think of images. I just thought about what do we do and how can I inform patients about what we do . . . I did intend it as an advertisement but I didn't want it to look like an advertisement. I wanted it to look like a source of information. (Dr Daniel Cole)

> In what public discourse does the reference to black people not exist? (Toni Morrison 1992: 65)

Introduction

After moving to Edinburgh in late 1998, I spent some time in November and December of that year and January and February 1999 searching the internet for the websites of British fertility clinics. I was looking for two different types of information. On one quite basic level, I sought to determine where clinics were physically located, which ART they offered and how much they charged for various assisted conceptive technologies, ranging from relatively low-tech drug regimens designed to induce ovulation to considerably

more high-tech procedures such as IVF, ICSI (intracytoplasmic sperm injection) and oocyte donation. On another level, I was curious about how these institutions fitted into a medical system largely unfamiliar to me at that time; I also sought indications of the extent of the institutions' cyber presence. When I began my research, it was by no means clear to me that fertility clinics and other medical institutions in Britain might view the internet as a valuable marketing tool in the same way as clinics and other medical institutions in the United States appeared to view it.

Finding that many British fertility clinics did produce websites, I was keen to examine the kinds of information firms posted about the ART they sold, the staff members who performed these procedures, the facilities where the deployment of various ART took place and the fees charged, but I was equally interested in the manner in which such information appeared. I was particularly curious as to whether websites would be dominated by, for example, detailed descriptions of medical conditions and procedures, written text, tables, images, a combination of any of these or something else entirely. Furthermore, and regardless of whether individual sites could be roughly categorized as text-based, table-based or image-based, I also wondered how – if at all – the design and layout of the websites of British fertility clinics related to or differed from the design and layout of the websites of their American counterparts, with which I was much more familiar. At the time, it occurred to me that perhaps tracking the similarities and differences between British and American fertility clinics' self-representation on the internet could provide the foundation for a larger, although at that point necessarily not

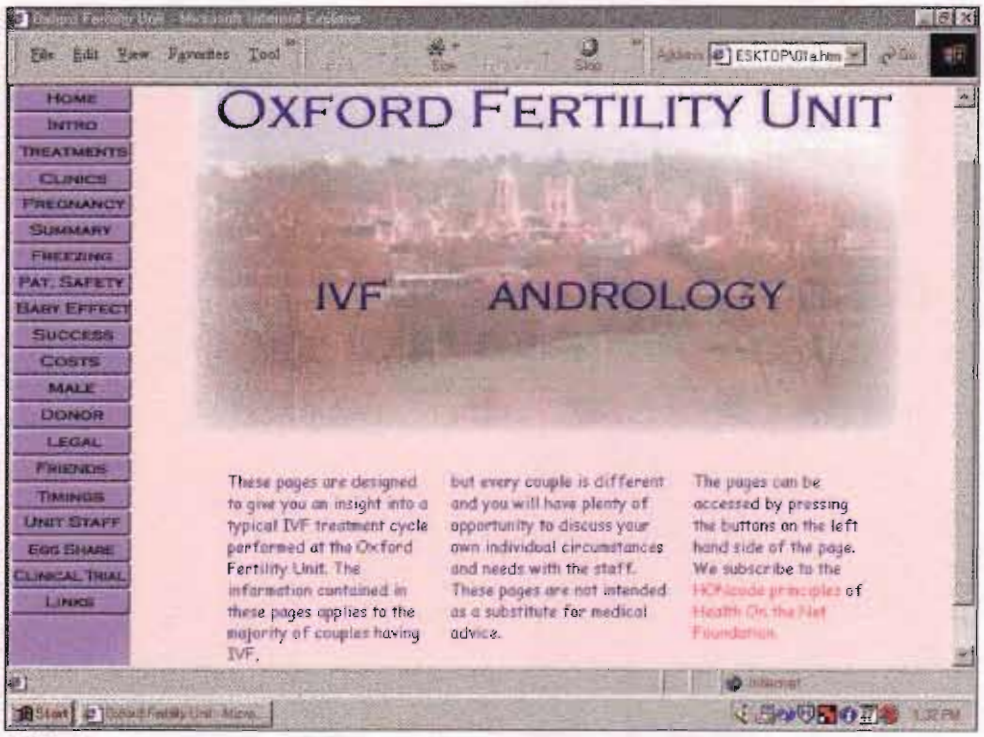
well-defined, comparative project on the contemporary Anglo-American fertility industry's visual culture.

Figure 3.01: *Oxford IVF Unit*

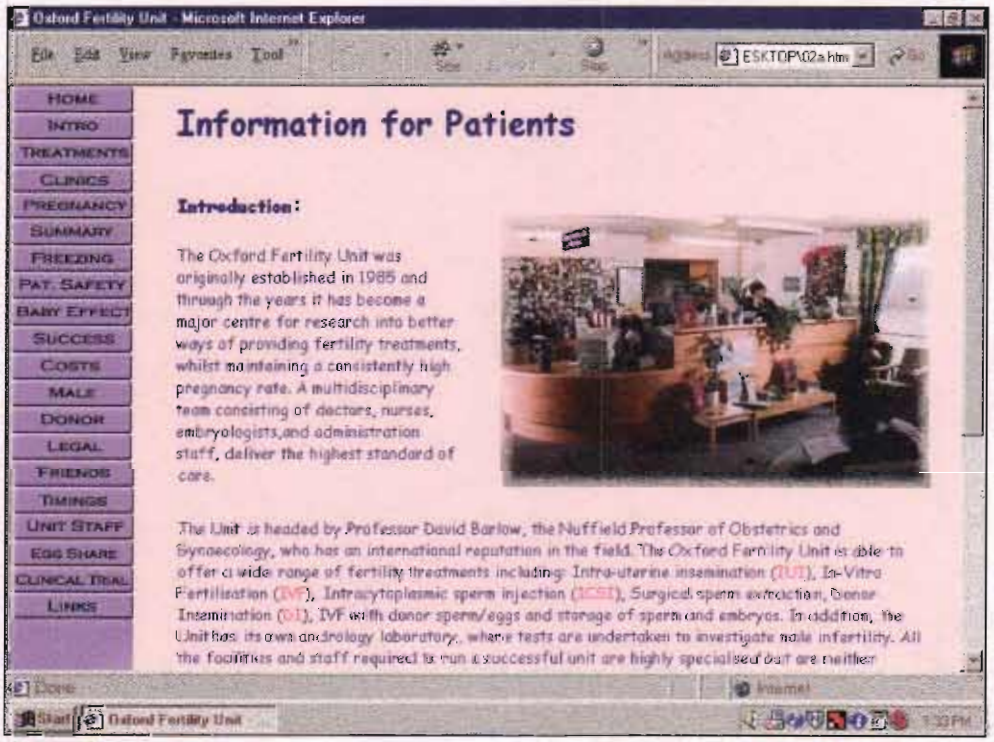
It was during one of these surfing sessions that I first encountered figure 3.01. Appearing in the midst of the Oxford Fertility Unit's virtual tour, and originally reproduced in chapter two as figure 2.04, the image appears on the thirteenth of the twenty main webpages that comprise the unit's website and provide a variety of information about the

clinic. As figure 3.02 shows, other pages present, *inter alia*, a discussion of the different types of treatment available at the clinic (slide 3), an indication of the clinic's rates of success in assisting its clients to conceive and give birth (slide 10) and a list of clinic staff (slide 17).

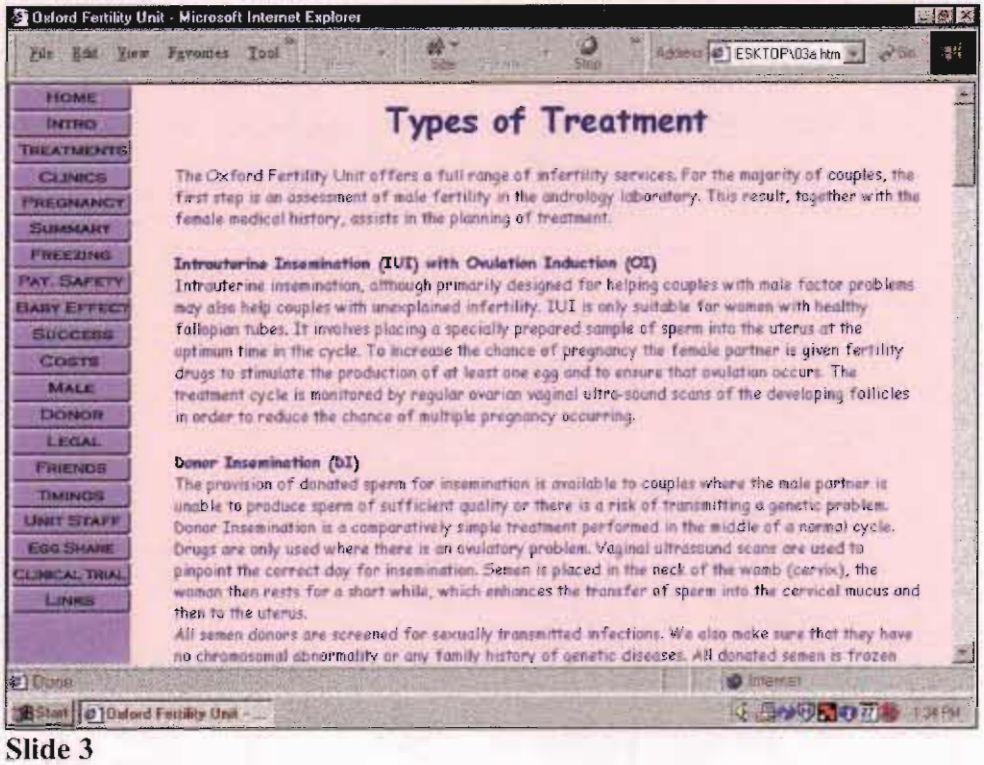
Figure 3.02 Oxford Fertility Unit Virtual Tour (website: www.fert.org.uk)



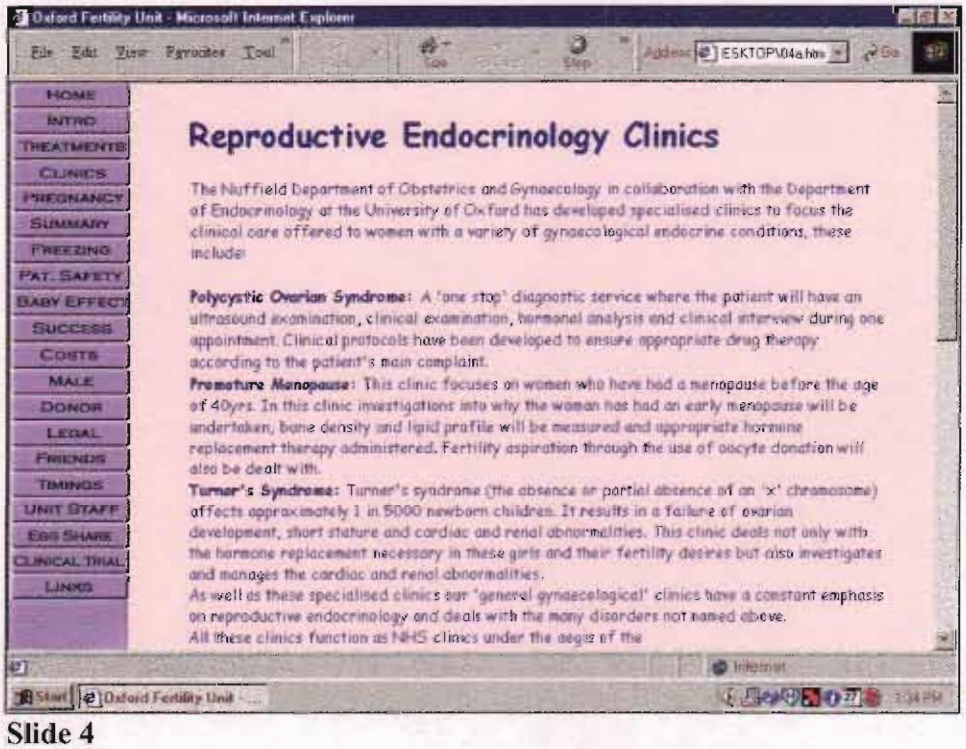
Slide 1



Slide 2



Slide 3



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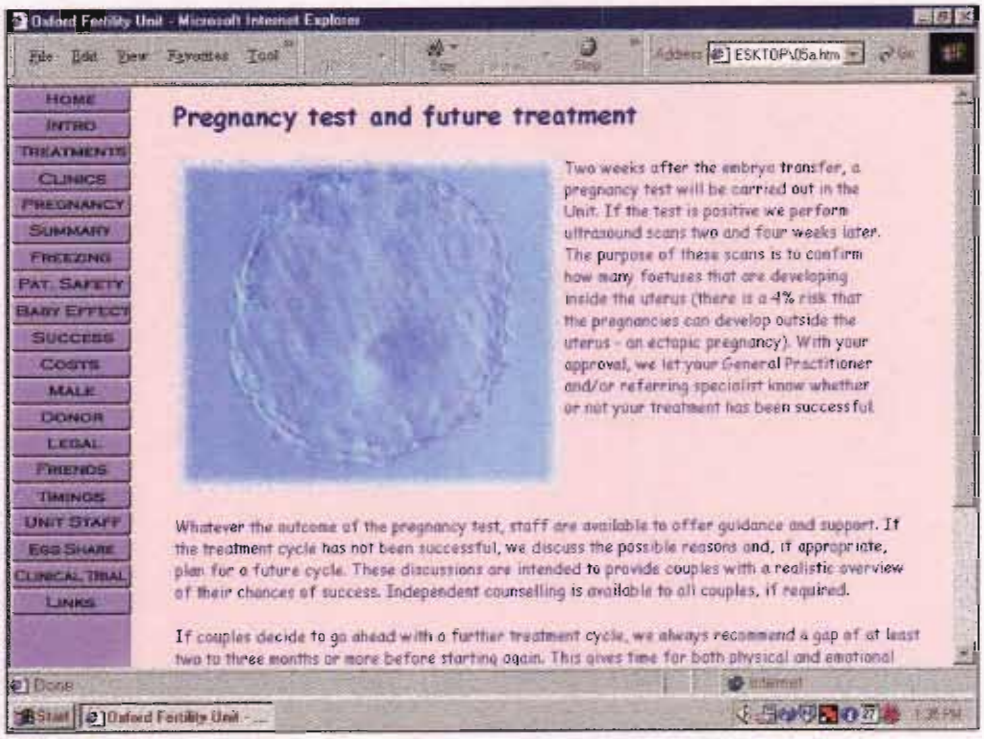

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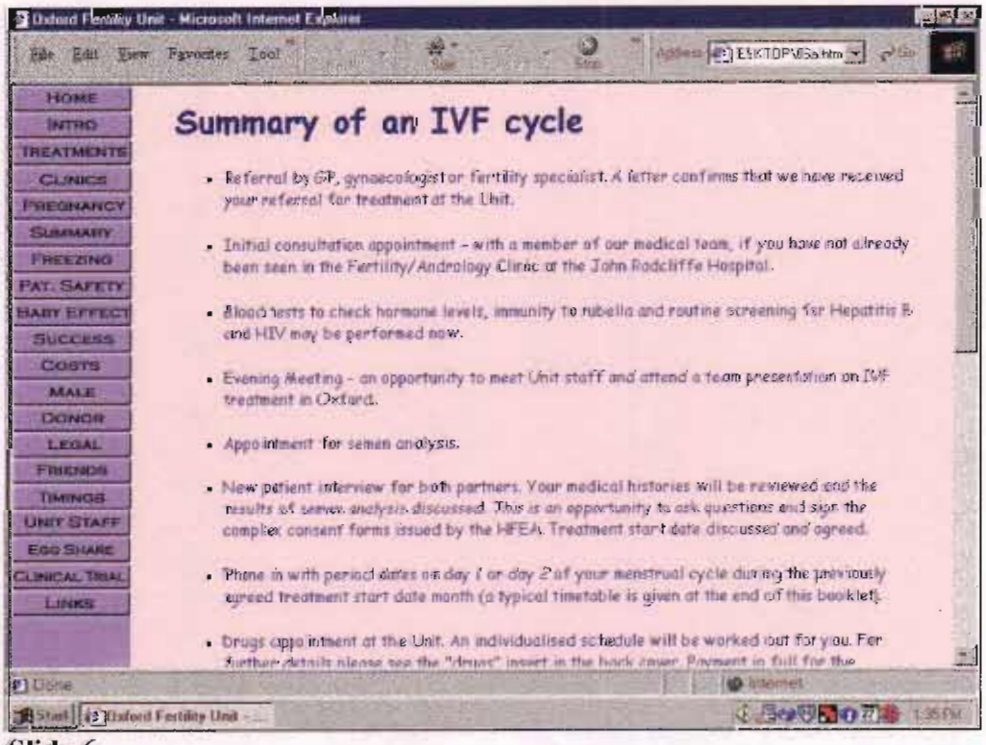

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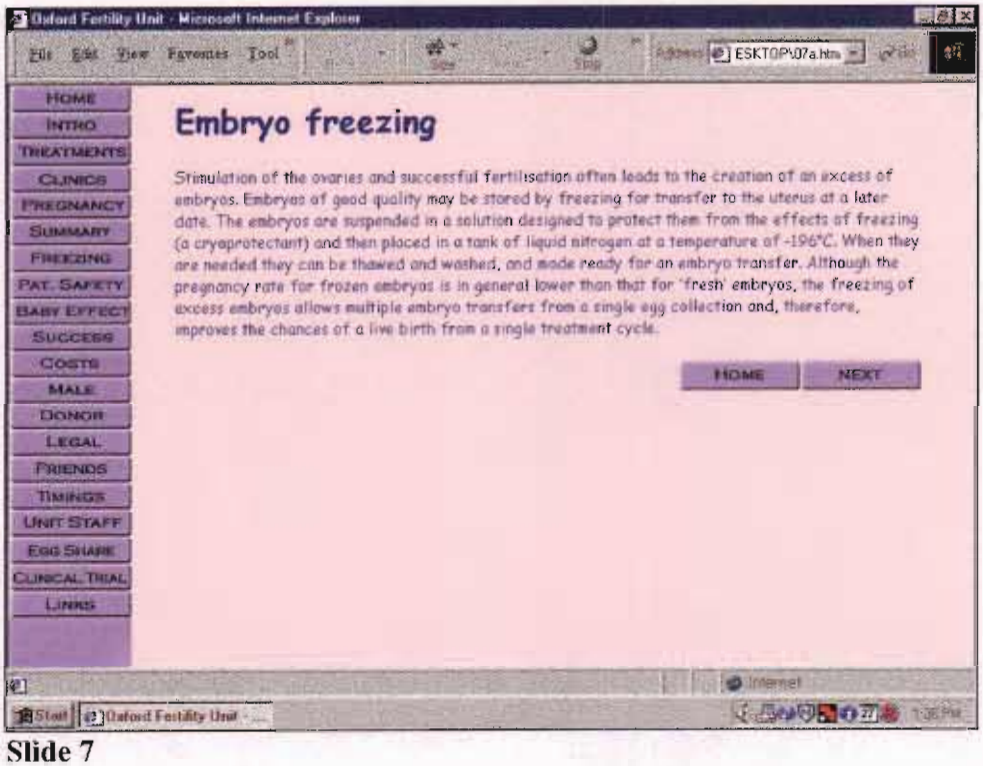

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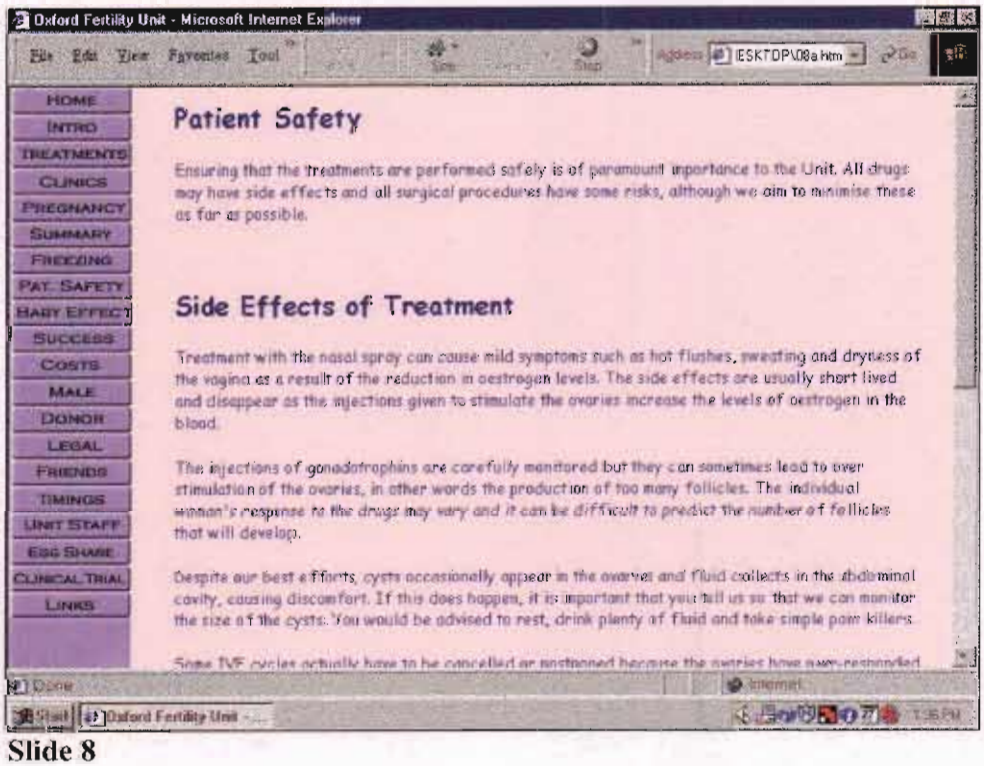

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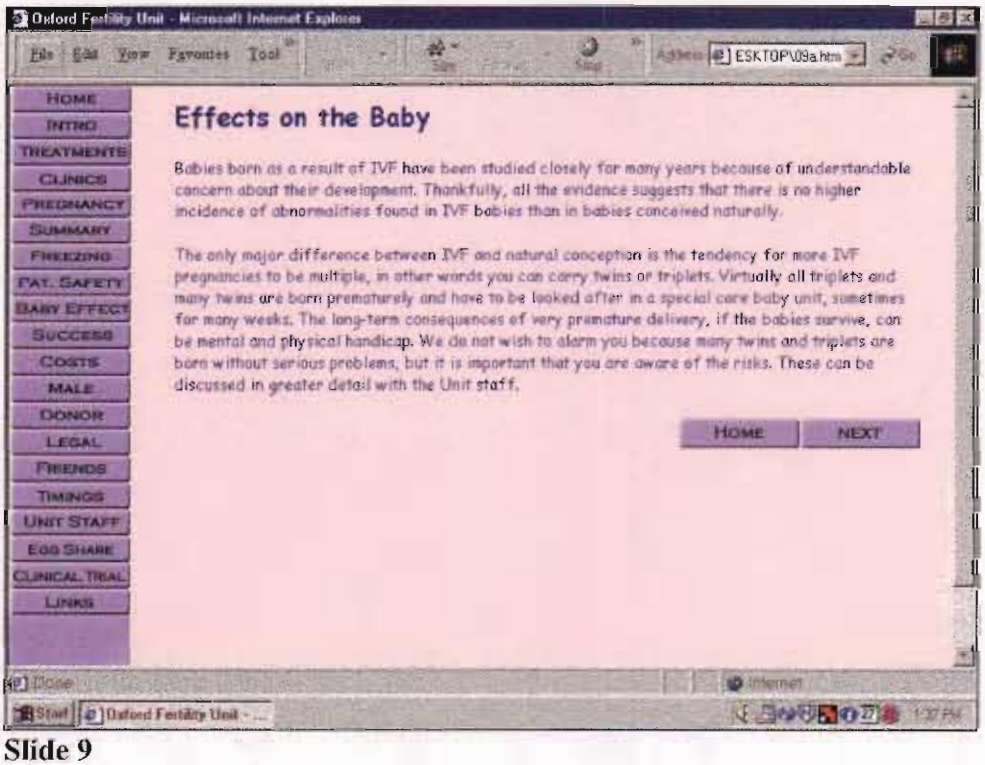

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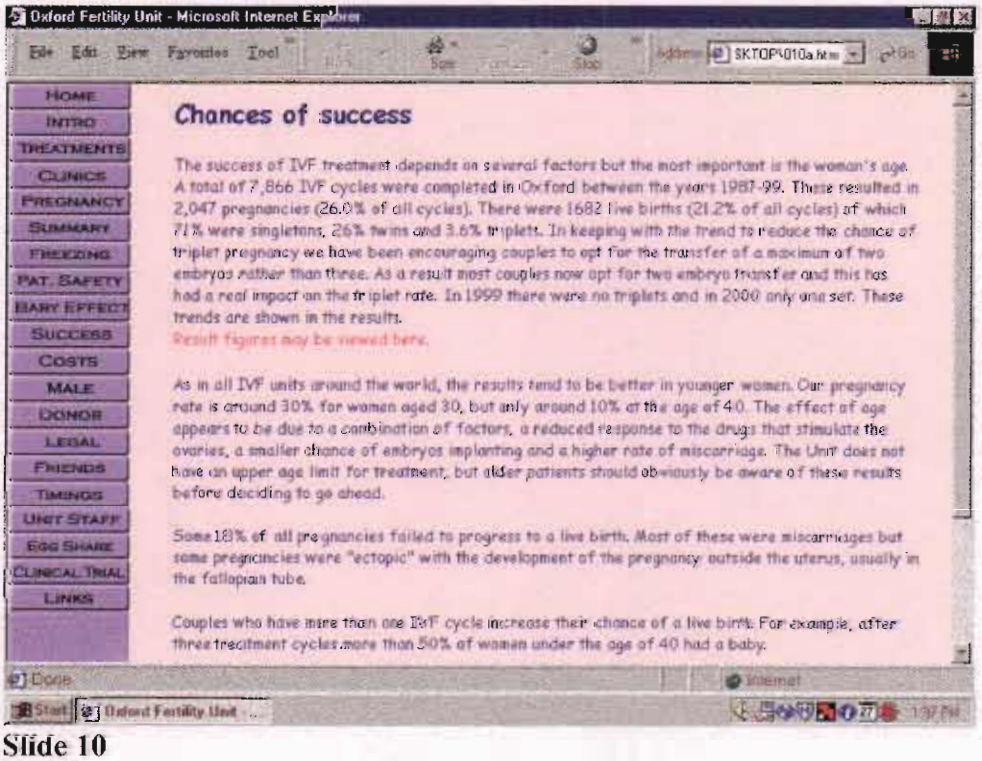

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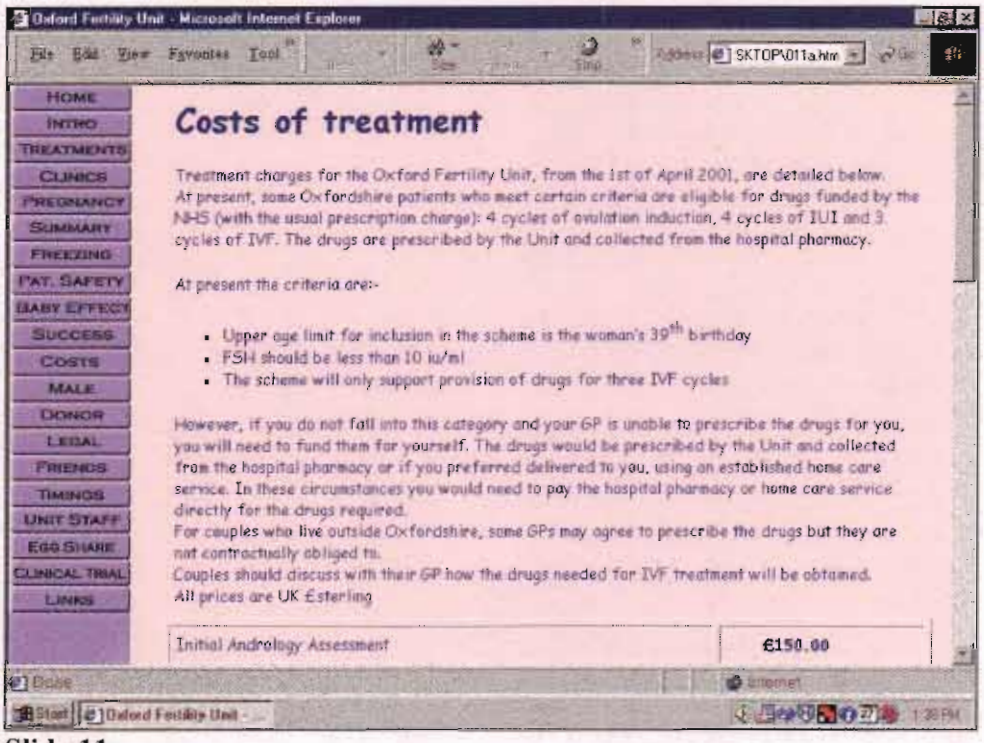

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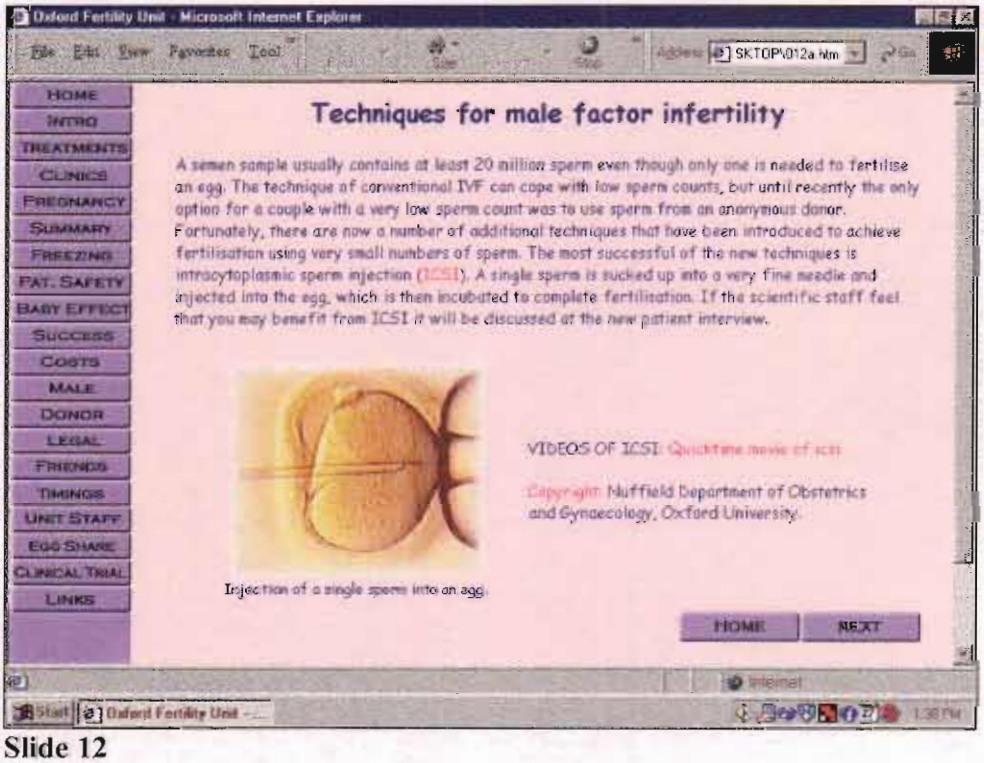

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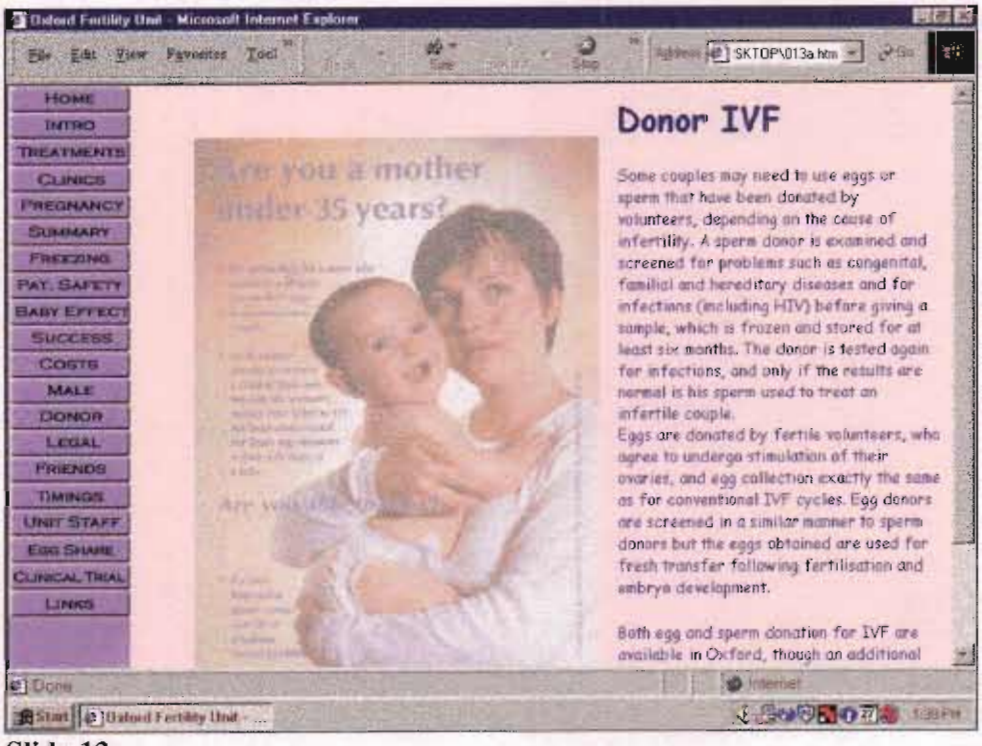

