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Selecting women, taming bodies? Body ontologies in egg donation practices in Spain

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ABSTRACT

According to the Spanish law of assisted reproduction, women intending to donate eggs must be “in good psychophysical health” and “do not suffer from genetic or infectious hereditary diseases transmissible to the offspring” (chapter II, article 5). What a “good” psychophysical health condition is, what the “transmissible diseases” are, and what counts as disease at all remains contested. In this paper, we explore how these broad legal criteria materialize through different tests and selection procedures. Drawing on extensive ethnographic fieldwork in Spanish fertility clinics and with egg donors in Spain, we argue that selection and management procedures are organized to split egg donors as “multiple bodies” (Mol 2002), which will have to be tamed in different ways. On the one hand, we will refer to the making of a “biographical subject,” for which we understand the donor to be a conscious autonomous subject. And on the other hand, we refer to the “body object,” for which we understand the donor to be a terrain of potential extractability. As we argue, clinics aim to select a responsible biographical subject who kindly obeys professionals’ instructions throughout the process in order to make the body object accessible to clinics’ extraction purposes. To conclude, our paper sheds light on issues of “reproductive in/justice” by discussing how the reproductive rights of intended parents through egg donation are entangled with inequalities of egg donors.

KEYWORDS

Egg donation; Spain; multiplicity; body ontologies; reproductive justice

PALAVRAS-CHAVE

Doação de ovos; Espanha; multiplicidade; ontologias corporais; justiça reprodutiva



PALABRAS CLAVE

Donación de óvulos; España; multiplicidad; ontologías de cuerpos; justicia reproductiva

Selecionando mulheres, domando corpos? Ontologias corporais nas práticas de doação de óvulos na Espanha

RESUMO

De acordo com a lei espanhola de reprodução assistida, as mulheres que pretendem doar óvulos devem estar “em boa saúde psicofísica” e “não sofrerem de doenças transmissíveis hereditárias genéticas ou infecciosas à prole” (capítulo II, artigo 5). O que é “boa” condição psicofísica de saúde, quais são as “doenças transmissíveis” e o que conta como doença permanece em disputa. Neste artigo, exploramos como esse amplo critério jurídico se materializa nas práticas clínicas por meio de diferentes testes e procedimentos de

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seleção. Com base em um extenso trabalho de campo em clínicas espanholas de fertilidade e em observações dos participantes, tanto em clínicas quanto em empresas genéticas e com doadores de óvulos na Espanha, argumentamos que os procedimentos de seleção e gerenciamento são organizados para dividir os doadores de óvulos como “corpos múltiplos” (Mol 2002), que terão que ser domados de maneiras diferentes. Por um lado, nos referiremos à criação de um “sujeito biográfico,” para o qual entendemos o doador representado como um sujeito autônomo consciente e, por outro lado, ao “objeto médico,” para o qual entendemos o doador como um terreno potencial de extração. Como argumentaremos, as clínicas visam selecionar um corpo biográfico responsável que gentilmente obedeça às instruções dos profissionais durante todo o processo, a fim de tornar o objeto médico acessível aos propósitos de extração dos médicos. Para concluir, o nosso artigo ajuda a analisar questões de “in/justiça reprodutiva” discutindo a forma como os direitos reprodutivos dos progenitores são enredados com desigualdades para as dadoras de óvulos.

¿Seleccionar mujeres, amansar cuerpos? Ontologías corporales en los procesos de donación de óvulos en España

RESUMEN

Según la ley de reproducción asistida española, las mujeres que quieren donar óvulos deben gozar de un “buen estado de salud psicofísica” y no padecer de “enfermedades genéticas, hereditarias o infecciosas transmisibles a la descendencia” (capítulo II, artículo 5). Sin embargo, lo que significa un “buen estado de salud psicofísica,” cuáles son las “enfermedades transmisibles” y lo que cuenta como “enfermedad” es debatido. En este artículo analizamos de qué modo este amplio criterio legal se materializa en los distintos test y procedimientos de selección. Basándonos en nuestros extensos trabajos de campo en clínicas de fertilidad y con donantes de óvulos, sostenemos que los procesos de selección y gestión de donantes están organizados para dividirlos en “cuerpos múltiples” (Mol 2002) que tendrán que ser amansados de diferentes formas. Por un lado, nos referiremos a la construcción del “sujeto biográfico,” por el cual entendemos a la donante percibida como sujeto consciente autónomo y, por otro lado, a la construcción del “cuerpo objeto,” con el cual entendemos a la donante percibida como campo de extracción. Tal y como proponemos, las clínicas buscan seleccionar un sujeto biográfico que obedezca las instrucciones de los profesionales durante el proceso para hacer así el cuerpo objeto accesible a los fines extractivos de las clínicas. Para concluir, nuestro artículo permite analizar cuestiones de “justicia reproductiva” al analizar cómo los derechos reproductivos de los futuros padres se entrelazan con las desigualdades de las donantes de óvulos.

1. Introduction: egg donors as multiple bodies

This couple is giving into our hands their future child. So we take this very very seriously. We cannot just take and buy the oocytes from someone, not knowing where they are from. The egg donors, and at the moment we have more than 600 in our bank, before they form part of

our program they will have to pass some strict, strict, strict selections. Because we have to give our best to our patients. And how to give the best? Guaranteeing quality since the origin of the process.¹

(Rosa², Clinic Manager, Alicante)

The initial epigraph raises some fundamental questions: What is a “strict selection” in the context of egg donation? How does the quest to guarantee ‘quality’ materialize in specific selection practices of egg donors?³ And finally, how do egg donors react to those criteria? These questions are at the core of this article, in which we ask how egg donors “are being enacted in practice” (Mol 2002, 152) in in-vitro fertilization (IVF) clinics. Our conceptual endeavor delineates the making of donors in private IVF clinics to show how they are constructed as “multiple” bodies (Mol 2002) that clinics need to “tame” through different strategies.