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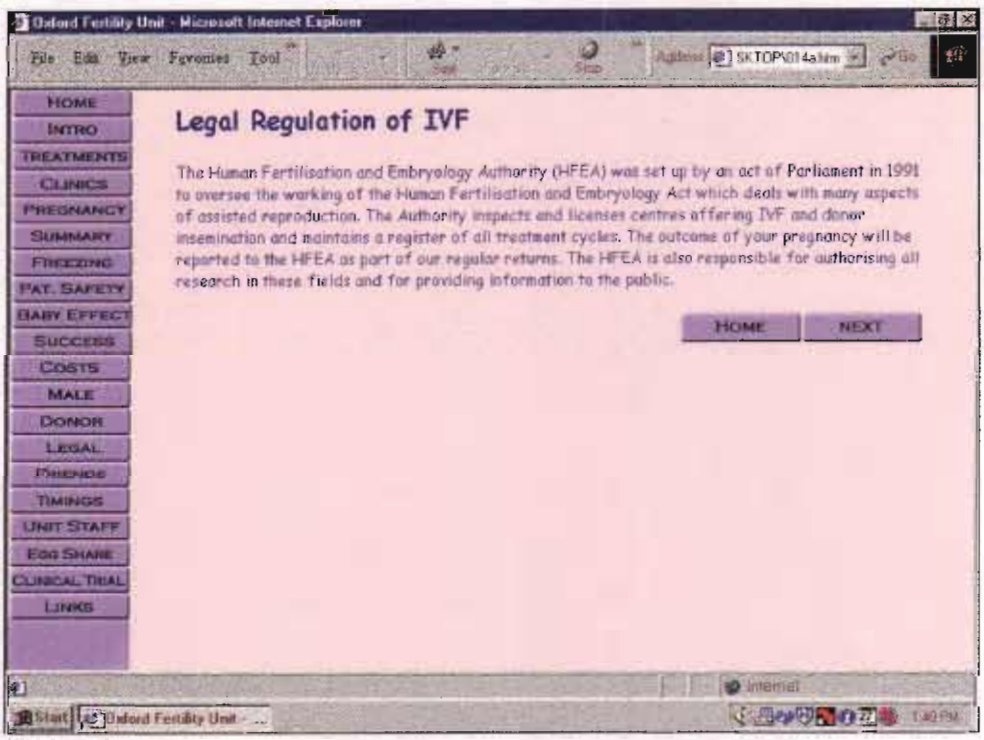

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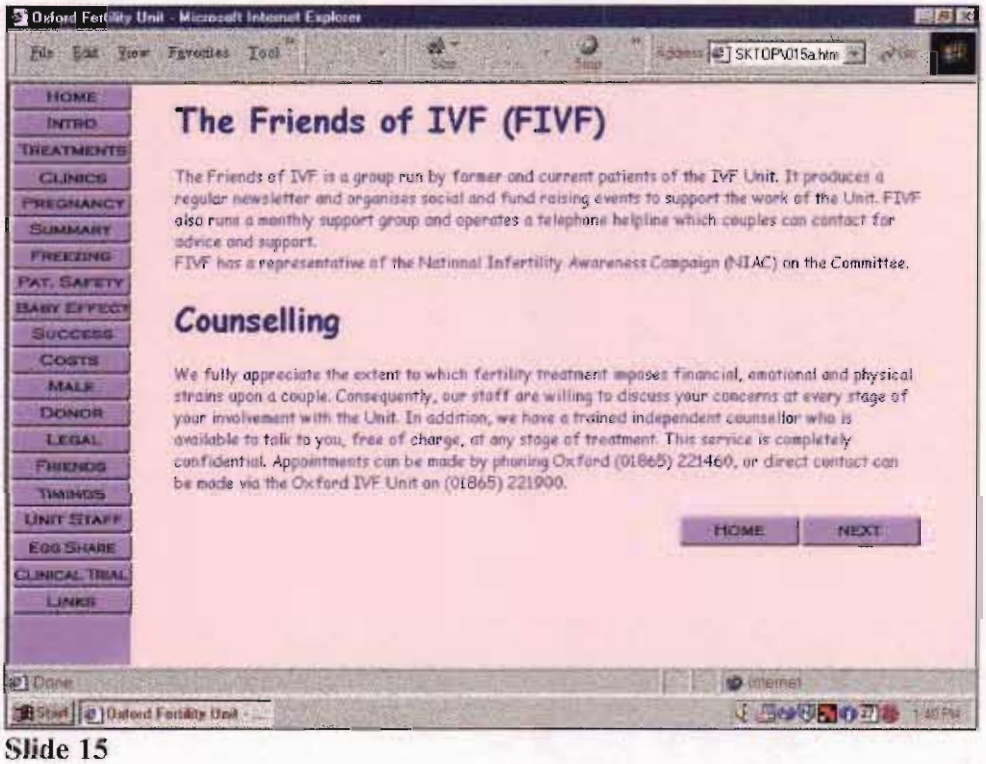
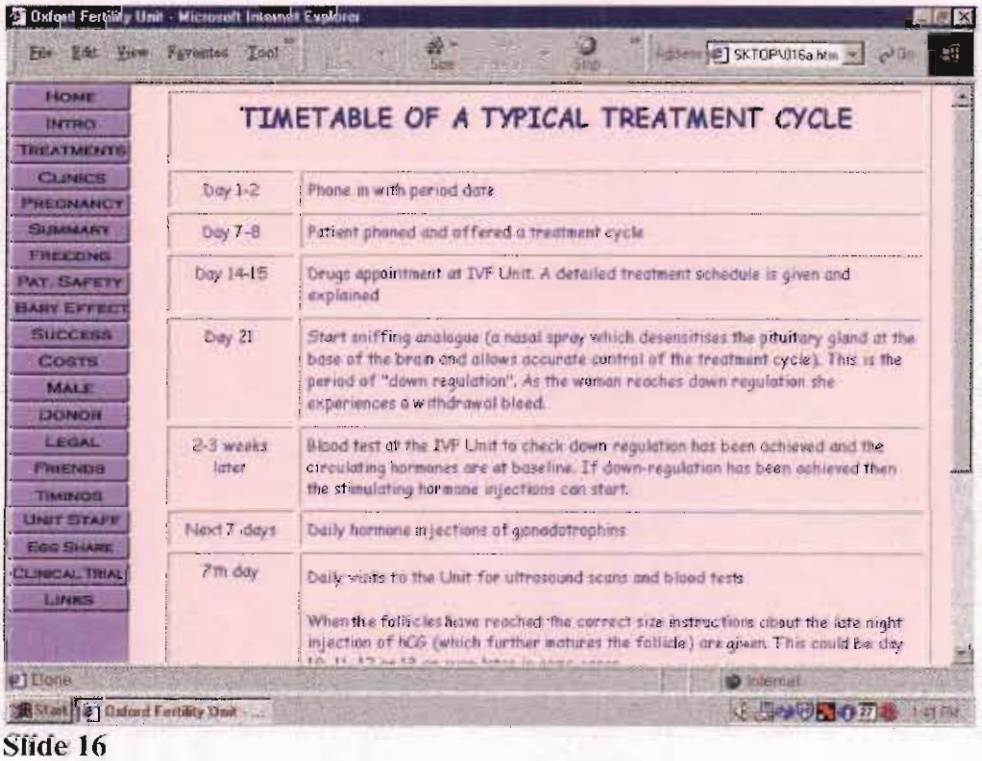
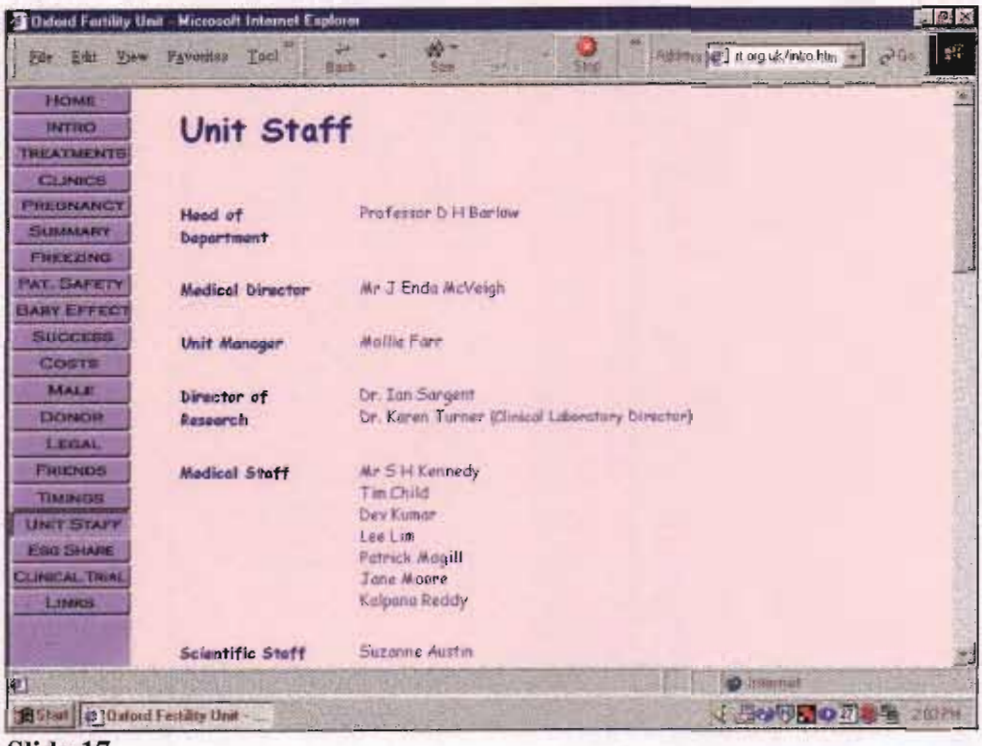


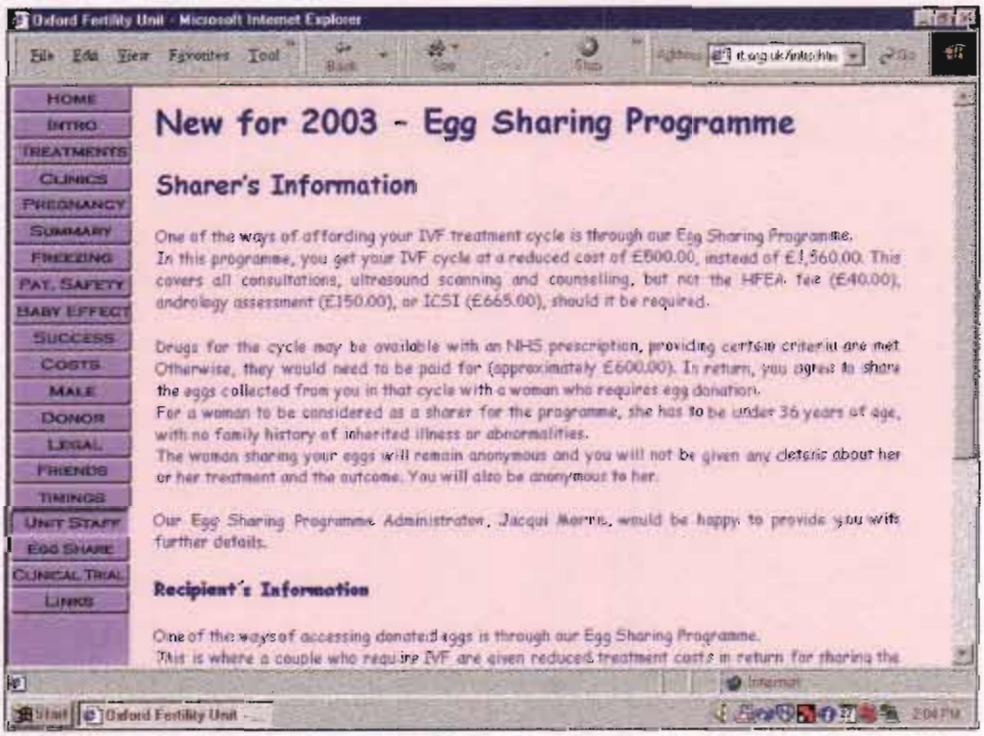
Slide 15



Slide 16



Slide 17



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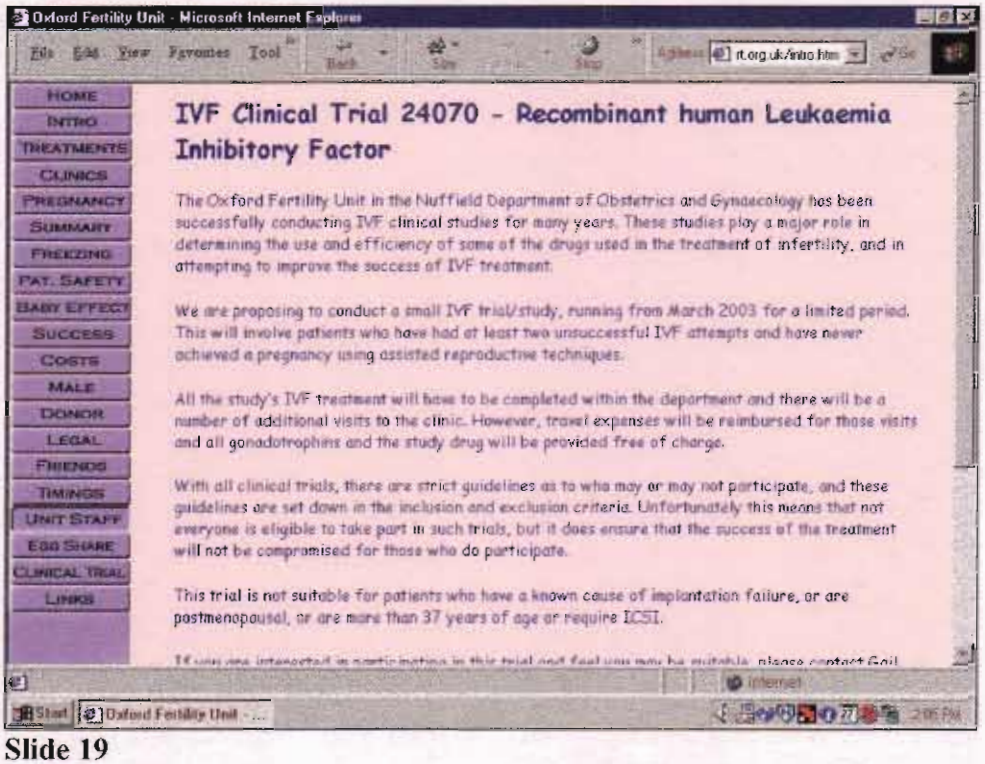

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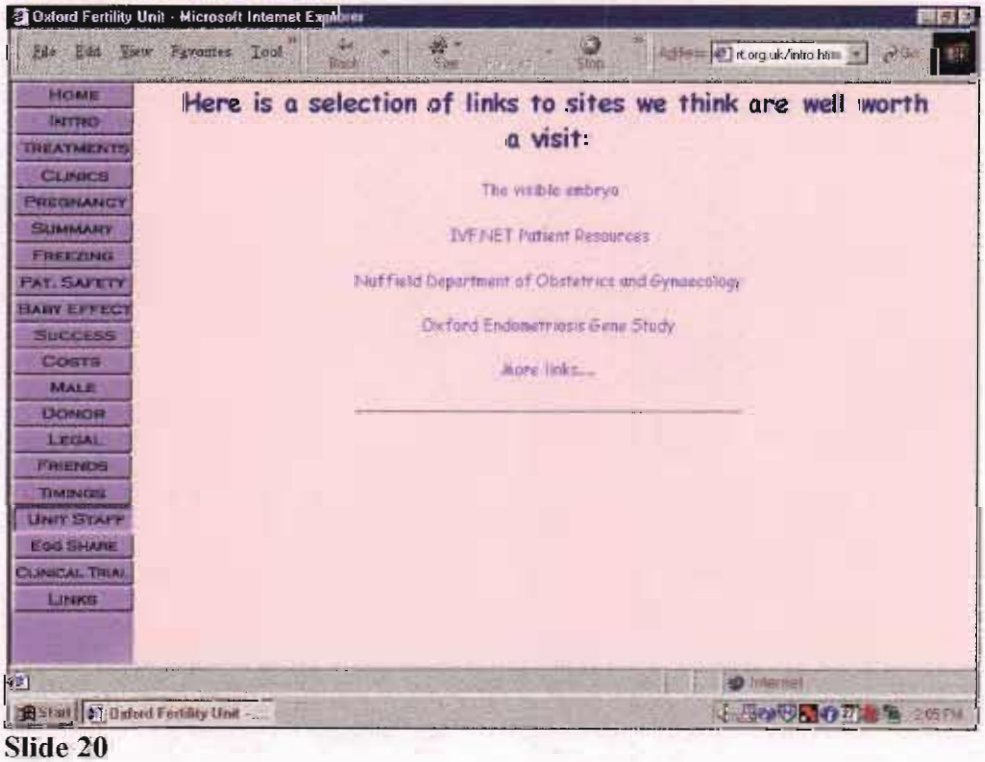


Slide 20

Since the time in late 1998 or early 1999 when I first became aware of figure 3.01, the image has undergone at least one significant change. As shown in slide 13 of figure 3.02, the now somewhat muted or soft-focus image appears within a webpage that contains a fair amount of text to its right. Although I cannot give any indication of when the page was updated or speculate as to the reason for this change, it is nonetheless important to highlight this shift in design. When I first saw the image, it alone comprised the entire webpage and was in sharp focus. That is to say, other than the text within the image, there was no additional written information on the page and the image appeared as it does in figures 3.01 and 2.04, not with the softer focus that characterizes its current appearance in the webpage.

Whether this change is foregrounded or ignored, there are a number of ways of engaging with figure 3.01. Focusing on the advertisement's external narrative, it is possible to begin to track both the clinic's acknowledgement of its need to acquire the eggs upon which the practice of egg donation depends and its initial effort to acquire them. Working to persuade other women to consider donating eggs, the image of the woman and the child provides the Oxford Fertility Unit with one means of negotiating one of the central issues that this ART poses for clinics on both sides of the Atlantic and for third-party agencies in the United States. Figure 3.01, like the posters referred to in chapter two that Konrad discussed in her own dissertation, may help to bring prospective egg donors into the Oxford Fertility Unit's programme. Thus, it may assist in enabling a new prospective egg recipient to be matched with an acceptable donor or reduce the amount of time an existing prospective recipient must wait in order to be matched with a prospective donor.

Also worthy of sustained critical engagement is figure 3.01's internal narrative. This, it may be argued, addresses the issue of the firm's need to be seen to manage the genetic difference that inheres between a mother and a child conceived through egg donation. In other words, the advertisement takes up the second of the two fundamental issues egg donation poses for the institutions that offer and arrange this ART. Withholding the data required to enable the reader to determine whether the woman pictured used her own eggs to conceive the child she holds or whether she purchased another woman's eggs in order to so, figure 3.01 does not simply pronounce genetic difference to be effectively manageable; its internal narrative actively performs this. There is no way to tell by looking how this woman and child are related.

When read in this way, figure 3.01's external narrative can be understood to join with its internal narrative to meld two different and, for all intents and purposes, mutually exclusive roles of egg donation into the figure of a single woman. The indeterminacy as to whom the written text above and to the left of the woman addresses – for example, does it address the woman pictured or does it address an unseen intended reader – coupled with the impossibility of the visual detection of genetic difference, makes figure 3.01 function as a crossover image. In other words, the woman pictured could represent an egg donor at the same time as and to the same extent that she could represent an egg recipient. Given the information provided, there is simply no way to determine whether this mother and this child are or are not genetically related.

Although it is not possible to conclude definitively to which side of the donor-recipient divide the woman holding the child 'rightly' belongs, or within which visual convention figure 3.01 ought finally to be classified, the pictorial merging of two distinct roles into the figure of one woman can be recognized as bringing together two discrete visual conventions. This, in turn, enables the identification of traits common to the Oxford Fertility Unit's imaging of both an ideal egg donor and an ideal egg recipient. Age and able-bodiedness are two such traits; to the extent that either one of them may be read from an image such as this, it is reasonable to conclude that the clinic imagines both donors and recipients as relatively young and free from marked physical disability. There is also a commonality in terms of race; as is clearly seen in figure 3.01, the Oxford IVF Unit images both its ideal donor and its ideal recipient as racially marked as white.

As egg donor becomes egg recipient and vice versa, what stands out is the whiteness that characterizes both reproductive roles. The fact that the woman holding the child is racially marked as white in a single advertisement representative of not one but two distinct visual conventions invites comparison with other advertisements found in these same groupings. When figure 3.01 is read alongside other images of donors and for donors, such as those reproduced in chapter two, it becomes apparent that whiteness as the pre-eminent racial categorization is very far from being confined to one clinic's representation of its imagined donor and recipient. Even the most cursory glance backwards through the images reproduced to illustrate chapter two's discussion of these two visual conventions reveals that whiteness is as pervasive in images of donors and images for donors as I indicated it was in images of the child.

Why is it that, like fertility clinics in Britain, clinics and third-party agencies in the United States visually represent egg donors and recipients (and the children conceived as a result of egg donation) almost exclusively as racially white? Although I will argue that this is highly unsatisfactory for a number of interrelated reasons, it is nonetheless possible to identify broad endorsement for a reading of the whiteness in the industry's visual culture that figures it as mirroring the dominant racial categorization of the industry's clients. In other words, one answer to the above question is that clinics and agencies tend to depict egg donors and recipients as overwhelmingly racially white simply because the majority of their clients are white. If the majority of egg recipients were, for instance, black, Asian or Latino/a, then donors and recipients would be visually represented as black, Asian or Latino/a by clinics and agencies. In short, the industry's visual culture does nothing more and nothing less than reflect the reality of the day-to-day lived practice of fertility medicine.

While the issue of racialization in the industry's visual culture has not been addressed by other feminist and cultural studies theorists' work on ART, key support for what I term this 'reflective hypothesis' may be located in, among others, an epidemiological evaluation of egg donation, a newspaper article detailing the shortage of racialized gamete donors, and remarks made by the industry practitioners with whom I spoke in October 2001. Each one of these can be read as contributing to the endorsement of a reading of the industry's visual culture which figures it as reflective of a reality wherein white women opt to pursue ART more often than do non-white women.

Beginning with the epidemiological study of egg donation, and focusing on the practice of this ART in the United States, in what follows I examine each of the above-mentioned texts against feminist and cultural studies analyses of race and against feminist analyses of reproductive politics, policy and practices. This enables me to show that, while the texts and others like them may be used to support a reading of the industry's use of whiteness that maintains that it unproblematically reflects clinics' and agencies' client base, this contention is ultimately flawed because it fails to contend with the hydras of racialization and legitimacy that do not merely underpin but are constitutive of reproductive discourse, policy and practice in the contemporary United States. As I argue throughout this chapter, it is only by taking account of long-standing discourses on racialization and reproduction that it is possible profitably to engage theoretically with the whiteness that I have sought to identify. My aim in theorizing the industry's reliance on this whiteness in imaging its egg donors and egg recipients is to combat, albeit in a small way, what I regard as the far from benign reign of this whiteness over the contemporary American fertility industry's visual culture.

I. Reflecting the 'Real'? Epidemiological Narratives of Infertility

Is the contemporary American fertility industry's persistent visual representation of egg donors and recipients as racially white intended directly to reflect epidemiological data that indicates that white women constitute the majority of this ART's clients? In other words, could the industry's visual culture be considered to be purely indexical? Whether by design or chance, do visual images of white women in clinics' and agencies' advertisements, brochures and webpages mirror the fact that more white women than

African-American women, Asian-American women, Latina women and/or any other group of racialized women in the contemporary United States elect to pursue egg donation?

In 'The Differential Effects of Race, Ethnicity, and Socioeconomic Status on Infertility and its Treatment: Ethical and Policy Issues for Oocyte Donation' (hereafter referred to as 'Differential Effects'), the medical ethicists and policy researchers Elizabeth Heitman and Mary Schlachtenhaufen do not address the industry's visual representations of its work. Differently oriented, their essay 'explores the ethical questions and policy challenges raised by racial, cultural, and socioeconomic issues for the practice of OD [oocyte donation]' (1996: 189). Endeavouring to plot the multiple, lived intersections of race, class, ethnicity and ART, Heitman and Schlachtenhaufen take up the issue of access to egg donation and demonstrate how women's assumed as well as self-reported racial, ethnic and class affiliations may impede or enable individual subjects to purchase this ART. Nevertheless, as a result of this concern, their essay provides a point of departure for an engagement with the cultural logic undergirding clinics' and agencies' continual reliance on whiteness in visually representing their clientele. In this section, therefore, I draw on Heitman and Schlachtenhaufen's text in order to begin to contest the notion that the whiteness characterizing the fertility industry's visual culture must be read as reflecting the lived practice of egg donation. The article also serves to launch the larger argument that any assessment of industry-produced representations of the practice of fertility medicine that figures these representations as re-presenting the 'real' is inadequate.

'Differential Effects': Infertility and Racialization

Characterizing their 'primary focus' as 'an examination of problems raised by imprecise conceptual definitions and differences in cultural perspectives on fertility, motherhood, family, heritage, the role of women in society, and appropriate medical intervention in procreation' (ibid: 189), Heitman and Schlachtenhaufen distinguish their work from that of other researchers concerned with female infertility. They maintain that one problem repeatedly encountered in the work of others is the deployment of inadequately conceptualized racial, class and ethnic categories. Due on the one hand to a long-standing concern with the 'the *overfertility* of poor and nonwhite women' (ibid: 191; emphasis in original), and on the other to the fact that surveys designed to elicit information on reproductive health have tended to feature very limited options for the racial and ethnic categorization of respondents by either themselves or, more problematically, the data collectors who interview them, the racial, class and/or ethnic categories used in epidemiologically-based discussions of infertility tend, according to Heitman and Schlachtenhaufen, to have little internal coherence. (ibid: 189).[1] Thus, the researchers may be said to consider these of questionable analytical value.

Having stated the deficiencies particular to previously gathered data that aimed to address the incidence of infertility according to race, class and/or ethnicity, in the remainder of their essay Heitman and Schlachtenhaufen concentrate on two interrelated issues. Firstly, they assert convincingly the paucity of information about non-white and/or poor women's rates of infertility. Secondly, they attempt to determine whether egg donation, as it is currently practised in the United States, exploits non-white and/or poor women.

Bound up in a discourse specific to medical ethics, the need to make such a determination stems, Heitman and Schlachtenhaufen write, from the view that 'the full moral significance of any issue depends upon the experience of the least powerful members of society, classically the poor and, in the contemporary United States, nonwhites' (ibid: 188–9). No matter how beneficial egg donation may be for middle-class white women, if the two researchers come to the conclusion that this ART is exploitative of non-white and/or poor women, then it may well be that Heitman and Schlachtenhaufen will adjudge egg donation to be an ethically problematic ART.

For Heitman and Schlachtenhaufen, the exploitation of non-white and/or poor women *vis-à-vis* egg donation manifests itself in one of two ways, depending upon whether a woman is a prospective egg recipient or a prospective egg donor. A prospective recipient who is non-white and/or poor may be actively discouraged from the pursuit of egg donation or, given its high cost and her physician's presumption of her inability to afford it, she may never be told of its existence as a reproductive option for her. On one level, therefore, Heitman and Schlachtenhaufen understand exploitation to include non-access to fertility 'treatment'.

For a non-white and/or poor prospective egg donor, however, exploitation does not involve a lack of access to fertility medicine. Rather, it concerns the question of access itself. Heitman and Schlachtenhaufen initially posit that, as a prospective donor, a non-white and/or poor woman may be unduly susceptible, given the relatively large financial reward to be gained from it, to being persuaded to donate her eggs when it might not be

in her best interest to do so. Therefore, on this level exploitation is understood to mean not non-treatment but improper treatment, defined as inappropriate financial coercion of non-white and/or poor women to undergo a drug regimen and a surgical procedure which are not only completely unnecessary to their own well-being but which may, in fact, cause them harm or even death.[2] Leaving aside further discussion of this issue for the moment, I wish to return to the problem of whiteness in the industry's visual culture. I approach this through a consideration of Heitman and Schlachtenhaufen's work on the relative dearth of non-white and/or poor prospective egg recipients.

On the Possible Exploitation of Poor and/or Non-white Egg Recipients

According to data compiled by researchers at the Centers for Disease Control and Prevention (CDC) in the course of completing the regularly conducted National Survey of Family Growth (NSFG), black women within the United States have higher rates of infertility than do white women. According to the most recent NSFG, conducted in 1995, rates of infertility for black women were 10.5% (CDC). For the same period, rates of infertility for white women were 6.4% and for Hispanic women 7.0% (ibid.). These findings are consistent with data from the 1982 NSFG cited by Heitman and Schlachtenhaufen in their article. Working with this earlier group of data, the latest survey available at their time of writing to include a set – albeit limited – of data on race, the two researchers indicate that the rate of infertility for married black women is 21%. As they comment, this is '1.5 times greater than the rate of 13% reported among married white women' (1996.: 195).

If in addition to Hartouni as discussed in the Introduction to this thesis, Heitman and Schlachtenhaufen and the NSFG are correct and it is black women who have the highest rates of infertility in the United States, then this reinforces what I contend is the peculiarity of the persistent representation by the fertility industry and the mainstream media of egg recipients (and donors) as almost exclusively white. One would expect the industry's visual culture to be concerned with the group presumed to be most in need of fertility 'treatment'. According to the data reported by Heitman and Schlachtenhaufen and recorded in the NSFG, this would be black women. Yet it is white women who are most frequently visually linked to ART. Why is this the case? Moreover, if the overwhelming whiteness in the fertility industry's visual culture cannot be understood, as indeed I have been arguing it cannot, as reflective of the population most in need of ART, how can it be conceived?

Heitman and Schlachtenhaufen's work provides partial answers to these questions. Shortly after presenting the percentages cited above, the two researchers note 'significant differences in rates of infertility for black and white women' (ibid: 194–5). They go on to state that this 'documented high prevalence of infertility among black women suggests that they should constitute a considerable proportion of women seeking infertility services'. Yet, they add, 'most women experiencing impaired fecundity do not seek treatment, and infertile nonwhite women seek reproductive services less often than their white counterparts' (ibid: 195). From this statement, it appears reasonable to conclude that the notion that the representation of egg recipients as racially white reflects the lived reality of this ART's client base may not be completely devoid of explanatory legitimacy.

Perhaps it may have something to contribute to the resolution of the question about clinics' and agencies' persistent reliance on whiteness in their visual culture. Although it is evident that non-white women have significantly higher rates of infertility than do white women, the former, for as yet largely unspecified reasons, seek fertility 'treatment' less often than the latter. It can therefore be concluded that the whiteness characteristic of the industry's representations of egg recipients does, in fact, relate to the lived practice of this ART and thus other motives need not be attributed to it. There is, for example, no evidence of a blatantly white racist refusal to include non-white women in representations of egg donation. If nothing else, Heitman and Schlachtenhaufen's work – which did, as discussed above, initially raise the spectre of racism – makes it possible to begin to read the industry's reliance on whiteness as evidence of shrewd business practice. The revelation that, while non-white women have higher rates of infertility, they have lower rates for the pursuit of ART, makes it conceivable that clinics and agencies do not deploy whiteness in visual representations of their work in order to exclude non-white women. Rather, it becomes possible that they do so in order to target their most likely clients – white women.

While compelling, this conclusion fails for two primary reasons to resolve the issue of the overall absence of women racially marked as non-white in industry-produced representations of egg donation. Firstly, it ignores the manner in which the industry narrates its work. As I discuss in sections two and three, it does not necessarily follow that a reliance on the racial category white to represent prospective egg recipients in the visual register will be reproduced either textually or verbally. Indeed, the dominance of

whiteness in visual representations of egg donation cannot be claimed to exist to the same degree in clinics' and agencies' spoken and written representations of their work. These latter are characterized by what can be termed a nascent 'multiculturalism'. This manifests itself, for instance and as I discuss in section three, in verbal assertions that clinic and agency staff will try their utmost to locate a 'perfect match' for a racialized prospective egg recipient.

Secondly, and addressed in some detail immediately below, the conclusion is also inadequate because it fails to acknowledge that, in addition to age, mental and physical health, etc., categorizations of race, class and/or ethnicity are each, albeit differently, constitutive of notions of so-called 'legitimate' and 'illegitimate' reproduction. In other words, to speak about data gleaned from epidemiological analyses of reproduction – or, as I will argue further below, to speak about statistical analyses of its failure – is in some sense to speak about racial, class and/or ethnic categories. This is the case because it is through these groupings that reproductive successes – and failures – become visible in the first place. Hereafter exclusively concerned with race, I now turn to the work of, among others, the reproductive rights activist Betsy Hartmann to demonstrate that this is the case.

Racing Reproduction: 'Illegitimate' Fertility and 'Legitimate' Infertility

The multiple points of intersection of formulations of racialization and conceptions of illegitimacy within American discourse and policy on both foreign and domestic reproduction have been well established by feminist theorists as well as feminist activists working in the areas of birth control and population control. As Hartmann demonstrates in *Reproductive Rights and Wrongs: The Global Politics of Population Control*, rapid population growth has been and continues to be posited as the cause of endemic poverty by the American population control movement, which through governmental organisations such as the United States Agency for International Development (USAID) directly impacts on population policy and family planning practices in such disparate countries as Bangladesh, Indonesia, Kenya, and El Salvador.

It is now a commonplace to argue that if there were fewer people in postcolonial societies – what Hartmann, writing in 1987, terms the 'Third World' – hunger and malnutrition could be greatly reduced if not entirely eradicated. The method most frequently advocated for the reduction of population levels within both individual countries and specific racial, ethnic and class categories is a reduction in the number of children to whom women give birth. According to the logic of the population control movement, if women had fewer children, those they did have would benefit from increased access to food and other resources. The method of achieving this prescribed reduction in the birth rate is the control of women's fertility. To this end, a variety of methods designed to prevent conception, pregnancy and birth have been developed and either distributed to or forced upon women. These include birth control pills, cervical caps, Depo-Provera

injections, incentives for voluntary surgical sterilization, forced surgical sterilization and forced abortion.

Hartmann demonstrates that, despite established financial and political support for population control policies within the United States, population level is not an accurate formulation of the causes of postcolonial poverty. Tackling the myth that fewer people would mean greater resources for those who do exist, she contends:

> Today most countries have enough food to meet the needs of their growing populations. Yet even when food is plentiful, millions of people go hungry. They go hungry because individual families do not have land on which to grow food, or the money with which to buy it. The main problem is not that there are too many people and too few resources, but rather that too few people monopolize too many resources. The problem is not one of absolute scarcity, but one of distribution. (1987: 16)

The appropriate response to endemic poverty in postcolonial nations, according to Hartmann, is the redistribution of wealth, land and other resources, and most definitely not the control of women's fertility. The continued development of coercive, punitive and authoritarian measures, frequently presented in a discourse that hijacks the demands of women's movements for affordable, safe and effective birth control, does not – and by its very nature cannot – address the root causes of poverty. All it does accomplish by taking control of fertility away from women is the diminution of women's human rights and the theft of their autonomy by rendering their pursuit of motherhood 'illegitimate'.

It is not, however, only racialized and/or poor women outside the United States who have been figured as 'illegitimate' breeders. As Hartmann discusses, Margaret Sanger's movement for the legalization of birth control in the last century – which has received wide praise from liberal feminists – had close ties with eugenicists and racists and infamously proclaimed, 'More children from the fit and less from the unfit – that is the chief issue of birth control' (ibid: 97). More recently, environmental degradation within the United States has been blamed on immigrants and an overall decline in rates of violent crime has been attributed to the legalization of abortion(Branigin 1998a). In 1998, members of the Sierra Club called for 'reduced immigration as a means of limiting U.S. population growth to preserve natural resources' – a call which was ultimately defeated (Branigin 1998b: A16). Shortly after this, University of Chicago economist Steve Levitt and Stanford University law professor John Donohue released a study which claimed to show that the greater availability of legalized abortion dating from the early 1970s enabled more poor and/or non-white women to purchase this reproductive option, thereby allegedly diminishing the number of children born into poverty who would purportedly go on to commit violent crimes. Finally, work on the United States in the nineteenth century, particularly on the antebellum South, has documented the fact that racialization was not coincident to but constitutive of the construction of so-called 'legitimate' white womanhood and 'legitimate' white motherhood.[3]

Although markedly less work has been done on the intersection of formulations of racialization and conceptions of so-called 'legitimate' and 'illegitimate' infertility, it nonetheless appears that these follow the pattern outlined above. That is to say, white

women are viewed as the 'legitimate' clients of ART when their bids for motherhood prove unsuccessful and non-white and/or poor women are the 'legitimate' clients of family planning clinics. Echoing the work of many feminist activists, critics and theorists, Heitman and Schlachtenhaufen state that 'publicly funded fertility control programs have focused attention on the social and medical problem of the *overfertility* of poor and non-white women' (1996: 191; emphasis in original). Heitman and Schlachtenhaufen report that, as a result of the attention paid in the United States to the 'overfertility' of poor and non-white women, 'There is little data available on the actual prevalence of or causes of infertility among nonwhites or the poor' (ibid: 190–1). They add that some of the data on non-white women and infertility is less the result of studies focused on ascertaining the incidence of infertility in these populations than, as they rather alarmingly aver, the result of extrapolation from epidemiological data on the segment of the population already seeking 'treatment' for infertility: 'predominantly white upper-middle-class' women (ibid: 191). Thus, some of what is supposedly known about non-white women and infertility is actually known about white women and infertility.

This should not be taken to mean, however, that there is an absolute dearth of epidemiological data on non-white women and infertility. Heitman and Schlachtenhaufen reproduce some statistics on the incidence of infertility in non-white women in the United States (ibid.), based, in spite of the conceptual difficulties they consider it presents, upon the NSFG. It is, in fact, data from the NSFG conducted in 1982 that enables them to state that black women have a higher incidence of infertility than do white women. It also enables them to identify the cause of the infertility suffered by black women; 'PID

[pelvic inflammatory disease] is widely suspected to be the primary cause of rising infertility rates among young black women' (ibid: 195).

The National Institute of Allergy and Infectious Disease (NIAID), which falls under the National Institutes of Health (NIH), produces an online 'Fact Sheet' on PID. According to this, PID is not so much a single disease in and of itself as indicative of other pathologies. NIAID states that it is 'the most common and serious complication of sexually transmitted disease. [It] 'can affect the uterus, ovaries, fallopian tubes, or other related structures . . . [and] . . . causes scarring and can lead to infertility, tubal pregnancy, chronic pelvic pain, and other serious consequences'. Heitman and Schlachtenhaufen comment that, since PID causes blocked fallopian tubes, a large percentage of non-white women suffering from it might very well be candidates for IVF as opposed to egg donation; IVF is designed to enable fertilisation in cases where a woman's fallopian tubes are blocked but she still produces viable eggs. It is at this point in their essay, however, that Heitman and Schlachtenhaufen report that a considerable proportion of women with PID do not seek fertility 'treatment' and that non-white women tend to seek fertility 'treatment' significantly less often than white women; 'only 12.8% of black women . . . sought specialized infertility services (including ovulatory drugs, artificial insemination, surgery or other intervention for blocked fallopian tubes, or IVF) compared with 17% of Hispanics and 27.2% of whites' (1996: 195).

Why are the rates at which black and Hispanic women seek fertility 'treatment' so low? Heitman and Schlachtenhaufen have a strong tendency to conflate racialization with

poverty and one strand in their work can be seen as arguing that the relatively high price of ART explains why non-white and poor women who experience difficulty conceiving, gestating and/or giving birth do not pursue assisted conception at the same rates as white, middle-class women. Poor and/or racialized women are not the main clients of ART because often they cannot afford it. Heitman and Schlachtenhaufen write:

> Insurance coverage is an important socioeconomic factor, not measured by the NSFG, that influences the use of specialized reproductive services by nonwhites. Doctors who know of a woman's financial ineligibility may not provide referral information to fertility clinics, either in a conscious gatekeeper function or out of unwillingness to add to the woman's sense of personal loss by informing her of options that are not open to her. Women who depend on public health facilities will find almost nothing available for the treatment of infertility; although federal policies require that public facilities that provide family planning services also offer basic medical services to assist conception, there are few public infertility clinics (ibid.: 196).

From this statement it becomes conceivable to posit that, were the cost of ART to be dramatically reduced and were public healthcare facilities to take federal policy more seriously, more non-white and/or poor women could reasonably be expected to pursue assisted conception. Prohibitive fees and lack of service provision both act, according to Heitman and Schlachtenhaufen, as barriers to non-white and/or poor women's access to ART; if these barriers were removed, there is little reason to suppose that non-white and/or poor women's rates for seeking ART would not increase. Given that non-white and/or poor women have higher rates of infertility than their white, middle-class counterparts, it is entirely possible to conclude that, with improved access to ART and a

reduction in its cost, the rates of pursuit of assisted conception for women from these populations might eventually actually surpass those of white, middle-class women.

Such a supposition is, however, only sustainable as long as one ignores the racialized divide in formulations of 'legitimate' and 'illegitimate' reproduction. The discussion of this divide above indicates that the institutional structures restricting non-white and/or poor women's access to ART are undergirded by longstanding discourses which, in order to propose 'legitimate' formulations of motherhood to which all white, middle-class women should aspire, dialectically denigrate reproduction by non-white and/or poor women. The work of the legal theorist Dorothy Roberts is instructive on this issue.

In *Killing the Black Body: Race, Reproduction and the Meaning of Liberty*, Roberts goes one step further than Heitman and Schlachtenhaufen and argues that individual women's decisions about their reproductive futures are not among the driving forces behind the relatively low rates at which specifically black women seek fertility 'treatment'. Instead, she argues that many black women do not even have the possibility of making a decision about whether or not to pursue fertility 'treatment'. This is a determination that their doctors make for them, without even consulting them. In addition to this, Roberts shows that racialization not only plays a part in deciding which patients are informed of which reproductive options, but can determine the actual diagnoses doctors make.

In the chapter entitled 'Race and the New Reproduction', Roberts focuses on PID. Her work demonstrates the way in which the gatekeeper function discussed above by Heitman

and Schlachtenhaufen may be played out on the level of individual women's bodies as well as on the level of assumed personal finance, as discussed in 'Differential Effects'. Roberts posits that, while it is true that a high proportion of black women is diagnosed with PID, this does not mean that women actually have this 'disease'. According to Roberts, 'doctors' diagnoses of the cause of infertility often depend on race' (1997: 255). To illustrate this Roberts turns to endometriosis, a painful condition in which endometrial tissue occurs outside of the uterus. This disease, she writes in an echo of other feminist work on endometriosis, has been constructed as a 'white, 'career woman's' disease' (ibid.).[4] Citing Dr Donald Chatman, she explains that 'most textbooks of gynaecology are in agreement that endometriosis is rare in the indigent, nonprivate patient and, therefore, by inference . . . uncommon in the black woman . . . Instead gynecologists are more likely to diagnose Black women as having pelvic inflammatory disease, which they often treat with sterilization' (ibid.). As proof of this she again turns to Chatman, indicating that he 'found that over 20 percent of his Black patients who had been diagnosed as having pelvic inflammatory disease actually suffered from endometriosis' (ibid.).

Roberts' work points to the same centrality of racialization in formulations of 'legitimate' infertility as exists in formulations of 'legitimate' motherhood. Constructed as 'legitimate' mothers, white middle-class women become, not unexpectedly, 'legitimate' fertility patients when they encounter difficulty in conceiving and/or sustaining a pregnancy. But the condition of the legitimation of white, middle-class women as mothers – and hence, I posit here, as 'legitimate' fertility patients – is the de-legitimation of non-white and/or poor women as mothers and the concomitant inability to perceive

their infertility as such. The result of this is that women who either classify themselves or who are classified by others as non-white and/or poor must defend their right to have children – and to pursue the necessary medical interventions in order to achieve this when it proves difficult – just as white, middle-class women must defend their right to remain childless.

When read alongside Heitman and Schlachtenhaufen's text, Roberts' work combines with theirs to discredit any understanding of the persistent representation of prospective egg donors as racially white in the visual culture of clinics and agencies that maintains that this representation reflects the fact that white women decide to pursue ART more frequently than do non-white women. The possibility of attributing the contemporary American fertility industry's reliance on whiteness to a reflection of the 'real' necessarily shatters upon the presentation of evidence that this 'real' does not and indeed never has existed. It cannot be that images of white women in advertisements, brochures and websites merely mirror the fact that white, middle-class women are referred to fertility clinics more frequently than non-white and/or poor women because they have higher rates of infertility. As discussed above, it not white middle-class women who have the highest rates of infertility; it is black, Hispanic and/or poor women who do. What white middle-class women do have, however, is a racial (and, on occasion, a socioeconomic) status that predisposes them to be considered good candidates for motherhood and, when they encounter difficulty conceiving, for ART.

This of course leaves unanswered the question of how the whiteness in the contemporary American fertility industry's visual culture should be read. If this whiteness does not reflect white, middle-class women's higher rates of infertility, what, if anything, does it reflect? Furthermore, does the notion of 'reflection' hold any explanatory value *vis-à-vis* this issue? If it does, could it be that it is indeed possible to read clinics' and agencies' visual culture as reflective – but not reflective of the epidemiological non-fact that white, middle-class women have higher rates of infertility than do non-white and/or poor women? Perhaps what is being reflected in clinics' and agencies' brochures, advertisements, and webpages is not epidemiological reality but epidemiological desire. That is to say, does the insistence of firms on representing their prospective, imagined and actual clients as racially white reflect the discursive construction of white, middle-class women as 'legitimate' mothers and, when conception and pregnancy proves difficult, as 'legitimate' fertility patients? If so, what evidence would be required in order to substantiate such a claim?

Continuing my effort to theorize the contemporary American fertility industry's reliance on whiteness in visually representing its clients, I now turn to a newspaper article about the difficulty an African-American couple faced in attempting to locate a prospective egg donor. From my reading of Paul Shepard's article, 'Assisted fertility techniques present harsh realities for African Americans' (hereafter referred to as 'Harsh realities'), it begins to seem that my concern with whiteness might be somewhat misplaced. As I show in sections two, three and four below, the whiteness with which I have been concerned, although still pervasive, cannot rightly be figured as permeating clinics' and agencies'

written and spoken assertions about their work to the same extent that it dominates their visual representations of it. Although this is by no means expansive – especially in Shepard's article – it is nonetheless possible to begin to trace within the industry a concern with non-white clients. This leads me to reconsider whether the fertility industry can be held solely responsible for the fact that an overwhelming whiteness characterizes its visual culture. That is to say, it may very well be that clinics and agencies have attempted to hail non-white women but that these latter, for a variety of reasons, have decided not to answer the industry's call.

II. The 'Racial Squeeze': Tracking the Lack of Racialized Egg Donors

On 25 July 1999, the *Los Angeles Times* carried Shepard's article, 'Harsh realities.' In it he identified a racial divide in the demand for egg as well as sperm donors in the United States. Outlining an African-American couple's several year long struggle to find a black egg donor, Shepard identified 'a racial squeeze in the rapidly growing field of assisted fertility' and noted 'a severe lack of black and other racial minority donors of eggs and sperm' (1999: A8). While white prospective egg recipients can generally locate a prospective egg donor within a relatively short period of time, the same does not hold for their non-white counterparts. It is not uncommon, according to Shepard – and, as I discuss in section three, according to the industry practitioners with whom I spoke – for racialized prospective egg recipients to have to wait months or even years before finding a suitable, racially similar match.

In his attempt to identify the main factors determining why an African-American prospective egg recipient may have to wait for such a comparatively long period of time before being matched with an acceptable African-American prospective egg donor, Shepard shifts his initial focus away from prospective egg recipients and towards prospective egg donors. In so doing, and in marked contrast to analyses produced by Roberts, Hartmann, and other feminist theorists and activists working on reproduction and racialization, he comes to locate resistance to racialized women's participation in egg donation in particular and ART in general within individuals themselves. In other words, clinics and/or agencies cannot be held accountable for the fact that they have mostly white prospective egg recipients and thus require mainly white egg donors. According to Shepard, members of African-American communities have specific reasons for not participating in assisted conception.

'Harsh Realities'

Writing that '[r]elatively few members of minority groups seek out donors for assisted fertility' (ibid.), Shepard initially attributes the shortage of African-American donors to demand. Because few African-Americans elect, for whatever unnamed reason or reasons, to pursue assisted conception by donor, there is not a great need for African-American gamete donors and thus, by inference, clinics and agencies do not keep the names of many prospective African-American donors on their rolls. According to Shepard, however, this does not wholly explain the shortage of African-American donors, which he also attributes to a complex set of phenomena that might best be described as 'cultural'. Based upon his conversation with Dr Abraham Munabi, who founded a

fertility clinic located near Philadelphia called the Reproductive Science Institute, Shepard writes:

> Munabi suggested that several issues may underlie the dearth of black donors: a lack of knowledge about the science of assisted fertility, religious prohibitions against masturbation, a scepticism of medical authorities in general and a fear of being identified. 'People in general aren't aware of how they can help another couple,' Munabi said. 'Others are very suspicious of the medical establishment and fear the commitment. They don't want to be tracked down' (ibid.: A8).

Emphasizing broader cultural mores, Shepard's initial résumé of Munabi's remarks points to a range of factors which, taken together, might be used to begin to explain the relative absence of African-American gamete donors within the contemporary United States without reference to the internal machinations of the fertility industry. Instead of being actively barred from entry to the industry, it appears that the absence from it of African-American women and men may be attributable to a general disinclination to participate in gamete donation. Following Shepard, this reluctance is based upon a mistrust of medical practitioners and a lack of awareness of the need for donors.

When Shepard goes on to quote Munabi directly, however, the sense that this disinclination is driven by cultural practice begins to dissipate. Taking its place is an increasingly strong sense of individual deficiency. Following Munabi, it quickly begins to appear that black men and women in general do not wish to donate sperm and eggs because they do not adequately understand what gamete donation involves. As a result, and perhaps irrationally, potential prospective donors turn away from donation because

they fear future demands that might be made upon them by the children they help to create.

This perception that the overall lack of African-American donors can be at least partially attributed, not to validated cultural practices and belief systems, but to some kind of personal failure on the part of potential donors, dominates Shepard's discussion of two black egg donors. Shepard reports of the couple, re-named 'Cathy' and 'David', whose story frames his article that their 'dream was dashed when [Cathy's first] would-be donor backed out of her contract. The reason: She was scared of needles' (ibid.). Later we are told that when this woman saw the [quite long] needle that would be inserted through her vagina in order to aspirate her eggs, she panicked and called off the donation.[5] Cathy did not fare any better with her second donor. Shepard writes that just before this woman was to start the hormone regimen that would enable her body to produce multiple eggs, she 'began complaining of stomach cramps. In a cruel irony she had just gotten pregnant' (ibid.).

As was the case with Cathy's first attempt at pregnancy via the purchase of third-party gamete donation, her second attempt was foiled through no fault of her own. What emerges, quite problematically, from Shepard's narration of these two events is less a sense that the racial divide in egg donation can be legitimately attributed either to a comparatively lower demand for non-white egg donors or to the historically grounded unease with the medical establishment felt by members of a community, but rather a sense of an atomization of the notion of community and a concomitant condemnatory

impulse *vis-à-vis* racialized women who will not donate their eggs. In short, both of Cathy's prospective donors appears to be profoundly silly and irresponsible. Even though Cathy and David spent $12,000 to locate their first donor and an additional $3,500 on her hormone regimen, this woman lacked the courage to go through with her donation and dashed the couple's hopes of having a child because she was unduly frightened of a surgical instrument. No less silly and irresponsible, Cathy's second donor did not take the necessary contraceptive measures and thus unexpectedly became pregnant.

In terms of the article's narrative structure, Shepard's depiction of Cathy's first two failed would-be donors as, at the very least, not completely serious about donating their eggs serves to gain empathy for her and her husband. Coupled with the mention that David is a clergyman (Shepard never directly quotes Cathy, nor does he present her in any other role than that of would-be mother) and the persistent tallying of all the time, money and effort this couple has put into having what Shepard calls 'their own baby', his depiction of the two donors as cowardly and irresponsible underscores Cathy's and David's eminent reasonableness (ibid.). Here is a couple asking for something very simple – the chance to have a child – and because of the astonishing ineptitude of the women they have not simply asked but *paid* to help them, they have thus far been unable to achieve their dream of parenthood. Like latter day Sisyphuses, they are seemingly eternally condemned to start and restart their search for a donor. What, as Shepard points out, is especially tragic about this case is the fact that Cathy is not looking for the perfect match that white prospective egg recipients can get seemingly anywhere. All this woman and her clergyman husband want is a reasonable black woman who will enable them to have the

child they have desired and fruitlessly worked for over the course of more than three years.

What is distressing about Shepard's article is that, in a contemporary rehearsal of the dialectic of 'legitimate' reproduction, he denigrates the would-be donors in order to depict the plight of Cathy and David sympathetically. The first donor becomes an hysterically ignorant and selfish woman who cannot deal with what by implication is run-of-the-mill, everyday technology. Unable either to have anticipated the need for a long needle or, even better, to have held her fear in check, this woman appears to be wild and out of control. The second donor is also out of control, but it is not her fear that cannot be held in check; it is her sexuality. She winds up pregnant.

As a result of Shepard's treatment of these two women, there is by the end of his article no longer any sense that members of the African-American community/ies may have valid reasons for not wishing to become gamete donors. Instead, pathologised by Shepard, black and by implication other non-white women who are not willing to donate their eggs or to consider doing so are rendered, purely and simply, selfish. Not only is the whiteness characteristic of the industry's visual culture re-installed as reflective of epidemiological reality but the industry's reliance upon it comes to seem almost reasonable. Why do clinics and agencies most often rely on women racially marked as white to visually represent egg recipients and egg donors? After reading Shepard's article, it would not be out of the realm of the possible to conclude that, within their visual culture, clinics and agencies not only reflect the dominant racial categorization of

their client base but actively choose to depict the kinds of women who are willing to work with them. In other words, they have decided not to represent visually those who are unreliable and who, unable to follow through with their commitment, ultimately make assisted conception even more emotionally and financially draining for the prospective egg recipients than it is already said to be. Instead, and pushing Shepard's discussion of Cathy's two would-be donors as far as possible, clinics and agencies use white women to visually represent egg recipients and egg donors because women so racialized not only comprise the majority of their clients but also tend to be more willing to participate in the multiple, expensive and time-consuming processes that constitute assisted conception.

Shepard's article was the only treatment of egg donation to address race that I was able to locate in the mainstream American press. It, and my discomfort with it, informed much of my thinking on the intersections of racialization and ART in the contemporary United States. When I began developing questions for the interviews I was to conduct in autumn 2001, I was curious as to whether my informants would echo Shepard and report difficulty in locating non-white prospective egg donors. If they had this difficulty, I was also interested in how they might narrate it. To what extent, I wondered as I was setting up my interviews, would Shepard's tendency to dismiss what seemed to me to be completely legitimate anxieties about egg donation on the part of the women who were contemplating donating their eggs circulate throughout the industry? Was Shepard's demeaning of Cathy's first donor, who started the process of preparing her body to produce a large number of eggs only to decide that she could not go through with the retrieval, an aberration? Or was this indicative of a more widely shared way of figuring

women in whom the clinic or agency had invested time and in whom the prospective recipient had also invested time and – unlike the clinic or agency – a significant amount of money? Finally, I was equally curious as to whether my informants, with whom I would be speaking more than two years after Shepard's story had appeared, would report having markedly fewer non-white as compared to white prospective egg recipients. Perhaps, I thought, unlikely though I surmised it to be, my continually developing understanding of the industry tended to be unfairly pessimistic. Although not entirely probable, it was certainly possible that substantial changes had occurred both within and outside the American fertility industry over the course of these two years, and more and more non-white women were seeking egg donation. Thus, I turned to my informants to clarify these and related issues.

III. Other Realities: Locating Racialized Donors in 2001

With one exception, which I address at the beginning of section four, all my informants revealed that, although s/he did not encounter many non-white prospective egg recipients, when s/he did, it was difficult to attract not only African-American but Asian-American, Hispanic and/or Jewish women willing to consider donating their eggs to similarly raced prospective recipients. Beginning with a conversation conducted towards the end of my fieldwork visit to the United States, I present and discuss some of these responses below. This leads me to propose, at the end of this section, a reading, very different from and much more complex than Shepard's, of racialized women's relative absence from the contemporary American fertility industry, especially as regards their absence as egg donors.

Dr Cole

In the penultimate interview I conducted, I spoke with Dr Cole, who had been among the first of the practitioners to respond to my email requesting an interview. Closing the door to the bedroom in which I was staying while in Washington, DC, I put Dr Cole – as I did all of my informants with whom I conducted telephone interviews – on speakerphone, sat in an aging rocking chair and taped our forty-five minute long conversation. In this I learned that Dr Cole had grown up in Germany and did his PhD in London. Having enjoyed living in Britain, he was interested in possibly returning to live and practice there. Remarking that the industry in the United States was 'all business driven' and that although very technologically advanced there was a lack of 'ethical debate' in American medicine, Dr Cole went on to state that he 'like[s] the British approach in the sense that they have some pragmatism and are not as dominated by business interests as the Americans are'. Categorizing American fertility medicine as 'simplistic', he declared the German fertility industry no alternative. For Dr Cole, where the former ignored ethical debate, the latter delved too far into them, 'couldn't see the forest for the trees' and concerned itself with inane distinctions that Dr Cole deemed akin to questions about the number of angels that could dance on the head of a pin. Inhabiting the middle ground, in Dr Cole's opinion, the British fertility industry had the most reasonable policies. Thus, right before wishing me luck, towards the end of our conversation and à propos of his comments on his dissatisfaction with the American fertility industry, Dr Cole said to me, 'If you come across anybody who is looking for a German-American RE [reproductive endocrinologist], let me know. I'll gladly send out my c.v.'

Early in our conversation I asked Dr Cole how his clinic recruits women for its anonymous egg donation programme. His response led to a more focused discussion of race, during which he offered two wholly different but nonetheless frequently recurring explanations of why his firm encountered difficulty recruiting African-American and Asian-American women as egg donors. Although the issue of race only comes to the fore at the end of the following fairly long extract, it is nevertheless worth reproducing here. In addition to giving a general sense of the tenor of the nine interviews I conducted, this part of my conversation with Dr Cole also raises two key issues that crop up in discussions with some of my other informants and which I address in further detail in section four.

The first of these issues relates to the resistance from within the wider community that can face even clinics with small, relatively obscure egg donation programmes when they attempt to advertise for donors in newspapers. Foregrounded to a significantly lesser extent, but no less important, the second issue relates to internal divisions within the American fertility industry over the ethics of the recruitment of college and university students as egg donors. Both these issues, as well as the discussion of the difficulties faced by Dr Cole's institution when attempting to recruit non-white donors, emerged from a question I asked towards the beginning of our interview. Hearing that practitioners at Dr Cole's clinic are willing to work with prospective egg recipients who have paid a third-party agency to assist them in locating a donor, I was curious about the clinic's own anonymous egg donation programme. The fact that Dr Cole and his colleagues worked with donors found through agencies and did not regard the agencies themselves as

competitors seemed noteworthy. I asked Dr Cole to describe the recruitment process for his firm's anonymous egg donation programme and he responded as follows:

DC: We have to advertise for them basically and we advertise in local papers. I think the typical candidate is probably between twenty-two and thirty years old, has children and may be either a college graduate student or a young mother. For the typical applicant, once they contact us, we invite them for an interview, we screen them medically, psychologically. We tell them why we do egg donation, what the process is, what the visits for the egg donors are, and what the benefits to the egg donors are.

KB: Have you ever received negative commentary from the community because of your advertisements?

DC: That's a good question. The major local newspaper is the *Columbus Dispatch* and at one point they refused our ads because they said they don't want to be involved in the sale of body parts.

KB: Did they subsequently decide against this refusal?

DC: I think we currently don't advertise with the *Dispatch.*

KB: Do you advertise in college and university papers?

DC: No. We like to avoid that.

KB: Why is that?

DC: Basically, I think the reason is that we feel that college students may be poor and that the economics may become a major factor in their decision to pursue this – and it shouldn't be, number one. Number two, we also worry that maybe someone as young as that – she probably hasn't had children, we don't know as much about her reproductive history, and she may not be living in as stable an environment as an egg donor ideally would so that we can always reach her when we need to reach her. I don't recall seeing any college students as egg donors here.

KB: That's interesting. Are there any criteria that are more difficult to find in a donor?

DC: Well, you know, if you're in the mid-west, you're not going to find many donors who would be labeled as ethnic. The Columbus area is pretty much white.

KB: Right. And do you have a demand for ethnic donors?

DC: Well, you'd think that the demand would equal the representation in the community. In other words, you know, if we have many black patients who need egg donors, probably there are many black people living here. There is actually demand and we've found, yeah, that we've had trouble recruiting African-American or Asian donors. We have a fair number of African-American and Asian people living in the area. At least in our practice we see them occasionally. We sometimes have difficulties finding donors for them.

KB: Right. That seems to be common throughout the United States at least in terms of the other people that I've spoken with.

DC: You know, again, you would assume that demand for ethnic donors – let's call them ethnic donors – would be proportional to the number of people of that ethnicity living in the area and therefore, if it's difficult to recruit ethnic donors, then that must be due to a decreased willingness of non-Caucasian women to donate eggs.

As was the case with 'Harsh realities', what emerges from Dr Cole's narration of the difficulty he and his colleagues encountered in recruiting racialized donors is an inability to articulate precisely why this is the case. Initially Dr Cole attributes his firm's trouble in finding African-American women and Asian-American women willing to donate their eggs to demand. In a way that is again very similar to Shepard's argument, this notion of demand is underwritten by an alleged overall absence of women so racialized in the population of Columbus. The city and its environs, Dr Cole says, are 'pretty much white'. I take this to mean that there is not a comparably large number of African-American and

Asian-American prospective egg recipients in the area. Although not empirically grounded either at this precise point in my analysis or by Dr Cole, it may be assumed that if Columbus does not have a large African-American or Asian-American population in the first place, then these relatively small populations will not give rise to be a great number of women seeking out egg donation, nor, in all probability, will there be many women within these two reportedly limited populations who would be willing to donate their eggs. Even if there were, it nevertheless stands to reason that among these women there would be relatively few who would fall between the ages of twenty-two and thirty, have given birth to at least one genetically-related child, and be able to meet other of Dr Cole's firm's requirements for prospective egg donors. In short, because of its location and the area's history, Dr Cole's practice does not encounter many African-American and Asian-American prospective egg recipients. On the few occasions when it does happen, it can be time-consuming and difficult to find acceptable donors for these women. Were Dr Cole to practice in an area with a more racially diverse population, the situation might be markedly different.

Or would it? In the second of the face-to-face interviews that I conducted in California, I spoke with Nancy Young, who is white, at her high-rise office in Beverly Hills. In chapter five I discuss the brief tour I was given of the premises rented by Young's firm. Located on the upper floors of a huge office building with a security guard and a small shopping complex on the ground floor, my informant's office featured a stunning wall of windows from which most of downtown Los Angeles was visible. After declining offers of coffee, herbal tea, and varieties of waters, I sat down with Young at a table located

between her desk and an arrangement of comfortable-looking chairs and a sofa and proceeded to tape our conversation.

When, with Shepard's article in mind, I asked Young specifically if she had difficulty recruiting African-American women as egg donors, she reported that she did. This was despite the fact that, according to her, Los Angeles has 'a huge population of African-Americans'. Her response is as follows:

> Yeah! Surprising! I mean here we are in LA – a huge population of African-Americans and it's very hard to recruit them. They don't seem to respond to the ads. We've always got couples waiting. But it's harder to find African-Americans that want to be donors. And the same with surrogate mothers. I can't find them. And then the Asians are very difficult. Becoming a little easier. The last few years I found a little easier. The hardest is African-American and Jewish. Those have become the hardest. Asian is becoming a little easier for us. The society's getting a little more used to egg donation and a friend tells a friend who tells a friend and so it goes round. But Jewish donors are still maybe two or three a year.

While Dr Cole's remarks suggest that the make-up of the population is an important factor in explaining why both fertility clinics and third-party agencies in the United States experience difficulty recruiting non-white women as egg donors, Young's statement refutes this. According to her, demography does not adequately explain this difficulty; even in an area like Los Angeles, with a comparatively large African-American population, African-American women still do not respond to requests for prospective egg donors. It appears that Dr Cole may be mistaken. Perhaps it is not the nature of the population but something else entirely that causes non-white women in the Columbus

area to reject the possibility of donating eggs. My informant Laura Green is instructive on this point.

In the last telephone interview I conducted, I spoke with Green. A white subject who with her sister runs Texas Third Party Agency, Green was a very cheerful interviewee who was always willing to engage. From the time I landed in the United States, we struggled to find a convenient time for our interview. Playing round after round of phone tag, both of us proved ourselves rather inept in dealing with the need to work with more than one time zone. I could never figure out what time it was in whatever time zone Green was in and she reported having the same difficulty when she attempted to contact me. We finally managed to find some time on the Sunday afternoon before I was to return to Ireland. Our interview took place while Green and her sister were advertising their firm at a convention and waiting for a prospective donor to arrive to be interviewed by them.[6]

In an echo of Munabi, as reported by Shepard, Green also attributes this unwillingness of non-white women to become egg donors to 'cultural factors' and most definitely not to the nature of the local population. She reports that, unlike Young, her greatest difficulty is not in recruiting African-American prospective egg donors but in finding Asian-American prospective egg donors. In response to my query as to whether or not she had difficulty recruiting donors from specific groups, Green told me:

> The Asian donors are very difficult to get. There's something in their culture. I asked a Vietnamese friend of mine, what is the deal here, nobody wants to be a donor. She told me it was because they think they won't be a virgin after and I just

> almost laughed. I thought, you're kidding. She goes no. And so my thought was to go to the married couples. Maybe the married couples wouldn't have a problem. But I haven't really had a chance to delve into that yet. Well, at any rate, I consulted an Asian doctor in infertility and I said, *why*? What is the problem? He goes, I don't know but send me all you have. And I'm like, yes. Okay. He said, there's something about their culture. They just don't want to do that. And I said, Is it because they think they're not a virgin and he said, No. I don't know. So, I really don't know. But we don't have any problem with African-Americans. We've got plenty of African-American donors. And we have a few Mexican-Americans. We have enough, really. We have some pretty nice ones.

Gesturing towards a 'cultural' explanation for the difficulty she routinely encounters in attempting to recruit Asian-American prospective donors, Green's comments combine with those of Young to provide a powerful counterpoint to Dr Cole's initial remarks on population. Figuring Columbus as largely 'white', these of course proposed a mono-racial demographic as the reason Dr Cole and his colleagues find it challenging to accommodate their non-white prospective egg recipients with racially matched egg donors. Nevertheless, it is not possible to draw a neat line with Dr Cole placed on one side and Young and Green on the other. It should not be thought that the two agency directors propose one explanation for the difficulty they share with the clinic practitioner in recruiting non-white donors and that he, himself, proposes another radically different explanation. As it turns out, Dr Cole's views have more in common with those of Young and Green than might initially have appeared. This becomes increasingly apparent towards the end of that part of my interview with Dr Cole.

Closely following his attempt to make sense of the overall lack of African-American and Asian-American prospective egg donors by attributing this to demography is a related but contradictory statement, in which Dr Cole expresses his sense that there is a 'decreased willingness of non-Caucasian women to donate eggs'. No longer attributable to a material absence of women meeting specific characteristics, the difficulty in recruiting non-white prospective donors is here seen by Dr Cole to relate to another type of absence. This is an absence of inclination. It is not that there are desperately few African-American and Asian-American women in Columbus to whom an appeal to donate their eggs can be addressed. Rather, there are a number of African-American and Asian-American women in the area and the problem – one that is completely divorced from population size – is that these women have heard appeals for donors only to turn away from them. According to Dr Cole, there is some unknown reason why non-white women do not wish to donate eggs. In other words, it is difficult for Dr Cole and his colleagues to match African-American and Asian-American prospective recipients with egg donors because, as indicated by Young and Green, other African-American and Asian-American women do not wish to donate their eggs to his clients.

But perhaps even this is not the most accurate formulation of the issue. Although what little evidence I have does not come from non-white women with firsthand experience of the processes involved in egg donation, upon closer inspection it appears that the problem of the reported lack of non-white women interested in donating eggs may ultimately rest not in women's refusal to donate their eggs to other women but, echoing a comment made by Munabi and quoted by Shepard, in their negative perceptions of the medical

> I think that there is a level of mistrust in the minorities. I am Caucasian. I think some have a concern that they would have their gametes used or sold at a profit – so that the majority could profit. Minorities might have that feeling. And that they don't want to be used.

In this statement, I read Dr Jackson as saying that he believes that non-white women may actually consider donating their eggs. Although he presents no direct evidence of this, I conclude from his remarks that he feels that appeals for non-white egg donors may not be categorically dismissed by potential prospective donors. Rather, these women are aware of the need for egg donors but, ultimately, they decide not to pursue this. This decision stems not from a reluctance to help other women but from a belief that their altruistic gesture will be co-opted by market forces. In other words, although a woman may very well believe that she can help another woman by heeding the call of a clinic or third-party agency to begin the process of egg donation, the prospective donor sees the institution, rather than herself or the prospective recipient, as the primary beneficiary of the donation, and she opts not to participate.

Although it would require another dissertation to undertake the ethnographic work necessary to begin properly to support the above supposition, there is no question that, as far as the sale of the gametes of minoritized women is concerned, it is neither the donor nor the recipient, but the clinic or agency that at present derives the greatest [financial] benefit. Indeed, the institution profits enormously even when the recipient does not and, it can be argued, to a greater degree and more consistently than either she or the donor ever will. In the majority of those cases in which egg donation is performed but is declared

unsuccessful because it does not lead to a pregnancy and the subsequent birth of a child, the egg recipient is left to decide whether or not she will pursue this ART again, the donor is left with her fee (which, as I discuss in chapter four, appears to be always in the process of being driven downwards), and the clinic or agency is left with a profit (and, depending on the contract it has with the donor and the recipient, it may also be left with some frozen embryos to sell to someone else at a later date).