We engage with the interest in multiplicity from the field of Science and Technology Studies (STS). We understand multiplicity as the fact that any relation in a given field enacts multiple realities rather than a single one (Tsing 2010; Law and Mol 2011; Mol 2002). To frame our argument, we draw from Annemarie Mol’s conceptual contribution in her book *The Body Multiple* (2002). In this book, the author undertook fieldwork in a Dutch hospital, where she observed the clinical practices surrounding atherosclerosis. She explains how, in hospital practice, one medical condition is enacted differently through multiple actors, places and practices, and how this results in atherosclerosis being different things in different places and at different moments. As an example, “the atherosclerosis enacted in the outpatient clinic contrasts with the thick vessel wall that can be observed through a microscope” (Mol 2002, 50). Mol engages with ontologies when she asks about what is being done in practice rather than focusing on actors and their motivations (2002). What interests us for the purposes of this paper is her argument on how objects come into being as articulations of practices. As Mol contends, because practices are multiple, the object itself multiplies. The practices we observed in relation to egg donors were the selection procedures that aim to select a viable donor body as well as their management once they have been accepted.

We draw on three concepts which, in their interconnection, help us to articulate the arguments of this article: *biographical subject*, *body object*, and *taming*. The first two concepts allow us to describe the ways in which egg donors are enacted in the clinic, while the third helps describe the mechanisms in place to manage those different enacted donors. We will use the concept “biographical subject” to refer to the donor enacted as a conscious autonomous subject, especially to link our argument to the notion of egg donors as having certain “reproductive biographies” (Perler and Schurr 2020; Perler 2015). The idea of “reproductive biographies” underpins the multiple entanglements between donors’

¹Esa pareja pone en nuestras manos su futuro hijo. Entonces nosotros eso nos lo tomamos con mucha, mucha seriedad. No podemos coger y comprar (...) los óvulos de un sitio que yo no sé de dónde vienen. Entonces (...) las donantes, que en este momento tenemos más de 600 en nuestro banco, antes de poder pertenecer al programa de donación pasan unas estrictas, estrictas, estrictas selecciones. (...) Porque para nuestros pacientes tenemos que darles lo mejor. ¿Cómo se da lo mejor? (...) garantizando desde el origen la calidad de todo el proceso.

²In order to maintain anonymity, we have used pseudonyms for all participants.

³We use the terms *donor* and *donation*, as they are emic descriptions egg donors use to refer to themselves, while recognizing the problematics of this word as it covers the capitalist logics behind the act of donation. For a further discussion about the terms that can be used to refer to the women providing their oocytes in the global bioeconomy, see Nahman (2008).

reproductive lives and their socioeconomic and political environment, arguing that the entanglement of those multi-scalar power relations and related gendered obligations of care are the primary reasons of their bioavailability as donors. Building on this idea, we demonstrate how IVF clinics in Spain conceptualize egg donors as having reproductive biographies that are likely touched by instability at different levels. With the term “body object,” instead, we understand the donor as a terrain of potential physical extractability. With this concept, we point out the privileged conversations that take place between donors’ fleshy corporeality and medical experts. These conversations, we argue, leave out the donor as a biographical subject.

Finally, we will describe the mechanisms in place to manage egg donors in the clinic by using the term “taming.” With this term, we refer to the set of disciplining, control and contention techniques in place to manage egg donors’ minds and bodies to achieve a successful egg retrieval. We rely on the use of the term proposed by Arregui (2019). While discussing animal-human affective intimacies, Arregui argues that in contrast to other terms such as *domestication*, which doesn’t leave room for considering bidirectionality and agency of the domesticated (2019, 7), the term “tame” acknowledges the complex, bidirectional relation between those *taming* and those *being tamed*. A relation that in its power relations is similar to those of a tamer dealing with a wild animal, where power relations are clearly in favor of the tamer but where the notion of risk and bidirectionality remains tangible. We transpose this argument to the clinic–egg donor relationship. While the notion of the egg donor as a “risky subject” will be elaborated in depth in this article, we will briefly discuss the question of bidirectionality that can materialize in dynamics of resistance and contestation. In this sense, we call to engage with an approach of reproductive justice, a lens that precisely aims to draw attention to the different stratified inequalities, power mechanisms and moral dilemmas at play in a transnational fertility industry (Smietana, Thompson, and Twine 2018). Such a perspective aims to bring the “people made most vulnerable by issues to the center” (Luna and Luker 2013, 344), and “addresses the social reality of inequalities” (Ross 2006, 14) rather than individual questions of access and choice.

2. Context: Spain as the European hotspot for egg donation

The relation of egg donors and clinics is particularly interesting in the flourishing and highly competitive Spanish market (Mouzon et al. 2010; De Geyter et al. 2018). The first Spanish law on assisted reproduction in 1988 was one of the earliest among European countries. It came into effect under the government of Felipe González (the third Prime Minister of Spain after the dictatorship of Francisco Franco) from the Spanish Socialist Workers’ Party (PSOE). However, different assisted reproductive techniques were being used and normalized much before the law in 1988. The first sperm bank in Spain, for example, was founded 11 years prior and resulted in the birth of thousands of babies within a decade. Also, the first “test tube baby” in Spain was born in 1984 in the Institut Universitari Dexeus, a private clinic in Barcelona. Just 1 year later, the first successful IVF treatments using donated eggs resulted in the birth of twins in the same clinic (Coroleu Lletget 2011). Soon after, a high number of private fertility clinics popped up, mainly in the tourist hubs along the Mediterranean coast (Alkorta Idiakez 2006; Pavone and Arias 2012). Ever since, Spain has become the European leading destination for what is called “cross-

border fertility care/travel” (Pennings et al. 2008; Inhorn and Patrizio 2009; Whittaker and Speier 2010). As the Spanish Fertility Association (SEF) reported in 2017, 14,846 patients from other countries “circumvented laws” (Bergmann 2014; 2011) to gain access to fertility treatments in Spain (Sociedad Española de Fertilidad (SEF) 2017). The report also states that 51.8 percent of those patients travelled to undergo IVF with donated eggs, in high demand across Europe due to restrictions and bans in most countries (Pennings et al. 2008; Hudson et al. 2011). In 2017 alone, Spanish fertility clinics underwent 15,136 egg extractions on women’s bodies, which were used for 11,440 IVF treatments within their 239 fertility clinics (Sociedad Española de Fertilidad (SEF) 2017).

The reproductive landscape in Spain has always had major differences in the private and public sectors in terms of treatments available, conditions of use and waiting lists. While public health care covers in-vitro fertilization treatments (with women’s own eggs) and artificial insemination, the former has a waiting list of more than 1 year and a half, and the latter, around 6 months (with minor differences across regions in Spain). Moreover, unlike the private clinics where there is no official age limit for access, in the public system women need to be under 39 years of age to access those techniques. Public health care has as well a limit of attempts: three for IVF and four for AI, after which patients will not be able to undergo a cycle in the public system anymore (Generalitat de Catalunya 2016). Finally, and most importantly, oocyte donation is generally not offered in public centers due to its unaffordability (Pérez Milán 2011). While the law stipulates that the donation has to be “altruistic,” a compensation of about 900–1300 euros is paid to donors in private clinics. This amount is higher than the minimum interprofessional gross salary per month for a full-time job, currently 900 euros (Eurostat 2020)⁴, and is also not subject to taxation. The compensation is usually paid in cash right after the successful retrieval or the post-extraction control around a week after.

Spain has steadily established its leadership in the repro-market over the last decades as has scholarly interest on egg donation. However, the shortage of qualitative studies, and even more those of ethnographic nature, is still remarkable (Rivas, Plaza, and Jociles 2018). Nevertheless, some studies have marked important points of departure for the study of the Spanish reproductive bioeconomy. Some ethnographic research has focused on kinship arrangements, motivations of donors, and imaginaries related to donation (Álvarez Plaza 2008; Orobítg, Bestard, and Salazar 2013; Molas and Bestard 2017; Molas 2017). Other important recent contributions have expanded the field of egg donation by connecting it to broader global dynamics. In this sense, Marre, Román, and Guerra (2018), position anonymous adoption and egg donation as forms of invisible reproductive work fueled by the supposed altruism and the anonymity of the donation. In the same line, Rivas, Lores, and Jociles (2019) articulate further how altruism and anonymity are the cornerstones of success of the Spanish IVF industry. Conditions that allow the public and private system to appropriate “donated” eggs in an industry that Degli Esposti and Pavone (2019) name a “(quasi) social market,” highlighting how the currency of altruism turns *providers* into *donors*, prevent the debate of alternative forms of valuation for their reproductive labor. The work of Lafuente-Funes is also key for the conceptualization of this article, as she has

⁴The minimum salary per year in Spain in 2019 was 12,600 euros gross, which we divided by 14, the usual number of payments in Spain per year.

taken interest in the materiality and ontological realities of eggs in different contexts (clinic, labs and universities) of the Spanish landscape (Lafuente-Funes 2017a), as well as the roles of egg donation in IVF clinical practices, and in professionals' narratives (Lafuente-Funes 2017a, 2017b).

The present paper aims to contribute to the previous literature by providing detailed ethnographic insight on the logics in which egg donors are managed in practice in clinical settings, and how multiple body donor ontologies are coming into being through these practices. The article draws from the fieldwork conducted by both authors in Spain between 2018 and 2019.⁵ Anna conducted 6 months of ethnographic fieldwork from January to June 2019 in Catalonia, mainly based in Barcelona. During that time, she conducted semi-structured interviews with egg donors and IVF professionals from different areas. She also conducted participant observation in an IVF clinic in Barcelona between May and June 2019. Laura conducted 10 months of ethnographic fieldwork from February to December 2018 in Valencia. Her fieldwork consisted of 8 months of participant observation in a clinic, semi-structured interviews with egg donors, intended parents, geneticists, IVF professionals from different areas, and companies that sell their services to IVF clinics. All of our interviews were conducted either in Catalan or Spanish, and we translated into English ourselves both the excerpts from the interviews and the fragments of the official documents provided in this paper. The original versions of the interview fragments provided in this paper can be found in the notes section and will be referenced through footnote numbers. Finally, both research projects have been conducted according to the human research ethics standards from Monash University and St. Gallen University, respectively.

3. The making of the biographical subject

A normal girl, a girl, ehm, that is functional on a social level, on a personal level, on a family level (...) so these are my criteria. A criterion of common sense also, to stay inside of normality, an adapted girl, ok?⁶

(Elena, a psychologist talking about the selection criteria for egg donors, Valencia)

Adapted, functional and normal. That is what psychologists in IVF clinics repeatedly claimed proper egg donors should be. But how does this rather vague criteria of "normality" and "common sense" materialize in the process of egg donation? By analyzing the different selection processes as well as the rationalities underpinning them, we will delineate how the donor as a "biographical subject" emerges and how the dangers associated with her agency are subsequently managed in IVF clinics.

Oocytes are at the core of the business of reproduction, due to their limited availability in a lifetime, they are a "biological rarity" (Waldby 2019, 33). This fact leads to strict control over those who produce this valuable and scarce good: the donors. According to critical scholarship on reproductive technologies, egg donors are considered as "vessels for oocytes" (Nahman 2011, 631) whose rights and obligations are subordinated to a

⁵The research is based on our respective doctoral theses. The ideas in this paper were cultivated and shaped throughout the sharing of our research interests, points of views and ethnographic material. Both authors contributed equally to the ideas developed in this paper.

⁶Una chica normal, una chica, eh, funcional a nivel social, a nivel personal, a nivel familiar (...). Entonces ese es mi criterio. Un criterio de sentido común también, dentro de la normalidad, de una chica adaptada ¿Vale?

growing bioeconomy (Ikemoto 2009; Cooper and Waldby 2014). We could therefore conclude that what clinics need are easily extractable, subordinate and docile women. But if we take a look at the advertising campaigns of fertility clinics in contemporary Spain, we see a completely different picture. Under #Diferentesperoiguales (*different but equal*) a clinic evokes imaginaries of powerful, modern, free women that help each other to attain the dream of motherhood. In clinics' marketing material, egg donation is usually pictured as a feminist project. Under #MuchoCambio (*a lot has changed*) a clinic establishes imaginaries of urban, professional, self-determined women wanting to make a change through donating eggs. As Anna pointed out elsewhere, these portraits "seek to picture egg donation as an experience rather than a practice. An appealing subjectivity encompassing desirable material and moral attributes rather than a precarious subsistence option" (Molas forthcoming).