A similar situation inheres with sperm donation, as is borne out by Shepard. When speaking to John Olson, head of Cryogenic Laboratories, Inc., which Shepard describes as 'one of the nation's oldest and largest semen banks', Shepard learns that, despite the fact that the sperm of minoritized men, especially Jewish men, is most in demand – and presumably the most costly – all donors receive the same amount of money per donation: $40 (1999: A8). This of course means that, when recipients pay more for the sperm of minoritized men, it is not the donors who receive this extra money but the sperm bank. A similar but even more striking version of this phenomenon exists for egg donation. Many egg donation programmes, especially those run by clinics, tend to keep their pay-out to egg donors quite low, yet they charge recipients more money for the eggs donated by women who possess highly valued or relatively 'rare' social characteristics. These characteristics include advanced education, athletic ability, beauty, and, on occasion, even race. In chapter five I discuss how education in particular, which is closely associated with class, has been and continues to be 'geneticized'. For the moment, it suffices to point out that some institutions stand to profit especially handsomely on the sale of minoritized women's eggs.

Even though non-white women's eggs are positioned and/or priced within the economy of egg donation as a 'luxury' item, images of these women are almost nowhere to be found in the industry's visual culture. I have tried to show here that demography is not an adequate explanation for this. But does positing an unsubstantiated, politically motivated refusal to engage with the industry on the part of racialized women provide an adequate alternative understanding of the reign of whiteness in the industry's visual culture? Turning in the next section to the industry's written culture, I will argue that it does not.

IV. Working to Recruit Racialized Egg Donors

As mentioned above, not all my informants reported finding the recruitment of non-white prospective egg donors consistently and significantly more challenging than the recruitment of their white counterparts. In a telephone conversation some thirty-five minutes long, which constituted the first of the set of interviews I conducted in October 2001, I spoke to the attorney John Reed. Employing two secretaries and based in the American middle west, Reed has a law practice – as distinct from a clinic or a third-party agency – that specializes in arranging not just egg donations but also adoptions and surrogacies.[7] With Shepard's article in mind, I asked Reed whether he found it difficult to recruit prospective non-white egg donors. He told me:

> I have not found there to be a shortage of ethnic egg donors. I think that there is less demand for ethnic egg donors. I mean, the vast majority of my clients are white. So we simply don't look for black or Asian egg donors. But when I have

had clients who have wanted an Asian or an African-American donor, finding them has not been difficult for me.

What I understand Reed to be saying is that, even though he does not look with any great frequency for non-white women to donate their eggs, on the rare occasions when he is called upon to do so, he does not find it any more difficult to locate a 'perfect match' for an Asian-American woman or an African-American woman than he would for a Caucasian-American woman. No matter what qualities his clients deem important in a prospective donor, Reed is able to locate easily women who possess these qualities and who are willing to consider donating their eggs to his clients.

Although he was the most forceful of all of my informants in asserting a lack of difficulty in recruiting racialized women as egg donors, Reed was not the only one to have made such a remark. Quite unexpectedly, Dr Jackson also told me that recruiting non-white women as donors was perhaps not as difficult as he may have initially led me to believe. Immediately after narrating his unsuccessful attempt to engage an Asian-American woman willing to donate her eggs to his client and then going on to express his sense that the continued difficulty he encountered in recruiting not only Asian-American but African-American and other non-white women to donate eggs was partially attributable to minoritized women's mistrust of the medical establishment, Dr Jackson made what I considered to be a somewhat surprising statement. He said: 'We've been able to get minority donors – we just have to search a little bit.'

Seemingly rendering Dr Jackson experientially closer to Reed than to Dr Cole, Young or Green, this statement might legitimately be read as contradicting his earlier assertion that he did in fact find it hard – if not on occasion absolutely impossible – to recruit racialized women to donate their eggs to his clients. He no sooner makes that point than he moves on to maintain that, although it may require slightly more attention than is the case with their white counterparts, matching an African-American or an Asian-American prospective egg recipient with a racially similar prospective egg donor is well within the realm of the possible. All that is required, Dr Jackson seems to say, is a bit more work.

That work is the subject of this section. In what follows, I track the effort to recruit racialized egg donors in order to locate representations of non-white women. I seek to find out what kind of search is required in recruiting racialized egg donors. I want to know what the search consists of and how it manifests itself. I ask by what means it is apprehensible and to whom. In asking such questions, I wish to learn how this need to search a little more thoroughly for racialized egg donors sits alongside the whitenesses which, as I have been arguing, dominate the visual, written and spoken representations of the industry that are produced by both individual institutions and the allied media. Having most clearly articulated this need to expend more effort in order to recruit non-white prospective egg donors, Dr Jackson's discussion of his recruitment practices provides a sound starting place for this investigation.

Extra work: Recruiting Non-white Egg Donors

According to Dr Jackson, the extra work required for the recruitment of non-white women as egg donors involves chiefly the creation of a tailor-made advertisement. The text in the advertisement is designed to target women possessing the specific characteristics deemed desirable by the egg recipient. That this is how Dr Jackson goes about recruiting non-white prospective egg donors was articulated by him as he responded to a broader question I asked about where he advertised.

KB: Do you advertise anywhere else besides colleges?

IJ: You know, we tend to advertise in the parenting magazines. *Southwest Florida Parenting News*, I think, is our primary and we advertise every month in there. We have a routine ad that we use and I think even some of those ads are available on the website but if somebody wants a specific donor, for example Mediterranean descent, certain height, education, then I'll design a different ad.

KB: So in other words, instead of working with a third-party agency you'll advertise yourselves for a specific donor.

IJ: Yeah, and I think it's very cost-effective - especially because it keeps the cost down for the patients. Also, I do a lot of lecturing and a fair amount of teaching of nurses and I'm always trying to recruit.

Concerned here, as elsewhere, with the costs his clients incur in their pursuit of egg donation, Dr Jackson does not refer those of his prospective recipients who cannot find a match in his donor bank to a third-party agency which may have a significantly larger prospective donor database.[8] Instead, he asks them what they are looking for in a donor.

He uses this information to design an advertisement that will, he hopes, lead to the successful recruitment of a woman with the desired traits.

Figure 3.03 is an example of such an advertisement. Along with figure 3.04, it appears on Dr Jackson's website. Downloaded and read side-by-side, these two advertisements reveal that the additional work required to recruit non-white prospective egg donors involves, among other things, foregrounding – and hence reinscribing – racial difference by calling attention to ethnicity. That is to say, it is ethnicity – and not race – that is the trope through which racialization is articulated. This is true of Dr Jackson's advertisements and is equally true of the wider industry. As I trace the mobilization of this trope, it becomes obvious that, just as Heitman and Schlachtenhaufen predicted, race is articulated through ethnicity. What is more – and the two researchers did not forecast this – it also becomes clear that race is referenced, spoken about and taken up to a significantly greater extent in the industry's written texts than it is in its visual culture. In other words, as I show below, clinics, agencies and even law practices such as Reed's appear to prefer to speak about non-white women rather than to image them.

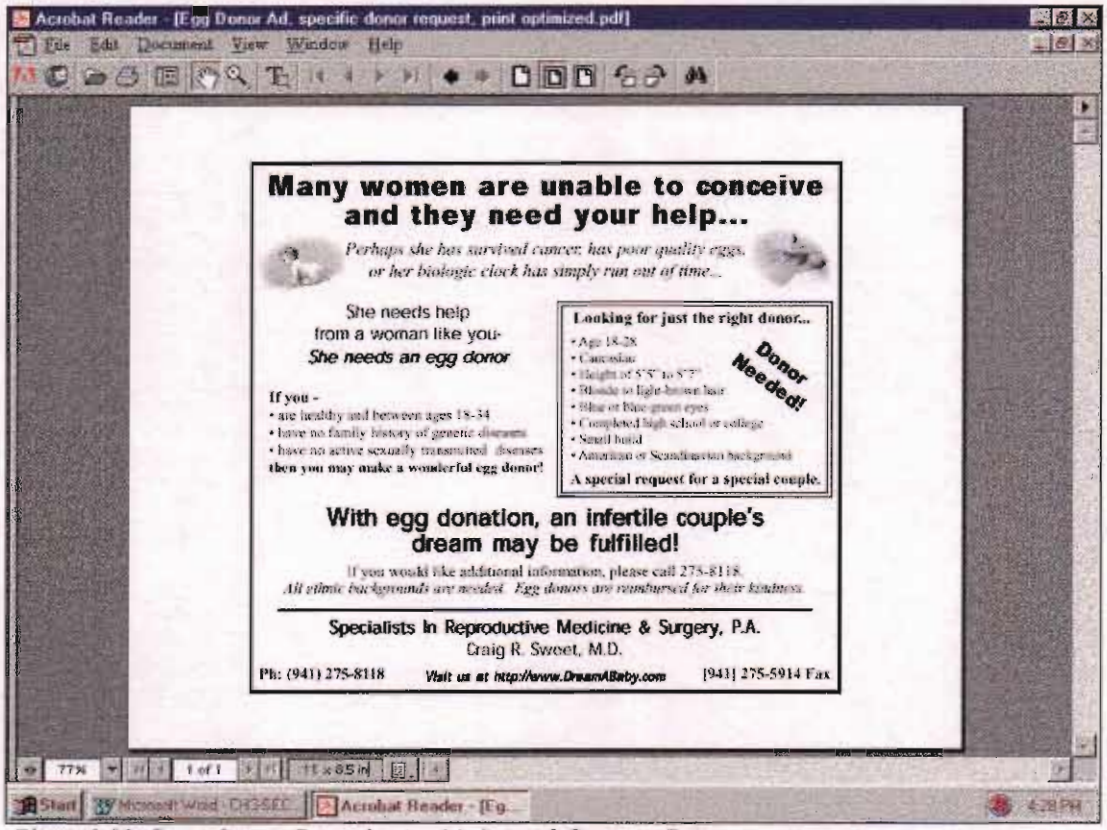


Figure 3.03: *Specialists in Reproductive Medicine & Surgery, P.A.*

Figure 3.04: *Specialists in Reproductive Medicine & Surgery, P.A.*

Two examples of 'images for donors', figures 3.03 and 3.04 are similar in a number of ways. Given the presence of the two images of infants in the upper left and upper right hand corners of figure 3.03 and the girl holding the doll in figure 3.04, each one could just as easily have been classified as an 'image of the child'. There is also marked similarity across the two images in terms of the written text. Each image presents the same list of three bulleted qualifications a woman must possess in order to be considered as an egg donor; if, the list concludes, you have these qualifications, 'then you may make a wonderful egg donor!' Additionally, each image reproduces – with only the slightest variation – the rhetoric of the dream. In the case of figure 3.03, the prospective donor reading the advertisement is told that 'With egg donation, an infertile couple's dream may be fulfilled!' In figure 3.04, the reader is told that the same ART has the potential to fulfil 'an infertile woman's dream'. But, regardless of whether the dream the prospective donor may help to come true belongs to a woman or to a couple, this rhetoric of the dream is reproduced visually. Somewhat hazy and indistinct, the two small pictures of infants in figure 3.03 can be seen to serve as visual manifestations of the content of the infertile couple's dream of a child. These babies are representations of that of which each member of the couple dreams. In figure 3.04, the presence of the doll and the way the girl cradles it visually attest to the fact that the girl dreams of becoming a mother. What is more, the image shows that this dream of motherhood is no ephemeral desire only whimsically taken up later in a woman's life. On the contrary, the advertisement's reader is clearly shown that the dream of motherhood is deep-seated. Formed during childhood, it is no fleeting fancy but constitutive of the woman the girl will become (or the girl the woman still is).

Where the two advertisements do noticeably differ is less in terms of the kind and more in terms of the degree of information each one imparts. Thus, the more text-dependent figure 3.03 enumerates precise reasons why a woman may need an egg donor (cancer, oocyte quality, age) while figure 3.04 does not. The one area where this general tendency for figure 3.03 to give more textual information and figure 3.04 to give comparatively less is reversed has to do with donor reimbursement. While figure 3.03 simply states that 'Egg donors are reimbursed for their kindness', figure 3.04 indicates that donors stand to earn $2000.

This effort to differentiate between the two advertisements in terms of the degree and not the kind of information each one imparts also provides a useful rubric for consideration of the ways in which they address the issue of ethnicity. Immediately before the two slightly different formulations of reimbursement, each advertisement reproduces what is essentially the same statement about ethnicity, which does nonetheless contain a minor variation in terminology. Figure 3.03 advises its readers that 'All ethnic backgrounds are needed', while figure 3.04 states that 'All ethnic backgrounds are desired'. Although it is important to point to the difference in terminology here, this is a minor point and the difference should not be thought to be relevant to my argument.

What is relevant to this analysis is the clinic's stated need for donors from what it terms 'all ethnic backgrounds'. In figure 3.03, however, no further textual information is given which might reveal just what is meant by the term 'ethnic backgrounds'. The absence of

any written indication as to what categories are being brought together forces the question of what precisely it is that Dr Jackson's clinic is seeking.

This is a key point, as there is no great stability in the everyday use of the terms 'ethnic' and 'ethnicity'. As noted by the cultural studies theorist Stuart Hall, use of the terms originated in progressive politics to signal the 'end of the essential black subject' (1996: 443). In other words, and directly traceable to anti-racist work and 'the post-war black experience in Britain' (ibid: 441), 'ethnicity' comes to replace 'race', which itself comes to be understood as an outmoded social construct that pretends to address biology. According to Hall, in terms of this shift away from race and towards ethnicity,

> What is at issue here is the recognition of the extraordinary diversity of subjective positions, social experiences and cultural identities which compose the category 'black'; that is, the recognition that 'black' is essentially a politically and culturally *constructed* category, which cannot be grounded in a set of fixed trans-cultural or transcendental racial categories and which therefore has no guarantees in nature' (ibid: 443; emphasis in original).

Foregrounding the theoretical poverty of 'race', 'ethnicity' is not a synonym for it. Rather, for Hall, ethnicity supersedes race.

Nevertheless, 'ethnicity' actually does tend to serve as a synonym for race within contemporary discourse in the United States. This is evident in my conversation with Dr Cole. In the segment of the interview reproduced above, he switches between the use of 'ethnicity' and the use of terms such as 'African-American' and 'Asian-American',

which would seem in current parlance to identify specific racialized groups of people. Reed makes a similar shift. In the segment of our conversation reproduced above, he initially responds to my question about whether or not he encounters difficulty recruiting non-white donors by indicating that he does not have difficulty recruiting 'ethnic' donors and by the end of the segment he has switched to the use of terms such as 'African-American'. Thus for Dr Jackson and Reed, as well as for some of my other informants, I would argue that the term 'ethnicity' is, for all intents and purposes, synonymous with the term race.

It therefore appears that the use of the term 'ethnic' in figure 3.04 can also be used to indicate race. In the absence of any other textual or indeed visual information as to what this term might be referring to, the advertisement's reader is left with the little girl. She, of course, is white. Could, then, the advertisement be saying that, despite the fact that the little girl is white, donors of other races are needed as well? This is in fact how I read figure 3.04.

In figure 3.03, the prominent text box that appears on the right of the page represents the additional work that a practitioner like Dr Jackson has to do in order to attract specific types of donors. The donor specifically requested here is of medium height, of light complexion and has a high school diploma. She is white. What I find striking about this is the highly complex way in which race is articulated within the fertility industry's visual culture. When it does not refer to whiteness, race can be spoken but is only rarely seen; non-whiteness appears almost entirely in a textual context; Hence, in the guise of

ethnicity, racial formations can be discussed in epidemiological texts, in newspaper articles and in interviews with informants.

V. Conclusion

I return to a question already posed: why does the contemporary American fertility industry overwhelmingly represent its egg donors and egg recipients as white? I propose that it does so not because each and every fertility clinic and third-party agency is a crudely racist organization driven solely by the conscious desire to increase the white population as quickly as possible. Instead, I posit that both the industry and the mainstream media represent egg donors and recipients through images of predominantly white women (and children) because ART remain highly problematic within contemporary American society. However much prestige may accrue to it, no firm can appear to go about blithely attempting to impregnate any and every woman who says she wants to try to become pregnant and give birth to a child. As I have begun to show here and continue to discuss in the next chapter, debates about 'legitimate' and 'illegitimate' reproduction are not simply a part of contemporary public discourse on reproduction; under the rubric 'legitimate' reproduction, these twinned concepts are the axis upon which debate about reproduction turns. In other words, it is currently impossible to have a debate about reproduction without entering into discussion of its legitimacy. Fertility clinics and third-party agencies must negotiate these concerns if they are to survive. Whiteness offers them one means of signalling their concern with 'legitimacy'.

Notes

1 See Heitman and Schlachtenhaufen's section 'Defining Racial Categories: Exclusion by Design' for a discussion of the racial categories used in the NSFG, the problems presented by these, a critical summary of the CDC's and NIH's formal review of the use of race in government statistics and a critique of these institutions' proposal that 'ethnicity . . . as a matrix of racial (biological) and cultural (social and environmental) features is more accurate, more precise, and more flexible than any system that uses race alone' (1996: 191–3).

2 While Heitman and Schlachtenhaufen ultimately conclude that 'poor and nonwhite women . . . are unlikely to become the victims of commodification or more general exploitation from OD per se' and go on to predict that 'the differential effect of OD on the poor and racial and ethnic minorities is likely to be a reinforcement and extension of current exclusionary practices,' neither the question of exploitation nor this formulation of it is by any means exclusive to them (1996: 190). The former formulation of exploitation has also been a recurrent feature of feminist and cultural studies critiques of egg donation. Although I engage directly with it in chapters four and five, it is worth considering here. Frow charges that as far as human organ transplantation is concerned – and based upon his reference to it, I would argue that this extends to egg donation as well – the wealthy benefit from the poor. He states:

> . . . even where market forces are quite strongly controlled, the practice of organ transplantation still constructs a market in which the cannibalized bodies of the poor, of women, and of blacks are used to feed the bodies of the rich, of men, and of whites (Frow, 1997: 177).

Similarly, but exclusively in relation to egg donation, Van Dyck forecasts a situation in which non-white and/or poor women's eggs are sold to wealthier white women who wish to attempt to become pregnant with and give birth to a child but who cannot use their own eggs in order to do so. Like Frow, and in contrast to Heitman and Schlachtenhaufen, she anticipates a situation in which non-white and/or poor women's eggs (and uteruses) are used by wealthier white women. In the chapter 'From Legalization to Legislation: Race and Age as Determining Factors' Van Dyck writes:

> Egg donation might enable women past menopause to become pregnant, but this new opportunity could also usher us into a new trend stimulating older women to

> carry babies for younger women so that the latter can remain fully employed during their most fertile years. 'Granny mums,' like black women, might be exploited by white yuppies to serve as breeders. Of course, egg donation can make a 33-year-old woman who suffers from early menopause very happy, yet it might also be a euphemism for 'egg selling': teenagers desperately needing money might want to sell their eggs, knowingly neglecting the risks involved in hormone injections (1995: 190).

This is a conventional projection about the future exploitation of prospective donors in egg donation and one which can be traced at least (if not further) as far back as *Test-tube Women*. Replacing Van Dyck's emphasis on the free market with her own emphasis on patriarchy, Genoveffa Corea proposes, in 'Egg Snatchers', that human eggs used for experimentation in IVF may be procured through unnecessary oopherectomies (1984: 39–43). In 'Egg Farming and Women's Future' Julie Murphy, also writing against patriarchy, fears that the increased practice of egg donation will mean that:

> In an entire society, all women could be engaged in reproduction, either as egg layers or egg hatchers. Both egg layers and egg hatchers would be controlled in terms of food, travel, work, and stress to ensure optimal conditions for the embryo. Women as egg layers are already in demand ... Women as egg layers and egg hatchers would be seen by patriarchy as the means to a vital commodity – eggs. Women will be forbidden to keep our eggs out of circulation in patriarchy. Birth, administered by reproductive technology, will be the rule and abortion the exception. Women will not be allowed to not use, to destroy, our eggs (1984: 73).

My main concern with the scenarios described by Frow, Van Dyck, Corea and Murphy is that, while attempting to anticipate future dystopian scenarios, each fails to account precisely for restrictive and exclusionary discourses and structures – especially those concerned with class – that are operative at the present moment. As I show in chapters four and five, on this issue I agree with Heitman and Schlachtenhaufen that these tend not to exploit women in particular groups directly but rather to cut them out of participation in egg donation altogether.

3 See Patricia Hill Collins (2000) for an analysis of controlling images of black women, especially around the issues of reproduction and sexuality. See Patricia Williams (1995) for a preliminary discussion of the ways in which black women are cut out of the

economy of egg donation. See bell hooks (1981, 1992, 2000) for an analysis of the ways in which white women's movements for suffrage in the United States were tied to the delegitimation of black women and analyses of race, class and gender. See Wahneema Lubiano (1992, 1996, 1997) and Davis (1996) for a discussion of the ways in which race and racism benefit the elite in the United States. See Van Dyck (1995) for an analysis of racialization as a legitimating strategy in terms of egg donation in the United States and Britain. See Dill (1998) for an account of differently racialized women's labour in the United States in the eighteenth and nineteenth centuries. See Gabriel (1994) for a discussion of the ways in which public sector institutions in Britain may be considered to be 'racially white'. For discussions of whiteness and imbrications of race and class in contemporary Anglo-American culture and society and historical antecedents see Ware and Back (2002), Hill (1997), Wray and Newitz (1997), Schiebinger (1993), Allen (1994), Roediger (1991, 2002), Fine (1997), Fine et al (1997), Winant (1997), Nakayama and Martin (1999), Johnson (1999), Wander et al (1999), and Steyn (1999).

4 For further discussion of the construction of endometriosis and discourse on its treatment and management, see Shohat (1998).

5 For an incisive discussion of the medical establishment's tendency to downplay the pain involved in egg donation and the invasive nature of the procedures, see Konrad (1996: 313–17).

6 National and international conferences and conventions represent an important advertising and recruitment opportunity for clinics and third-party agencies. One of the biggest conventions is World Conference on IVF.

7 In addition to clinics and agencies, law practices constitute another major group of firms involved in the practice of egg donation. Lawyers are consulted when clinics and agencies draw up contracts with prospective egg donors and, apparently as an outgrowth of the practice of adoption in the United States, there are a number of firms, like Reed's, solely devoted to arranging adoptions, surrogacies and egg donations. See Gupta (1996) for a highly critical account of one such law firm (which subsequently became a third-party agency).

8 Unlike all of my other informants, Jones repeatedly articulated a concern with clients' ability to afford his services. He is aware that some clients get heavily into credit card debt in order to pay for ART. Therefore, like staff at the Jones Institute as discussed in

chapter one, he has set up a financing arrangement with a local bank and recommends that, when necessary, clients take out home equity loans.

Chapter Four

Reading Fertility Clinics and Third-Party Agencies: A Rhetoric of Transparency

I. Introduction

Demonstrating a profound anxiety about both the comparatively large sums of money circulating around ART and the absence of a viable regulatory framework capable of fully preventing the exploitation of either egg recipients or egg donors, *Shock*, the second of Robin Cook's medical thrillers to be concerned with the practice of fertility medicine in the United States, narrates the fictitious experiences of two Harvard postgraduates who become egg donors.[1] Joanna Meissner and Deborah Cochrane see the Wingate Clinic's advertisement for female students who are 'emotionally stable, attractive, not overweight, and athletic' to donate eggs (Cook 2002: 23-4). Finding themselves seduced by the notion of earning $45,000 per donation – a sum of money which, when pooled, will enable them not only to jointly purchase a condominium but to finance a year's stay in Venice, where they can complete their doctoral dissertations – the two women begin to think that egg donation might be for them (ibid.). Ringing the telephone number printed in the advertisement in the *Harvard Crimson*, they contact the clinic for more information. Within less than an hour of their call, Dr Sheila Donaldson drops by the apartment shared by Joanna, a PhD candidate in economics, and Deborah, a PhD candidate in biology, in order to explain precisely what it is that donating eggs entails and to answer any questions that either of the two women may have about the processes involved.

Impressed by Dr Donaldson's professionalism and by the Wingate's attention to the health of its donors, one manifestation of which is the Clinic's 'organic' approach to egg donation, whereby doctors extract relatively small numbers of eggs – often a single egg – from a donor who has not undergone a controversial hormone therapy designed to induce ovarian hyperstimulation, Joanna and Deborah decide to go ahead and donate (ibid.: 32). While the former elects to have her extraction under a general anaesthesia, the latter who has 'this thing about not being put to sleep' opts for a local anaesthesia and remains awake during the short procedure (ibid.: 52). Having experienced no marked side effects or complications and collectively $90,000 richer, soon after their donations, which take place on the same day, Joanna and Deborah depart for Venice. There, Cook writes, they spend the mornings working on their theses and the afternoons lunching, sightseeing, and having 'a *blast* dating almost exclusively Italian men' (ibid.: 73; emphasis in original).

Close to a year and a half later, however, on the return flight to Boston, with Deborah sleeping soundly in the seat beside her and her completed doctoral dissertation safely stowed in the luggage compartment above her, Joanna is most decidedly not enjoying herself as much as she did while in Venice. Unable to relax, she finds it impossible to 'dismiss the nagging feeling that her life was not complete despite all the gaiety, the travelling, and the intellectual stimulation' (ibid.: 75). Although Deborah, having seen her friend break off her engagement, is 'convinced that Joanna's restlessness had something to do with her rejection of traditional female goals: house, husband, children,' Joanna herself has a different explanation for her feelings of disquiet (ibid.). 'Seeing the Italians' continual love affair with infants left her wondering about the fate of her

harvested egg' (ibid.). In other words, much like my informant Anne Ames who reported finding it hard 'just wanting to know so bad what happened', Joanna cannot quell her curiosity about the 'five or six' eggs which, she was told, had been extracted from her body during her donation at the Wingate Clinic (Cook 2002: 62). Feeling that she cannot rest until she knows for certain what became of the eggs she donated, Joanna, unlike either Ames or the hypothetical, psychologically screened, 'appropriate' donor discussed by my informant Nancy Young (see chapter one), decides she must act.

Once installed at home in the Beacon Hill condo she co-owns with Deborah, Joanna persuades her friend to help her in her quest to learn about the fate of her eggs. Ringing the Wingate Clinic with Deborah close by, Joanna is connected with Dr Donaldson. She explains to her that she and Deborah, would 'like to find out what happened to our eggs' (Cook 2002: 80). Elaborating on this desire, Joanna tells the doctor that she is interested in learning 'how many children resulted and maybe even their sex' (ibid.). Much to both her and Deborah's surprise, however, Dr Donaldson icily tells Joanna that such information is strictly confidential and that the Wingate Clinic will not, under any circumstances, breach this policy – especially for a reason as trivial as the satisfaction of a donor's curiosity. Emphatically told by the doctor that neither she nor Deborah may have access to their records, Joanna finishes her call but refuses to give up her quest. Telling her friend that 'The possibility that I've got progeny out there has eaten up too much emotional energy for me to just let it go,' Joanna continues to try get information about the outcome of her donation (ibid.: 81).

From her home computer, Joanna first browses the clinic's website and then attempts to hack into its files. When both strategies prove unsuccessful, she and Deborah together hatch a plan to gain access to the information they seek by getting jobs at the Wingate Clinic. They reason that working on site will enable them to determine the location of the server room and then to break into it. Once they gain access to the server proper, they will be able to locate their files and learn whether any women were fortunate enough to become pregnant and give birth as a result of their donations.

Physically disguising themselves, using assumed names and 'borrowing' social security numbers from the death certificates of recently deceased young women, Joanna and Deborah successfully clear their first hurdle and land jobs at the Wingate Clinic. The former is employed as a word processor and the latter hired as a lab assistant. Despite a series of mishaps in which the women are amorously pursued by the Clinic's acting director, Dr Paul Saunders, and its founder, Dr Spencer Wingate, everything goes more or less according to their plan, at least until Joanna and Deborah, hacking into the Wingate's computer files, not only find their own records but stumble upon incontrovertible proof that the directors and staff of the clinic, including Dr Donaldson, are not solely dedicated to helping women with impaired fertility to become pregnant and give birth. Rather, Dr Donaldson, Dr Saunders and Dr Wingate, among others, are working together in an attempt to clone human beings. What is more, Joanna and Deborah discover that, in order to procure the vast quantities of eggs required for the perfection of the cloning technique, doctors at the clinic do not merely remove donors' eggs. In those cases where a donor undergoes a general anaesthesia for her oocyte

extraction – as Joanna did and as is the more usual practice at the Wingate clinic – doctors take one entire ovary from the unsuspecting egg donor. Stored in a vaulted 'organ room', the ovaries are kept alive by technicians whose job it is to 'mimic . . . their accustomed internal environment with oxygen, nutrients, and endocrine stimulation' (ibid.: 286). As Joanna and Deborah learn, staff at the Wingate Clinic, engaged not merely in stealing women's body parts but in clandestinely harnessing their reproductive capacity, are guilty of two of the grossest violations of medical ethics and human rights imaginable.

As the novel draws to a close, the two heroines make this discovery only to have their own breach of the computer room detected. This causes them to be imprisoned within the gates of the Wingate Clinic's sprawling complex, which previously functioned as a mental institution and which, ominously, has its own crematorium. Forced to move from building to building by running through subterranean passageways and from floor to floor by crawling through elevator shafts, Joanna and Deborah are hunted by the clinic's crazed security agents, acting under the direction of the institution's ruthless senior staff members. Although Carlton, Joanna's former fiancé, arrives at the last minute to rescue the two women, the novel does not, somewhat unexpectedly for this reader at least, conclude with the arrest of the unethical directors of the Wingate Clinic. Instead, in the thriller's final pages Dr Saunders takes care to maximize his and his willing colleagues' ability to continue their horrific and unscrupulous practices by actively planning the relocation of the entire operation to the clinic's alternative offshore base in the Bahamas. Thus, although Joanna and Deborah may have helped, inadvertently but felicitously, to

shut down one sizeable part of one renegade practice, given the absence of a national regulatory framework and the absolute lack of independent bodies staffed by professionals in possession of the legal standing required to access clinics' premises and the scientific knowledge required successfully to monitor these institutions' practices, there is little cause for hope that other morally bankrupt doctors will be significantly deterred from following the example set by Dr Donaldson, Dr Saunders and Dr Wingate and conducting their own appalling and illicit experiments. In other words, in the absence of committed governmental initiative, there is no prospect of shutting down each and every illegitimate node of a well-resourced and deceptively secretive industry that counts among its members individuals who, Cook maintains, have no compunction about twisting science and pushing it to its very limits.

The contemporary American fertility industry portrayed by Cook in *Shock* is thoroughly immoral. The practitioners of fertility medicine in general and egg donation in particular are profit-seeking egomaniacs who have – quite ironically for a group of people who are so bent upon its creation – no apparent care for human life whatsoever. Nor do they have any regard for human suffering. Instead, Dr Donaldson, Dr Saunders and Dr Wingate are driven by the pursuit of adulation from their colleagues at other institutions and the promise of phenomenal wealth, should they be the first to successfully clone a human being. Yet, because these profligate fruits of a criminal labour are inextricably bound to the practice of medicine, senior staff at the Wingate Clinic must operate in such a manner that their peers, their clients and their egg donors do not merely have no cause to become suspicious of them, but rather remain entirely persuaded that these doctors' principle

motive in running the clinic is altruistic and completely consonant with medicine's discourse of patient care. In other words, as long as senior staff at the Wingate can convincingly appear to be attentive to the well-being of donors, recipients and clients of other ART, while also demonstrating their dedication to the alleviation of the alleged suffering of the recipients and other clients by continuing their attempts to enable them to conceive, Dr Donaldson, Dr Saunders and Dr Wingate can exist above suspicion and continue unimpeded their awful and unlawful avocation.

At the Wingate Clinic, these senior staff members achieve the requisite alignment with dominant medical discourse through, *inter alia*, a rhetoric of institutional transparency that I term 'openness'. Characterized by the voluntary revelation of the inner workings of the clinic, in *Shock* the performance and subsequent re-inscription of openness is effected primarily through informal discussions in which staff members explain various processes and procedures either directly to Joanna and Deborah or within their hearing. Attending to three key examples of the reliance on openness in Cook's novel, in section III I argue for the analytical profitability of close attention to a fictional institution's reliance on a slippery discourse of openness. Among other things, and as I demonstrate, this permits a multifaceted and rewarding engagement with a number of the contemporary American fertility industry's strategies of self-representation, which are variously activated and differentially mobilized by a range of quite disparate fertility clinics and third-party agencies. Before moving into that discussion, however, I elaborate in section II on how I use this concept of 'openness' and sketch the limits of its employment.

II. Performing Transparency: Discourses of Openness and Closedness

Although it may be imagined that openness is closely related to, if not wholly indistinguishable from, informed consent, the two concepts are not identical. Even though it is not always possible to disentangle them completely, in what follows I will attempt to account for the ways in which the former differs substantively from the latter. On its bioethics webpage, the University of Washington School of Medicine defines informed consent as follows:

> Informed consent is the process by which a fully informed patient can participate in choices about her health care. It originates from the legal and ethical right the patient has to direct what happens to her body and from the ethical duty of the physician to involve the patient in her health care (UWMC 2003).

Concerned with making sure not only that the patient is aware of the manner in which a medical procedure will be conducted, but that s/he understands the risks involved, whether or not there are alternatives to the proposed plan of care, of what these latter consist and the risks inhering in them, informed consent aims to empower the patient. According to the University of Washington School of Medicine, 'The most important goal of informed consent is that the patient have an opportunity to be an informed participant in his health care decisions' (ibid.).[2] In short, informed consent claims to make a partner of the patient. This is in direct contrast to openness which, as I discuss immediately below, attempts to gain a client for the institution that deploys it.

Openness is at once more expansive and more limited a concept than is informed consent. While in some sense encompassing the latter, it extends beyond ensuring that the client

understands whatever medical procedure she has been advised to undergo. Often, but by no means always, relying heavily on a variety of marketing media including virtual tours, actual tours, seminars, websites, videos, CD-ROMs, newsletters and press releases, openness in its most general form shows the fertility clinic or the third-party agency to the client. If informed consent is an exercise in the development in the patient of a depth of knowledge about a single procedure, a set of one or more alternatives to this, and a specific medical condition, openness is an exercise in instilling in the prospective client a superficial breadth of non-specialist knowledge about an institution, its capabilities, policies and selected staff members, of the kind that is indistinguishable from the sub-genres of medical advertising (see chapter two).