3.1. Searching for a "responsible donor"

As different clinicians claimed in our fieldwork, the search for socially adapted women as donors is meant to assure that those who enter the process will also continue until the extraction, because a donor means first of all "a huge investment in personnel and money"⁷ for the clinic (Elena, psychologist, Valencia). Indeed, the screening of egg donors entails different stages. As presented on most clinics' websites, egg donation encompasses four steps. First, an informative interview usually followed by exhaustive questionnaires on health family records and personal life. Second, medical and psychological tests which include a karyotype, blood analysis (also used for the genetic carriers test), a gynecological check, and a psychological evaluation usually comprised by a personality test and an interview. Third, the ovarian stimulation, for which women have to self-inject hormonal medication in a process that usually lasts between 10 and 12 days. Finally, the egg retrieval, which is an intervention done in the surgical ward under general anesthesia. It takes around 1 month until the results of the initial tests of a first-time donor are back and she can start the hormonal process. This is why clinics claim to need donors who "can be trusted" and who guarantee the return on investment. Following this logic, Spanish clinics show a clear preference toward "donors who behave in particular ways: altruistic, calm, responsible, and discreet" (Lafuente-Funes 2017b, 264). Our data reflects this finding: A successful adaption to societal norms and rules is an important criterion behind accepting donors, as this is perceived to be related to the performance of the donor during the cycle and thus the donation's success or failure. Psychologists from different clinics underscored that addiction problems, anorexia, depression, trouble with the law, sexual behavior perceived as promiscuous, or multiple abortions could lead to an exclusion from the donation program. In contrast, donors who are outgoing and have a solid social life, hobbies, long-term relations and a steady job are preferred.

The preference toward this kind of donor is reflected particularly in the first stages of donor selection like the psychological screening, where different selection criteria define the donor in biographical terms in order to deduce behavioral aspects. As Raquel, a psychologist from Barcelona said, "that is why it is so important to take this time, I see how is her life, what she is doing ... I am checking if she is a responsible or irresponsible

⁷Un gran gasto de personal, de dinero.

person, how she is adapted to her professional life for example, to social life ... (...) So you have an idea how this person is functioning.”⁸ Another psychologist talked about how important it was that donors showed commitment in their lives, because commitment was also needed in the donation process: “We see for example if it is a person that doesn’t have any rules at her place, if she had many jobs because she got fired, because she was never on time. Or maybe she didn’t follow the rules there. Perhaps she has sexual relationships every week with someone different. Of course, these are indicators that maybe those people haven’t got the responsibility that we demand for such a treatment, because she does not commit to anything, right?”⁹ (Gemma, psychologist, Barcelona). Indeed, psychologists frequently ask questions about sexual behavior to provide hints on the overall level of commitment the potential donors have in their lives. Alba, a psychologist from Valencia expressed this in the following way: “A very promiscuous person is more at risk of contracting a disease than a person who is not promiscuous, yes or no? Those are risky behaviors that we don’t want from donors.”¹⁰ Interest in donors’ abortion medical records was also common. When asked why they were interested in those, Alba responded, “Of course, a girl that had five abortions seems to be impulsive because there are many contraceptive methods at hand, so a girl that aborts so much does not think. And if she does not think, we do not take her.”¹¹ Following the same line, another psychologist argued that many abortions would indicate that the girl was *una cabra loca*¹² (Gemma, psychologist, Barcelona).

Those narratives link responsibility with being adapted to what is considered a ‘normal’ social, sexual and labor life. The same narrative is further exemplified in a 13-page questionnaire used in a clinic in Valencia that donors are asked to fill out at the very beginning of the selection process. Besides questions about physical and phenotypical characteristics, there are sections about sports, language and music skills, talents and temperament. In the largest part about medical records, the donor is asked whether she has been imprisoned or active in prostitution in the last year, how many sexual partners she has had and if any of her partners were bi- or homosexual.

We can summarize that egg donors are not only selected with regard to health issues that could potentially be passed on to the offspring but also with regard to their biographical features: Sexual and reproductive records, labor, social and family life and leisure activities are features assessed in fertility clinics. The desired biographical characteristics (adapted and responsible) should assure a trouble-free cycle in which the donor undergoes all the regular medical check-ups, takes her medication on time, and continues with the treatment until the day of extraction. Clinics therefore choose a donor as a

⁸Por eso es tan importante dedicarle este tiempo, veo cuál es su vida, qué es lo que está haciendo, veo si es una persona responsable, si no es responsable, qué adaptación tiene a su vida laboral, por ejemplo, a nivel social ... (...) Y tú te vas haciendo un poquito la idea de cómo está funcionando esa persona.

⁹Tu veus (...) si per exemple és una persona que no té cap tipus de normes de casa seva, que ha fet ... que ha sortit i entrat dels treballs perquè l’han fet fora, doncs perquè no arribava l’hora. O no ha seguit les normes que tocaven, que a lo millor té moltes relacions cada setmana amb una persona. Clar això són indicadors de persones que dius pot ser que a lo millor aquesta responsabilitat que nosaltres li hem de donar en el tractament no ens la pugui fer, perquè ella no es compromet en res, no?

¹⁰Una persona muy promiscua tiene más riesgo a contraer una enfermedad que una persona que no es promiscua ¿sí o no? Son conductas de riesgo que para donar pues no queremos.

¹¹Claro una chica que aborta cinco veces nos parece que es impulsiva porque hay muchos métodos anticonceptivos al alcance de la mano, entonces una chica que aborta tanto, no piensa. Y si no piensa, no la cogemos.

¹²Informal Spanish expression, literally translated as “crazy goat,” used to refer to people perceived as impulsive, and more concretely, to those who practice sexual behaviour considered promiscuous.

“biographical subject” likely to obey professionals’ instructions to make her bodily material extractable. But even if well chosen, donors are still perceived as risks because they may abandon the treatment or self-administer the hormonal drugs incorrectly. In the following subsection, we will therefore turn to the different techniques put in place to tame potentially risky “biographical subjects” throughout the donation process.

3.2. Taming donors as biographical subjects

Clinics intend to ensure a smooth, fast and profitable donation cycle in different ways, one of which includes doing the psychological and medical tests the same day that donors come to inform themselves about the process. This fast-track procedure enables the clinic to keep donors in the program. In the manifold information sessions Laura observed in Valencia, only a handful decided to reconsider donation, while the vast majority started the selection procedure immediately, clearly invited to do so by the doctors.

A second common method clinics use for taming donors is threatening to pay less or not to pay the financial compensation at all, when the process does not go as expected. Although egg donation in Spain is framed as an “altruistic” act in which the payment is considered a “compensation for physical discomforts, travel costs or loss of salary that is due to donation” (Law 14/2006, Cap.2, Art.5), professionals recurrently described it as simple labor. If a donor does not do the work properly or if she does not “make it to the puncture,” normally she will not be paid. As a nurse explained to Anna, “many donors do it wrong but they don’t tell you because they are afraid. They know that, of course, if they did it wrong ... they won’t be compensated” (Paula, nurse, Barcelona).¹³

Despite the effort of professionals to select donors perceived as reliable, the donors are usually not trusted when things go wrong. Clinics might put controls in place for these situations. During Laura’s fieldwork, a multiple donor who did not have any extractable oocytes on the day of the puncture was required to do a blood test to check if she had taken the last medication that induces ovulation. If the results showed that the donor had not taken the medication, the compensation would not be paid. Astonishment of this clinical practice was not shared by the nurses, who replied that this was “like a contract – when you go to work and you have your tasks and all of a sudden, you just don’t go to work anymore but nevertheless insist on payment. Even if you haven’t worked? This is not possible!” (fieldnote, Laura, Valencia). Our fieldwork proved that the way in which most clinics proceed with the economic compensation represents a contradiction to the current law in which physical discomforts, travel costs or loss of salary are compensated. Therefore, if a donor had gone through the process but there were no extractable eggs at the end she should still be paid. Moreover, many times donors were not just threatened in terms of not being paid but also coerced with the possibility of having to reimburse the treatment expenses in case they wanted to abandon the process at some point. As the recommended informed consent template of the Spanish Fertility Association states, “if the puncture does not proceed because of withdrawal, negligence or bad faith of the donor, the center will also be able

¹³A vegades moltes ho han fet malament i no t’ho diuen tampoc, perquè tenen por. Saben que clar, si ho han fet malament no ... no se’ls hi compensa.

to claim that she refunds the expenses of the explorations and the treatments that might have occurred.”¹⁴ Although different professionals stated that they had never enacted this clause, we believe that this coercion through money is the reason for occasional donor disappearance, which many professionals reported to us.

A third taming method that appeared recurrently in our fieldwork was through the use of WhatsApp. This instant messaging platform enables the clinic to communicate with the donor in places outside the clinical realm that otherwise remain uncontrolled. WhatsApp is used for communication with donors in different ways. In some clinics, the medical director personally sends text messages to the donors at any time of day, though other clinics use WhatsApp only during daytime. But in general, WhatsApp enables clinics to perform a kind of control that goes beyond simple communication: they can see if their message has been read by the donor (with the “double blue ticks” visible in the application) as well as their profile pictures, which allow them to check on their phenotypes even before they come to the clinic. This was the case in a fertility clinic in Barcelona where Nuria, a nurse, stated that the first thing they did once they had a prospective egg donor’s number was to check the profile photo to see whether she had “very pronounced Latin features,” in which case she could be discarded before the first appointment (field observations, Anna). When WhatsApp is used as a taming device, profile pictures vector ideas of (un)desirable traits, allowing for a racialized selection. As we both observed in fieldwork, there was a clear preference for Spanish donors with a “Caucasian phenotype” over donors perceived as having indigenous features from Latin America or those labeled as “Gitanas.”¹⁵ This mirrors the finding of Kroløkke on how Spanish egg donors are conceptualized by Danish Intended parents according to geographical imaginaries of Spain as a white, western and civilized country (Kroløkke 2014, 63). Indeed, in the Spanish reproductive industry, “whiteness operates within a racial economy of reproduction as an added extractable resource” (Nahman 2018, 84).

A fourth technique of donor taming is enacted through the medication itself. Advances in fertility drugs have also led to the possibility of minimizing behavior interference during the hormonation process, which is one of the most common reasons of cycle failure according to many professionals interviewed. For example, with Corifollitropin alfa (distributed under the commercial name of Elomva), a long-acting follicle-stimulating hormone prescribed at the beginning of the stimulation process, the first 6 days of daily injections can be substituted by a single shot distributed at the clinic.

There is a medication which is the most expensive and that not all donors can have, but it is one shot and that’s it. After that they need to have more injections, but at least we would do this first recapture fine. And this one they have it in here [the clinic]. Then many times you say [presumably to the doctor] ‘prescribe her this one because I think it will be the only way to do it correctly.’¹⁶ (Paula, nurse, Barcelona)

¹⁴Si la punció no se llevase a cabo por abandono, negligencia o mala fe de la donante, el centro podr adems exigir que sta reembolse los gastos que de las exploraciones y tratamientos se hubiesen derivado.

¹⁵We use the term gitana, meaning “gypsy,” as an emic concept used by our interview partners, acknowledging its problematic potential.

¹⁶Hi ha una medicaci que s la ms cara per i que no totes la poden portar, per qu s un cop i punt. Desprs s’han de punxar ms, per almenys la primera recaptaci la fariem okay. I aquesta se l’han de venir a posar aqu. Llavors moltes vegades dius “pauta-li aquesta perqu aquesta penso que ser l’nica forma de poder fer-ho b.”

As Paula states, the higher price of Elomva usually leads professionals to save it for women whose ability to follow the medication instructions is not clear or, as found out in clinics' observations, whose phenotypes are of high interest for the clinic, so that professionals do not want to risk a cycle cancellation for misadministration of the medication.