By revealing the everyday practice of a given institution, the deployment of openness seeks to make clients equally aware of both the most mundane activities taking place at the clinic or agency such as, for example, the processes involved in the registration of clients, and the most extraordinary and technically complex activities such as, for example, the use of preimplantation genetic diagnosis (PGD) to determine whether a child born from a fertilized egg will be born with or will be likely to develop an incurable genetic disease. While the rhetoric of informed consent alleges that it enhances an individual's knowledge so that she may make an informed decision about her health care, openness exposes a client to selected sets of knowledge so as to persuade her that she is witnessing – without the mediation of any member of staff or indeed any other individual – how the clinic or agency functions on a daily basis. What is more, openness also attempts to persuade the client that this purportedly unmediated access to the clinic or

agency provides a sufficient basis on which to determine whether or not she should commission the institution to perform any of a range of medically unnecessary procedures on her body and, in the case of egg donation, on that of another woman.

In *Shock*, openness is largely manifested not in print-based or image-based marketing materials but through the spoken explication of specific medical epistemologies, together with the willingness of the staff at the Wingate to allow Deborah in particular to tour parts of the clinic not generally seen by other prospective egg donors or prospective egg recipients. The exact way in which this discourse is performed at the Wingate is irrelevant to my argument at this juncture; it suffices to state that openness enables Dr Donaldson, Dr Saunders and Dr Wingate to certify that their practice of fertility medicine is completely legitimate. In Cook's fictive clinic this discourse of openness operates in exactly the same manner as it does in many contemporary American fertility clinics and third-party agencies. In such institutions, staff have developed sophisticated programmes and sub-discourses in order to affirm the transparency of their practices and the ability of these practices to withstand what is sometimes intense public scrutiny.

These programmes and sub-discourses are examined more fully in the next several sections. For the moment, however, it must be emphasized that the above should not be taken to mean that openness has become dominant in the practice of either fictive or lived fertility medicine in the United States. Rather, and confirming Jordanova's suggestion 'that both medicine and science bear ambivalent relationships to the public realm socially, culturally, professionally and ideologically'(1989: 137), openness co-exists

alongside an equally powerful discourse on privacy or 'closedness'. Where openness draws upon contemporary marketing discourses in order to show an individual who is positioned as a client the medical institution from which she may decide to purchase a set of biomedical procedures, closedness draws upon established medical norms in order to protect the individual who is now necessarily re-positioned as a patient. Thus, the main manner in which closedness differs from openness relates to the way it positions the subject. In the discourse of closedness, the subject is less of a client and more of a patient; in the discourse of openness, the subject is more of a client and less of a patient.

The Discourse of Closedness

Perhaps the best evidence that the discourse of closedness co-exists alongside the discourse of openness in the contemporary American fertility industry comes from clinics' and agencies' efforts to conceal the identity of egg recipients. One example of this concerns figure 1.02, the photographic portrait of Shelley Smith and her two children who were conceived as a result of egg donation. This image is remarkable because one only rarely encounters pictorial representations of egg recipients. Although clinics and agencies produce hundreds of photographs of egg donors, there are very few images of egg recipients to be found in brochures, advertisements and websites. As a result of their history of infertility – no matter what its origin – women belonging to this group tend, I speculate, to be much more closely aligned with traditional conceptions of the patient and thus their identities are closely protected by clinics and agencies. Referred to by pseudonyms by such organisations, they are also largely absent from the industry's visual culture. They are absent also and as noted in the Introduction, to a significant extent, from

this dissertation. As I discuss in further detail below, the closedness practised by clinics and agencies, evinced in their overall unwillingness to identify egg recipients, has had a much more marked impact on this dissertation than my decision to include within it one exceptional photograph.

In 'Producing Reproduction' Cussins recalls the *ad hoc* manner in which she gained permission to speak with one of the patients at the clinic at which she was working. She writes:

> One day one of the physicians came dashing in and told me that if I ran I could catch up with a patient and possibly interview her. It would interest me greatly, he thought, because she had just decided to stop treatment even though she was not pregnant. 'Is that so rare?' I asked. 'Put it this way – you may not see another case while you are with us.' I did run, I did catch her up, and she did agree to be interviewed (1998a: 75–6).

Noting that this woman was in fact 'the only person I saw during my time at that clinic who gave up treatment without a recommendation from the physician' (ibid.: 76), Cussins attributes her informant's ability to decide to leave the programme to her religion. She writes:

> On being interviewed, the unusual commodity this woman appeared to possess was a network for interpreting her infertility outside of the medical one – she credited her Mormon religion – that was at this point in her treatment as powerful as the medical operationalization (ibid.).

It is irrelevant for my purposes here who this woman is, what her reasons for leaving the IVF programme were, and/or whether or not Cussins may be judged to have interpreted and communicated these accurately. What is absolutely vital at this stage in my argument is the fact that Cussins was able to integrate herself into the life of the fertility clinic to such an extent that practitioners were not only acutely aware of her research questions and interests, but went out of their way to facilitate conversations between this external researcher and their clients. This is the opposite of my experience with the very same American fertility industry (see chapter one). Although on the whole I was overwhelmed by the graciousness, interest, and helpfulness of my informants – most especially the physicians, whom I had incorrectly expected to have neither the time nor the inclination to speak with me – I did not receive permission from a single institution to speak with even one egg recipient. Hence the complete dearth, in this thesis, of ethnographic material derived from conversations I myself conducted with women who have attempted to conceive a pregnancy by using another woman's eggs.

Unlike Konrad, who in support of her own dissertation interviewed egg recipients as well as egg donors in Britain, any information that I have gathered on egg recipients in the United States has been drawn exclusively from secondary sources. These include, among others, interviews conducted by other academics, Konrad among them, statements incorporated into brochures and information packets produced by fertility clinics and third-party agencies, and accounts of egg donation appearing in the popular media.

My own inability to gain any kind of access to egg recipients struck me as odd, especially in retrospect. The sense that I should have been able to interview at least one current or former egg recipient was largely due to the strong presence of this group of women in all of the conversations I had with my informants. A concern with egg recipients tended to emerge regardless of whether or not the focus of the conversation was on them in the first place; these women were absolutely central to the majority of my informants' formulations not only of why egg donation was necessary but of their own ongoing involvement in it and commitment to it. This is best exemplified in a portion of the interview I conducted with Anne Ames.[3] When I asked her if there were anything of which she felt I should be especially aware when writing about egg donation, she responded as follows:

> AA: I think a first and foremost take on it would be the recipient mother's reasons for doing this and what they go through and why this is something that should be talked about, why this is something that knowledge should kind of flow a little bit more freely about. So there aren't so many rumors about it and so that we become less afraid of it – because we tend to be afraid of new things and with things we don't understand, you know. And I know this is so cliché, we hear this about everything, but knowledge is really what we need. As well as empathy towards these women. You know, there are very religious women who come in and want to have a family they are highly embarrassed to talk about it openly. But the more common this becomes the more I think it is our ethical responsibility to talk about it openly. Because otherwise you're going to hear an eventual *Jerry Springer* story and anything you're ashamed about – for any reason – then therein lies the problem. And so I think it needs to be something that people should be very open about. I almost feel like it should be our

responsibility to make sure that everybody is open and that we should do this before we move forward with the process at all but, unfortunately, you would never stay in business if that's the rule.

KB: That makes a lot of sense.

AA: Hopefully, though, someday it will get to that point. Otherwise you *are* going to run into one of those situations. I think probably the oldest child of egg donation couldn't be older than between thirteen and fifteen years old at this point so it hasn't happened enough for it to be something that you're going to hear any sort of strange rumors about but yeah, it needs to become something that we openly talk about, you know? Women who had artificial insemination – it was made fun of a lot when it first started and now no one thinks twice about it. At least here they don't. It needs to get to that point. It really does, I think. You know, it's hopefully not as disconnected as artificial insemination has to be but I think it needs to be as openly talked about as that.

Although Ames was persuasive about the need for research on egg donation to foreground the experience of the egg recipient, at no point was either she or her employer willing to provide the names and telephone numbers of recipients who might be amenable to speaking with me about their involvement in this ART. Once again, and somewhat surprisingly, the only point of access that I was able to gain to the experiences of these women and the reasons driving their pursuit of egg donation was mediated by Ames herself. Withholding the information I required in order to contact them for their own views, Ames told me how egg recipients felt: it was through her, for example, that I heard of religious women's embarrassment about needing to turn to this ART in order attempt to conceive.[4] Therefore, the accuracy of Ames's assessment of such women's

experience remains, in the face of egg recipients' inability to speak for themselves, not only an open question but a crucial one.

During the course of conducting my fieldwork and in the period immediately following it, I found myself extremely frustrated by this repeated inability to gain access to egg recipients. I was utterly convinced at the time that this group of women was central to the story that I wanted to narrate about this ART. But, as a result of being persistently denied access to them, I began to attribute my difficulty in gaining permission to speak with egg recipients less and less to flaws in my attempts to communicate effectively to clinic and agency staff that I was a 'legitimate' researcher, who not only bore no ill will to recipients but was completely capable of preserving their privacy. The perception that my difficulty in this area must be attributed to my own shortcomings as a researcher came gradually to be replaced by a sense that I was requesting permission to enter a space that was generally highly restricted. Reconceptualising the symbolic place held by egg recipients in formulations of egg donation by members of the industry, I began to think of these women as surrounded by a usually impenetrable wall of noise. In other words, egg recipients could apparently be spoken *about* endlessly, but could only rarely be spoken *to* by researchers such as myself. To this day, this formulation seems to me to capture precisely the way in which closedness sits quite comfortably alongside openness in the contemporary American fertility industry.

While not losing sight of the above, for the remainder of this chapter I leave aside, for the most part, a concern with closedness. This permits me to focus almost exclusively on

how fertility clinics and third-party agencies rely upon a discourse of openness. Pointing to several varied instances of its existence, I ask what it consists of and how its deployment might best be theorized. I begin by returning to *Shock*. Instantiating, as noted, a deep cultural suspicion of fertility medicine throughout, the first third of Cook's novel offers a variety of examples of openness against which it is possible to contrast examples drawn from the fertility clinics and third-party agencies with whose staff members I have spoken.

III. Caring at the Clinic: The Discourse of Openness in *Shock*

Evidence of the extent to which senior staff members of the Wingate Clinic rely on openness is especially prevalent early in *Shock*. One of the initial manifestations, briefly introduced in the summary of the novel given above, centres on Dr Donaldson's willingness to discuss the Wingate's refusal to hyperstimulate its egg donors. In her visit to their apartment, Dr Donaldson tells Joanna and Deborah about her clinic's alternative 'organic' approach to egg donation. Cook writes:

> 'We don't feel we have to hyperstimulate', Dr Donaldson had said early in the discussion. 'In fact we don't stimulate at all. We call it our 'organic' approach. The last thing we want is to cause any problems with our donors, which synthetic or pooled hormones can do.'
> 'But how can you be sure you'll get any eggs at all?' Deborah had asked.
> 'Occasionally we don't', Dr Donaldson had said.
> 'But you'd still pay, wouldn't you?'
> 'Absolutely', Dr Donaldson had said.
> 'What kind of anesthesia is used?' Joanna had asked. It was her major concern.

> 'That will be your choice', Dr Donaldson had said. 'But Dr Paul Saunders, the individual who does the retrievals prefers light general anesthesia.'
> At that point Joanna [who is the more reticent of the two women] had given Deborah a thumbs-up. (2000: 31–2)

By no means a figment of Cook's imagination, the 'organic' approach to egg donation presented by Dr Donaldson equates with what is known as a 'natural cycle' in IVF. In this procedure, the patient does not undergo a hormone therapy designed to make her ovaries simultaneously mature a large number of eggs. Instead, once the single egg usually matured by the ovaries of a woman who has not undergone hyperstimulation is fully developed, it is retrieved, fertilized *in vitro* and replaced in the patient's body, where it is hoped it will implant and develop. Cussins has indicated that 'natural cycle' IVF, which has been used with varying degrees of success, has been presented as a means of both boosting patient participation in and decreasing the cost of this ART (1998a: 77).

The claim that 'natural cycle' IVF is less expensive for the consumer of this ART than a cycle in which the woman undergoing IVF is superovulated hinges, above all, on the former's obviation of the patient's need to purchase a hormone course designed to cause her ovaries to mature a large number of eggs simultaneously.[5] The only hormones required in 'natural cycle' IVF are those regularly produced by the woman's own body. Dr Donaldson's 'organic' approach to egg donation may also be presumed to be less expensive for the egg recipient than a cycle in which her donor undergoes hyperstimulation. Recalling the experience of 'Cathy', the prospective egg recipient who twice believed she had located a suitable donor only to have each woman find herself unable to proceed with the donation (see chapter three), it becomes clear why this might

be the case. In an 'organic approach' to this ART the recipient does not have to pay a significant amount of money, such as the approximately $3,500 Cathy and her husband spent on her first prospective donor, for the woman to undergo ovarian hyperstimulation.

The premise that 'natural cycle' IVF increases patient autonomy is predicated on an understanding of 'autonomy' as, in this instance, primarily biological. Rather than having her cycle controlled by a drug regimen which determines when the egg extraction will take place, in 'natural cycle' IVF it is the woman's cycle – uninfluenced by her taking of any additional hormones – which will determine when the extraction ought to be scheduled to occur. Hence, Cussins understands 'natural cycle' IVF as potentially 'decreasing the extent of the disciplining of the woman's body in IVF ...' (1998a: 77). In other words, it is possible to maintain that when practised in this manner, this ART does not give doctors that degree of control over a woman's body that it is possible to achieve with the prescription and administration of hormone therapies.

As illustrated above, 'natural cycle' IVF has a history of being proffered as a desirable alternative to what has been understood, particularly by feminists, as a potentially dangerous drug regimen that hijacks women's corporeal autonomy.[6] When this is taken into account, Dr Donaldson's assertion of the Wingate's commitment to what she terms an 'organic' approach to egg donation figures the clinic as committed to making the 'patient' as much of a partner as possible. This commitment is also manifested in Dr Donaldson's response to Joanna's query about what type of anaesthesia is used in egg extractions. Reproduced in the extract above, the former tells the latter that each

prospective donor must determine for herself what kind of anaesthesia she wants used during her extraction. An integral decision, the selection of a local as opposed to a general anaesthesia or vice versa will determine not only how the donor experiences the extraction but which procedure Dr Saunders must follow in order to perform it. As a result of this, when she defers to her client on such an important decision Dr Donaldson becomes the very model of modern clinical openness. She provides her prospective patients with as much information as they require and in so doing she safeguards their autonomy to as great an extent as possible. Thus, it is no wonder that Dr Donaldson manages to sway even hesitant Joanna who finally, via her thumbs up sign to her room-mate, announces herself willing to donate eggs.

Although the Wingate's mobilization of openness is gradually replaced by a discourse of closedness by the time Joanna and Deborah are in the employ of the clinic, it is, as noted, quite prevalent early on in *Shock*. There are two additional examples of the clinic's desire to be seen as being open that I wish to address here. They occur within moments of one another, on the day on which Joanna and Deborah are scheduled for their egg extractions. Each episode takes place primarily while Deborah is on her own after Joanna, who is the first of the two women to have her eggs extracted, is called into the operating theatre.

In the first these instances of openness, a woman enters the room as Deborah is talking with her friend just before Joanna is wheeled off for her procedure. Overhearing the two friends wondering about whether or not the woman is another egg donor, the nurse attending to Joanna explains, 'That's Dorothy Stevens . . . She's a Wingate client who's

here for yet another embryo transfer. The poor dear has suffered a lot of disappointment' (Cook 2002: 53). Turning her attention away from Stevens, the nurse tells Deborah that she cannot accompany her friend into the operating theatre but must wait to be in called for her own extraction.

Sitting in the waiting room as directed, Deborah encounters Stevens a second time. Introducing herself, the egg donor begins a conversation with the client about the Wingate and learns that Stevens is at the clinic for her ninth attempt to become pregnant via embryo transfer. After calling Stevens in for her procedure, Cynthia, the nurse, turns to Deborah and remarks: 'She's quite a soldier . . . I sure hope this turns out to be a successful cycle. If anyone deserves it, she does' (ibid.: 56). This leads Deborah to ask how much a cycle costs, to which Cynthia replies, 'on average it's around eight to ten thousand dollars' (ibid.: 56). Shocked, Deborah calculates that Stevens has spent approximately $90,000 at the Wingate. Cynthia comments:

> Probably more . . . That doesn't include the initial infertility workup or any ancillary treatments that might have been indicated. Infertility is an expensive undertaking for couples, especially since insurance doesn't usually cover it. Most couples have to come up with the cash somehow (ibid.).

Shortly after Cynthia makes this statement, Deborah tells her, 'Dr. Donaldson mentioned that I could have a tour of the laboratory. Who should I see about it?' (ibid.). Not expecting such a request from an egg donor, the nurse instructs Deborah to have the public relations representative, Claire Harlow, paged. Deborah does so and within a few minutes, in the second of the two instances of the mobilization of the discourse of

openness, Harlow arrives to escort her to the clinic's primary laboratory. While she roams around the huge room which 'extend[ed] along the back of the building for almost the entire wing occupied by the Wingate', Deborah is amazed by the equipment in the lab which, Cook writes, 'was the newest and best available and included surprising things like automated DNA sequencers' (ibid.: 57). As disconcerting for Deborah as the presence of highly sophisticated technologies which have no use in either IVF or egg donation is the fact that one of the buildings she sees when glancing out the lab's window is a power plant which, Harlow tells her, formerly did double duty as a crematorium for the mental institution that preceded the Wingate's occupancy of the extensive grounds on which the fertility clinic is located.

Foreshadowing the Wingate's links to insanity and death, the deployment of the discourse of openness in the above instances operates on multiple levels. For instance, while Deborah has access to only the most superficial version of this discourse, Cook gives the reader a seemingly much more profound version. As I discuss below, it is this, in conjunction with the novel's prologue, that leads one to suspect that all is not quite as wonderful below the surface of the Wingate as its seems to be above. Leaving aside discussion of the effect of the deployment of openness on this level for the moment, in what follows I wish to concentrate on the ultimately more limited form of openness to which Deborah is privy and which itself can be conceived of as operating in two different dimensions.

In Deborah's conversations with Cynthia and Stevens, in which the focus was on the latter's so-called 'desperation' to become pregnant, the discourse of openness reveals some hard 'truths' about the Wingate clinic. For example, Deborah learns that the clinic cannot automatically answer every allegedly 'desperate' woman's prayers and enable her to walk away from the clinic pregnant. The fact that this is Steven's ninth attempt at becoming pregnant via embryo donation clearly shows that ART fails more often than it succeeds. Deborah's brief conversations with the two women also make it evident that, even when it does fail to result in a pregnancy, an attempt at embryo donation does not come cheaply. Not only have this woman and her husband spent approximately $100,000 on failed fertility 'treatment' but, as Stevens says, they plan to continue pursuing this 'until we've used up all our credit' (ibid.: 55). Having been able to speak with Stevens, Deborah encounters for herself the alleged 'desperation' of the infertile and, what is more, has firsthand proof that the Wingate does not conceal its failures. Deborah's ability to meet and speak with Stevens attests to the clinic's straightforwardness about its sometimes very limited ability to help its clients.

On a second level, the two examples discussed above instantiate the physical openness of the clinic. Deborah's movements through the institution are not overly circumscribed. Allowed to have a look around, she has the opportunity to see for herself what goes on at the clinic and the layout of the institution. Seemingly nothing is hidden from Deborah, for she encounters first Stevens and then the unexpected DNA sequencers in the lab and then, finally, she learns for the first time about the crematorium on the clinic's grounds. Thus, although the fertility part of this fertility clinic may be something of a front, in that

the head doctors are primarily concerned with cloning, there is nonetheless the sense that the practice of fertility medicine does take place, at least above ground, at the Wingate Clinic and that this can withstand the scrutiny of a relatively well-informed member of the public.

Below ground, as indicated, it is a different story altogether. Not only are staff at the Wingate actively attempting to clone human beings (or, to be more precise, Dr Saunders is attempting to clone himself) and involved in the theft of living women's organs in order to further this purpose, they also deal in death. The novel opens with the death of Kristin Overmeyer, a Harvard undergraduate who, along with her friend Rebecca Corey, decides to donate her eggs at the Wingate. As a result of the misadministration of anaesthesia, however, Kristin awakes mid-procedure. This startles Dr Saunders who accidentally injects her with a gas which causes her to have a seizure which in turn proves fatal. Instead of opening the clinic to the gaze of the authorities and reporting Kristin's death, Dr Saunders endeavours to hide it, with the full knowledge of Dr Donaldson and others. He does so by ominously telling his chief of security to find the young woman's car, locate her friend whose own extraction proceeded without incident, and 'take care' of the situation.

Six months later, when Joanna and Deborah are considering donating, the former expresses the desire to speak with someone who has already been an egg donor before she makes up her mind about whether or not she will donate her eggs. Remembering that one of her former students donated at the Wingate, Deborah sets out to telephone Kristin

Overmeyer to inquire whether she would be willing to talk about her experience as a donor. Unable to find a listing for the young woman in the school phone directory, Deborah contacts Kristin's former roommate who tells her that Kristin disappeared and is presumed dead. In response to Joanna's query as to what she learned in her conversation with the former roommate, Deborah tells Joanna that Kristin 'and another freshman by the name of Rebecca Corey were last seen by a Wingate Clinic employee picking up an apparent hitchhiker just after leaving the clinic' (ibid.: 29). Recalling that she had heard this story at the time Kristin and Rebecca disappeared, Joanna shudders briefly before quickly moving on to reassert her desire to know more about egg donation.

In *Shock* the mobilization of a discourse of openness that is operative on two different levels results in the fertility clinic being figured as a Janus-faced institution. At the same time as senior staff are consumed by the desire to gain fame and fortune by winning the race to be the first to clone a human being, they nonetheless do their best to appear to serve their patients and care for the donors whose bodies they pillage but without whom procedures such as egg donation could not be conducted. Thus, while above ground at the Wingate Clinic all appears to be above board, below ground there exists a medical and ethical hell. In the institution's basement, and in direct contrast to the rhetoric indulged in by, for example, Dr Donaldson, women's bodies are valued only for their reproductive potential and neither women's lives nor their desires *vis-à-vis* their bodies are of the least significance as far as the Wingate's senior staff are concerned.

By imaginatively pushing the boundaries of fertility medicine, Cook crafts a nightmare scenario in which greedy doctors involved in 'boutique' medicine become killers. What is more, by concluding the novel as he does Cook maintains that the only hope, given the current non-existence of any system capable of monitoring the contemporary American fertility industry, of forestalling the replication of such events as he describes and preventing the financial, physical and/or psychological abuse of clients and donors, depends soley upon a doctor's own sense of ethics. In the absence of this, one winds up with the Wingate Clinic – the symbol of everything a fertility clinic should not be but very well could be.

It is of little interest to me here to determine whether Cook may be understood to have grasped 'realistically' the malfeasant potential of the contemporary American fertility industry; what is of interest is the fact that *Shock* can be read as a critique of that industry. In gathering under one roof the worst of the worst-case scenarios, Cook's novel articulates anxieties about fertility medicine. In so doing it permits actually existing institutions to demonstrate to their clients and donors alike that they neither operate sub-basements wherein they perform horrific experiments on human subjects nor use their earnings from their seemingly legitimate practice of egg donation to bankroll their true passion: cloning. Varieties of openness relating to price, donor 'quality' and client care are mobilized by the staff of clinics and agencies in order to proclaim themselves different from one another and from the likes of the Wingate Clinic. Difficult at times to disentangle these appear, *inter alia*, in informants' speech, on donor application forms and in brochures and webpages; they are the subject of the next section.

IV. 'We Want to Do the Right Thing': Institutional Narratives of Openness

Incorporated in 1999, Laura Green's firm Texas Third Party Agency (TTPA) grew out of both women's struggles with infertility. As Green explains below, their dissatisfaction, as potential egg recipients, with the institutions to which they turned in order to find a suitable egg donor was the catalyst for the inception of TTPA.

Although, like the portion of my conversation with Dr Cole that I presented in chapter three, it is quite long, it is nonetheless worth taking the space to reproduce this part of my conversation with Green in its entirety. Green's narration of her agency's operation contains within it several themes which are central to this chapter and recur with frequency in many of my other informants' narration of their own business practices. Green's introduction of Texas Third Party Agency began when, early in the interview, I asked her how she came to be in the business of locating prospective egg donors for prospective egg recipients. She responded as follows:

LG: We were actually incorporated in June of '99. However, we did not start serving recipients until July of 2000. I mean we actually started meeting people and showing donors then. And we had our first contract, our first cycle, in I think it was November or December of 2000. And that cycle actually occurred in January of this year. So 2001 was our first cycle and now, Kate, it has gone up and we can't keep up.

KB: Really?

LG: The growth has been logarithmic, not linear. It's just surprised us. But we as previous potential recipients, we were referred to an egg donor agency and we were *so* unhappy with the lack of service and I just said forget it. What about SAT scores? What about a lot of pictures? I want to know

what I'm getting here, you know. This person is going to be part of my family. I just was so fed up. So I said to myself, just forget it. I will move on, I will get on with my life. And my sister, who is my identical twin, said watch this. I'll do a better job. So she and her husband who's a lawyer incorporated [TTPA] with two things in mind. She wanted to be recipient-oriented and to keep the fees low. Those are the two things that we really emphasize in terms of how we really are different but there's more than that. Much more. We keep our fees low, in fact, if you look around I am positive that we are the lowest you will find *anywhere*. If you find somewhere lower I want to know about it.

KB: All right.

LG: Because I don't think anybody's agency fee is lower than ours. Ours is $1500. And the others that are even close are $2100 and up. Now I know out in California they're like $3500 and up to $5000 – just with the agency fees. Our donor fee is at $3,000. Other competitive agencies in the state are $3,500 up to $4,000. So we're trying to put a cap on this – it's getting out of hand. I mean around the country you can see donor fees up to $30,000 which is ridiculous. There's got to be a stop to this. There's got to be some sanity so we're trying to put some realistic factors into the equation in keeping the price down. Keeping it reasonable is one of them.

KB: Right. I see what you mean.

LG: Okay and how are we different. We want donors to have SATs of 1100 or higher. Now, that's not saying that all of ours are that right now because when we started out we were a young agency and we needed to gather a donor base. But donors come and go because they're so young and their lives change so quickly. Who's available today will not necessarily be available tomorrow. See?

KB: Yes. That's clear.

LG: They get pregnant themselves. They get married and move off, you lose them. Let's see what's happened to some. It's mostly pregnancy. And we've learned how to keep up with the ones that we have. Which was an issue

because we were losing some at first. But the bottom line is we are now – as of about a month ago – requiring SAT scores of 1100 or higher. A comparable ACT will be 25 or higher. Now that's a pretty high intelligence quotient, if you will. If a donor hasn't taken the SAT or the ACT and all they have is a GPA, you know, we say okay we'll take the GPA. If they don't have a 3.0 at least they're probably not going to be chosen by a recipient couple. Okay, here's another thing that makes us different. We keep our fees low, we're recipient-oriented in that we will address the issues that you want to know. In other words, we will do all the pictures you want, we will do SAT scores and we will answer questions that you want. I mean any question that you want us to ask your prospective donors, we will go find it and get back to you with an answer. No questions asked. I mean, there's none of this, you know, hemming and hawing, and waiting three months to have an answer for so and so. All that kind of stuff. We are here to serve the recipients. You want to know something, we're going to find it out if we don't have it already. Our application slash questionnaire for the donor is very extensive. It's eleven pages long.

KB: Wow. I think I saw that online.

LG: Yeah. It's that long. Okay, that's how we're different from others because other agencies want to charge you to look at pictures, they want to charge you to research SAT scores, all this stuff. And we let people view our donors at no charge. Everybody else charges from $75 to $300 just to look.

KB: Really?

LG: That is nonsense. We're like oh *please*! And here's another thing. This is something that really got my goat. If you gave your money to an agency, you are like signed with them so that they would be looking for your 'perfect donor' so to speak. But say they never send you one who you even remotely like and you get fed up. You've already given them at least $5,000 that's not refundable. When you tell them you're not happy, they

say, too bad, so sad. They've got your money and it's not refundable and if they're sending you undesirable donors, it's like 'tough luck'. What is wrong with that picture? Oh, help me. I mean, I've been in customer service for twenty years and I know something about what people want. And they want value for their money. And if you're forking over all this money and it's like, [sings] take the money and run [laughs]. Excuse me. That's not right. That's not good business and that's not right. What I'm leading up to is this is what *really* makes us different. If you do not use our donor, you get your money back. This is a novel idea. It's a *maverick* idea in this industry. It's just not done. I mean, they keep your money. [Laughs.] If you go through a cycle, we give you your money back. Now, here is one instance where we take a part of it. If your donor starts her shots and the cycle gets cancelled, the donor gets five hundred dollars for services. Well, we do too. But the rest of that fee is refunded. You see?

KB: Yeah.

LG: It's basically, if the donor gets paid, we get paid. If the donor doesn't get paid for not going through the cycle, we're not going to keep your money. It's just not right. We want to do the right thing and believe me, the right thing was not being done in this industry.

Calling the drive she shares with her sister to 'be recipient-oriented', 'maverick', Green, in the course of narrating TTPA's origin, identified a number of areas in which she believes her firm stands apart from its competitors. These include low fees, a 'sane' approach to egg donation, allegedly demonstrably intelligent egg donors, the ability to track prospective egg donors effectively, so that if a prospective egg recipient declares an interest in a woman in the former category it may reasonably be expected that she will be available for further consultation, an extensive application form which all women desirous of becoming prospective egg donors must complete and a devotion to quality

customer service which is understood to translate into the rather amorphous 'value for money'.

Even though Green maintains that TTPA's commitment to and excellence in any and all of the above areas indicates that her firm stands apart from its competitors, what is striking about the above traits is not their exclusivity but their commonality. That is to say, the majority of my other informants relied upon the same or a very similar rhetoric in order to distinguish their firms from those of their competitors – including of course, Green's. Remarks made by, among others, Nancy Young and Anne Ames instantiate this. So too do Lisa Davis's comments. To illustrate how very different firms rely upon very similar discourses of openness in order to assert their exceptionality and to attempt to persuade new and existing clients of their expertise and dedication, I now take a closer look at some of these, beginning with Davis's observations.

Common Uniquenesses

A former egg donor and surrogate who runs her own surrogacy agency – which I have renamed The Surrogacy Agency (TSA) – Davis was among the first of my informants to agree to speak with me and I arranged to interview her at her home office in suburban San Diego.[7] Scheduled to meet with her after my interview with Young, I raced out of the latter's office in Beverly Hills and drove two hours south to San Diego, where it was arranged that I would telephone Davis for directions to her home. Only when I stopped to do this did I learn that I had arrived on her assistant's day off and while she was out

running errands. Until she returned home there would be no way to contact Davis for instructions on getting to her house.

Although I did have her street address, being completely unfamiliar with San Diego I had no idea where Davis lived or even in which direction to head. Unable to reach my informant, I became increasingly annoyed – not to mention lost – as I drove from gas station to fast food restaurant to post office in search of anyone who could either give me directions to Davis's area or sell me a map that featured not the tourist spots of San Diego but the brand new subdivisions and commuter towns on its far outskirts. Eventually succeeding in finding an enormous county map, and $20 poorer for it and its poor relations, I located Davis's community and pulled up in front of her large contemporary-style house about twenty minutes later. There I was warmly greeted by both my informant and her children, whom she had just returned from collecting from school.

After starting to talk in her sitting room, we were interrupted by the noise of her husband mowing the lawn and her children playing, and Davis suggested that we move into her office where it would be quieter. There she told me that, although she herself had been an egg donor, she did not arrange this ART but referred any clients who were interested in it to a different organization. Exhausted from the ordeal of trying to find Davis's house and frustrated since I only pursued the interview with her because I believed that part of her business involved the location of egg donors, upon hearing this my first inclination was to thank Davis for her time and leave.

Instead, mainly because I was hot and tired and her house was cool, I decided to proceed with the interview. Yet, I became increasingly convinced as I did so that my questions were too general and that as a result I would learn very little from my conversation. Eager to stop feigning interest in an ART that had never captured my full attention and to begin the long drive back to Los Angeles, that afternoon I was sure I would use no part of Davis's tape and contemplated not even transcribing it. A year and a half later, however, because Davis's comments, like those of my other informants, can be read as another illustration of the profound commonalities across narratives of institutional uniqueness, I am very glad that I did go ahead and preserve and transcribe our conversation.

Framed by a discussion of the general public's misperceptions of surrogacy and the apprehensions experienced by individuals pursuing this reproductive arrangement, early in our conversation Davis insisted on the necessity of using an agency such as her own when contracting with a surrogate. This led her to state, in a manner similar to Green, that TSA does not merely differ from its competitors but actually surpasses them in terms of its ability to offer its clients value for money. This part of our conversation is reproduced immediately below.

KB: What are some of the biggest fears women have about pursuing surrogacy?

LD: I think the biggest fear is that the surrogate won't give the baby to them at the end. I've never had that problem – ever. We've been really lucky. I know most agencies don't. That type of problem makes media attention. If a surrogate does not relinquish a child, believe me the news will be *all* over that.

KB: That seems to be the case.

LD: And so, I think, in the back of their mind they're just afraid that the surrogate will hold the baby hostage for nine months, won't let them be actively involved in the pregnancy and then at the end, you know, will she let me be there during the birth? You know, how will it be? They just kind of worry. So I think that's why an agency's really important because they can really match the couple and the surrogate together. Kind of go by, you know, the way the surrogate is, the way the intended parents' attitude are, how their involvement should be, they both agree on certain issues such as, like, abortion, number of fetuses to transfer, number of fetuses they'll carry. I mean an agency really is a big part of it and I know it's an added cost and a lot of couples look at it like, I can do it independently. I have a lot of time. But it's not necessarily the time. It's the extra person stepping in that has a connection to both parties that can kind of put them together if they belong together. You know what I'm saying?

KB: Yes, that makes sense.

LD: It's easy to find people on the internet. I mean there's many websites that, you know, surrogates put their profile up on or advertise on but you really don't know what you're getting. You don't know if that person is being truthful and usually if the surrogate goes through an agency, they're not in it for the money because they know the agency pays a certain amount but if they go independently they can ask for more because there's no agency to regulate it. So. I think – I think an agency is a very important aspect in the whole circle of an arrangement.

KB: Do you ever sell your agency then as performing that role?

LD: Basically what I feel is – in the information we give our couples I provide a document that says the services that an agency will provide and I list everything that our agency does. And basically, our fee is one of the lowest fees out there. I know some other agencies are recently opening, trying to charge less, but they don't have the experience. They don't have, you know, the proven record that I do. They don't have the references that

> I can provide. So I mean you kind of have to weigh, you know, the experience versus the fee. I mean, what's, you know, more important in the long run? Do you want to pay less to somebody that doesn't know what they're doing? And then end up paying more because you've got to get out of that? Or, do you pay a decent amount to somebody who's done this for years and knows what they're doing and is reputable? I guess we don't try to sell ourselves – we try to provide a service. And, I mean, being in business six years and having what I have, I think I have a really good proven track record. And I've given couples discounts in the past that just don't have a lot of money, that don't feel secure going independently. I guess it's on a case by case basis. It really just depends on who the person is and what their situation is.