Virginia, a biologist and the coordinator of the egg donation program of a fertility clinic in Barcelona, also pointed out the increased benefits that the implementation of this medication provided: "So with this hormone you are already avoiding mistakes during five days. (...) So the hormone diminishes ... in fact since we use it, the percentage of bad responses has lowered a lot. Before we reached a discard of the seven, eight percent [of potential donors]. Now we have a discard of a two percent of donors, okay?"¹⁷

Finally, donors are more profitable if they donate several times. One strategy to encourage multiple donations, used in both clinics in Valencia and Barcelona, is to pay donors not the whole amount on the day of extraction, but when they come back to do the post-extraction gynecological control. While some doctors claimed that the reason for this was to motivate donors to come back for a check-up, ergo for their own well-being, in several informal discussions, clinical administrative personnel emphasized that the hidden agenda of this was to schedule donors for a new cycle.

Despite all the aforementioned techniques, it is important to highlight that clinics invest significant affective capital in the management of egg donors. In practice, this materializes, for example, in the hiring of specific staff to talk with and treat egg donors; in the practice of calling the donors by their first name and personalizing the attention; or sometimes even doing little favors such as implanting an intrauterine device (IUD) or doing a pregnancy ultrasound for free for recent donors (Field observations Anna, Barcelona).

The discussed taming mechanisms are directed to minimize the interference of the donor as a biographical subject during the egg donation process. If everything goes according to the clinic's aims, the biographical subject will facilitate the doctors' management of her medical body for extraction purposes. Those mechanisms are far from being neutral or value-free instruments; rather, they construct the desirable donor along lines of class (e.g. donors that have stable work), sexuality (e.g. the preference for monogamous donors) or race (e.g. the preference of Spanish over Latin-American or 'Gitana' donors). In the next section, we will have a closer look at the selection and taming of donors constructed as medical body objects.

4. The making of a body object

A gynecologist talking about the selection criteria of egg donors:

We divide patients ... I simplify a lot, okay? High ovarian reserve, normal ovarian reserve and low ovarian reserve. Normally an ovarian reserve ... a girl with a normal ovarian reserve produces between nine and fifteen ova. On average for a donor, a good one, a standard donor is about fifteen ova (...) most clinics make shared donors, although the recipient often does not know. The same donor serves for more than one recipient. Then they give a lot of medication to get more eggs. And maybe if you have 30 eggs or 25 you give eight to a recipient, ten to

¹⁷Amb lo qual amb aquesta hormona ja estàs evitant que durant cinc dies hi pugui haver errors. (...) Amb lo qual es redueix ... De fet nosaltres des de que ho fem, el percentatge de males respostes ha baixat molt. Abans igual teníem un *descarte* ... havíem arribat a tenir un set o vuit per cent, i ara tenim un *descarte* d'un dos per cent de donants, vale?

another, eight to another (...). And it's more ... business is more profitable, because a donor serves several recipients.¹⁸

(Gerard, gynecologist, Barcelona)

The donor as a medical body object is selected for its ability to reproduce desirable phenotypes and health standards as well as its ability to be managed through medication for an optimized cycle. Our interest here is to delineate the construction of the donor as a “body object” through medical selection criteria. In this quest, we will analyze the rationalities of clinicians and psychologists when they find themselves in a position of suspicion about health conditions of prospective donors. We will then have a look at medication as a further expert tool to “tame” the donors’ insides for optimizing the donation cycle.

4.1. *Selecting donors in “good psychophysical health”*

According to our observations, the selection of bodies able to reproduce desirable health standards is a complex task. The Spanish law on assisted reproduction does not provide great clarity in this matter when it states that donors will have to be in a “in good psychophysical health” and that IVF clinics will have to make sure that donors “do not suffer from genetic or infectious hereditary diseases transmissible to the offspring” (chapter II, article 5). What a “good” psychophysical health condition is, what the “transmissible diseases” are, and what counts as disease at all remains unanswered.

There is a constant tension between achieving “health quality” and getting enough ova for the increasing demand in a transnational market with different legal frameworks. This usually leads to medical precaution and eventually the rejection of the bodies labeled *at risk* of disease transmission (Lafuente-Funes 2017b, 266). Our fieldwork revealed that this precaution relies on a lack of knowledge to determine whether a condition is “social” or “genetic,” and that this uncertainty is further shaped by classed and racialized criteria. In this sense, we coincide with Wahlberg and Gammeltoft, who state that selective reproductive technologies “are shaped by cultural values and social norms around notions of what a ‘high quality’ or ‘good quality’” is (2018, 8), rather than by “objective” medical criteria. A further complexity in this issue is the fact that egg donors’ “reproductive biographies” heavily rely on their respective living contexts (Perler and Schurr 2020). As a report about the relation between austerity and mental health in Spain shows, there was a substantial increase of patients with anxiety, somatoform and alcohol-related disorders in the period of economic crisis (Gili et al. 2013). The relation between social and genetic grounds for health issues, even more in a time of economic deprivation, is thus deeply entangled and probably impossible to divide.

A central figure in the quest for healthy donors is the clinical psychologist. Elena, a psychologist from Valencia, explained that she had a dilemma once with a girl who had a father with a personality disorder. The intending donor assured that the disorder was

¹⁸Nosaltres dividim les pacients ... et simplifico molt, eh? Elevada reserva ovàrica, reserva ovàrica normal i baixa reserva ovàrica. Normalment una reserva ovàrica ... una noia amb una reserva ovàrica normal produeix entre nou i quinze òvuls (...). Les donants aproximadament de mitjana, per una bona, una donant estàndard són aproximadament uns quinze òvuls (...) la majoria de clíniques fan donants compartides, tot i que la receptora molts cops no ho sap. La mateixa donant serveix per més d'una receptora. Llavors donen molta medicació perquè treguin més òvuls. I potser si té trenta òvuls o vint-i-cinc se li donen vuit a una receptora, deu a una altra, vuit a una altra. I és més ... empresarialment més rentable, perquè una donant serveix per varies receptors.