As stated above, Davis works in a different state from Green and sells the arrangement of an entirely different ART. Yet, at least as far as price is concerned, her narration of its influence on and relation to the practices, aims and epistemologies undergirding TSA's operation is remarkably similar to the ways that Green connects price to the practices, aims, and epistemologies undergirding TTPA's operation. Like Green, Davis claims that the fees she charges her clients are among the lowest in the field. This is the case even when, as Davis herself says, other, newer firms are actively undercutting her on price. Although it is true that these firms may charge less than she does to locate a surrogate and to make arrangements for this woman to be paid to become pregnant with and give birth to a child whom, shortly after delivery, she will relinquish to another woman to raise, Davis maintains that her competitors have less experience than she does and that therefore they cannot provide as professional a service for the money they charge. Thus, according to Davis, given her considerable experience, she ultimately charges her clients

less for her services than competing organisations charge their clients – even when their actual price is lower.

It is worth pointing out here that the kind of criticism of other institutions that is implicit in Davis' discussion of price tends to be voiced much more frequently by the owners and staff of third-party agencies than by doctors working at clinics. For example, although my main impression, hearing Dr Cole express a desire to return to practice in Britain where he had studied, was that he was rather disenchanted with his chosen field and the practice of reproductive endocrinology in the United States, I did not come away from our interview with the sense that he felt that his own clinic offered a better (or lesser) quality of service than any other. Instead, when Dr Cole spoke about needing to attract clients and ways of doing this, the concerns he voiced were quite different from those raised by Green and Davis. Rather than competing directly with other clinics, for instance, Dr Cole maintained that it was necessary to 'massage' general practitioners and gynaecologists for referrals. In another necessarily long segment of our interview, Dr Cole discusses how he came to be part of his current practice and the manner – very different from Green and Davis – in which he has attempted in the past and continues into the present to build his client base:

DC: Basically, when I came in '94 I didn't have a full practice. So I had a) a lot of time on my hands and b) I had to look at tools for recruiting patients.

KB: Based on the website as a tool for recruiting patients, you have a lot of fairly detailed and complex information –

DC: Which is worthless as a patient recruiting tool.

KB: Oh. Is it?

DC: Oh yeah.

KB: Okay. What works as a patient recruiting tool?

DC: Massaging the referring doctors.

KB: Really?

DC: You see, in infertility our business is 99 per cent referral. So, you know, almost all the patients I see are referrals from local doctors. So you've just got to talk to the local doctors. It's the only way of recruiting patients. The only practical way.

KB: Right.

DC: This website is purely a hobby.

KB: In terms of recruiting patients through their physicians, is it just a matter of calling the physicians and saying I'm in the neighbourhood, I do this or would it be –

DC: You've got to visit.

KB: You do visit?

DC: What I found worked best was giving lunchtime presentations at their offices.

KB: Okay.

DC: It's by far the best way to do it.

KB: Okay.

DC: In our industry, if you want to talk to the doctors, you've got to work with the nursing staff.

KB: So quite a bit of energy has to be expended.

DC: I think initially yes.

KB: Okay.

DC: It depends on the partnership model. You see, you might join a practice that is an equal partnership where all the physicians share patients and revenue and they work at about the same pace. In that case you greatly profit from the goodwill and reputation of the existing partners. But, you have a large buy-in. It costs a lot of money to join that practice. That's not the model in the practice that I joined where they basically provided me

with office space but I had to recruit my own patients. I had to generate my own good will and that takes a few years. But in such a situation the buy-in then becomes nominal. It's very cheap to join a practice like that and you have a lot of time on your hands when you start off.

KB: That's very interesting. Would you say that the same is true of many clinics in the U.S.

DC: Oh, this is not typical.

KB: It's not typical?

DC: It is not a rare model by any means. But more common is the model where you take on a partner because you've got too much work. So, you want to shift some of that to your new partner. But then you're giving away sweat equity as it were. And so you want to be compensated for that. So, you know, if you join a legal partnership, the buy-ins are around a million bucks. If you join the sort of competitive model that I joined, the buy-in is about a thousand bucks.

Compared to the general tenor of Green's and Davis's comments, what is striking about Dr Cole's description of what practice-building entails for him is the absence of any sense of or reference to competition. Nowhere in his account of the business of fertility medicine does he provide any indication that a practitioner such as himself must closely monitor his colleagues in order to gain clients, price services, keep abreast of the latest trends or perform any other function or task that is central to the running of a contemporary fertility clinic. This sense of self-containment contrasts strongly with the manner in which the majority of my informants from third- agencies discuss their practices. In addition to Green's and Davis's remarks on price, my interviews yielded many further examples of ways in which these and others of my informants perceived competition to be a major force in their professions. Young, for example, was so

convinced of the centrality of this that she posited that third-party agencies have competed with one another to such an extent that, at least superficially, they have become virtually indistinguishable:

KB: In terms of other organisations that are similar to yours, how would you distinguish your company from others?

NY: You know at one time there was quite a difference between the agencies. Now I don't think there's *as* much a difference 'cause everyone copies everyone else. I mean, the minute I do something on the internet, a week later I find it on someone else's site. So they just copy each other continuously. It's maddening but that's what they do. And our actual process of screening a donor, including psychological screening, is duplicated by almost everyone else around because we're one of the oldest companies. So *everyone* does what we do. So what's happened is, we've sort of all begun to look alike.

KB: Right. I see.

NY: What I say to couples, though, is although we look alike and it's easy to copy someone, it doesn't mean you are alike. As an example, I say to couples, where are your records going to be in ten year's time? You've got a lady working out of her kitchen – she might be wonderful, professional – but she's working out of her house and then she goes and moves house. Where do you think your records are going to end up? In her garage somewhere? Is she going to put them in the dump somewhere? Where is she securing that very vital information? Is she going to give it to another agency? What is she doing to secure your information? On the other hand, what if her house burns down? Does she have an off-site location where she's keeping the backup? You know, this is something that as a professional organization everyone does. I mean if I get hit by an

earthquake here, we have a duplicate of every single day of backup tape elsewhere.

KB: That makes sense.

NY: So it's always offsite. But if you're working from home and you're a very small agency, you can't afford a big computer system like that where you totally backup to an offsite area. So if a couple wants to find their donor 'cause they never met her, because their child is very ill and the agency no longer has the information or is no longer in business, what are they going to do? So not all agencies are created equally. You've got to be a little more careful with your information. And if you do work with a smaller agency, make sure that *you* have control over the information. You've got the lady's name, you've got her social security number and you've met her at one time. 'Cause the agency's not there to protect you. They're just too small and they go out of business.

KB: Right.

NY: Or give the records to someone, you know. I'm not going to do egg donation any more but my friend is. Maybe she'll call you and see if she can help you. And they just pass names around. So it's hard to say who's professional in the field because our field changes so much and there's so much copying going on. For instance, they all play on the same names. Our program is called Oocyte Donation, Inc. and then you've got Egg Donation Program, Inc. and Egg Donation. They're all playing with the same names so they can all look alike. Does that make them professional? No. Does that make them non-professional? I don't know. Maybe they just haven't been around long enough and most of them don't stay around long enough. It's generally someone who either was an egg donor herself or she needed to work with an egg donor who now starts her own business. Does that make you professional? No. You've got to have a business sense about you. You've got to have some sort of qualifications. You don't just start a business. On the other hand, if you do just start a business, you learn to be professional. So would I work with an agency that's only a few years old?

> Under no circumstances. Would I work with someone who's been around for five years? Yeah. But, she might have been around for five years and done two egg donations a year. You don't know, 'cause everyone's going to lie about their stats.

Initially asserting that competition, in the guise of needing to keep up with the latest trends, has resulted in a pervasive similarity among third-party agencies in terms of, for example, the names they choose for themselves and the processes on which they rely in order to develop a prospective donor database, Young nonetheless goes on to argue that there are significant differences across this subsection of the fertility industry in terms of business practice. One of the most salient of these concerns the post-donation period and the storage of information. Only the more established agencies like her own, Young says, have the systems in place to keep track of what has been exchanged in egg donation – whether, as discussed in chapter one, this is conceived of as genetic material or the non-biological 'chance for motherhood'. Albeit less specifically, Young's conviction that there are essentially two tiers of agencies – the more professional, experienced firms and the newer, more profit-oriented firms – is echoed by Davis. When I asked her to tell me how she interacted with other similar firms and whether or not she felt there was a lot of competition, my informant responded as follows:

> It's really sad to say but a lot of the agencies do not want contact with other agencies. They look at it as a competitor and I don't feel that way. I mean, I feel very secure in the surrogacy field and there are a couple of agencies that have opened up because I've got them started. Like Fertility Alternatives. There's one run by Marci Stafford, New Creations I think it's called. She's a surrogate of mine and she started her agency after talking to me about it. There's a couple of others

that have just recently opened up. Basically, what they do is they kind of get to know the agency and then branch off. That's why a lot of agencies are popping up now. They are kind of jumping on the bandwagon type. A lot of them aren't making it because they're not doing the research properly and they're just trying to get in for the easy money. Because, I mean the money is great. I can't speak highly enough about it. I mean we were able to buy a home, you know? I mean it's amazing but if they go in for just profit and gain then they're not going to make it. They have to have the knowledge and the know-how, and have done the background research before they jump into that.

In response to a question I asked about agencies that depict themselves as doing a substantial portion of their business over the internet, Ames also addressed the issue of competition with other firms. Unlike Young, however, she indicated that the weakness of her firm's primary competitors related not to the storage of information but to the quality of the donor's egg donation experience. According to Ames, some firms operate in such a manner that donors are treated not as 'friends' but as 'commodities':

KB: What do you think about these other organisations, agencies which arrange egg donations which operate mainly on the internet?

AA: I'm assuming you mean the ones where it's about the beauty?

KB: Well, there's that one and then there are other ones that –

AA: Just very impersonal? That what you mean?

KB: Uh-hmmm.

AA: Personally, I don't like it simply because the way we work is everyone is satisfied, fulfilled and every donor we have in our program is an amazing human being. And we're all friends with them. It's not like a commodity.

KB: Right.

AA: The second human beings get treated like a commodity, is the second they will start to act like one. So we have women who we call egg bidders.

> They will write in and say I want to donate with your program but I won't do it for any less than $15,000 or $20,000 and I need this, this and this and it's kind of like wait a second, you know? I mean, it's not a commodity. This is a life. The second somebody does that, they don't care who the recipient parents are as long as they get x amount of money and I don't like it when you disassociate life from experience. You make it something that is so inhuman. We offer $5,000 which, in a lot of cases, is enough to get people to call in and inquire but it's just not enough money to get somebody to do it – definitely not in L.A. You know what I mean? I honestly believe in compensation because it's time, it's effort, in some cases some people will lose time at work, you know, but, it is a certain amount of soul searching you need to do and I believe that $5,000 is a very adequate amount for what you're doing. But I there's no monetary value that you can put on what you're giving someone else is. It really has to come from your heart and because you think it's the right thing to do. That the kind of women we want to be egg donors. With internet sites, it's very impersonal and probably always anonymous and I just think you take away from the human element of it.

Like other issues raised in my interviews with my informants, the quality of the experience had by the donor in the donation process is a topic that recurs frequently. No matter whether the firm in question is a clinic or an agency, as my conversation with Young indicated, one of the major ways in which firms compete with one another is through the experience they claim to be able to offer the donor. One manifestation of this is the psychological evaluation. In addition to the submission of a written application form, many clinics and agencies, including the Jones Institute, require that prospective egg donors undergo a psychological evaluation. Although I was unable to pinpoint the exact kinds of questions asked in a typical psychological evaluation, the packet

distributed to prospective recipients at the Jones Institute states that 'a staff psychologist must determine that the donor is well adjusted, without psychopathology, and has a good understanding of the process and the required anonymity' (1993: 3).[8]

Although it appears that at the Jones Institute only prospective egg donors undergo a psychological assessment, this is by no means the standard across the industry. Some programmes, such as Reed's, do not require any kind of psychological examination. Others, such as Green's, require that prospective donors pass an examination but they themselves do not conduct it. In Green's case, she retains a psychologist who speaks to prospective donors. There is a similar procedure of outsourcing the psychological examination at Dr Ian Jones's clinic, but one key difference between his programme and Green's is that at the former, as mentioned in chapter one, both prospective donors and prospective recipients must undergo psychological evaluation. Jones explains the rationale behind this as follows:

> Everyone undergoes psychiatric evaluation. Both the egg recipient and the egg donor. For the egg donor, it's mostly we're looking to make certain that they're not being coerced by their husband, the pimp, you know, who's trying to get them to make money on their eggs. Trying to make sure that if it is a designated donor – like a sister – that she's not being coerced by her family members. We'll often ask them to go through various scenarios on the designated donor like what if the sister's one child dies and the only baby that she has is of the other couple? Or what happens if the other couple gets divorced and so on and so forth. The MMPI [the Minnesota Multiphasic Personality Inventory] is done on the egg recipient. Mostly, though, we're looking for coercion. We only pay our egg donors $2000 which judging from the market is on the lower end of the scale and so we try to

make sure that the money isn't an enticement. We don't want to overly entice these individuals.

In my interview with Dr Schnorr I was unable to verify whether or not any prospective egg donor had had her application successfully reviewed by a physician and had passed the blood test(s) only to be rejected as a donor on the basis of her psychological assessment. Such a situation does appear to have occurred at the agency at which Ames works. Although she made no mention of a psychological evaluation conducted by a licensed psychologist, Ames nonetheless discussed interviews that resulted in the prospective donor being turned away. As she indicated, what was at issue was not prospective donor's physical health or the suspicion that she had a condition that could be passed on to a child. The issue was whether the prospective donor was presumed to be emotionally capable of dealing with the physical and logistical processes involved in donating and with the fact of the donation itself. Ames explained:

AA: We choose donors from twenty-one years of age and above because we feel if they're a little bit older, they've had a little bit more time to think about it. A lot of the questions that we ask donors are, you know, what's going to happen if this child wants to find you someday? Will you ever want to meet the child? Do you feel like you deserve custody? You know, that type of thing. These are questions that in order for someone to be a donor they really need to think about. They're evaluated not so much for a right or wrong answer but to see if they're really thought out. Is the prospective donor aware of the repercussions of something like this, you know? Are you going to always wonder where this child is or how this child is being treated? Will you always wonder if you did the right thing? Will you tell your own kids? Are you going to be open about this? Et

cetera, et cetera. If you haven't thought about all of that then you're probably not ready to do it.

KB: Right. Do you get a lot of women who are dead set on doing it and then it becomes very evident that they aren't ready? Or, are most of the women who go to you ready, in fact, to do it?

AA: I would say the majority are ready. And the ones that we don't allow in probably think that they're ready but that's a decision that we make. As an example, maturity level is important. Somebody who comes in that may be in their mid-twenties, who comes across as highly immature, we probably wouldn't do it. First of all because we probably wouldn't feel comfortable with the fact that they would have to take their hormone injections at the same time and make all their doctor's appointments and whatnot. That type of thing. Also we've had situations where women have come in and have said things such as, you know, well, they're living with somebody and they want to get out and they need money. When people come in desperately needing money we generally won't work with them. And we'll tell them, that that's the case. We'll say, you know, you're in a desperate situation and you're trying to get money and this is not the way to go because you're obviously not thinking about the repercussions of what you're doing. You're just thinking I get money from this and so you know, we have turned people down for those very reasons.

Rather than the issue of a prospective donor's potential psychopathology, for which the Jones Institute's prospective recipient packet maintains prospective donors must be screened, and the issue of spousal or familial coercion, against which Jones attempts to guard, the most commonly raised non-medical issues about which clinic and agency staff expressed concern had to do with the cash payment women would receive for donating their eggs and the maturity level of prospective donors. Ames is informative on both of these issues, but she is not by any means the only one of my informants to speak about

them. Dr Cole has similar concerns. In answer to my question as to why the clinic does not advertise for prospective donors in college and university newspapers he replies:

> Basically, I think the reason is that we feel that college students may be poor and that the economics may become a major factor in their decision to pursue this – and it shouldn't be, number one. Number two, we also worry that maybe someone as young as that – she probably hasn't had children, we don't know as much about her reproductive history, and she may not be living in as stable an environment as an egg donor ideally would so that we can always reach her when we need to reach her. I don't recall seeing any college students as egg donors here.

Young is also informative on the issues of donor maturity and payment for donors. The first of these two issues arises when I ask her what she looks for in a donor. She replies:

> You're looking for someone who is over the age of twenty-one. You know, anyone who works with a donor under the age of twenty-one I just think is – it's probably the most horrible thing you can do to a person. And I think those donors as they grow up, may not fully understand what they did. And it may haunt them. So, I have a couple in my program right now doing surrogacy and they're working with an eighteen-year-old and it horrifies me. I can't stop them because it's not my program. You know, the donor's from somewhere else. But you've got an eighteen-year-old who's recently left home, gone to college, donating and will never meet the couple. You know? She's had one boyfriend so she's not exactly sexually exposed to the whole world. Does she really understand what she's doing? Does she understand that there's a kid out there that has her genes and that – although we all agree that we won't contact each other – the donor won't contact the couple, the couple won't contact the donor – no one's got an agreement on behalf of these children. So one day, this child could come and knock on the donor's door and say, Hey! you helped give birth to me!

The issue of money arises a short time later when I ask Young where she advertises. She responds:

> Mainly parenting magazines. A little bit at universities but I'm sort of still reluctant, Kate, to advertise on university campuses. I still wonder if that's sort of dangling this wonderful carrot in front of these young ladies and enticing them to donate because of the money whereas when I advertise in a parenting magazine or in the *L.A. Times*, it's more a curiosity. People happen to be looking and say, hey, I could do this. Whereas if I'm only going off to university students, it's a lot more about money. And I'm not quite as comfortable with that.

If Dr Cole, Dr Jackson, Young, Green and Ames are all uncomfortable accepting women who want to donate just for the money they stand to earn and if they are wary of accepting very young women into their programmes, then the question arises of just who these institutions and others like them will accept as an egg donor. Given that an acceptable donor must be psychologically mature, not interested in donating solely for financial gain, interested in donating purely of her own volition, and free from psychopathology, are there any other characteristics a woman interested in donating her eggs must possess in order to become a prospective donor and perhaps even an actual donor? Reading the Jones Institute's prospective donor application form and referring to other fertility clinic and third-party agencies' application forms and interviews with staff members at these institutions, I attempt to answer this and related questions in the next section.

'Quality' Donors

While the large number of firms offering egg donation in the United States means that a woman could be enrolled as a potential egg donor at more than one institution,[9] completing, submitting and having an application form accepted will most likely be one of the first hurdles a woman must clear if she is to be accepted as a prospective egg donor at any one of these many institutions. Although it may not be true that every single fertility clinic and third-party agency requires a prospective egg donor to complete and submit an application form, every American institution with which I am in some way familiar does so. This means, as I noted above, that it is in no sense guaranteed that the submission of an application form will automatically earn a woman a place in an institution's donor database. In order for a woman to be accepted into an egg donation programme as a prospective egg donor, the information on her application form must be deemed acceptable by a staff member at the institution to which she is applying. Green is informative on this point. She discusses a situation in which she found a woman whom she very much wanted to sign up as a donor but was unable to do so as a direct result of the information contained on the woman's donor application form:

> There was this *precious* donor. I just *loved* her. She had a great personality. She was cute as a bug. Had a *high* SAT score. She was local. Right there in Dallas. I mean I was drooling to sign this girl up. [Laughs.] Lo and behold, I'm looking at the medical thing. She's got a little bitty case of – holy cow, how can you say little bitty, because this is a gene? A little piece of skin on the roof of her mouth had to be closed when she was born. She had cleft palate. Well you see cleft palate is a gene and it doesn't matter the degree of impairment. It can be a little bit or it can be a whole lot. The point is, that gene is there. And if you have cleft

> palate yourself, your chances of passing it off are one in thirty. Well, we just can't take that chance. This is too expensive and too emotionally charged of an issue to risk it. I had to turn that girl down. It broke my heart. I was drooling to sign her up and I just couldn't do it.

Because this donor disclosed on her application form that she had cleft palate at birth, Green felt that she could not present the woman as a prospective donor to her clients and she turned down her application to donate eggs. The risk that in using this woman's eggs a recipient would give birth to a child with the same condition was, in Green's assessment, too high. Thus, she did not accept this prospective egg donor into her programme even though the woman possessed other highly desirable characteristics such as physical attractiveness and high SAT scores.

The submission of an application form that reveals that a prospective donor has a particular medical condition or an assumed predisposition to that condition may well prevent her from getting a place in an institution's donor database, but there is no guarantee that an application form that reveals no history of any kind of 'defect' whatsoever will earn a prospective donor such a place. Young is instructive on this point. When I asked what she looks for in prospective donors, this was her response:

> We're looking for a clean medical history. Now, no one is perfect and I get suspicious if a donor has *nothing* in her background. So if you tell me that you, your mother, your father, all of your siblings and your grandparents on both sides have absolutely no cancer whatsoever and no illnesses, I have to be suspicious that there's something wrong with your genes. There's something really bad in your family that you're not telling me. So I'm looking for does she have a

> reasonable medical history and I know that other agencies will have total blank medical histories that I'm very suspicious of. Everyone has something no matter what it is. You might have, you know, a skin cancer or *something* in your family's history – so I'm looking for a relatively clean history, I'm looking at how honest she is in the profile, does she tell me all the things she should be telling me?

If, unlike the women Green and Young speak about, a prospective donor submits an acceptable written application form and goes on to pass the personal interview and psychological examination and an institution agrees to include her in its database of available donors, the information contained within the application form does not become obsolete. At many institutions the donor database presents the same information, in much the same order, that appears on the application form. For example, many of the entries in the Colorado-based third-party agency Creating Families, Inc.'s donor database appear in exactly the same order as on the firm's online egg donor application form.

No matter in what order it appears, the information derived from the prospective donor application form is crucial to the matching process. It is the information on this form that allows fertility clinics and third-party agencies to group prospective egg donors in particular ways. One of the most immediately apparent ways in which this occurs is by enabling the grouping of prospective donors according to one or more criteria. For example, an institution with even a fairly unsophisticated donor database can quickly pull up all the prospective donors with green eyes, all the prospective donors who have donated previously, or all the prospective donors who possess a certain hair colour or a particular SAT score.

However, this is not the only way in which the information yielded on the prospective egg donor application form is used by clinics and agencies. There is another key issue. The way in which a prospective donor responds to questions about her height, weight, eye colour, education level, religion, racial taxonomy, whether or not she has donated before and a myriad of other questions, may enable her to earn significantly more money per donation than a donor who responds to these questions in a different manner. For example, when discussing the payment structure at her firm, Young told me, 'If you donated and you were successful, you would get more the second time.'

In the parlance of the industry, a taller woman, a woman with an advanced degree, a Jewish woman, or indeed any woman who has some attribute that is deemed to be positive and that is not shared by the majority of the firm's prospective egg donors may become an 'extraordinary donor'. To my knowledge, limited to third-party agencies, this phenomenon means that the institution charges its clients more for the eggs of a woman who has been so categorized and it passes part of the comparatively greater fee on to the donor.

I return to address the phenomenon of the extraordinary donor in more detail at the end of chapter five. By way of conclusion here, it is necessary to emphasize that donors are one of the major ways by means of which clinics and agencies distinguish themselves from one another. The major trope they use to assure prospective recipients of the quality of their donors is that of 'middleclassness' – which, as I show in the next chapter, is curiously entangled with race.

Notes

1 *Vital Signs* tells the story of a doctor who undergoes IVF with disastrous consequences.

2 Informed consent does not extend, as far as I am aware, to issues involving commercialisation. See Frow (1997) for discussion of this issue with regard to a patient's say in the commodification of body tissues.

3 All names have been changed.

4 Although it has not been a central concern in my work here or in most feminist literature on ART, the issue of religion appears frequently in other analyses of ART. Beginning with 'traditional Judaism' and going on to Christianity, 'the religious and cultural traditions of Confucianism, Hinduism and Islam,' Heitman and Schlachtenhaufen present some of the broad implications of infertility for women belonging to any of these faiths. They conclude that, in both 'traditional Judaism' and non-western traditions, 'a woman's infertility traditionally has been grounds for divorce, often leading to her abject poverty, prostitution or death' (1996: 197–8). In 'pre-Reformation Christianity', they write, 'Infertility was interpreted as a sign of God's disfavor and punishment, particularly for sexual transgressions, and an infertile woman needed to seek forgiveness before she could conceive' (ibid: 197). On the question of the possible benefits of ART for infertile women belonging to any of the above faiths, they conclude:

> Among many women for whom motherhood is a woman's most important social role, infertility is exceptionally tragic because it also represents a loss of spiritual identity. For many poor and nonwhite women, the images of infertility as a religious, spiritual, or moral problem point to the need for a related response. If infertility is one in a series of negative, irreversible life events, it is more likely to be interpreted as fate or God's will, which no human intervention can redress. Women who share this worldview would be unlikely to seek treatment under a system that focuses on medial/scientific questions to the exclusion of the spiritual and moral; however, the profound meaning of infertility for them and their families suggests that programs tailored to certain cultural perspectives might attract greater numbers of patients (ibid: 198).

As a counterpoint to the above, and while encouraging me to address seriously the role of religion in egg donation, Dr Jackson told me:

If you're going to be doing societal issues I think you have to look carefully at religion. I've given presentations – it's kind of a fun one – on the religious perspectives of infertility treatment that evaluates the treatment. I went through all the major world's religions: Buddhism, Islam, Christianity, Judaism. Christianity I broke up into Catholicism, Methodist, etc. and I gave this to a bunch of different types of clergy. I was actually asked to take it on the road but unfortunately I just couldn't travel as far as they wanted me to go on it. I think it's very interesting to review as I have some of the religious perspectives here and then when you get into the religion you can kind of understand why there are some of these rules and regulations in various countries. Countries will forbid this. Some countries will forbid that and if you look at the predominant religion, you can kind of see why they're forbidding it. Especially prominent – at least I found it prominent – in the Middle East. We have patients coming from as far away as Kuwait and they come because, I think, of the website, they come because there are family members in south-west Florida and they come because there are regulations in the Middle East that make it just about impossible to do what they want to do.

Instantiating a moment when, contra Heitman and Schlachtenhaufen, a deep religious faith actually empowered a woman to become the co-director of a third-party agency, Laura Green discussed the role of her own religious faith in her decision to work alongside her sister, Mary Bates, at their third-party agency:

LG: Even though I really wanted to help Mary to do this I was a bit hesitant because I was not sure what God our Father was going to say on it or had to say or how He felt. I have a very deep faith which I depend on and if it was in the Scriptures – one way or another – I would just make it what I do. Okay?

KB: Uh-hmmm.

LG: I really wanted to do it but I was real hesitant because I thought I really don't know. And in doing a little research – early on – there's Scripture after Scripture in the Old Testament supporting sperm donation. The issue of sperm donation is all over the Old Testament and I can't see how – since God our Father doesn't change His ways over the years –egg donation is too much different.

Later when I asked her whether her firm found egg donors for single women, Green said that they did so and that her feeling that this was absolutely appropriate was based in her religious faith. She told me:

> You know, when I was first dabbling in this and trying to figure out where – if at all –I belonged in this, I was trying to get direction from my Father in Heaven. I consulted a spiritual friend. This woman is a fellow believer and she said, well, if it's an error, it's an error on the side of life. And I thought, you know, what a wonderful thought. If it's an error, it's an error on the side of life. So, it's a nice way to look at it.

5 Cussins also indicates that 'natural cycle' IVF is less expensive because the extraction can be done in the doctor's office.

6 Cussins is not completely convinced of the inherent beneficence of 'natural cycle' IVF. She writes:

> In the natural cycles I observed, or read the records for, a significant number of cycles were cancelled because the patient spontaneously ovulated, or the single egg was lost at retrieval, or was not properly mature or didn't fertilize. The strain of having all one's eggs in one basket (almost literally) negated the feeling patients had of increased agency. With superovulation there was some slack; embryos could be frozen for a later cycle, and if some eggs were not mature or did not fertilize, there would still be some that that were fine. Relying on one's own body also increased the feeling of failure if something went wrong. For the staff, monitoring and retrieval are more nerve-wracking than usual in natural cycles because they might lose or damage the single eggs. As an embryologist told me, 'No one likes going through natural cycles. They're too stressful; they're too hit or miss.' It is of course possible that the sense of being hit or miss only arises by comparison with the superovulatory protocols where things go wrong but not usually at the point where eggs are retrieved and fertilized. Certainly, this comparative failure was always pointed out, and seemed to alarm patients and thus possibly unnecessarily (i.e., not as a direct result of comparing overall success rates) to discourage them from undergoing natural cycles (ibid.: 78).

7 TSA is a relatively large venture. It consists of one branch located in southern California, which Davis runs from her own home with the help of an assistant, and one branch

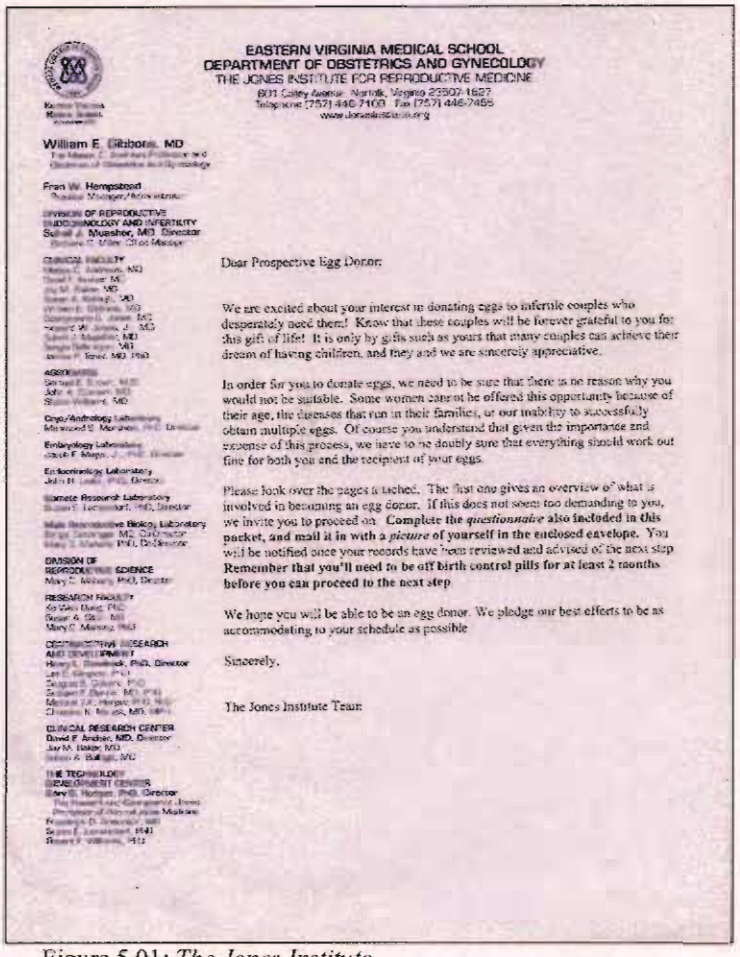
located in northern California which, with its own staff but to be overseen by Davis, was several months away from opening at time of our interview in early October 2001.

8 What I find quite interesting about the psychological examination is not so much the fact that it must take place, but rather that it is the packet designed for the prospective recipient that contains the most information about the evaluation. In other words, the woman who will actually undergo the evaluation receives less information about it than does the woman for whose benefit the prospective donor purportedly undergoes the examination.

9 This is something that donors appear to do. It seems particularly possible and even prevalent in the case of companies doing business over the internet.

Chapter Five

Screening Egg Donors: The Geneticization of the Social



EASTERN VIRGINIA MEDICAL SCHOOL
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
THE JONES INSTITUTE FOR REPRODUCTIVE MEDICINE
601 Colley Avenue, Norfolk, Virginia 23507-1627
Telephone (757) 446-7100 Fax (757) 446-7455
www.jonesinstitute.org

William E. Gibbons, MD

Fran W. Hempstead

DIVISION OF REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY
Samuel A. Muasher, MD, Director

Dear Prospective Egg Donor:

We are excited about your interest in donating eggs to infertile couples who desperately need them! Know that these couples will be forever grateful to you for this gift of life! It is only by gifts such as yours that many couples can achieve their dream of having children, and they and we are sincerely appreciative.

In order for you to donate eggs, we need to be sure that there is no reason why you would not be suitable. Some women cannot be offered this opportunity because of their age, the diseases that run in their families, or our inability to successfully obtain multiple eggs. Of course you understand that given the importance and expense of this process, we have to be doubly sure that everything should work out fine for both you and the recipient of your eggs.

Please look over the pages attached. The first one gives an overview of what is involved in becoming an egg donor. If this does not seem too demanding to you, we invite you to proceed on. **Complete the *questionnaire* also included in this packet, and mail it in with a *picture* of yourself in the enclosed envelope.** You will be notified once your records have been reviewed and advised of the next step. **Remember that you'll need to be off birth control pills for at least 2 months before you can proceed to the next step.**

We hope you will be able to be an egg donor. We pledge our best efforts to be as accommodating to your schedule as possible.

Sincerely,

The Jones Institute Team

Figure 5.01: *The Jones Institute*

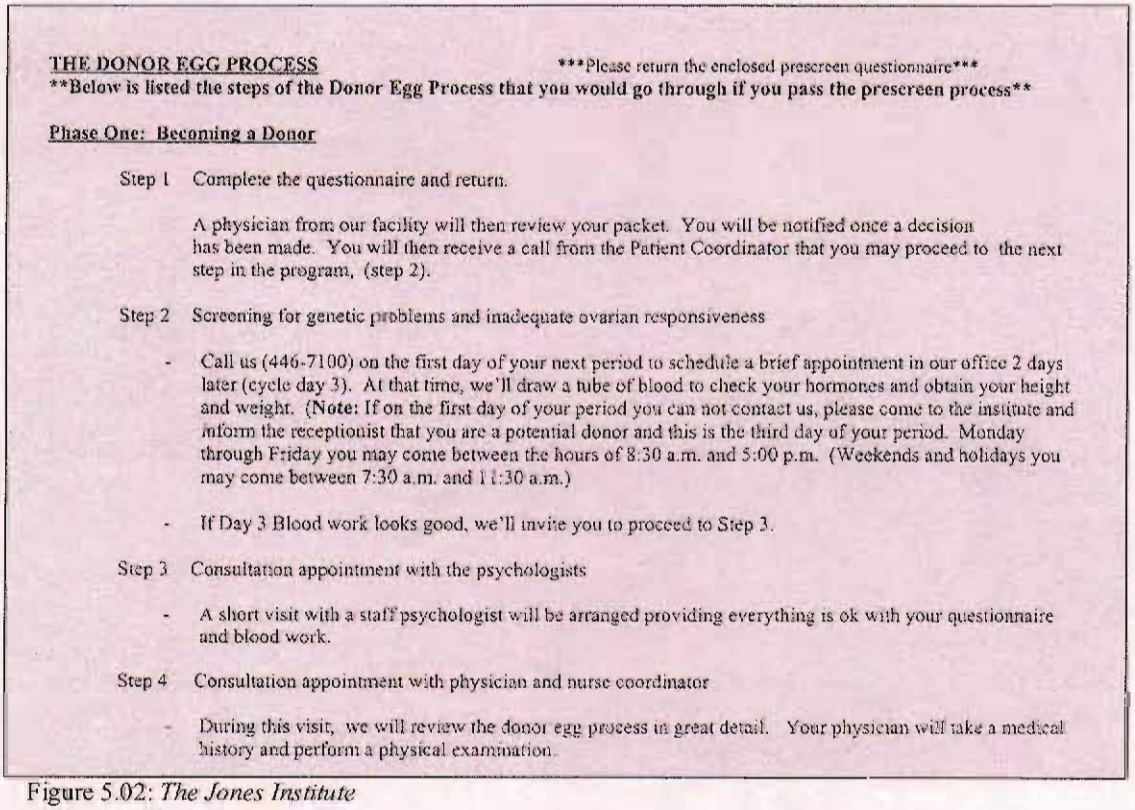
To say that something is socially constructed does not make it inherently evanescent, it merely signals that we are speaking not of a (natural) given but of a (human) construct. Determining the terms under which artefacts are constructed is a vital part of understanding them. Continuity and change are equally central to this task (Ludmilla Jordanova 1989: 4).

Introduction

Upon declaring an interest in donating eggs at the Jones Institute's Norfolk, Virginia headquarters or at any of its branches, including that located in Fairfax County, Virginia, a wealthy suburb of Washington, DC, a woman can expect to receive a donor information packet from this clinic that is allied with the Eastern Virginia Medical School. Updated at regular intervals, this bundle of documents contains, as in figure 5.01, a form letter expressing the Institute's gratitude for the 'gift of life' that the prospective donor proposes to make, an outline of the processes enabling and surrounding the extraction of a large number eggs from this woman's body, instructions for filling out the 18 page questionnaire entitled 'Donor Medical and Genetic History,' and the questionnaire itself. Concluding with three pages of maps and driving directions to the Institute, the packet also contains four individual single-page forms. On these the donor applicant is required to certify that she has responded truthfully to all items on the questionnaire, attest that she has not 'received injections of human pituitary-derived growth hormone between 1963 and 1985', consent to screening for HIV, and agree to release the results of this blood test to staff at the Jones Institute.

Comprising the bulk of the prospective donor information packet, the donor questionnaire plays a fundamental role at two key stages in the overall process of matching a prospective egg donor to a prospective egg recipient at the Jones Institute. In some sense setting this process in motion, information solicited on the form about the applicant's age and genetic history, as indicated in the clinic's introductory letter and reiterated on the packet's first page (figure 5.02), contributes to the determination of whether a woman

will be successful in her initial bid to become an egg donor in the Jones Institute's programme. Should an applicant reveal on her donor questionnaire, for instance, that she is above the institution's age limit of 33 years for prospective egg donors or, like the young woman about whom Laura Green spoke in chapter three, that she had cleft palate or another heritable condition, she will not be accepted into this clinic's programme.[1] Should, on the other hand, the applicant indicate on this form that she is within the firm's age limit and may be reasonably presumed to be free of genetic disease, this woman may be contacted by a Patient Co-ordinator.



THE DONOR EGG PROCESS ***Please return the enclosed prescreen questionnaire***

Below is listed the steps of the Donor Egg Process that you would go through if you pass the prescreen process

Phase One: Becoming a Donor

Step 1 Complete the questionnaire and return.

A physician from our facility will then review your packet. You will be notified once a decision has been made. You will then receive a call from the Patient Coordinator that you may proceed to the next step in the program, (step 2).

Step 2 Screening for genetic problems and inadequate ovarian responsiveness

- Call us (446-7100) on the first day of your next period to schedule a brief appointment in our office 2 days later (cycle day 3). At that time, we'll draw a tube of blood to check your hormones and obtain your height and weight. (**Note:** If on the first day of your period you can not contact us, please come to the institute and inform the receptionist that you are a potential donor and this is the third day of your period. Monday through Friday you may come between the hours of 8:30 a.m. and 5:00 p.m. (Weekends and holidays you may come between 7:30 a.m. and 11:30 a.m.)

- If Day 3 Blood work looks good, we'll invite you to proceed to Step 3.

Step 3 Consultation appointment with the psychologists

- A short visit with a staff psychologist will be arranged providing everything is ok with your questionnaire and blood work.

Step 4 Consultation appointment with physician and nurse coordinator

- During this visit, we will review the donor egg process in great detail. Your physician will take a medical history and perform a physical examination.

Figure 5.02: *The Jones Institute*

A specially trained nurse charged with the organization of the administrative processes and procedures enabling egg donation, the patient co-ordinator arranges the subsequent

screening phases that follow an applicant's submission of an egg donor application form that, having been reviewed by Jones Institute staff, has been deemed acceptable by them.[2] In the initial telephone conversation alerting the applicant that her application to donate eggs has been provisionally accepted, the patient co-ordinator will instruct this woman to telephone the Jones Institute on the first day of her next menstrual period so that an office visit can be scheduled for her for 48 hours later. At this appointment, blood will be drawn in order to check the applicant's hormone level and a staff member will also measure the applicant's height and weight. Provided, as noted in the explanation entitled 'Phase One' in figure 5.02, this woman's blood hormone levels are within an acceptable range, she will be scheduled for a session with a Jones Institute staff psychologist. Having successfully completed this assessment, the applicant then meets with a staff physician. At this encounter egg donation is explained to her in more detail and she undergoes a physical examination. Only at the successful completion of this last stage does the applicant actually become a prospective egg donor, thereby beginning the wait to be selected as another woman's 'perfect match'.

It is according to a different set of information contained on the Jones Institute's prospective donor's application form that the determination of precisely which egg recipient any given donor will be anonymously matched with is made. A prospective egg donor's provision of information about, among others, her race, height, weight, hair colour, and eye colour contributes to the creation of her 'donor profile'. This is the concatenation of physical qualities and personality traits used by staff at the Jones Institute, but by no means unique to this clinic, to gauge a prospective donor's physical

similarity to any prospective egg recipient. As discussed in chapter one, and critiqued again further below, the objective of this exercise is to effect a 'perfect match:' the pairing of an egg recipient with an egg donor who physically resembles her to as great an extent as possible in order that any child born as a result of the donation may not be presumed, upon visual comparison with her/his mother, to be genetically different to her.

While I have no doubt that it would prove fascinating to collect and analyze a set of completed donor application forms, perhaps with the goal of identifying applicants' strategies of self-representation and, based upon the outcome of this endeavour, to establish the existence (or not) of specific discourses about donor acceptability and to investigate to what extent applicants may be presumed to be already disciplined by these, at no point in this project, differently oriented as it was, was it possible for me to gain any kind of substantive access to even a single completed donor application form. The closest I did come to reading such a document occurred when I accessed online donor databases and when, immediately after our interview, Young took me on a brief tour of her office.

Opening a door off of a side corridor, my informant showed me into a small, starkly furnished, windowless room that seemed better suited as a closet than a work space. Containing a small table and two metal chairs in addition to the wall of filing cabinets, the room, Young explained, offers prospective egg recipients who are not interested in selecting a donor via Oocyte Donation, Inc.'s online donor database, a place to sit and privately peruse the 'donor book', this third-party agency's roster of available egg donors. At least two inches thick, the donor book was built from a mass-produced photo

album comprised of plastic-covered, cardboard-backed pages into which were inserted, on the left hand side, completed donor application forms and, on the right hand side, snapshots and, on occasion, professional portraits of the donor.

Standing beside me and flipping through the donor book while I watched, Young paused on a page that contained a completed application form and, opposite to this, a set of advertisements featuring the image of a smiling, young Japanese-American woman. Abandoning my attempt to if not read than scan the application form, I listened as Young told me that this egg donor, who she did not name, works part-time as a model. But modelling and gamete donation are not this woman's only two sources of income. In a subsidiary type of arrangement with Young's company she reportedly established a firm in Japan which, because the practice of egg donation is illegal in that country and women must therefore travel abroad to avail of it, sells reproductive medical tourism packages to Japanese women. Co-ordinating her clients' travel to California, this young woman, like Young, also facilitates her clients' selection of an egg donor and arranges the medical procedure itself.[3]

Hoping to learn more about this woman and to have the opportunity to look through the donor book on my own in the approximately 15 minutes remaining to me before I had to begin the drive to meet with Davis, I was disappointed when Young told me that rather than allowing me to remain in the room with the book, she preferred to introduce me to members of her staff. Reluctantly following her down another corridor to an area with approximately eight open-plan work stations, I was briefly introduced to several

administrators who, Young explained, co-ordinate the screening of prospective donors and clients' selection of them, before being walked back to the reception area where Young shook my hand and handed me a copy of Oocyte Donation, Inc.'s brochure. Wished well by my informant but without having been granted the chance to read the completed donor application forms I was convinced were integral to my work, I quickly found myself fighting bumper to bumper traffic trying to get on to the freeway so that I could head south to San Diego.

Looking back on my interview with Young and taking into account what I have learned about the contemporary Anglo-American fertility industry in the course of undertaking the research for this dissertation and in the time devoted to writing it, it makes absolute sense to me, for a number of inter-related reasons, that Young did not leave me on my own to read the completed donor application forms and to look at the photographs of prospective egg donors accompanying these, both of which were, as noted contained in her firm's donor book. Given, as presented and discussed in chapter four, Green's, Davis', and, Young's proprietary sense in relation to the women listed on their rolls as prospective egg donors, the fact that the simple perusal of a donor database – whether on-line or in the form of a book – is a service for which many a firm not only charges prospective recipients but for which they stand to earn a significant amount of money, and the quasi-medial discourse operating around donor application forms evinced by the requirement that prospective donors furnish detailed medical information about not just themselves but about their parents, grandparents, siblings, first cousins, aunts, uncles, and children, it seems reasonable that a researcher conducting a one-off interview might not

be permitted to view completed application forms and the photographs submitted in support of these.

My inability to gain access to completed egg donor application forms submitted by successful applicants to either Oocyte Donation, Inc. or any other firm clearly precludes an analysis of applicants' textual strategies of self-representation as evinced in these documents; yet, this does not mean that a sustained engagement with this determinative subset of the contemporary American fertility industry's visual culture must be left aside for the time being, considered effectively stalled until proper access to completed forms can be negotiated. Even when uncompleted, fertility clinics' and third-party agencies' prospective egg donor application forms – and these same institutions' prospective egg recipient application forms – function as key visual texts. Although as indicated in chapters one and two, they, like other visual texts, have heretofore been overlooked in feminist and cultural studies critiques of the industry, application forms demand a thorough engagement from any serious critique of the industry's visual culture. I propose to begin this in this chapter. In what follows, I inter-cut a close-reading of parts of the Jones Institute's uncompleted egg donor application form with the lessons learned from the critical readings of visual cultural texts proffered in chapters two, three and four. This permits me to track fertility clinics' and third-party agencies' simultaneous mobilization of race and class as two mutually contradictory lived practices. In order to effect this, and as a narrative device and organizing textual strategy deployed strategically throughout the chapter, I wish to selectively respond to a limited number of the application form's blank spaces which a prospective egg donor is required to complete, providing information

about both herself and her kin, if she is to enter into an institution's programme. There is, however, a fundamental difference between my attempted response in this regard and the contingencies of that of any imagined prospective egg donor. This concerns the manner in which I, far removed from the disciplinary regime of the institution producing the form, fill in the blanks. For while the applicant assumedly does so in order to compile a compulsory biological and socio-cultural profile of herself, my objective here is certainly not to provide a corresponding and allegedly factual sheet. Rather, in interrogating certain of the mandatory questions the industry asks of the women who make its existence possible, the discussion in subsequent sections foregrounds the contemporary American fertility industry as a problematic site in which, as previously noted, its potentially progressive impulses and practices not only sit comfortably alongside its more regressive impulses and practices but actually receive their conditions of existence from them.

I. Form-ing the Match

I. PHYSICAL CHARACTERISTICS

Date of Birth: _____ Place of Birth: _____

Race: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Hair (check one)	Hair (check one)	Complexion (check one)
_____balding	_____curly	_____fair
_____thin	_____wavy	_____medium
_____average	_____straight	_____dark

Body type/bone structure: small_____ medium_____ large_____

Handedness: right _____ left _____ ambidextrous _____

Figure 5.03: *The Jones Institute*

Neither the Jones Institute, Young's Oocyte Donation, Inc., Green's Texas Third Party Agency (TTPA), nor any other fertility clinic or third-party agency currently practising

egg donation in the United States – or anywhere else in the world for that matter – maintains racial taxonomies such as, for instance, Asian, black, Latino/a, and white by matching one purported bio-genetic marker of any of these races to another.[4] Rather, these and related categorizations are preserved when institutions match egg donors with egg recipients. That is, by finding a prospective donor who describes her race as white for a prospective recipient who also identifies her race as white, clinics and agencies uphold the racial category white. Similarly, these institutions reinscribe such racial categorizations as Asian, black, and Latino/a when they pair a prospective egg donor who classifies her race according to one of these designations with a prospective egg recipient who does the same.[5]

Not referring to the presence of specific bio-genetic markers existing within individuals, such racial categorizations as Asian, black, Latino/a, and white enact 'biologistic explanations ... of social and institutional phenomena' as John Rex writes in his definition for the term 'Race' in *A Dictionary of Marxist Thought* (1991: 456). When recognized as the socially constructed designations that they are, I argue that the racial taxonomies reproduced by fertility clinics and third-party agencies are most profitably engaged with when they are conceptually re-positioned alongside the other socio-cultural determinations, for instance ethnicity, religion, and education level, with which donors and recipients are presented on their respective application forms and amongst which they are required to select in order to describe themselves to clinics and agencies and to one another.

Before moving into such a discussion, however, it is necessary to note that although, as indicated in figure 5.03, it is one of the initial categories with which a prospective donor at the Jones Institute is presented and asked to identify herself in terms of, and one of the main determinants in the overall matching process at this institution and others, race is, of course, not the only socio-cultural designation amongst which an applicant is required to select. Neither, it must be stated, are socio-cultural designations the only category of designation offered to prospective donors and recipients. In addition to these, applicants must also use what I term 'biological' criteria to describe themselves. Noted in the discussion of the Jones Institute's donor application form in this chapter's Introduction, these range from eye colour to height to body structure and beyond and donors and recipients are required to choose from among sub-groupings within these and similar categorizations that are widely presumed to be genetic.[6] They do so in order to provide clinics, agencies, and one another with a more complete idea of both how they look and who they are. Like a woman's racial categorization and regardless of whether these criteria are ultimately recognized as 'social' or 'biological', individual women's attempts to give an account of themselves according to these criteria are recorded in the different application forms that they must complete and submit to the institution(s) with which they desire to work.

That an application form must be completed and submitted appears to be an industry standard and it is something that is required irrespective of whether a woman expresses interest in becoming an egg donor or an egg recipient. While both the prospective egg donor application form and the prospective egg recipient application form play key roles

in the processes involved in matching a woman from the former group to a woman in the latter group, it should not be thought that each of these forms exerts exactly the same kinds of pressures on women from these two different groups. As I propose below, largely on the basis of interviews conducted with clinic and agency staff, it appears that the information contained in the donor application form plays a much greater role in the determination of which applicants will be invited into an institution's programme than does the information contained in the recipient application form. In order to clarify why this might be, it is to a discussion of this latter form that I turn first.

Prospective Egg Recipient Application Forms

There are two primary determinants of whether a prospective egg recipient joins an institution's egg donation programme. These are her desire to do so and her ability to raise the fee required to undergo this ART.[7] This latter begins at around $8,000 for one anonymous egg donation cycle at a small fertility clinic in the American mid-west, approximately $12,000 for an anonymous single cycle at the Jones Institute, and around $15,000 for one known cycle co-ordinated by a large third-party agency in Los Angeles. Provided her desire to attempt to become pregnant via donor eggs comes with a substantial cheque or a high credit card limit, a woman can initiate the processes and procedures that comprise this ART by either contacting a fertility clinic or third-party agency herself directly or by asking her physician or gynaecologist for a referral. Regardless of the particulars surrounding the making of contact with the selected institution, one of the clinic's or agency's first requirements will most likely be that this woman complete a prospective egg recipient questionnaire.

At the Jones Institute, the prospective egg recipient questionnaire is, like the clinic's prospective egg donor application form, part of a larger packet which, as in figure 5.01, is fronted by an introductory letter. Unlike, however, the letter to the prospective egg donor in figure 5.01, which was aimed only at this woman, this letter is addressed to both the prospective egg recipient and her presumed husband. Beginning 'Dear Couple, it situates egg donation at the Jones Institute within heterosexual marriage through the bold assertion that 'The program is designed for couples whose own eggs are absent, unlikely to produce pregnancy, or might transmit genetic disease to offspring' (Jones Institute 1999). Discussed in further detail below in relation to TTPA's and Oocyte Donation Inc.'s recipient application forms, this discursive manoeuvre is by no means specific to the Jones Institute any more than it is limited to this single document produced by this multi-sited clinic. Reproduced throughout the remainder of the Institute's prospective egg recipient packet, the reliance on this rhetoric of heterosexual marriage is evident in the majority of the written texts pertaining to the ten bulleted points that comprise the bulk of the introductory letter. For example, the first text to follow the letter, entitled 'Our Results', only rarely refers to an egg recipient, preferring instead to discuss the Institute's success rates in enabling a woman to become pregnant with and deliver an infant in terms of 'the couple'. Following the spirit of the introductory letter and in equally blatant disregard for established biological fact, in this document it is 'the couple' and not the recipient who receives donated oocytes and who decides whether to destroy or to store by freezing 'extra' embryos – embryos that have been fertilized but, mainly because others have been selected ahead of them for exactly this purpose, cannot be placed in the egg recipient's uterus at the time of the present donation.

The Jones Institute's reliance on this rhetoric of heterosexual marriage to present egg donation to its prospective clients is also manifest in the packet's penultimate document: the 'Donor Egg Recipient Questionnaire'. Consisting of two pages, this form's second page is roughly equivalent to that part of the donor application form reproduced in figure 5.02 in that it solicits information about the prospective egg recipient's age, race, hair colour, eye colour, height, weight, etc. and contains blank spaces in which this woman is to apparently provide yes/no answers to questions that ask whether she has diabetes, hypertension, or is, presumably, a carrier of such genetically-linked diseases as Tay-Sachs Disease, sickle cell anaemia, or Thalassemia. Where this form differs from the prospective egg donor application form is precisely where the reliance on the rhetoric of heterosexual marriage is most marked: in a column beside that reserved for answers to be provided by the prospective egg recipient – or in the parlance of the form, the 'wife' – the 'husband' is required to respond to the same questions about his physical attributes and health in the same yes/no format.

Lest it be thought that in requesting personal information from someone who, at least from a biological standpoint, is only tangentially involved in the egg donation process the Jones Institute is somehow exceptional and stands apart from its competitors, it is important to underscore here that many other firms also require that the prospective egg recipient's assumed male partner or 'husband' furnish similar types of information about himself and they provide space for this purpose. Toward the end of this section, drawing on readings of TTPA's recipient questionnaire, Oocyte Donation, Inc.'s recipient questionnaire, Reed's firm's website and interviews with Green, Young, and Reed I

return, following Franklin (1990) to the issue of clinics' and agencies' reliance on hetero-normativity as a legitimating discourse for ART. At this juncture, however, and in anticipation of my argument in Section III on the contemporary American fertility industry's simultaneous reproduction and subversion of race and class as a biological construct, I wish to briefly consider the epistemological ramifications of this solicitation of biological and socio-cultural biographical information from the egg recipient's 'husband' or assumed male partner on the Jones Institute's and other firm's egg recipient application forms.

Another Perfect Match: Donors and Dads

In chapter one I discussed how advocates of anonymous egg donation maintain that anonymity minimizes the allegedly negative impact that the purchase of third party gamete donation has on the nuclear family. As stated, this assertion is based upon the premise that the less one knows about one's egg donor, the easier it is to obscure the fact that the reproduction of the nuclear family depends upon recourse to a third party's genetic material. What I find interesting about, for instance, the Jones Institute's solicitation of biological and socio-cultural biographical information about the prospective egg recipient's 'husband' is that it may be conceived as a parallel to this. In the first case, the maintenance of a fiction about the nuclear family depends upon recourse to a third party: the egg donor; in this case the maintenance of a fiction about the efficacy of egg donation also depends upon recourse to a third party but, here the third party is the prospective egg recipient's 'husband' or male partner and not the egg donor. In other words, in order to preserve the fiction that clinics and agencies are capable of

finding a prospective egg recipient her perfect match – a donor who resembles her to such an extent that it will prove impossible for even the most sophisticated geneticist, such as Dr Schulman himself, or indeed any of the doctors listed in the left border of the Jones Institute's headed notepaper, to visually determine that a child is genetically different to her/his mother – one must match according to the 'father'. By soliciting biological and socio-cultural biographical information from the man whose sperm will fertilize the eggs donated by an anonymous woman at the Jones Institute, one has a better chance of obscuring the recourse to third party genetic material that is constitutive of egg donation. This is because the provision of this information enables the making of a match based upon the egg recipient's male partner's physical attributes, thereby maximizing the chance that any resultant child will look like her/his father. If, in yet another re-inscription of hetero-normativity, the child does not physically resemble her/his mother but does physically resemble her/his father, the physical dissimilarity of mother and child may be narrated as the outcome of genetic chance and not as the result of a biological need to go beyond the boundaries of the nuclear family in order to preserve this very entity.

In raising this issue, my intention is not to accuse those fertility clinics and third-party agencies that perform and sell egg donation of fraud or of attempting to deceive their clients. My point is not that patient co-ordinators and programme administrators falsely promise a prospective egg recipient that they can enable her to give birth to a child who resembles her when in fact they know that this woman will deliver a child who looks like her husband or male partner. More indicative of the absurd level to which both genetic

determinism and the refutation of egg recipients' agency can be taken, such a statement does not in the least approximate clinics' and agencies' *modus operandi* and nor is it intended to do so.[8] Rather, and as stated, my aim in raising the issue of the frequently reproduced request for biological and socio-cultural biographical information about a prospective egg recipient's male partner is to interrogate what I view as one of the more curious components of egg recipient questionnaires. When the male partner of the woman who is to have a number of embryos which have been developed from her partner's sperm and another woman's eggs placed in her uterus is asked to indicate his hair colour on one firm's form and another firm's form asks this woman to indicate which of her partner's physical attributes she would like matched in a donor, it becomes difficult to read egg donation as always and uniquely premised upon the matching of a prospective egg donor to a prospective egg recipient. I therefore propose that while necessarily dyadic, the creation of 'the perfect match' does not always revolve around the prospective egg recipient and the prospective egg donor. While the former indisputably receives the possibility of becoming pregnant with and giving birth to a child, what the industry terms 'the gift of life', from the latter, this does not necessarily encompass physical resemblance. The achievement of this, somewhat contrary to the rhetoric around matching, may involve another dyad, one which is comprised of the egg recipient's male partner and the egg donor. Thus, as in the case of the use of anonymous egg donation to seemingly preserve the boundaries of the nuclear family that are being transgressed, so the actual practice of egg donation may be read as similarly transgressing the boundaries by which it defines itself in order to preserve them. A third example of this ART's propensity to transgress a boundary in order to reinscribe it concerns race; as noted

above, I address this in further detail in Section III. In order for this to be in any way comprehensible, however, it is necessary for the time being to return to the discussion of the egg recipient herself.

Selecting Recipients

While, like every other institution with which I am familiar, the Jones Institute requires prospective egg recipients to complete a questionnaire, I do not have the impression that either at the Jones Institute or at any other clinic or agency the information contained in this document is used to vet prospective recipients to quite the same extent that the information contained in this form's counterpart, the prospective egg donor application form, is used to eliminate certain women from the pool of prospective egg donors. To be certain, however, this should not be taken to mean that clinics and agencies accept absolutely any woman as a prospective egg recipient. All staff with whom I spoke insisted that their firms do put limitations on who they will accept into their programme. Given that I argue that matches between prospective egg donors and prospective egg recipients are most often, and at least outwardly, driven by the latter, any analysis of the overall matching process must take account of the prospective egg recipient. To this end, and despite the fact that this woman has not been my main focus in this dissertation, I now explore some of the mechanisms of inclusion and exclusion that fertility clinics and third-party agencies employ in order to both regulate and to *appear* to regulate who they allow into their egg donation programs.

Excluding money, two of the most frequently cited factors that curtail a prospective recipient's ability to join in an egg donation programme relate to this woman's health and her behaviour.[9] The issue of the prospective recipient's health first arose when I asked Dr Jackson what, if any, requirements women wishing to purchase donated eggs must meet at his institution. He told me:

> It has to be appropriate. We look for reasons to do egg donation. We want it to be medically indicated. They [the recipients] have to be just as healthy [as the donors]. They're not supposed to have any significant diseases that are going to impair their ability to conceive or carry. Obviously, if I had a diabetic out of control I'm not going to do an egg recipient egg donation cycle on them. They just have to be healthy and well.

Recalling the University of Washington Medical Center's list of indications for egg donation presented and discussed in chapter one, the fact that a woman meets any of the eight criteria indicative of a 'need' for egg donation, together with her ability to pay for this ART, is not sufficient to gain her automatic acceptance in a programme such as Dr Jackson's. A prospective egg recipient must, according to this practitioner, be able to demonstrate a minimum level of health and well-being before she can begin the process of finding her 'perfect match' or having this woman located for her.

The other most frequently cited factor, that of recipient behaviour, arose in my interview with Young. After she had addressed the issue of donor acceptability, I asked her whether, aside from the ability to pay the fee charged by Oocyte Donation, Inc., her firm

had any mandatory requirements for prospective egg recipients. Young responded to my question by stating:

> I think it's more of an attitude. If a couple approaches us and they're aggressive and they treat us more as if they are purchasing a service and they won't be guided by us, I can't work with them. 'Cause so many things can happen that I might need them to do a little extra here or there or because it's life. It's more a personality thing - why are you doing this and who are you? I mean there's a lot of couples you just can't work with. It's like yeeech. You're nasty and aggressive with me on the telephone, how am I going to help you choose a donor? That's sort of not worth it. Right? You want to work with nice people 'cause otherwise you get no fun out of this. Or at least pleasant people. We have couples that sometimes yell and scream at us on the telephone. She's angry at her infertility, not at me and no matter what I do I'm not going to be able to help her. She needs to go away, go home, go on a vacation, go to therapy and another time come back to me. It's just too hard to work with her.

Although the issues of health and behaviour received frequent mention by my informants, these are not the only two axes along which institutions appear to imagine acceptable egg recipients. Clinics and agencies can also be argued to imagine acceptable egg recipients via the biases written into the questions they ask these women. The prospective recipient application form required by Young's firm is a case in point. Like the Jones Institute's prospective egg recipient questionnaire, Oocyte Donation, Inc.'s version of this form has a bias towards heterosexual married women all the way through it. This application form solicits much of the information it requests about a prospective egg recipient through the assumption that this woman is a heterosexual married woman. This assumption is equally

inscribed in the form's final question which asks the prospective applicant to write a personal statement. The request reads as follows:

> Please write a one page personal statement describing yourselves. You may want to consider the following questions: How did you meet, how long you've known each other, how long you have been married, your occupations, fertility problem, details about your relationship, perhaps your outlook on life, etc., what you do for enjoyment, do you have other children? Do you plan more?

This bias exactly reproduces what in the context of British newspaper stories about women undergoing and seeking to undergo IVF Franklin writes in 'Deconstructing "Desperateness"' is an erasure of any but straight, married women from the popular narratives designed to sell and to help gain legitimacy for this older ART. What is most odd about the reproduction of this erasure in Young's and other clinic and agency prospective egg recipient application forms is its complete inability to account for the clients with which many firms actually work. In other words, it just does not sit easily alongside what I heard to be a general insistence by the majority of the fertility clinic and third-party agency staff with whom I spoke that they not only work with single men, single women, lesbian couples, and gay couples but, regardless of how much or how little of their business is derived from clients describing themselves as belonging to one or more of these categories, that they are seriously committed to continuing to do so. When considered alongside the prospective egg recipient application forms produced by their firms, my interviews with Green, the attorney John Reed, and Young herself all provide examples of this.

On its recipient questionnaire which is available through its webpage, Laura Green's firm, TTPA, imagines its clients as, if not married, then partnered straight women and solicits biographical biological and socio-cultural information from the prospective egg recipient's imagined male partner. Yet, as is clear from a portion of my interview with her, Green is very committed to working with single women. She says:

> I don't have any problem helping a woman have a baby who never found her partner in life. There's single women who adopt children from China, Russia, whatever and if a single woman just has put off having children because she never found her life partner, and she really wants that family so bad, you know, there's people who would say, but every child needs a father. And I'm like, listen, please mind your own business because this woman is in deep pain. Okay? You know, you just can't imagine how much a woman wants a family. And for one reason or another she may not be able to adopt. Okay. I mean, there's so many factors that go into it and there's so many people out there that are ready to tell you their opinion whether you've asked for it or not. It's like please keep your opinions to yourself. So, I mean, really and truly, this woman is very brave. She's going to do this to have her family which she could never have. So, you know, we don't have a problem with doing that for people.

Young and Reed make similar comments in which they express a willingness to work with lesbians and gay men. Young does this while speaking not about egg donation but while briefly referring to her firm's surrogacy programme. She says, 'Surrogacy, Inc. is there to help couples become families and we only deal with couples. Now, you can be a gay couple, but you've got to be a couple in a committed relationship.' As long as the criterion of being in a committed relationship is met, one criteria that is necessary according to Young because state law mandates that two names be recorded on a child's

birth certificate, she declares that she has no problem working with lesbian and gay couples.

Practising in a small town in the mid-west, Reed is also willing to work with lesbians and gay men. That this is the case is apparent from both statements on his website and those made in the context of my interview with him. His website declares that his programme 'does not discriminate against clients based on … sexual orientation.' When I asked him about this statement, he said:

> The reason that I don't [discriminate] is pretty simple. First of all, the other part of my practice is that I do a lot of criminal defence work. So, I've represented a number of people who have done some horrific things to children. My feeling is if I can bring a child into the world who's loved it doesn't make the slightest bit of difference to me whether s/he is loved by a man and a woman or one man or two men or whatever. You know half the kids in this country are being raised in dysfunctional upbringings and, you know, it just is astonishing to me the number of children who are brought up in single family homes or homes with divorce or abuse or all of those kinds of things that are not good for relationships.

From comments made by Green, Young, and Reed it is possible to identify a chasm between clinic and agency staff member's narratives about their institution's operations and the ways in which these firms actually do carry out their day-to-day business of matching prospective egg donors to prospective egg recipients. Although this issue did not arise in my interviews with clinic staff, I have no reason to believe that the same is not true of these institutions. Excluding Reed because I was not able to procure examples of either donor or recipient application forms from him, Young's firm's prospective egg

recipient application form and Green's website both imagine recipients as straight women in, if not marriages, then long term relationships. Yet, Green is committed to working with single women and Young is committed to working with lesbians and gay men. This leads me to conclude that fertility clinics and third-party agencies imagine their prospective clients in one way and work with women who are very different from this and this raises a number of questions. First, does there exist a similar gap between the way firms imagine their prospective donors and the women they actually accept as donors? Second, if so, what characterizes this other chasm? Is it also a matter of marital status and sexual orientation or does it involve some other set of criteria either alone or in addition to these? In an attempt to begin to respond to some of these questions I now turn away from prospective egg recipient questionnaires to prospective egg donor application forms.

Prospective Egg Donor Application Forms

While the prospective egg recipient's payment of a retainer fee kicks off the matching process, this does not in any way nullify the importance of the information recorded on the egg recipient application form. Although not absolutely integral to an institution's initial decision to offer its services to a prospective egg recipient, the application form this woman completes nonetheless drives the matching process which itself drives the subsequent mobilization of the set of practices and procedures known as egg donation. The information required by the egg donor application form works in a manner exactly opposite to this.

The information solicited by this form is of primary importance to a firm's decision to accept a woman as a prospective egg donor and it is of great importance to the subsequent step of matching this woman with a prospective egg recipient. As far as this issue of matching is concerned, the form is of secondary importance because the criteria according to which an institution matches a donor to a recipient does not ultimately depend upon the donor – at least according to clinic and agency rhetoric. It depends first and foremost on the recipient. What, as addressed above and in previous chapters, drives the making of a match is the way the recipient conceives of herself physically and the way she conceives of herself in terms of personality. What is more and at least to the extent that a clinic or agency permits her to articulate these, the determination of which two women constitute a match may also depend upon the prospective recipient's explicitly stated desires as to what characteristics or qualities her preferred egg donor will have.[10]

As a result of the biological logic that drives the matching of an egg donor to an egg recipient, and because a prospective egg donor's application form may reveal that she has a genetic predisposition for a disease or condition that might be passed on to a child gestated and delivered by the recipient, the information carried on her application form may mean, again as previously discussed, that an institution rejects her as a donor. As was also noted above, from interviews conducted with clinic and agency staff, it has never been clear to me that the recipient's application form carries the same weight at the same very initial stage of the matching process when the three parties (egg recipient,

fertility clinic or third-party agency, egg donor) are entering into contractual agreements with one another.

So far as American clinics and agencies are concerned, the discrepancy between the lack of authority invested in the recipient application form and the significant authority invested in the donor application form can be largely attributed to the fact that the recipient is a paying customer. This means that the onus is on the clinic or agency to attract her and to accommodate her. If not on the level of the local or on the level of the regional then certainly on the level of the national, each American institution has a number of competitors. Hence, should a prospective recipient not be happy with the service offered by a particular clinic or agency, provided she has the financial wherewithal to do so, there is nothing to prevent her from taking her business elsewhere. Although the prospective donor certainly has the possibility of enrolling as a donor at more than one institution, her possibility for movement among institutions differs from that of the prospective recipient, as does the direction in which she can move. Regardless of the number of fertility clinics and third-party agencies at which a prospective egg donor is registered and regardless of the peculiarities of each firm's application form, it is possible to form some general conclusions about the prospective egg donor application form. In order to do, I turn, perhaps somewhat paradoxically, to the Jones Institute's packet for prospective egg recipients.