due to his addiction to alcohol. However, Elena chose to discard her: “As we don’t know ... I mean. As we don’t know what is first, the genetic or the social, so I discarded her. She said no, that is because he was an alcoholic and so. I said yes, but sorry, if there are psychological and psychiatric antecedents, I cannot accept you as donor.”¹⁹ In the same line, Mirena, a gynecologist working in a IVF clinic in Barcelona, traced in a rather arbitrary manner what she perceived to be the boundaries between the social and the genetic: “We discard all the conditions based on medical reasons. Family history of Schizophrenia, I mean, things that are genetic. (...) So a bipolar person has a genetic tendency, a schizophrenic, an autistic ... those things would be discarded straightaway. However, a tendency to a secondary depression, in the society where we live in is not a genetic problem, so that wouldn’t be discarded (...) A suicidal attempt, yes.”²⁰ Alba, a psychologist in a fertility clinic in Valencia argued why she discarded a girl suspected to have Attention deficit hyperactivity disorder (ADHD) and implied the idea that the possibility to apply “strict” selection criteria depended on the number of donors in the pool at a given moment: “If I simply see a sign, she’s out. There is a diagnosis but what for? We can take another one, okay? So, a very impulsive girl, out! (...) It seems to be inherited by men, but it is not proved. Just in case. And as we have donors (...) we can make a good selection. If we don’t have many, we cannot do it.”²¹ Later in the conversation, Alba, however, expressed that the level of assumable risks relied on the level of interest in their phenotypes. She said, “Imagine that we are interested in a rare phenotype. (...) We have a recipient who wants to be a mommy, who is 1.80 cm, who is red-haired, with green eyes, white skin and an RH AB negative. (...) If I see a red-haired donor I think: ‘hope she has nothing, hope she has nothing.’ Then I would be very understanding with her.”²²

As we observed, IVF professionals are in constant negotiation to delimit the boundaries between the ‘social’ and the ‘genetic’ in their quest to reproduce babies with “high health standards.” However, as Alba and others told us, the strictness of these standards is always assessed against the backdrop of other variables, such as the number of donors they have and the desirability of their phenotype, usually resulting in more flexibility with donors with phenotypes in high demand. We argue that by choosing to discard certain biographies, IVF professionals undergo a “strategic naturalization” (Thompson 2005) of pathologies whose origins are uncertain. Further, this can be seen as an example of what Franklin (2013) names “biological relativity,” through which the ways the *biological* and the *technological* (or in other words, the *natural* and the *social*) inevitably merge and coproduce each other in the field of IVF. As Franklin contends, while intending to reproduce nature, IVF practices reproduce naturalized and normalized logics of kinship,

¹⁹Entonces como no lo sabemos, o sea no sabemos que es antes si lo genético o lo social, pues entonces la descarté. Ella dijo no, porque es alcohólico y porque tal, dije ya pero no, lo siento, si hay antecedentes psicológicos y psiquiátricos no puedo aceptarte como donante.

²⁰Todo esto se descarta desde la parte médica. Esquizofrenias familiares. O sea, cosas que son genéticas. Porque a ver, un bipolar es tendencia genética, un esquizofrénico, un autismo. Estos sí que se descartan de entrada. Ahora, una tendencia a una depresión secundaria, en la sociedad que vivimos, no es un problema genético. Con lo cual esto no (...) Un intento de suicidio sí.

²¹Simplemente veo si hay un signo, fuera. Porque hay un diagnóstico pero es carísimo, ¿y para qué? Cogemos a otra, ¿me entiendes? Por tanto, una chica muy impulsiva, ¡fuera! y ya no la diagnosticamos. Bien parece ser que se hereda por varón pero no está comprobado. Por si acaso, por si acaso y como nosotros tenemos donantes (...) pues podemos hacer una buena selección, si tenemos pocas donantes no podemos hacerla.

²²Imaginate que nos interesa un fenotipo raro. Tenemos una receptora que quiere ser mamá, que mide 1.80, es pelirroja, ojos verdes, piel blanca y un RH AB negativo (...) claro, si veo la donante pelirroja, digo “que no tenga nada, que no tenga nada.” Entonces sería muy comprensiva con ella.

parenthood, and reproduction. Therefore, these practices are relevant objects of cultural analysis. In the case mentioned above, the selection of egg donors reveals how the clinical conceptualization of the heritable features (e.g. the genetic) is embedded within normative ideas of class and race.

4.2. Taming donors' insides: discipline, control and resistance

The body object in IVF clinics is conceived as a site restricted to medical expertise. This medical body, however, is not constructed as lifeless matter. On the contrary, doctors recurrently refer to egg donors' bodies as organisms with agency, different to one another, whom they need to "get to know" in order to effectively manage. The achievement of a profitable cycle will depend on their ability to tame the body for extraction processes. For this taming process, the doctor disciplines the body through stimulation medication, controls its reactions through ultrasound controls and contains or corrects any misbalance in this tense equilibrium between optimization and risk control.

The disciplining of the medical body is enacted through different existing IVF medications. As different doctors stated, the discovery and implementation of antagonists²³ resulted in a complete change for the egg donation industry in its ability to reduce the chances of hyperstimulation syndrome. According to Montse, a lab director in a clinic in Catalonia, this allowed doctors to increase medication at a much lower level of risk of hyperstimulation:

Of course, doctors push them more, they push them more without fear. Before pushing them was "oh, I've crossed the line!" I've crossed the line means that she has reacted a lot with this dose that I gave her, right? Yes, I think now doctors they are much more ... well, they live much more relaxed. Because that was a constant worry. I mean, I don't even want to talk or think about how we would be in here with the number of donors we have, because we would have constant donors with low hyperstimulation. It would be constant. Instead now ... we don't even talk about it, right? It is something that has gone down to history.²⁴

The conversations between doctors and body objects are enacted as privileged communication to which the biographical body – i.e. the donor as subject – does not have access. The only function of the biographical body at this stage is to allow doctors to have this intimate communication with its insides by attending to all controls and following the instructions. In our observations in both Barcelona and Valencia, donors were neither informed about the progress of their cycle nor explained why one drug was prescribed instead of another. Ultrasound controls usually happened in absolute silence, with the doctor noting the information on the computer (number and size of follicles, whether there are any cysts, etc.), and eventually changing the medication prescription with no

²³Scientifically known as Gonadotropin-releasing hormone antagonists, these are a class of medications usually administered during the late-follicular phase in ovarian stimulation treatments to prevent a premature rise in serum luteinizing hormone (LH) levels and a premature ovulation. (Tarlantzis et al. 2006)

²⁴Clar, els metges les apreten més, les apreten més sense por. Clar abans era ... apretar-les era "ah! Ostres m'he passat, se m'ha re ... " m'he passat vol dir m'ha reaccionat molt amb aquesta dosi que li ha donat, eh? Val. Sí, jo penso que ara els metges van molt més ... bueno es que viuen molt més tranquils. És que allò era un mal viure, eh. Vull dir ara jo no vull ni parlar, ni pensar com estaríem en aquí, amb aquest volum de donants que tenim, perquè seria constant de donants hiperestimulades lleus. Seria una constant. En canvi ara ... no, és que no, no ... és que ni en parlem, saps? O sigui que és una cosa que ha passat a la història.

explanation of the reasons. The body object is thus alienated from the biographical subject, leaving egg donors to self-interpret their bodily experiences.

Finally, to address our interest in “how do donors react to selection criteria?” we will expose a joint encounter of our fieldwork²⁵. Both in Valencia and Barcelona, we found donors who lied to the clinics about their psychophysical health, donors who (due to the absence of a national registry) donated (far) more often than legally allowed, donors who knew what they were expected to tell to the psychologist in order to get accepted as an eligible donor, or donors who kept knocking multiple clinics doors until one, presumably shorter on donors, would accept them. Succinctly, this was mentioned by various participants as “every law has a loophole.”²⁶ Therefore, we contend that donors actively show “resistance to exploitation and precarity through ‘gaming’ the system” (Fannin 2018, 131).

Even if clinical settings are these powerful locations where egg donors are enacted as extractable bodies, the donors remain embodied subjects with a certain scope of action. Nevertheless, we agree with Nahman that both agency and choice “operate within the neoliberal epistemology rather than outside it” (2008, 67). Further, in the words of Mol, in multiple worlds there are “no independent actors standing outside reality [...] who can choose for or against it” (2002, 179). Women are thus deeply entangled with the powerful context through which they are coming into being as egg donors. Our endeavor here, therefore, is not so much to ask if egg donors have agency or not, but much more to show the powerful context in which their scope of action is played out. In this sense, we follow Andrea Whittaker’s claim that “the critical issue for feminists is not so much the content of women’s choices but the conditions under which they are made” (2015, 266).

5. Conclusion: the donor as an embodied subject

Throughout this paper, we aimed to demonstrate how egg donors are enacted in clinical practices as multiple bodies. In the first part, we outlined that the preference for what is considered a ‘responsible donor’ entails a normalized understanding of what a responsible person actually is (socially adapted, enrolled in wage labor and with long-term relationships). We then argued that as biographical subjects, donors are seen to have agency that could interfere with the donation procedure. Therefore, they are tamed throughout the donation process with different techniques, such as fast-track procedures toward donation, different coercion strategies with the economic compensation, and further control through WhatsApp and medication.

In the second part, we looked into the enacting of donors as body objects, i.e. extractable value-generating bodies. The most important features for the selection of these bodies are that they are in “good psychophysical health” and that they “do not suffer from genetic or infectious hereditary diseases transmissible to the offspring” (Spanish law on assisted reproduction 2006, chapter II, article 5). As we demonstrated, psychologists try to figure out if donors’ *undesirable features* have genetic or social foundations, and thus if there is a risk of hereditary transmission. This quest of differentiating

²⁵Talking about the point of view of egg donors in relation to clinics’ rules is an important issue that, unfortunately, we do not have the space to elaborate in depth in this article. Nevertheless, we feel that it is important to fully acknowledge the possibility of resistance and contestation of donors, and we plan to develop this further in other work.

²⁶Hecha la ley, hecha la trampa.

genetic from social grounds is marked by uncertainty and leads to a flexible (and stratified) implementation of the aforementioned principle stated in the Spanish law. Therefore, again, the body object is tamed to achieve a successful cycle, a process that is done through medication and various medical encounters between doctors and donors. We proposed to see these communications as privileged conversations between the doctor and the body object that are not translated to the biographical subject, leaving donors alienated from the process.

We contend, therefore, that the ontological making of what Mol called “multiple bodies” in clinical practices is a required operation for successfully extracting the surplus value that egg donors generate as “clinical labourers” (Cooper and Waldby 2014; Waldby and Cooper 2008). Egg donor’s bodies, however, are not conceptualized as lifeless matter, but more as having the ability to resist and contest. Taming techniques, therefore, allow the clinic to manage the multiple body ontologies which operate under different logics and require different methods of contention.

Delineating the making of donors in clinical practice meant following our subjects while they were being “enacted in practice” (Mol 2002, 152). The aim in showing this strategical enactment of donors as biographical subjects and body objects used by clinics in order to transform “human eggs and embryos into capital” (Ikemoto 2009, 767) was to dismantle the specific “politics of what” (Mol 2002) that are at stake in the practices of fertility clinics in Spain. As we pointed out, the clinical practices and technologies used in the donor selection process “depend on social matters: practicalities, contingencies, power plays, [and] traditions” (Mol 2002, 171). Rather than relying on “objective criteria,” clinical practices stabilize blurry ideas of what the reproducible subject should be while at the same time reproducing normative assumptions about class, race and bio-value more broadly.

Our findings highlight that the selection and management of clinical laborers in the context of egg donation in Spain is accomplished through power and control mechanisms that alienate women from the product value of their labor and leave them in a position of vulnerability when the process does not work as expected. While donors indeed have the ability to contest and resist, the discussed clinical control mechanisms are designed to limit donor’s scope of action. As we argue, egg donation as a technology that is based on the “transference of reproductive capacities” (Lafuente-Funes 2019) brings with it a dilemma: The *right* to have a child for some is based on unequal systems of exchange, leading to reproductive injustice for others. We therefore think that it is necessary to address egg donation “among an array of social justice concerns” (Luna and Luker 2013, 343) and to critically analyze the “reproductive oppressions” (Ross 2006, 14) that are played out in those complex reproductive arrangements.

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