The second page of the Jones Institute's packet features a breakdown of its success rates. Not the only figure contained in the packet, the clinic's letter to prospective egg

recipients proudly states that as of 14 October 1999 (the date the packet was generated) the program could claim to have 'provided an excellent opportunity for pregnancy to nearly 500 couples'. Neatly reproducing the often cited vagueness around the industry's success rates together with the rhetoric of heterosexual marriage discussed above, this statement makes it impossible to determine exactly how many women – and perhaps more importantly for a woman considering purchasing this ART – what percentage of the total number of recipients who underwent egg donation - wound up giving birth to 'healthy' infants as a result of participation in the Jones Institute's programme. Yet, even in the face of the absence of such vital information, the initial impression given by the prospective egg recipient packet is that the clinic has stringent guidelines in terms of who may become an egg donor. This is due to what I term the 'superficial thoroughness' of the application packet. Whether it is 'truly' thorough or not and of what such thoroughness consists is largely irrelevant for my purposes here. So too is the issue of whether or not the Jones Institute operates fairly stringent guidelines in terms of who may and who may not become an egg donor. What is at issue is the way the application material operates two common tropes, which are also apparent in other firms' marketing materials and application packets, in order to aver that this institution is quite thorough and selective as far as the recruitment of donors is concerned.

Discussed in chapter four and thus not something I again take up here, one of the ways that this is achieved is through the trope of a visual, written, and public discourse on openness. These assertions of openness by the institution, like the images discussed in chapter two which often accompany them, can be read by a prospective client as an

assurance that the clinic or agency is so measured, so cautious, and so completely attuned to the best interests of its clients in its every move that it does not hesitate to open its doors to women contemplating ART and the general public. Daring a curious onlooker to find something wrong, the clinic installs itself as expert and in making this gamble it announces to prospective egg recipients, other clients, and the general public that it has nothing to hide.

The second trope through which clinics construct thoroughness has again less to do with the actual content of the egg donor application form and more to do with its length. In interviews with both clinic and agency staff, one common theme was the length of the application form required of all prospective egg donors. After speaking to a number of clinic and agency staff members, it appeared to me that perhaps what mattered most of all to doctors, nurses, directors, co-ordinators and administrative staff was less what was in the actual form and more that the form was long, complex, and fairly time-consuming in order to complete.

Green is informative on this point. She says, 'Our application slash questionnaire for the donor is very extensive. It's 11 pages long.' Here, what appears to matter is not so much the profundity of the questions but the fact that there are many of them. This yields the above mentioned superficial thoroughness – or a lot of quite basic information on a wide range of topics. By far, however, the best evidence that the length of the questionnaire is important to clinic and agency staff comes from a portion of my interview with Ames in which she narrated how she first came to be an egg donor:

> My brother actually majored in molecular biology and philosophy and we were flipping through a school paper and we came upon one of those more ridiculous ads where they're asking for like fifty to a hundred thousand dollars if you have the right stats - that type of thing. And then we got to talking about it and he said, you know, well why don't you call up and see what it's about. We were just kind of curious and I called the office and ended up talking to someone probably for over an hour. It was *so* interesting. And so I said, all right, you know. They asked if I wanted to get some information in the mail and I said sure. After the application came I gave it some thought and went ahead and filled out the twelve page form. It was very extensive and asked for information on our entire medical background, philosophies on life, messages we'd want to give to the parents, what our childhood was like, the occupations of family members. Basically, the form asks for information that would help someone choose you.

Like Green, and in an echo of Dr Jackson's comments on his firm's commitment to the psychological screening of all egg donors and all egg recipients and the Jones Institute's written description of the multi-phase screening process, what Ames communicates in describing above how she decided that egg donation might be something that she would be interested in doing, is the importance of the length and the types of questions on the form. While certainly the nature of the questions themselves is important and absolutely integral to the matching process, it may also be concluded that as significant as the individual questions themselves is the number of questions. In other words, length matters in both the recruitment process and the narration of this for a firm's prospective egg recipients.

III. The Matching Process: Race Moves

As noted in both chapter four and the introduction to this chapter, a woman moves one step closer to becoming an 'available egg donor' if the information she provides about herself and her family on the application form most institutions require prospective egg donors to complete is deemed acceptable. At many but by no means all clinics and agencies, however, a woman's achievement of this status is dependent upon more than the submission of a completed application form, no matter how lengthy. As discussed above, a prospective donor may also be required to undergo a range of medical tests, a psychological screening and an interview. It is only after these are successfully completed that the newly 'available egg donor' begins her wait to be matched with a prospective egg recipient.

As a means of both teasing out some of the complexities and contradictions that govern the matching of egg donors to egg recipients and concluding the discussion of the broader socio-cultural ramifications of the practice of egg donation, I wish in the remainder of this chapter to focus on race and class in the matching process. However, my goal will not be to map exhaustively the possibilities for movement of different racial and class taxonomies. Rather I wish to engage critically with the ways in which selected social categories and parts thereof operate in commercialized egg donation as it is practiced in the contemporary United States and to consider what this reveals about dominant reproductive discourse and practice. This will lead me to ask whether and to what extent the transgressive potential inhering in ART, defined as the increased feasibility of biological reproduction outside the boundaries of hetero-normativity, might be extended

to encompass the operation of race and class in egg donation. Thus, I conclude this chapter with a consideration of whether the matching of egg donors to egg recipients might, in as much as race or class is concerned, be regarded as a 'moment . . . of transgression' wherein dominant reproductive discourse and practice is destabilized (Cartwright 1995a: 228).

In chapter three I discussed the relative shortage of racialized potential egg donors and the concomitant fact that these women's eggs operate as luxury items within the micro-economy of egg donation. In that chapter I reproduced a portion of my interview with Young in which she told me that, although it was becoming easier to find Asian-American egg donors, she still found it especially difficult to locate African-American and Jewish women who were interested in donating their eggs. When I asked Young whether the shortage of African-American and Jewish egg donors meant that she turned prospective egg recipients seeking eggs from women falling into these categories away, she told me that she did not. Instead, she reported attempting to persuade prospective egg recipients to select a donor from another category. Young explained:

> We ask couples to change their minds about the kind of donors they are looking for. For a Jewish couple, I'll tell them that they don't absolutely need a Jewish donor. They could choose another donor with a different background. An African-American couple could choose someone who is Mexican or Italian. Someone with very dark skin and very dark hair, you know? Or they could wait. But if they wait it will take them longer to get matched with a donor.

The Colorado-based third-party agency, Creating Families, Inc.'s online donor database provides a similar example of how an institution can transgress racial categorizations in order to give the sense that it is working to preserve them. The directions for filling in the categories on this firm's online donor matching form tell potential egg recipients seeking a white donor to leave the category 'Race/Ethnicity' blank. By omitting specific racial and ethnic categorizations from search criteria, the prospective recipient will gather a larger pool of available donors from all racial taxonomies who possess other criteria, such as hair colour, religious affiliation and SAT scores, that she deems necessary traits in an acceptable egg donor. This enables the prospective recipient to select her 'perfect match' from among a larger group of egg donors, some of whom place themselves within racial categorizations other than that in which the prospective egg recipient places herself.

Both Young's comments and Creating Families, Inc.'s website indicate that, at least intermittently, American fertility clinics and third-party agencies practise race as a social construct. That this is the case is clear from these institutions' documented need to breach racial taxonomies in order to provide some of their prospective, racialized egg donation clients – invariably presented, as Young's comments illustrate, as married, heterosexual mono-racial couples – with their 'perfect match'. The demonstrable willingness of different firms to go, on occasion, outside a specific racial group in order to assist members of that group to reproduce children assumed to be racially similar suggests that, no matter how it is ultimately presented to clients or the public, on at least one important level race may be seen to be understood as inhering not in a person's genes but in socially

constructed traits. As a result, race is viewed and practised as being reproduced through kinship and not through biology or genetics.

That race, within the contemporary American fertility industry, may be understood and practised as being reproduced through kinship as opposed to biology or genetics is rendered especially clear by Young in the passage reproduced above. As indicated, she told me that at times she advises a racialized client to select a donor from outside her racial taxonomy. This, according to Young, means that her client avoids finding herself in a similar situation to Cathy and David, as reported by Shepard and discussed in chapter three. This couple, it may be recalled, had by 1999 spent more than three years and tens of thousands of dollars in an unsuccessful bid to find an African-American woman who was both willing and able to donate her eggs to Cathy. Young maintains that, in contrast to Cathy, a racialized client of hers can, by looking outside her racial taxonomy, so position herself as to have the potential of reproducing a racially similar child for much less money and without having to wait several years for a racially similar donor to be located. While Young's client, unlike Cathy and David, might forego the possibility of narrating her eventual child's race as having been biologically or genetically derived, it appears to me, in light of Young's comments, that within the industry this might be the only drawback associated with a woman's decision to use the eggs of a donor who is racially dissimilar to her. Certainly, following Young, the child born as a result of a trans-racial donation would be no more and no less racially similar to her/his mother than the child that Cathy was still unsuccessfully attempting to conceive in 1999 via the use of eggs from a yet to be located racially similar donor would be to her.

There is some evidence that Young's suggestion that her client search for her 'perfect match' from within a racial categorization different to her own and the actions to which this gives rise may be read as transgressive, especially when compared with other contemporary reproductive practices. There are two reasons for this. First, it disrupts dominant formulations of what race is. No longer a genetic 'fact' that is passed from one generation to the next, race, as we have seen, becomes the presence of a set of features or attributes such as, for example, hair colour and skin colour, that can be combined in one way to give the appearance of one racial categorization and in a different way to give the appearance of another. Second, and perhaps more to the point, Young's suggestion and the actions resulting from this may be read as transgressive because they disrupt a dominant practice of race whereby the movement of whiteness away from white subjects is prohibited. To see that this is the case, one need only compare the movements of whiteness and blackness in egg donation with those in trans-racial adoption.

As it is currently practised in the United States – and in Britain as well – trans-racial adoption largely consists of the adoption by a white individual or a white couple of a non-white child.[11] This appears to be the norm to such an extent that, like many other critics, I am unaware of even a single case in either country in which a white child has been permanently placed in a non-white home.[12] Thus, despite its name, trans-racial adoption may be read as operating in a unidirectional manner, transferring – for want of a better term – blackness to whiteness but not whiteness to blackness.[13] This is markedly different from the ways in which 'white' and 'black' move in egg donation. As noted, the relative lack of egg donors from racial categories other than white paradoxically means that eggs

from white women often serve as the catalyst for the reproduction of specific racial taxonomies such as Asian, black and Latino/a that are defined against both the racial category white and one another. While white children are rarely if ever permanently transferred from white to non-white parents, this same prohibition on transferring white to non-white does not govern the movement of human eggs. Rather, as discussed, the transfer of white women's eggs to non-white women often represents the condition of the 'biological' reproduction of specific racial categories that are at least partially defined in opposition to the racial category white.

The evidence that this transfer of white women's eggs to non-white women does indeed occur in egg donation is not provided only by Young and Creating Families, Inc.'s website. This also has been documented, albeit in a sensationalistic manner, in the mainstream media on both sides of the Atlantic. There are three frequently cited representative cases. In Britain in 1993 the press reported on a black woman who, after waiting in vain for a black egg donor for four years, decided to use a white woman's eggs to try to become pregnant. At the same time as this story broke, the British and American press also reported on another black woman who used a white woman's eggs to become pregnant. This woman did so not because of any stated shortage of black egg donors but rather, according to media reports, because she was married to a white man and felt that a white child would be spared the racism she presumed a mixed-race child would suffer.

The third widely covered instance in which a white woman's eggs were transferred away from a white woman did not take place in Europe but in California. Not strictly a

straightforward case of one non-white woman purchasing eggs from a white woman, this occurrence in 1990 was slightly more complex than the two discussed just above and concerned a surrogate pregnancy. It has been of interest alike to feminists and to the mainstream media. Van Dyck outlines what she terms the 'facts' of the case as follows:

> Crispina and Mark Calvert, an affluent white couple, hired Anna Johnson, a black vocational nurse and co-worker in the hospital where Crispina Calvert worked, to carry to term the foetus that was created in vitro out of the Calverts' egg and sperm. A hysterectomy performed on Crispina Calvert had made it impossible for the couple to conceive a child. They signed a contract with Anna Johnson to pay her $10,000 dollars plus medical costs for carrying and delivering the baby. Johnson, who was implanted with the fertilized egg in January 1990, announced seven months into her pregnancy that she intended to keep the baby due in October, and she filed a lawsuit to get custody over the child. The Court hearings took place in October, and on the 23rd of that month Judge Parslow ruled that the Calverts were the 'legal' parents of the child (1995: 151).

In conjunction with the other two cases discussed above, and despite the fact that the egg donation at its centre was originally envisioned in the contract signed by both parties as 'temporary' in the sense that its purpose was to enable Johnson to gestate, deliver, and then deliver to the Calverts a child genetically related to them, Johnson's case is nonetheless crucial to any analysis of ART focused on race. This is because it clearly shows both the possibilities for and the limits to the movement of whiteness itself away from whites. Particularly germane to my analysis, Johnson's case does not only reveal the broader social acceptability of transferring eggs from a white woman to a non-white woman. Much more importantly for my purposes here, it exemplifies the fact that this sits

comfortably alongside the prohibition on the transfer of white children to non-white parents.

From revisiting Johnson's case and those of the other two women referred to above, the significant differences in the ways in which the two ART discussed above transfer racial categories become apparent. With egg donation it is possible to transfer whiteness to non-white subjects; in trans-racial adoption it is not. Thus, trans-racial adoption may be said to reinforce the boundaries between whiteness and non-whiteness, while egg donation may be said to undermine them. As a result, it appears reasonable to conclude that egg donation is in some sense transgressive. Unlike trans-racial adoption, this ART appears to disrupt normalized routes for the transfer of racial taxonomies.

On another level, however, the claim for the transgressive potential of egg donation appears less certain. If the trajectory taken by whiteness in this ART is examined more closely, it becomes clear that, contrary to the above, it is just as stagnant in egg donation as it is in trans-racial adoption. Given that whiteness serves as the condition of the reproduction of specific racial categories that are defined in opposition to it, it appears that in the case of egg donation, as well as in trans-racial adoption, whiteness does not travel. That is to say, while it is true that the eggs of an egg donor who categorizes herself as racially white may be sold to a non-white woman, in such situations whiteness does not remain whiteness but in general becomes the racial category of the egg recipient.[14] Thus I conclude that, because it reinforces pre-existing racial categories, there is as far as race is concerned little transgressive potential in egg donation as currently practised.

The same can be said of the practice of class in egg donation inasmuch as white women are concerned. While this ART possesses the capability of disrupting a class-based discourse on so-called 'legitimate' motherhood in which middle-class – and not poor and working-class – white women are authorized to mother, ultimately it does not realize this potential. Instead, what occurs is a re-inscription of a class-based discourse in which social characteristics are rendered genetic or, in other words, are geneticized. The operation of education in egg donation provides one of the best examples of this phenomenon. In order to illustrate this, I return to the open evening I attended, when Dr Schulman was attempting to sell egg donation to his audience.

Shortly after telling his prospective clients, as discussed in chapter two, that no one would be able to tell by visually comparing a child to her/his mother that the mother had used another woman's eggs in order to conceive, Dr Schulman went on to talk about the donors then enrolled at the Genetics & IVF Institute (G&IVF). These women were, he stated, young, attractive and selfless and were donating eggs not for the money they might receive but out of an altruistic desire to help others. Largely college students, if these women ever did think about the money they stood to earn for their donation, it was because they could put the $2,500 payment toward their college tuition or the purchase of books. Members of the audience, Dr Schulman assured them, need have no fears about the quality of the egg donors at his firm. After all, neither the doctor nor any other member of his staff was going to accept as a potential egg donor 'a financially desperate, four-foot eight, three hundred pound, elementary school dropout'. Serving as a safeguard, G&IVF Institute's application form – like that of all clinics and third-party agencies –

had been designed precisely to prevent such a woman from attempting to donate eggs at this institution.

What is telling about Dr Schulman's shocking statement, especially when read against his comments on the type of women who do act as egg donors in his firm, is the degree to which social phenomena such as access to education have become geneticized. From the statements reproduced above and the attendant emphasis on the information provided in donor application forms, it becomes apparent that, within the logic of the contemporary Anglo-American fertility industry, there is a complete and utter collapse of the boundaries between the social and the genetic; the social is emptied of any relevance and the genetic becomes all-determining. It is as if Dr Schulman is telling his audience that if they want their future child to have a college education, in much the same way as they would like her/him to have light hair, they must select an egg donor who herself is college educated. In this formulation, higher education becomes something that is de-linked to class status and becomes purely and simply a matter of genetics – because the egg donor had a BA your child too can have a BA.

Not simply spoken, this geneticization of education is effected through the donor application form. For example, in both the Jones Institute's application form and that of TTPA, requests for information on education level, grade point average and intelligence level sit alongside requests for information on phenomena more regularly associated with biology such as eye colour and hair colour. Perhaps more important, however, than the fact that there is nothing on these forms to signal an awareness by their producers that

they are requesting radically different kinds of information, is the fact that the ways in which different types of information are recorded are virtually indistinguishable from one another. Obliterating all possibility of determining the context in which the prospective donor pursued or did not pursue a high school diploma, a college education, etc., donor application forms provide the prospective donor with a range of small spaces in which she is to record her highest educational qualification and her intelligence level, etc. Thus, this visual technology participates to the same extent as spoken discourse in the geneticization of social characteristics in the contemporary American fertility industry.

Although not addressed in precisely the same terms, critical analysis of this situation, in which middle-class attributes become all-important and geneticized, may be traced to other feminist and cultural studies work on ART. Van Dyck's analysis, which takes up the issue of the potential exploitation of non-white and poor and working-class women in relation to egg donation, is especially informative. She writes:

> Egg donation might enable women past menopause to become pregnant, but this new opportunity could also usher us into a new trend stimulating older women to carry babies for younger women so that the latter can remain fully employed during their most fertile years. 'Granny mums,' like black women, might be exploited by white yuppies to serve as breeders. Of course, egg donation can make a 33-year-old woman who suffers from early menopause very happy, yet it might also be a euphemism for 'egg selling': teenagers desperately needing money might want to sell their eggs, knowingly neglecting the risks involved in hormone injections (Van Dyck 1995: 190).

Speculating about the forms exploitation will take in egg donation, Van Dyck posits that this ART opens up new paths for the exploitation of older women by younger women, the exploitation of younger women by older women, the exploitation of black women by white women, and the exploitation of poor women by middle-class women. Following Van Dyck, there are a number of different forms that this exploitation can take. One of these is the 'granny mum' phenomenon. In this scenario, which is presumably rooted in the racialized and class-based division of labour that sees poor and working-class black women delegitimized as mothers of their own children and yet engaged as child minders by white middle-class women, black women's bodies become the condition of possibility for middle-class white women's ability to reproduce in another way: they gestate and deliver the white children they will presumably mind while the children's white mother works outside the home.

Another form of exploitation proposed by Van Dyck concerns younger, presumably white, women. In this scenario, poor teenagers are potential victims of the fertility industry and its clients in that they may be susceptible to financial inducements to undergo egg donation while not properly advised of the risks to their health or, even if properly advised of this, not fully able to appreciate what these risks might mean.

When positioned alongside each other, these and similar scenarios lead Van Dyck to state that, 'It becomes increasingly pointless to concentrate on one factor that informs or structures public debate on the new technologies; gender, race, class, age and other factors are inextricably intertwined in the discussion' (ibid.: 191). She goes on to note

that '. . . the debate on postmenopausal pregnancies, transracial impregnation and the use of foetal eggs cannot be separated from the debates on genetic engineering, basic health insurance, abortion, prenatal care, racism and deregulation of public services' (ibid.).

While Van Dyck's statement is accurate and discussion of ART, and, in particular, of the anxieties it provokes, is inseparable from larger and more complex public debate, the visual ethnographic work I have undertaken at American fertility clinics and third-party agencies leads me to conclude that her predictions as to future exploitative arrangements are inaccurate in so far as egg donation is concerned. (My concern in this dissertation has not been to address surrogacy and I will not therefore further discuss the issue of black and other non-white and poor white women's gestation and delivery of infants conceived from the eggs of white-middle class women.) What clinic and agency discourse on donor application forms and Dr Schulman's comments above point to is a scenario very different from the exploitation of young women, non-white women, and poor white women by the contemporary Anglo-American fertility industry. As anticipated by Heitman and Schlachtenhaufen's work, what seems more likely than the exploitative arrangements proposed by Van Dyck is a continued exclusion of poor and working-class women of all racial taxonomies from egg donation – as both donors and recipients. On the one hand, poor women and working-class women already delegitimized as mothers, will not – no matter how they are racialized – be able to afford this expensive set of assisted conceptive technologies. As discussed, apart from the uneven coverage offered by Britain's National Health Service (NHS), there are no programmes designed to address infertility in poor women. This is especially the case in the United States. On the

other hand, and perhaps much more worryingly, it appears to me that poor and working-class women will not be able to sell their eggs. This is because what is being transferred in commercialized egg donation appears to be less, as discussed in chapter two, a reproductive substance and more a geneticized potential which in the last instance must be read as class. These women will continue to be cut out of egg donation because they lack the qualifications – such as the right grade point average and/or the social status that comes with affiliation with prestigious educational institutions – that can not only be recorded on donor application forms but which will standout on these.

Thus, however they are racialized, poor teenagers' eggs will be no more desirable than poor teenagers' babies currently are. Only women, increasingly recruited from colleges and universities, who by virtue of their grade point averages, SAT scores, stated philosophies on life, etc. can construct themselves on clinic and agency application forms as 'middle class' will be selected to donate eggs to other middle-class women. At most, following Ingrid Schneider, poor and working-class women's eggs will be used for stem cell and other biomedical research in which the creation of embryos will be swiftly followed by their destruction.

Notes

1 The rationale for age limits is that, as stated in the CDC report, 'eggs produced by women in older age groups form embryos that are less likely to implant and more likely to spontaneously abort if they do implant' (CDC 2002: 52). 'The likelihood of a fertilized egg implanting is related to the age of the woman who produced the egg. Egg donors are typically in their 20s or early 30s' (CDC 2002: 53).

2 To the best of my knowledge, to date there are no academic programmes in the United States that train patient co-ordinators for employment in either fertility clinics or third party agencies. In the case of an administrator or co-ordinator at the latter type of institution, interviews with my informants suggest that there is neither an established educational path nor set of qualifications an individual (generally a woman) need possess in order to apply for and be hired for such a position. Furthermore, it appears that the bulk of the training occurs on the job. Young was especially informative on this point. When I asked her how she trained employees she responded as follows:

> By having them work with me and overseeing them. On average it takes me almost a year before I can allow a staff member to work alone. That doesn't sound like a long time but it really is. Day-by-day I oversee the trainee: I sit in on every meeting she has, I read every letter she writes and I look at every donor she recommends to a couple. I have make sure that she's doing all the things she should do and I've got to remember to tell her all the stories that are in my head so that they become her stories. Otherwise clients are going to get a better service from *me* than they are from my staff.

In the case of a patient co-ordinator working at a fertility clinic, it does seem that there is a more generalized set of qualifications an individual (again, generally a woman) must possess in order to be considered for such a position. Although I did not have the opportunity to directly address this issue with my informants working at fertility clinics, it does appear that this position is most often filled by a senior nurse who has an advanced nursing degree. Enumerating the types of tasks performed by the patient co-ordinator employed at the University of Washington Medical Center (UWMC) Klein's, Sewall's, and Soules's essay is informative on this point because it provides a general sketch of the kinds of duties the Jones Institute's patient co-ordinator might be expected to perform. Writing that the UWMC Donor Oocyte Program Coordinator is 'a dedicated

full-time professional staff member ... [who] ... is a reproductive endocrinology nurse with an advanced degree in clinical social work who functions under the direct supervision of the Assisted Reproductive Technology director and clinic manager' they go on to more precisely outline the duties of the Donor Oocyte Program Coordinator as follows:

> As a clinician, she provides nursing care and counseling service to donors and recipients prior to and immediately following active oocyte donation cycles. Specific clinical tasks include recruiting, screening, and preparing donors for oocyte donation; meeting with the recipient couple to address psychoeducational needs; facilitating the matching of donors and recipients; and adjusting both donor and recipient hormone levels in order to synchronize their menstrual cycles. The coordinator also acts as a clinical liaison between the patient and the medical team by relaying information and maintaining daily communication with the Assisted Reproductive Technology patient care representative, nurses, and physicians.
>
> As a program administrator, the Donor Oocyte Program coordinator proposes program policies and procedures, manages financial issues, collects data and keeps outcome statistics. In addition, she develops educational material for the program and participates in public relations and community outreach education. She supervises the work of an administrative assistant who helps with correspondence, record keeping, and data collection. Frequent meetings are held with the Assisted Reproductive Technology director, the clinic manager and other departmental staff to monitor and facilitate program development and improvement. (Klein, Sewall, and Soules 1996: 4-5).

3 With its lenient laws and numerous private facilities, the United States is a destination for international reproductive tourism. So much is this the case that it is an open question to what extent the United States – and other countries with similarly lenient laws and wide availability of service – represent the condition of existence of the prohibition of various ART in, for instance, Germany and Japan. Whatever the response to this question, there are number of American firms which make use of both the internet and medical conventions in order to target client bases outside the United States. One example of this is San Francisco-based International Fertility Center (IFC). Similar to the firm Young's donor set up, this third party agency arranges egg donation and commercial surrogacy for

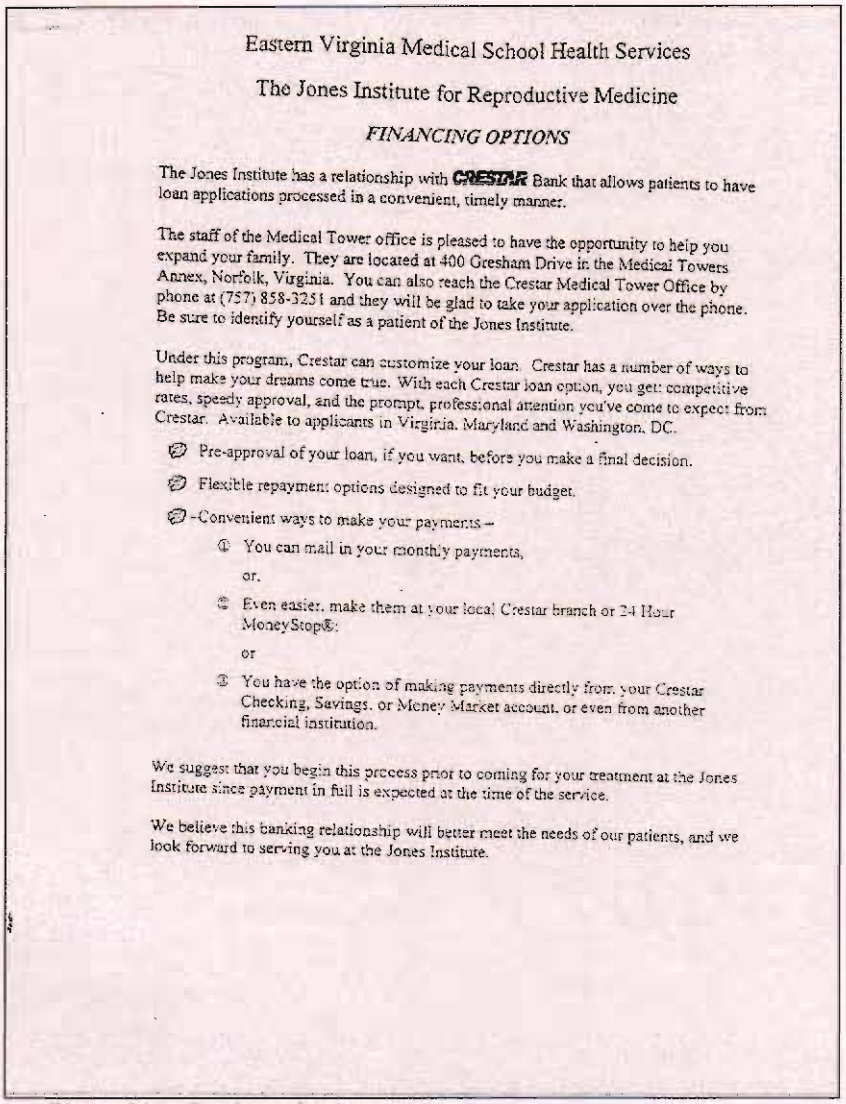
Japanese citizens. According to IFC's website (www.ifcbaby.com) clients are initially seen in Japan where their needs are assessed, processes, procedures, and financial requirements and arrangements are discussed. Once in the United States, clients are taken to and from medical appointments, provided with translators, and have their travel and accommodation arranged for them. Other firms target other nationalities. Young's firm targets European clients at conventions such as World IVF Congress and, although he does not advertise in the Middle East, Dr Jackson reports having treated a number of clients from Middle Eastern nations. He reported to me that he felt that his firm's internet presence as well as word of mouth from family members, friends, and acquaintances who had been clients of his contributed to an ongoing interest in his clinic by clients from abroad.

4 Although it is taken as established in cultural studies that race is a social construct and not a biological fact, this appears to be disputed even in medical literature which aims to take a sort of 'social constructionist' approach to race.

5 I am aware that this formulation, in which I single out whiteness, reproduces a standard split between white and, not black as Morrison (1992) indicates, but all other races. Given my desire to foreground the racialness of whiteness which has often been overlooked – see Dyer (1997) for a discussion of this, this seemed a necessary drawback.

6 See Fausto-Sterling (1992) for a discussion of genetics in relation to gender and a discussion of how traits are passed down but she does not take up race.

7 Increasingly, as a result of the wider availability of credit (Smith 1997) and the comparably high cost of ART, institutions offer their clients assistance in financing the purchase of egg donation, IVF, etc. Two examples of this are arrangements made by Jackson and the Jones Institute with local banks wherein prospective egg recipients can apply for loans in order to finance attempts at becoming pregnant. See Figure 5.04 below for a flyer produced by the Jones Institute describing financing arrangements available through Crestar Bank.



Eastern Virginia Medical School Health Services

The Jones Institute for Reproductive Medicine

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Figure 5.04: *The Jones Institute*

8 The best example of the absurd level to which genetic determinism can be taken is *The Bell Curve*. For critiques of Herrnstein and Murray (1994), see Fraser (1995), Jacoby and Russell (1995), Kincheloe, et al (1996), and Fischer (1996).

9 As previously discussed, the ability to pay for egg donation is a third, and arguably more fundamental, factor.

10 A prospective recipient's ability to articulate what she wants in a donor is something that is by no means standard across the board. Although problematic, it is possible to make the generalization that third party agencies appear to encourage their clients to more actively participate in the selection of a match while this is less well developed at fertility clinics with smaller egg donation programs. In making this statement, it must be borne in

mind that fertility clinic-based egg donation programs vary greatly in terms of, among other things, the size of the pool of available donors and the degree of input a prospective recipient may have in determining with which donor they wish to be matched.

11 There are both domestic and international components to this. In terms of the former and as discussed in chapter two, this aligns with a rhetoric about the lack of healthy white children available for adoption and has engendered debates within the Social Work community about forestalling the adoption of black and native American children by non-black and non-native American adults. (See also Williams (1995).) The international component revolves around the adoption of so-called 'third world' children by American citizens. This most frequently sees white adults adopting girl children from China and both boys and girls from impoverished former Soviet block nations such as Russia and Romania. It is highly unusual – and I know of no documented cases – for a non-white individual or family to adopt a white child.

12 This is of course couched in a rhetoric of shortage: there are no white babies available for adoption. Sometimes, in what strikes me as a anti-feminist rant, this is attributed to the advent of more effective contraception, the decreased stigma attached to being a young, non-married woman raising a child on her own and the liberalization of abortion law. For a persuasive critique of this notion of shortage, see Williams (1995).

13 For a critique of the 'adoption wars', see Gilroy (1987), especially pp. 64–7.

14 The one exception to this would, of course, be the case of the woman who brought a white woman's eggs in order that her child be racially white.

Conclusion

On 25 July 2003 Louise Joy Brown, 'the world's first test-tube baby', was twenty-five years old. During the week surrounding this anniversary, there was intense media celebration of the purportedly great advances made in infertility medicine over the course of the past two-and-a-half decades and speculation about the future of this still relatively new medical specialty. One representative piece is an article by Steve Connor which appeared in the *Independent*. Based upon an interview with 'Professor Alan Trounson, a fertility specialist at Monash Institute of Reproduction and Development in Victoria, Australia' Connor cheerfully forecasts the end of infertility (2003: 2). Repeatedly and at length quoting Trounson he maintains that within ten years a combination of cloning and stem cell manipulation techniques will assist physicians to enable women and men whose bodies do not produce eggs or sperm to produce them. Grouped with IVF and pre-implantation genetic diagnosis (PGD) into a set of 'standard' assisted conceptive technologies, this yet to be named set of techniques would mean, according to Connor and Trounson, that almost anyone would be able to reproduce biologically-related children.

Were Trounson's predictions to come true, egg donation (not directly mentioned in the article) would presumably be rendered obsolete. There would be no need to advertise for, interview and hyperstimulate an unknown woman in order to procure the eggs with which a middle-class woman could attempt to conceive. With this wonderful new

breakthrough the middle-woman would effectively be cut out and the middle-class woman could use her own eggs to become pregnant.

Beneficial though they might prove to be for some women, whether or not Trounson's predictions come true or not is largely irrelevant, I want to suggest, for the future of reproductive discourse and practice. No matter how many women are enabled by this new set of techniques to conceive, gestate and deliver genetically related children, it is highly unlikely that all women desirous of having children will be enabled to do so. This will not be because this new set of techniques is more or less expensive than others or more or less available. Rather, it will be because of the underlying, long-standing discourses on so-called legitimate reproduction which determine who may have children and under what circumstances they may do so, whose work at mothering is valued, whose is not, whose children will be valued and whose will not. Hovering over and receiving its conditions of existence from such discourse, this new set of techniques will partake of these reductive and exclusionary formulations of motherhood, looking to them for legitimacy but will not – and indeed cannot – by its sheer presence change them.

As I have shown in this dissertation, 'knowledges' about who has the alleged right to reproduce and who has not are firmly entrenched in two of the institutions selling one of the newest sets of assisted conceptive technologies. They are inscribed not only into their advertising practices but into their daily practices of egg donation. By attending to egg donation's visual economy in this ethnographic engagement with a highly complex industry, I have illustrated how reductive and exclusionary assumptions about and

practices of race and class, which are frequently mediated through visuality, do not just sit neatly alongside but are constitutive of the contemporary Anglo-American fertility industry. It is only by tackling these assumptions and practices – an exercise in which this dissertation aims to play some very small part – that the day will truly come when every woman who wants to is able to reproduce in the manner she deems fit and is affirmed in her decision to do so. I wonder what this will look like.

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